

SPECIAL PAPER

The Place of Private Health Insurance in Cyprus and its Prospects

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Abstract

The aim of this study is to investigate the future and the place of private health insurance in Cyprus. Even though this phenomenon has only recently appeared in Cyprus, it seems that up to now, and based on the current health system, it has not achieved to convince the public for its necessity. It is believed that by now, the right conditions have been created in Cyprus in order for this product to enjoy the market share it deserves.

It is estimated that the PHI will receive the part of the market share that amounts to them by having the place of a mainly supplementary health care insurance, especially after the application of the National Health System.

Key words: Health Insurance, Private Health Insurance

Introduction

It is commonly acknowledged that health and social security systems in general, in most developed countries, face significant financial problems.

The main causes are demographic ageing, the increased demand for health services and the technological revolution in the field of health. (Liaropoulos 1993)

The impoverishment citizens have to face in the recent years as well as the cuts in the spending on the health system will force in the near future an all-the more increasing number of people to ask for health care coverage in private health insurance schemes. The waiting queues, the deficiency in basic pharmaceutical products will

constitute this need for Cypriots even more urgent.

The aim of this study is to investigate the future and the place of private health insurance in Cyprus. Even though this phenomenon has only recently appeared in Cyprus, it seems that up to now, and based on the current health system, it has not achieved to convince the public for its necessity. It is believed that by now, the right conditions have been created in Cyprus in order for this product to enjoy the market share it deserves.

A disease is almost always inextricably linked to financial problems, even in the cases when high levels of care are provided for completely free. Financial problems can arise by the loss of income or the reversal of

personal plans and prospects (Liaropoulos 1993).

Definition of Private Health Insurance

Private insurance is a form of a social insurance system with a view to protecting the person from the repercussions of the disease (as this is defined by the World Health Organisation), accidents and in some cases of motherhood. Additionally it constitutes a system of personal initiative that aims to extend the cost recovery of health services. In most cases it acts as a complimentary institution to public health insurance by covering for its shortages (Souliotis 2006).

Health Insurance provides the person with the capacity to use health services and at the same time it pays up for his income loss due to his/her absence from work. The person that wishes to be insured seeks for a carrier i.e. for a private insurance company that takes up the role of "rectifying the damages" (financial loss) from random incidents that have already been agreed. It is worth noting here that the conditions and provisions of the agreement are different for every insured person. Insurance is based on the creation of a personal and particular contract that sets: the object to be insured, the amount of compensation and the premium i.e. the amount that the insured person is called to pay top the company in order to ensure his/her coverage. This amount ranges depending on the extent of the assumed danger.

What is insurable

In order for something to be insurable, some preconditions need to be met. Most importantly, it is salient to make sure that the damage or loss to be incurred can be measured in money and under normal conditions there should be a rationally great number of similar dangers to be insured against. Additionally, one has to consider the insurable interest of the insured person with regards to the insured object. One can only insure an object if a loss of or damage of the object will cause him a financial loss. It is also significant that the damage or loss must have occurred by chance as far as the insured person is concerned whilst insurance cannot go against public interest. Finally, in order

for one to insure against a danger then this danger needs to be simple and not to include any aspect of interest for the insured person (Christophides 1998).

The notion of insurance danger

It is a plain fact that the danger of losing one's health is unpredictable. This is what drives in the person the urgent need to feel safe against the danger that might threaten him/her. This safety consists of the certainty that the required health services will be available both in quantity as well as in quality at the right time (Liaropoulos 1993). Private Health Insurance predicts the possibility of a damage to be incurred based on laws of probability and statistics. The possibility that a person develops a disease against which he is protected, is considered an uncertainty while as the time passes, the possibility to contract this disease increases in such a rate that makes it a certainty. In other words, it is dangerous. In the following lines an attempt to clarify the notion of insurance risk will be made. The concept of danger comprises the possibility of damage, the idea of uncertainty with regards to the occurrence of the damage and the issue of the significance of the damage. It is distinguished by its possibility and frequency of occurrence. It also depends on age, sex, health conditions, way of life, conditions of life etc. In theory, any danger could be insured. Nevertheless, in order to insure a particular danger, it needs to be defined by the following characteristics: (Roupas 2006).

- The danger to be common for a wide number of people
- The danger to be clearly defined from the beginning
- The danger should be unexpected and unpredictable
- The danger should not be conspicuous
- The danger should not be unimportant
- The danger presupposes that the damage to be incurred can be measured
- The cost of the insured risk should be allowable

- The danger should create insurance interest.
- The insured danger should not go against social models and the principles that dominate a society.

Private Health Insurance Principles

The health insurance system is an efficient one. The current contributions are redistributed, most of the times immediately, in order to ensure health provisions and in contrast to social insurance, it has a distinct investment character (Giannitsis, 2007).

It is also defined by the following characteristics:

- It constitutes a personal choice and it is a personal obligation of the contracting-insured person.
- It is most often a complimentary insurance.
- It is optional
- There is a free contract between the insured person and the company that constructs the insurance policy.
- The contracts are governed by commercial laws
- The contributions correspond to each contracting party.
- They are profit-making.
- The benefits are personal and their scale depends on the height of the bestowed contributions.
- It is provided by private enterprises.
- There is no public funding in case of deficit when financial loss is faced (Giannitsis, 2007).

