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Study on the Social Protection Systems in the 13 Applicant Countries

Cyprus
Country Study

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Social Protection in Cyprus

1. INTRODUCTION: ECONOMIC, FINANCIAL AND DEMOGRAPHIC BACKGROUND

1.1 Main influencing factors for social protection

1.1.1 Economic and financial indicators

The Cyprus GDP level in EURO at current market prices, its annual growth rate in constant prices, the GDP per head in PPS (as defined by Eurostat) and the inflation rate of the Cyprus economy for the period 1995-2000 are shown in Table1.1 (see annex 1). On average, the Cyprus economy has been growing at around 4% per annum over this period, with GDP per head reaching €18500 in 2000.[1]

Table 1.2 (see annex 1) shows various components of social expenditure as percentage of GDP, including private health expenditure, over the period 1995-99. In terms of changes over time, public expenditure on education as a percentage of GDP increased from 4.5% in 1995 to 5.7% in 1999. Public expenditure on pensions as a percentage of GDP has also been rising over the same period. This increase reflects largely an increase in the *per capita* share of old age pensioners in GDP, given that the share of old age pensioners in the population has been rising at a lower pace than their GDP share.

The strikingly figure in Table 1.2 (see annex 1) is the share of public expenditure on health in GDP. At less than 2.5% of GDP, public expenditure on health is very low by EU standards and reflects the lack of a National Health system in Cyprus. The private health sector, representing nearly 4% of GDP, makes up for the inadequate provision of public health.

1.1.2 Demographic indicators

Cyprus is a divided island, with its Northern 36% occupied by Turkey. The population in the government controlled part of the island was 671.3 thousands in 2000 (Table 1.3, see annex 1). When the Turkish Cypriots living in the occupied areas are also included this figure rises to 759.1 thousands. This, however, does not include a large number of Turkish settlers living in the occupied areas. In general, the Cyprus government has no access to information concerning the occupied part of the island.

[1] The relatively poor GDP growth performance in 1996-97 was due to the drop in tourism arrivals. This was caused by the fear of intercommunal troubles caused by the killing of two Greek Cypriot protesters in Dherynia, a border town close to the popular holiday resorts of Ayia Napa and Protaras.

Therefore, unless otherwise stated, all the figures and discussion in this report will refer to the government controlled areas of Cyprus.

The population of Cyprus has increased by 4.03% over the period 1995-2000. The male population has increased by 4.2% while the female population by 3.9%. As shown in Table 1.4 (see annex 1), Cyprus exhibits the demographic characteristics of an ageing country: a declining rate of population growth, a sharp decline in the proportion of the population aged less than 15 years and an increasing proportion of the population aged more than 65 years, due to increased life expectancy.

As seen from Table 1.5 (see annex 1), life expectancy at birth is around 75 years for men and 80 years for women. At the age of sixty, life expectancy is around 20 years for men and 23 years for women. Furthermore, life expectancy at birth remained unchanged for men and increased for women over the period 1994 to 1999. The demographic dependency ratio has decreased from 0.56 in 1995 to 0.52 in 2000. However, since this decrease is mainly due to the decline in the proportion of younger people in the population, it is a matter of time before the demographic dependency ratio in Cyprus will start rising.

The figures in Table 1.6 (see annex 1) reinforce the conclusions emerging from the figures in Table 1.4, noticeably the sharp decline in the birth rate, from 15.4 births per 1000 inhabitants in 1995 to 12.6 in 2000. The fertility and net reproduction rates have also declined sharply over the same period. The mean age of mothers at birth of their first child increased from 25.5 years in 1995 to 26.1 years in 2000.

Table 1.7 (see annex 1) shows movements of people in and out of the country between 1997 and 2000 in numbers and in percentage of the population. The figures in this table suggest that the number of emigrants roughly matches the number of long-term immigrants, so that the number of short-term immigrants represent the net effect of migration on the island's population.[2] The short-term immigrants are largely foreign workers, imported in Cyprus to make-up for labour shortages, particularly in the fast growing tourism (hotel and restaurant) industry. Labour shortages have also been exhibited in industries supporting the tourist sector (e.g. construction). In general, foreign workers in Cyprus work mainly in unskilled, low wage occupations .

As shown by Table 1.8 (see annex 1), most of the immigrants are from EU countries. East-Europe also account for a large proportion of immigrants, followed by Asian countries. Interestingly, most immigrants

[2] Short-term immigrants are persons who came to Cyprus for employment and stay for a period less than one year, or came in Cyprus for studies; long-term immigrants are persons who came in Cyprus for employment and stay for a period longer than one year.

from EU countries are males whereas the opposite is true for short-term immigrants from East Europe.

1.1.3 Social indicators

Unemployment, participation and employment rates

The rate of unemployment in Cyprus has been relatively low over the period 1995-2000, although it increased from 2.6% to 3.4% (Figure 1.1, see annex 1). The unemployment rate among women is higher than men throughout this period, reaching 4.7% in 2000. The corresponding figure for men in the same year is 2.7%.