The need for private insurance

Despite the attempts undergone in the recent years for the development of a health system based on the principles of a welfare state, health expenditure in Cyprus still falls below the average of the other members of the European Union as the bibliography shows. It is calculated that 5.8% of GDP is spent with the biggest share to regard private insurance (INSURANCE IN CYPRUS, 2009). The need for the development of private insurance in the field of health is

derived when the coverage of the consumption of goods and health services from the public domain does not satisfy the insured people and so they are forced to seek for services from the private field. This deficiency regards both the extent of the offered benefits as well as their quality. The person is then addressed to organised enterprises and insurance institutions that can deliver to him complimentary or full coverage. It also seems that private funding agencies contribute more to the pharmaceutical expenditure. According to the bibliography, the reasons that drive one to seek for coverage from a private insurance company are the following: (Liaropoulos 1993)

- The quality of the services offered by the public health insurance
- The free choice of a doctor
- The free choice of a hospital or a diagnostic centre
- The choice of food
- The choice of a hotel level care
- The choice of visiting hours
- The choice of the time of the acquisition of health services

Forms of private insurance

Personal insurance

Personal forms of private insurance are provided to a limited number of people who are subscribed to the various trade unions or the various private insurance companies. The services that personal private insurance delivers are the coverage of expenses in the case of hospitalisation while they also provide other benefits outside the hospitals and other targeted allowances for their insured clients (Roupas 2006).

Group Insurance

Group private insurances are implemented on a level of companies, institutions, families, clubs and other organised sets. They cover all the members of a team based on a collective treaty and irrespectively of the private case of each member (Roupas 2006). Group health insurances are mostly delivered by private health insurance agencies and they provide health services for

the members of the “team.” These services essentially cover for hospitalisation expenses in private clinics, for various diagnostic tests and operations.

Bancassurance

Banking institutions and private insurance companies have many things in common as they both constitute enterprises that attempt to promote the products they offer. These similarities essentially allow for joint production. The term Bancassurance derives from the collaboration of the two enterprises with a view to distribute in the market life insurance products from the bank branch stores or investment products from a company’s sales network. (Roupas 2006).

Private Insurance in Cyprus

The development of insurance companies in Cyprus begins in the 1980s. Nevertheless, according to the Organisation for Economic Co-operation and Development the engagement of private insurance in the field of health is limited due to the lack of tax incentives. Most companies that provide health insurance do it mostly in order to complete other insurance contracts. As a result, the products offered for health in their packages are most of the time simple and plain. As the medical cost increases, the demand for a complete coverage increases respectively. Based on the annual report of the Insurance Association of Cyprus for 2009 there are a total of 34 registered insurance companies. Eight of this work solely on life insurance and three with life and non-life insurance. As Elpida Constantinou notes, there are other insurance companies of foreign interests that are solely active in the field of health, but as they are not registered in the association and so is no official data on them (INSURANCE IN CYPRUS, 2009).

In the category of private insurance one finds the various Health Care Funds that were created by trade unions in order to cover for the health care needs of their insured members. These have a semi-government status and all the members of the trade union, including those dependent on them, are entitled to them. The members are obliged to pay their subscription to the association and their donation to the Funds. They are also

bound to conform to the current rules and decisions of the Managing committee.

The agencies of private insurance in Cyprus are:

1. SEK (Cypriot Workers Confederation)
2. PEO (Pancyprian Labour Association)
3. DEOK (Democratic Labour Association Cyprus)
4. PACYDY (Pancyprian Association of Public Officers)
5. ETYK (Association of Bank Employees)
6. OELMEK (Association of Secondary Teachers Cyprus)
7. POAS (Pancyprian Association of Independent Trade Unions)
8. Private insurance agencies (i.e. TRUST, ΚΟΣΜΟΣ, Eurolife, Universal Life etc).

Exceptions – Diversifications

Private health insurances, in contrast to social insurance they do not cover the danger from certain diseases that are eligible, long-lasting or particularly costly i.e. pre-existent illnesses, optometric care, AIDS, dental care, chronic diseases, alcohol abuse, drugs, geriatric care, beauty surgery, psychotherapy, psychiatric care (Liaropoulos 1993).

In order for private insurance companies to maintain their premiums at an attractive level, they have come up with certain diversifications in their contracts as it for example happens in the contracts with limited use reductions. In this case, the company offers a reduction to those insured who rarely use their right to compensation. These diversifications also exist in the form of contracts with limited cover where a case is covered only when for several months, waiting lists exist in the public sector, or contracts with the participation of the insured person where a small amount burdens the insured person either as a percentage or an initial amount. These diversifications also take place in the case of contracts based on

the use of conventional beds or medical services when the insurance companies make sure they buy beds of medical services at a lower cost (Liaropoulos 1993).

The future of private insurance

It is admittedly a fact that Cyprus is lacking in a comprehensive health system and this creates a sense of dissatisfaction for the present situation. The need for reform is blatantly obvious and what is most crucial is the funding capital that has a key role in the development of a health system (Adamakidou, & Kalokairinou-Anagnostopoulou, 2009). According to the bibliography, the most efficient way to manage and distribute funds is by creating a carrier through which universal coverage will be given. This is the case of a health system type Bismark. (Charalampous & Socratous, 2009).

In 2001 the Cypriot Parliament voted on a law that calls for the introduction of a National Health System and is now on the verge of being implemented. In the case of introducing such a system, the whole Cypriot population will be placed under its umbrella irrespective of any financial criteria. Under these conditions one would expect the need for private insurance to be severely undermined. (The 2001 law on the National Health System (N.89(I)/2001)).

For the time being, the developments in the financial front are constantly changing while globalisation has spread significantly and it touches upon the various parameters related with the way health services are funded and offered to the public. At the same time, one notes a gradual preference in neo-liberal principles and policies and such a context sets the ground for the strengthening of private insurance's place in Cyprus (Charalampous & Tsitsi, 2010).

According to the Insurance Association of Cyprus, Casualty and Health Insurance policies represent in 2011 an estimated 21.7% of the total amount of non-life insurances.

Data on the premiums offered by insurance policies on Casualty and Health indicates that even though the rate of development has dropped to 6.3% in 2011 (7% in 2010), the

total amount of registered mixed premiums (excluding policy fees), has rapidly increased and has reached 101,8 million Euros in 2011. This is contrasted to 95,8 million Euros in 2010 and 89,5 million Euros in 2009. The growth in this field has been caused by the continuous consumer preference for a service from the private field due to the aggravation of the problems faced by the public sector (INSURANCE IN CYPRUS, 2011).

Key financial indicators on casualty and health insurances in Cyprus 2011.

One can find below the financial indications of the insurance industry in Cyprus in the casualty and health domain in the years 2010-2011. The indicators signify the demands, supplies and expenses as a premium index. The combined ratio is simply a combination of three previous indicators (demand, expenses and supplies). These indicators can be used by various companies at a given time or by an enterprise in the course of a number of years with a view to comparing performance and to track any trends towards better or worse as well as to trace any problematic areas that require more attention from the management. The lower these indicators are, the better. If there are lower demands or expenses in relation to premiums, then there is a greater profit (Korner, 1994).

Claims ratio is the difference between the ratios of premiums paid to an insurance company and the claims settled by the company. Loss ratio is the total losses that are paid by an insurance company in the form of claims.

The losses are added to adjustment expenses and then divided by total earned premiums. As Investopedia explains "loss ratio" varies depending on the type of insurance. For instance, for health insurance, the loss ratio tends to be higher than for property and casualty such as car insurance. This indicates how well an insurance company is doing. This ratio reflects if companies are collecting premiums higher than the amount paid in claims or if it is not collecting enough premiums to cover claims. Companies that have high loss claims may be experiencing financial trouble.

Graph 1: Facts on premiums of Casualty and Health insurance policies.



Source: INSURANCE IN CYPRUS, 2011, (used with permissions from the authors)

Graph 2: INSURANCE IN CYPRUS, 2011* (used with permissions from the authors)

CLAIMS RATIO (GROSS)
(GROSS INCURRED CLAIMS)/
(GROSS PREMIUMS EARNED)

CLASS	2010	2011
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Accident & Health	65.0%	68.6%
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CLAIMS RATIO (NET)
(NET INCURRED CLAIMS)/
(NET PREMIUMS EARNED)

CLASS	2010	2011
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Accident & Health	69.2%	69.7%
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GROSS EXPENSE RATIO
(OPERATING EXPENSES)/
(GROSS PREMIUMS EARNED)

CLASS	2010	2011
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Accident & Health	6.6%	6.8%
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NET EXPENSE RATIO
(OPERATING EXPENSES)/
(NET PREMIUMS EARNED)

CLASS	2010	2011
-------	------	------

Accident & Health	9.3%	9.5%
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GROSS ACQUISITION COST RATIO
((COMMISSION+ACQUISITION COSTS)/
(GROSS PREMIUMS EARNED)

CLASS	2010	2011
-------	------	------

Accident & Health	16.1%	15.8%
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NET ACQUISITION COST RATIO
((COMMISSION+ACQUISITION COSTS) -
(REINSURANCE COMMISSION&PROFIT PARTICIPATION))
/(NET PREMIUMS EARNED)

CLASS	2010	2011
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Accident & Health	13.3%	12.8%
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GROSS COMBINED RATIO(GROSS CLAIMS RATIO+GROSS EXPENSE RATIO+
(GROSS ACQUISITION COST RATIO)

CLASS	2010	2011
Accident & Health	87.7%	91.2%

NET COMBINED RATIO(NET CLAIMS RATIO+NET EXPENSE RATIO+
(NET ACQUISITION COST RATIO)

CLASS	2010	2011
Accident & Health	91.8%	92.0%

RETENTION RATIO (NET PREMIUMS WRITTEN/ GROSS PREMIUMS WRITTEN)

CLASS	2010	2011
Accident & Health	70.9%	72.0%

Source: INSURANCE IN CYPRUS, 2011 (used with permissions from the authors)

*The above graphs do not include health insurance policies that are associated with life insurance.

Investopedia also explains that **expense ratio** represents the ratio between underwriting expenses (fee paid agents, state and municipal taxes, provisions to employees and other operating expenses) and premiums earned expressed as a percentage. The indicator is calculated by dividing underwriting expenses with the premiums earned. The expenses indicators are usually low when concerning health insurance.

Additionally, Investopedia notes that the definition of **acquisition cost ratio** that is most often used in the insurance domain, occurs when a company calculates the sales costs that are associated with the acquisition of a new client in the course of an insurance policy. Most of these sales expenses result from the commission paid to external contributors and agents

Combined Ratio is a measure of profitability used by an insurance company to indicate how well it is performing in its daily operations. A ratio below 100% shows that the company is making underwriting profit while a ratio above 100% means that it is paying out more money in claims than it is receiving from premiums.

The combined ratio is comprised of the claims ratio and the expense ratio. The claims ratio is claims owed as a percentage of revenue earned from premiums. The expense ratio is operating costs as a percentage of revenue earned from premiums. The combined ratio is calculated by taking the sum of incurred losses and expenses and then dividing them by earned premium.

Investopedia explains that in the case of combined ratio, even if it is above 100%, a company can potentially still make a profit, as the ratio does not include the income received from investments. In actual fact, many insurance companies believe that this is the best way to measure the success of a company because it does not include investment income and therefore only includes profit that is earned through efficient management.