Figure 1.2 (see annex 1) shows the labour force participation rates for men and women over the period 1995-2000. In the case of men the labour force participation rate declines by 1.6 percentage points, from 90% in 1995 to 88.4%, in 2000, whereas for women it declines by 1.2 percentage points, from 56.7% in 1995 to 55.5% in 2000.

For both men and women, the decline in the labour force participation is due to two reasons:

1. the increase in the number of school leavers continuing their education in universities, and
2. the increase in the number of years spent in education, as more and more university graduates nowadays continue their studies for postgraduate qualifications.

The decline in the labour force participation among women is lower than men, although (1) and (2) above were more pronounced among women than men in recent years. This is because the negative effect on labour force participation from the two reasons above has been largely offset in the case of women by the positive effect from the fact that most young women in Cyprus no longer become housewives after they are married.

The structure of the labour force (percentage of employees, employers/self-employed and civilian employees) is shown in the diagram of Figure 1.3 (see annex 1). The interesting feature in this diagram is the relatively large proportion of the population of Cyprus which represents employers or self-employed, 21.6%. This phenomenon can be attributed to the large proportion of small family businesses and the traditionally enterprising nature of Cypriot people.

Table 1.9 (see annex 1) shows the division of the employed population by economic activity and gender. Overall, men account for 60.8% and women for 39.2% of the labour force. The service sectors, particularly community, social/personal services and wholesale trade, have a large and increasing

share in employment. In contrast, the primary sectors of the economy (agriculture, mining and quarrying) have a small and declining share. This reflects the character and orientation of Cyprus as an economy relying on services for its development.

As regards the gender characteristics, employment is dominated by men in all sectors, particularly in construction. The women/men ratio is relatively high in restaurants and hotels and in financial services (finance, insurance, real estate and business). Furthermore, the percentage of women increases, in financial services and in community, social and personal services; and decreases in agriculture and manufacturing.

Income distribution and poverty

The latest data available for assessing the distribution of income and poverty in Cyprus are those in the Family Expenditure Survey (FES) conducted in 1996-97 by the Department of Statistics and Research (Ministry of Finance).[3] The previous FES was conducted in 1991-92 and comparison of the data in the two Surveys are used by the Department of Statistics and Research to assess changes in the distribution of income over time.

The distribution of income corresponding to the data drawn from the FES 1996/97 is shown in Table 1.10 (see annex 1). The figures in this table suggest that the poorest 10% of households in 1996-97 have an annual net income below €5436, whereas the wealthiest 10% of households have an annual net income above €40424. The same table also shows that the poorest 10% of the households have only 1.2% of total household income whereas the better off 10% of households have 25% of total household income.

Using the FES 1996/97 data, the *Gini coefficients* for urban and rural areas are calculated to 0.365 and 0.349, respectively; whereas with the FES 1990/91 data the Gini coefficient was 0.351 for urban and 0.369 for rural areas. This suggests a reduction in income inequality in rural areas and a small increase in income inequality in urban areas. The most *vulnerable* groups are found to be households whose head is a chronically ill person, with 58% of mean income per *adult equivalent*[4], followed by households with a retired or housewife head, with 61% and 62% of mean income per adult equivalent, respectively.

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[3] The primary objective of the Household Expenditure Survey is the collection of data for the computation of the weights used in the construction of the Consumer Price Index.

[4] The 'income per adult equivalent' is the weighted average of income in a household, where children are given smaller weight than adults. Details about its calculation are given in Chapter 4.

The poverty line, in Cyprus is defined as the income corresponding to 60% of the median net income per adult equivalent. According to this definition 14.2% of Cypriots in 1996-97 and 13.3% in 1991-92 were below the poverty line. Poverty and the characteristics associated with vulnerable groups in the Cypriot society are further discussed in Chapter 4 of this report.

Family structure and demography

Table 1.11 (see annex 1) presents figures about the number of marriages and divorces in Cyprus over the period 1995-2000. The increasing mean age of the groom and bride at first marriage and the increasing divorce rate conform to expectation. The first is due to longer stay in education while the second a combination of the growing financial independence of women and the relaxation of conservative views about marriage.

The percentage of households classified by various demographic characteristics are reported in Table 1.12 (see annex 1). As shown in this table 12.1% of households in Cyprus are single adults. Among those, the majority are persons over 65. In contrast, only a very small number of adults (0.3% of all the families) under 30 years old live on their own. This shows the child-centred character of the extended family in Cyprus. As one would expect, single adults are of younger age in urban rather than rural areas.

Regarding the distribution by size, 1-person households account for 12.1%, 2-person households for 24.8%, 3-person households for 17.5%, 4-person households for 19.8% and 5-or-more-person households for 19.8%. The average household size in Cyprus is 3.08 members and follows a downward trend e.g. in 1995 the average family had 3.17 members (Table 1.13, see annex 1). The opposite trend follow the single parent households, although these are still a small minority in Cyprus: around 4% of which 3.4% are mothers with children and 0.4% fathers with children.[5]

1.2 How Does the Described Background Affect Social Protection?

1.2.1 Forecasts and projections

Economic forecasts

The government of Cyprus does not have an econometric model of the economy or other quantitative forecasting tools. Instead, it defines its objectives in a series of Five-Year Development Plans. However, one can treat these objectives as forecasts, in the sense that they often represent what the government officials consider to be the most likely outcomes of their policies.