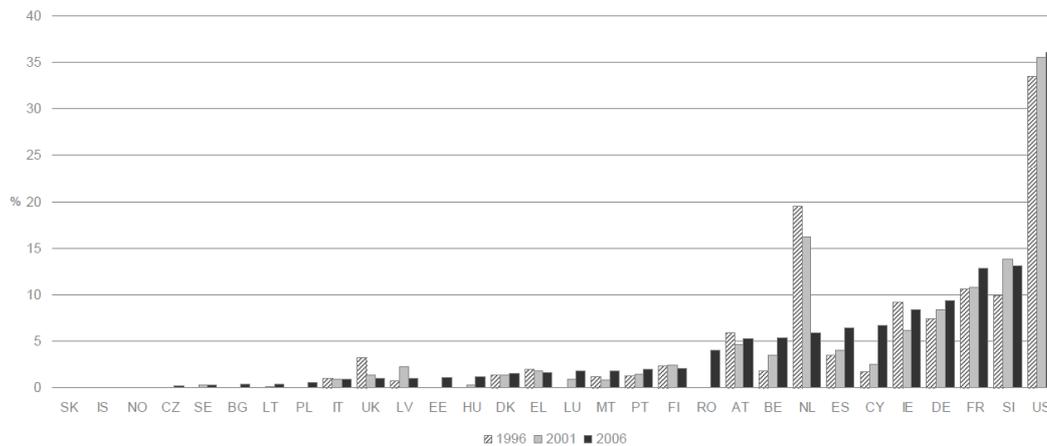
Investopedia defines **retention ratio** as the percent of earnings credited to retained earnings. In other words, the proportion of net income that is not paid out as dividends.

According to a study conducted by Sarah Thomson και Elias Mossialos,(2009), the figures presented below (Graphs 1.10.2,- 4) describe the situation for private hospital insurances. It is plain that health coverage is still in an embryonic state when compared to

other European countries and one can conclude that there is a wide spectrum for improvement. Another key factor that can influence the sector’s development is the tax-exempt status that health insurances enjoy.

Graph 3: Spending through PHI as proportion of total health spending 1996-2006

Figure 4 Spending through PHI as a proportion of total health spending, 1996-2006 (%)

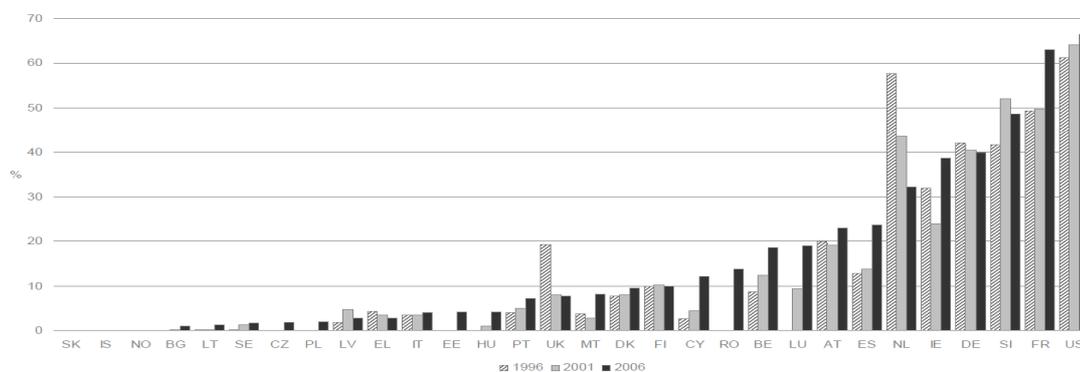


Source: WHO (2009)
 Note: Values for Slovakia, Iceland and Norway are equal to zero in all three years.

Source: Sarah Thomson και Elias Mossialos,(2009) (used with permissions from the authors)

Graph 4: Spending through PHI as a proportion of private health spending 1996-2006 (%)

Figure 5 Spending through PHI as a proportion of private health spending, 1996-2006 (%)

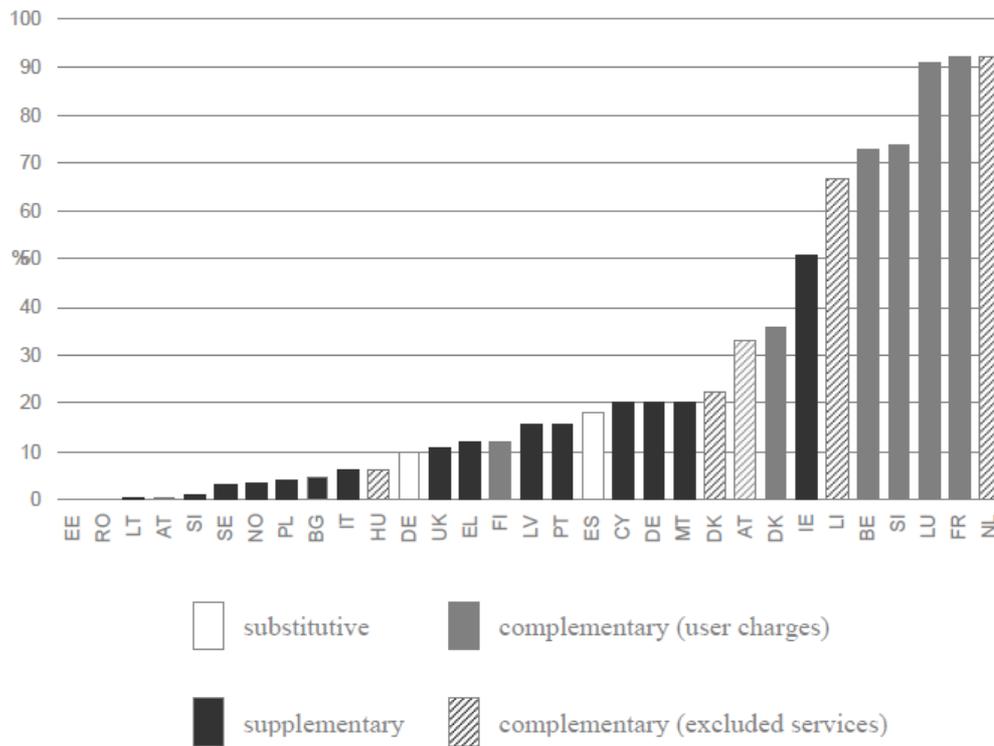


Source: WHO (2009)
 Note: Values for Slovakia, Iceland and Norway are equal to zero in all three years.

Source: Sarah Thomson και Elias Mossialos,(2009) (used with permissions from the authors)

Graph 5: Proportion of the population covered by PHI 2008(%)

Figure 6 Proportion of the population covered by PHI, 2008 (%)



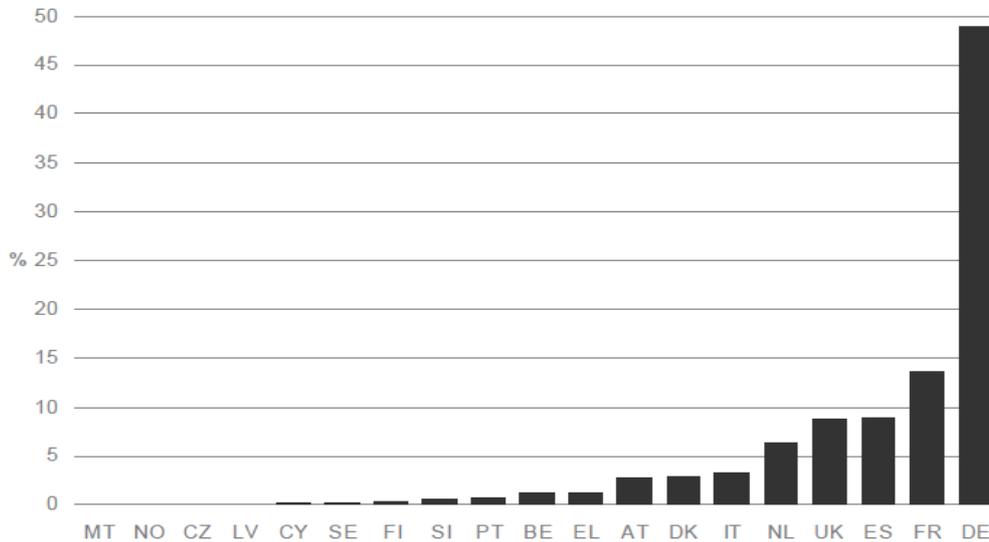
Source: Authors' estimates based on country reports
 Note: The figures are for different years for Finland (2005), Greece (2002), Latvia (2003), Norway (2007), Slovenia (2005) and Sweden (2007); values for Estonia, Romania and Lithuania are greater than zero but less than 0.5%.

Source: Sarah Thomson και Elias Mossialos, (2009) (used with permissions from the authors)

PHI (Private Health Insurance) (Graph 1.10.5.) has the role of a substitute in National Health System. When this System is implemented though, PHI will acquire a more complimentary role.

Graph 6: PHI premium income by country as a percentage of total EU PHI premium income 2006(%)

Figure 7 PHI premium income by country as a percentage of total EU PHI premium income (selected countries only), 2006 (%)



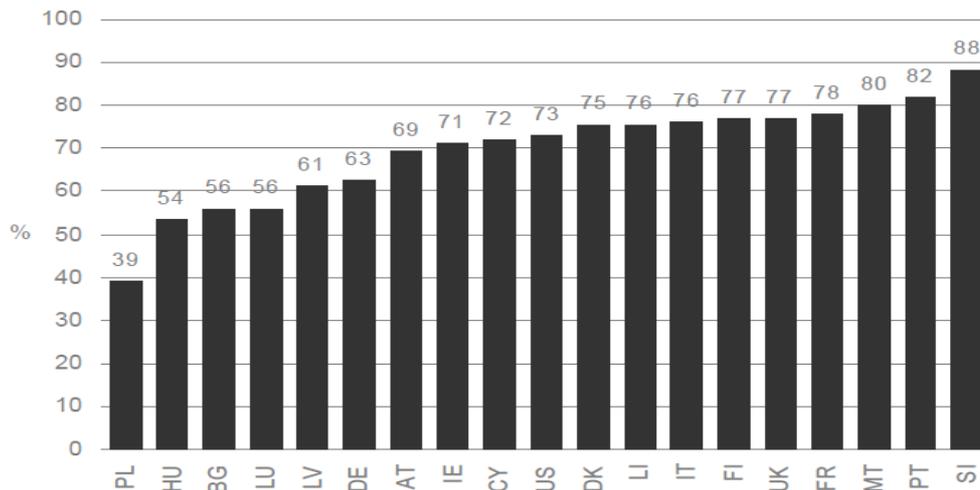
Source: CEA (2008)

Note: Values for Malta, Norway, the Czech Republic and Latvia are greater than zero but less than 1%.

Source: Sarah Thomson & Elias Mossialos, (2009) (used with permissions from the authors)

Graph 7: PHI average claims ratios 2006 (%)

Figure 10 PHI average claims ratios, 2006 (%)



Notes: Slovenia: this is for the complementary market covering statutory user charges only; Ireland: this is the unweighted average calculated from the claims ratios of the major insurers (BUPA Ireland: 75%, VIVAS Health: 41%, Vhi Healthcare: 97%); Liechtenstein: the figure is for non-profit insurers only; Luxembourg: the figure is for commercial insurers only; US: the most common estimate of medical-loss ratio for US PHI is 73%; for Medicare and Medicaid, estimates say that the proportion of money in the 'pool' going to health care is 96-97%.

Source: Sarah Thomson & Elias Mossialos, (2009) (used with permissions from the authors)

Taking into consideration the above graph one can conclude that there is a wide spectrum of profit for health insurances as well as an extended field of improvement.

PHI often undermine the targets of public health policy in the market (which can be different from the objectives of the public policy for the market). This is mostly the case regarding financial protection, equality in funding and the fair access to health care. However, this is most often a matter of public policy. On the contrary, PHI contribute to the financial protection of the wider health system. This explains the great extent of government intervention in the markets.

With regards to the impact on health policy targets on the extended health system, PHI results are key players in the provision of financial protections to subscribers. At the same time though, the existence of PHI undermines other health policy targets even when the market regulates itself cautiously. For instance, in Germany they have allowed people earning a higher income to choose between public and private coverage. This was a detrimental move as the state's funds are severely hit. This is because the state not only loses the contributions of high earners but it is also called to cover for the high-risk group of people

The use of tax allowances for subsidising PHI also reduces the market shares as people raise resources from public health care funding in order to be privately insured.

All in all, the argument that PHI will contribute to a state's financial sustainability by releasing pressure off the public budget cannot be concretely based on the evidence. It is absolutely salient for those responsible to appreciate the necessity for a new policy route regarding the advantages and disadvantages of promoting the development of PHI (Thomson & Mossialos, 2009).

The factors that influence buying of private health insurance

It is well proven that the per capita health expenditure on a national level are inextricably linked with the per capital gross domestic product. This link is omnipresent in the case of private health insurance that has a

purely complimentary character and can be considered a "luxury good" (Liaropoulos L. 1993).

There are also indications that public health spending is associated with expenditure on private insurance. It is furthermore possible that the efficiency of public health services in the way they deal with the needs of the public is linked to the spending on private insurance.

Additionally, the extent of social protection that is expressed through the GDP percentage distributed for pension schemes, is another influential factor that drives people to seek private health insurance (Liaropoulos 1993).

Retirement age and unemployment is also directly related with the security feeling that dominates. All these directly influence the income as well as the expenditure of social insurance (Liaropoulos 1993).

How the current financial condition of Cyprus took shape following the 15th March, what the Memorandum provides for the health sector and the possible repercussions.

In general, one can conclude that the Memorandum of Understanding on Specific Economic Policy Conditionality includes a programme of economic adjustment that will address the short- and medium-term financial, fiscal and structural challenges that Cyprus faces. However, is it as simple as it appears to be?

The main goals of the programme are:

To restore the soundness of the Cypriot banking sector and to regain the trust of the depositors and of the market by thoroughly restructuring, and downsizing financial institutions, strengthening of supervision and by addressing the expected capital shortfall, according to the political deal that was reached by the Eurogroup on the 25th May 2013 (Memorandum of Understanding on Specific Economic Policy Conditionality) (<http://www.scribd.com/doc/138159788>).

To continue the on-going process of fiscal consolidation in order to correct the excessive general government deficit, as quickly as possible, in particular through measures to reduce current primary

expenditure. Also, to maintain fiscal consolidation in the medium-term, in particular through measures to increase the efficiency of public spending within a medium-term budgetary framework and to enhance revenue collection and improve the functioning of the public sector. (Memorandum of Understanding on Specific Economic Policy Conditionality) (<http://www.scribd.com/doc/138159788>).

To implement structural reforms in order to support competitiveness and sustainable and balanced growth, allowing for the unwinding of macroeconomic imbalances, in particular by reforming the wage indexation system and removing obstacles to the smooth functioning of services markets.

More precisely, with regards to the domain of health and health care expenditure, the Cypriot Government has pledged the following: (Memorandum of Understanding on Specific Economic Policy Conditionality) (<http://www.scribd.com/doc/138159788>).

In order to strengthen the sustainability of the funding structure and the efficiency of public healthcare provision, the following steps should be followed before the first financial aid disbursement (Memorandum of Understanding on Specific Economic Policy Conditionality) (<http://www.scribd.com/doc/138159788>).

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

ii) As a first step for a system of universal coverage, introduce a mandatory contribution in health care for public officers and retired public employees. The contribution should reach 1.5% on gross wages and pensions. The measure will be examined by the second quarter of 2014 with the other members of the programme. For families with three or more dependent children, participation in this health care measure will be voluntary.

iii) Increase fees for medical services for non-beneficiaries by 30% in order 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 increasing fees for using higher levels of care for all patients irrespective of age.

iv) Introduce effective financial disincentives for using emergency care services in non-urgent situations.

v) Introduce financial disincentives (co-payment) to minimise the provision of medically unnecessary laboratory test and pharmaceuticals.

vi) The council of ministers should adopt a new decision regarding the restructuring plan for public hospitals. This plan will improve quality, and optimise costs while redesigning the organisational structure of the hospital management, by putting into practice recommendations from the 2009 "Public Hospital Roadmap."

vii) 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 that takes into account possible proposals for implementing NHS in stages.

Additionally, the other partners in the programme will first examine and then negotiate with Cyprus on the application of the following measures: (Memorandum of Understanding on Specific Economic Policy Conditionality) (<http://www.scribd.com/doc/138159788>).

viii) Make the award of the tender for the IT-infrastructure conditional upon the results of the study and the decision for implementing NHS.

ix) Reconsider the income limits for entitlement to free public health care, in comparison with the eligibility criteria for social assistance. At the same time, it will be ensured that co-payment will be implemented for public health care in order to effectively protect people and homes from disastrous health expenditure. (Q4-2013).

x) Create protocols for laboratory tests and the prescription of pharmaceuticals based on thorough scientific evidence.

xi) 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].

xii) Conduct an assessment of the basket of the top 4 publicly reimbursable healthcare products in terms of annual spending to increase 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 [Q2-2013].

xiii) To 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 (Q3-2013).

xiv) In a first step, establish non-stop 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 [Q1-2014]

xv) To define a basket of publicly reimbursable medical services based on objective, verifiable criteria including on cost-effectiveness criteria [Q2-2013].

Additionally, the Cypriot government will inspect the possibility for the establishment of a system of family doctors that will determine access to further levels of care. (Memorandum of Understanding on Specific

Economic Policy Conditionality) (<http://www.scribd.com/doc/138159788>).

On the one hand, one might argue that at least with regards to health care, the memorandum sets clear time schedules for applying related measures in order to finally move on to the application of the National Health System based on a rational and not wasteful management. On the other hand, the memorandum calls for the pricing of several services offered to citizens at a time when their financial state has been severely deteriorated.

Let us move on to take a more precise look into what changes, what is abolished and which groups lose privileges and those that can still benefit from free medical care at public hospitals. Minister of Health Mr. Petrides, issued a statement on the 4th April, regarding the conclusion of negotiations with the Troika and everything that was achieved throughout. After these statements, the Ministry's spokesman, Pamos Charilaou, was called to further enlighten the public on this issue in a radio programme hosted by Katerina Eliades at Super Sport Fm Radio Station. According to Mr. Charilaou, the following changes have been noted:

Criteria for fee reduction. Certain criteria need to be met in order for anyone to be able to claim a reduction in the fees needed for accommodation in public hospitals. Firstly, one needs to be a Cypriot or European citizen who lives permanently in Cyprus. Furthermore, he must have paid his/her contribution for at least three consecutive years. Finally, he must have completed his obligations as they fall under the law regarding tax collection 1978-2013.

Criteria for free care. According to the Ministry's spokesman, free medical care falls under certain financial criteria. One can benefit from free health care if his annual income is not greater than 15400 Euros. The same goes for a couple whose annual income does not exceed 30750 Euros while for every dependent child a further 1700 Euros are added.

Beneficiaries. As it has been mentioned by Mr. Charilaou, the process of applying for free medical care will be gradual, as the application of the measures will only start on

the 1st June. However, the process is still the same and the citizens entitled to free medical care should take along all the attestations for which the law has provided until today (social insurance, tax returns, incomes, etc.)

Abolishment of Beneficiaries Class “B”. The abolishment of the category of Beneficiaries class “B” is a significant amendment in the field of public health care as this category was until recently only paying half of health care cost. “Today, this category of people is abolished. The number of people belonging to this category is estimated around 17000”, Mr. Charilaou stated.

The loss of privileges by public officers. Following the spirit of reform, the right to free care in public hospitals is repealed for those government officials and public officers whose previous entitlement was based on their status rather than on financial criteria. From the 1st June they are called to pay 1.5% on their monthly income. This amount will be deducted by the Treasury of the Republic while the equivalent amount will be deducted from the professional pension of retired government employees. It is important to mention that in the case of a couple of two public officers, then they are both called to pay the 1.5% fee.

The Turkish Cypriots, lose the excessive privileges they previously enjoyed and are from there on treated in a similar manner to the rest of the public.

Exceptions. However, the modifications do not touch upon semi-public institutions and institutions who have agreed a particular deal with the Ministry of Health. Regarding the hourly government staff, they will be deducted a 1.2% from their monthly income, as has been the case for a number of years.

Voluntary contribution for a family with three children or more. Even though insurance is mandatory for public officers, families with three children or more can voluntarily participate in the 1.5% fee system on their income. “Families with three children or more are vulnerable and sensitive groups of people and following intense negotiations with the Troika, the Ministry of Health has achieved to include them in a plan

of voluntary contribution,” Mr. Charilaou further stated.

Patients suffering from chronic diseases. These patients fall in three categories. On a first basis, one finds the people who, regardless of their income, are entitled to free health care in public hospitals. In the second category fall the patients with specific diseases who are entitled to free health care if their annual income is less than 50.000 Euros. Finally, the third category comprises patients who are entitled to a number of free services (medical care, pharmaceuticals and laboratory tests for the particular disease), if their annual income does not exceed 15000 euros.

Fee Introduction. The changes in the field of public health presuppose the introduction of fees in medical care for those entitled to it. More specifically, for the general practitioner the fee is three euros, for the specialised doctor the fee is six euros and half a euro for every prescription drug and for every laboratory test. For Emergency Services the fee is 10 euros while the only ones excluded from this fee are those entitled to public assistance.

Maximum payment policy. The flexible policy is not influenced by amendments in the public health domain. The term “maximum payment” is introduced in order to help the citizens –non-beneficiaries, who based on their income they cannot pay the required cost for their hospitalisation. “There is a category of patients, the non-beneficiaries, who are entitled to come to the public hospitals, enjoy the services there but are obliged to pay for them. In order for this measure not to be detrimental for a family’s budget, we have achieved, following a strong battle against the Troika to introduce the notion of “maximum payment.” In this way, a non-beneficiary who will receive health care within the hospital will not be asked to pay for the whole price, but based on his income, he will be asked for a maximum amount that will be valid for a whole year. This goes regardless of the fact that he might need a second round of hospitalisation in that same year.

However, government intentions regarding the instant implementation of the NHS are

clear. More precisely, in a press Conference on the National Health Day, Mr. Petrides said that with regards to the National Health System, what Troika asked for “is the updated actuarial study for the implementation of the NHS and we are therefore on hold,” as the new financial circumstances need to be taken into consideration. The Health Minister noted though that « I will not try to court the public as the full implementation of the National Health System does not seem to be feasible at the moment and based on the financial state of the country today.”

Advantages of the National Health System

The urgent need for the completion of the National Health System is dictated by the plethora of advantages to the entitled patients in the public and private domain and their carriers. The entitled patients gain easy access to all the service providers in the private and public field even after their collaboration. After the abolishment of the waiting list instant patient service is achieved, while the patients are enjoying an upgraded service quality thanks to their correct allocation to the various carriers.

In the public field one achieves to decongest doctors' offices and hospitals since the patients are directed to competing providers. In this way, the pressure eases on government doctors and medical institutions with a view to the better and more efficient service and to the satisfaction of prospective clients.

Additionally, in the private sector one notes a more correct exploitation of the existing resources while the per capita cost is reduced with the inflow of patients. Its sustainability is hence ensured.

In general, with the application of the National Health System at the same cost, i.e. by having the same total spending on health care, all the above mentioned advantages are attained. Another advantage could be the fact that the cost's rate of increase will remain constant at lower levels, similar to that of other European countries.

Conditions for the Implementation of the National Health System

In order for the plan to be introduced the following conditions need to be met.

- The elimination of the existing health funds after the full application of the health system plan, the granting of rights to all those employed in the public health nursing service.
- There is a need for the creation of intensive integrated educational courses for private doctors.
- Public hospitals will be independent and autonomous and based on the modern management and cost accounting principles, without government subsidies and they will be in a position to compete against all health care providers.
- Finally, regarding the psychiatric, dental care and public health care services not covered by the General Health Care System, they will continue to be under state auspices. (Matsis 2008).

Conclusions

It is clear that the Cypriot private health insurance industry is still in an embryonic state with regards to health coverage. In particular, when one compares it to other European countries, he/she can conclude that there is a wide area for improvement. A significant factor that might influence the development of this field is the tax-exempt status that exists for health care insurance. On the other hand, it is predicted that with the application of the last memorandum measures on healthcare, the gates have been wide opened for the development of PHI. These measures call for the reduction of healthcare spending and are set to prepare the ground for the introduction of the National Health System. In this way, many previously privileged groups like civil servants and the semi-government sector employees are eager to cover the possibly new health care needs through the PHI. Finally, it is estimated that the PHI will receive the part of the market share that

amounts to them by having the place of a mainly supplementary health care insurance, especially after the application of the National Health System. When this occurs, things will be clearer and the public will get to understand the extent of health coverage provided by the National Health System.

References

- Adamakidou, Th. Kalokairinou-Anagnostopoulou, A. (2009) The financing methods of hospital and primary health care in Greece. *Nosileftiki* 48(1):37-49
- Charalampous, A., Socratous, S. (2009). Descriptive Analysis of the Cypriot National Health System based on the main principles of the Welfare State. *Nosileftiki*, (48(2), pp.136-142.
- Charalampous, A., Tsitsi, Th. (2010) The impact of globalisation on the field of health and the development of supernational buffer frame. *Archives of Greek Medicine*. 27(1):106-112
- Charilaou Pamos, spokesperson of the Ministry of Health in radio show hosted by Katerina Eliades at radio station Super Sport FM., 15/04/2013
- Christophides Yiannakis (1998), basic data on insurance, Edition iv, Insurance Institution of Cyprus, pp. 6-10.
- Giannitsis, T. (2007) The issue of insurance (that lacks policy) and a solution. Edition Polis, Athens.
- Government Newspaper (2001) Law No. 3497 “ Law that calls for the introduction of a national health system and related matters” 89 (I)/2001
- Insurance Association of Cyprus, Annual report, (2011) INSURANCE IN CYPRUS directory and statistical information.
- Investopedia, <http://www.investopedia.com> (last retrieved 15.09.2013)
- Korner S., translation P. Pantelis (1994), Financial Context and Insurance, Insurance Institution of Cyprus edition, pp.143-147
- Liaropoulous L. (1993), Private Health Insurance, its role, problems and its problems in Greece, Edition Financial Forum, Athens, pp. 15-18, 47-52
- Matsis S. (2008), Study on Medical and Pharmaceutical Care in Cyprus and the National Health System, Nicosia
- Memorandum of Understanding on Specific Economic Policy Conditionality (<http://www.scribd.com/doc/138159788>) (last retrieved 30.07.2013)
- Press Conference of Minister of Health Mr. P. Petrides for World Health Day, 04/04/2013
- Roupas Th. (2006), Private Insurance and Health Services, Papazisi editions, Athens
- Sarah Thomson, Elias Mossialos, 24th June 2009, Private health insurance in the European Union Final report prepared for the European Commission, Directorate General for Employment, Social Affairs and Equal Opportunities, LSE Health and Social Care, London School of Economics and Political Science pp.25-63
- Souliotis K. (2006), Health policy and health economy: strategic planning-organisation and management, financial functions and policies , Papazisi editions, Athens