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[5] Social Indicators, 2000

The latest Plan covers the period 1999-2003 and its main target is to maintain the rate of growth of the economy at 4% and increase employment by 1.2% per annum to maintain the level of registered unemployment below 3%. It is expected that consumer demand will increase by 3.8% per annum, mainly driven by a high annual growth rate of demand for exports (5.9%). Public consumption is forecasted to increase by 2% per annum and fixed capital formation by 2.1% per annum. Inflation is expected to be around 2% and the fiscal deficit below 2%. The Plan, also proposes measures dealing with harmonisation with the EU, and other policies.

In terms of structural changes, the service sectors are predicted to continue expanding. The branches of economic activity expected to have above average growth rates are communications, banking, insurance and professional and social services. The tourist sector (hotels and restaurants) is also expected to expand at an annual rate of around 6% in real terms. In contrast, the agricultural sector is expected to face increasing competition due to harmonisation with the European Union. The growth rate of this sector is expected to be below 1.5%. The manufacturing sector is also expected to have a growth rate below average, around 2%.

Demographic and labour market forecasts

The Cyprus government does not make forecasts about the population in the latest Five-Year Development Plan. It simply states the rate of population growth will be 1% per annum over the forecast period 1999-2003. The actual figures, however, suggest that this forecast is too optimistic, as the population increased by a slower pace over the first half of this period. A population growth rate of around 0.6% is more likely to be a realistic forecast over the next 3-5 years.

Nevertheless, the government is committed to encouraging population growth, by discouraging the drop in fertility and encouraging the repatriation of Cypriots living abroad. Measures taken towards encouraging repatriation include financial assistance for repatriates to set up their own business, subsidising the fees paid for the private tuition of their children and tax concessions for the purchase of car and other durables. Measures to increase fertility include the payment of generous child and mother's benefit to large families, subsidy for them to buy roomy cars and exemption from military service for the third male child in the family.

Regarding developments in the labour market, again, no forecast is made by the Cyprus government beyond placing among its medium term targets the increase in employment by 1.2% per annum so as to keep the level of registered unemployment below 3%, as said earlier. Active labour market measures towards combating unemployment and achieve this target include: the 'Scheme for the Self-Employment of Tertiary Education Graduates'; the 'Supported-Employment Scheme for Persons with Disabilities'; the 'Self-

Employment Scheme for Persons with Disabilities'; the 'Self-Employment Scheme for Repatriates'; and the 'Scheme for the Encouragement of Labour Force Participation by Older Persons'; and vocational guidance.

1.2.2 Influences of economic, demographic and social developments on the social protection system

The population of Cyprus is ageing as a result of the falling fertility rate and the increase in life expectancy. The increase in the number of old age pensioners together with the trend towards less strong family bonds suggest that the number of old people living on their own will increase fast. The increasing divorce rate suggests that the number of single parents will also increase in the future. These demographic changes, expected to take place in the foreseeable future, will lead to an increase in the number of people who either (i) are eligible for social assistance or (ii) belong to groups that are vulnerable to poverty and social exclusion.

Further increase in the cost of social insurance in Cyprus is likely to occur in the next few years due to the trend towards more people taking advantage of loopholes in the legislation concerning conditions of eligibility.[6] For similar reasons, short-term benefits such as sickness benefit, and all employment injury benefits are also expected to rise.

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[6] Actuarial Valuation of the Social Insurance Scheme of Cyprus, Ministry of Labour and Social Insurance, 1997.

1.3 Annex to chapter one

Table 1.1: GDP and inflation rate, 1995-2000

Year	GDP at current market prices (billion €)	Annual growth rate at constant prices (%)	GDP per head in PPS[1]	Inflation rate (%)
1995	6.8	6.1	13800	2.6
1996	7.0	1.9	14700	3.0
1997	7.5	2.5	15400	3.6
1998	8.1	5.0	16300	2.2
1999	8.7	4.5	17500	1.7
2000	9.5	4.8	18500	4.1

Source: European Comparison Programme (ECP) 1998, OECD, Eurostat.
[1]PPS: Purchasing Power Standards.

Table 1.2: Social expenditure by type as percentage of GDP, 1995-1999

Year	Public expenditure on education (%)	Expenditure on health services[1] (%)		Public expenditure on pensions and gratuities (%)
		Public	Private	
1995	4.5	2.2	3.1	4.2
1996	4.7	2.3	3.7	4.5
1997	5.0	2.4	4.0	4.7
1998	5.4	2.4	3.7	4.7
1999	5.7	2.4	3.6	4.8

Source: Statistical Abstract 1999, Department of Statistics and Research.
[1]Excluding capital expenditure.

Table 1.3: Population and its gender distribution (thousands)

Year	Total population, including Turkish Cypriots	Population in the Government controlled area	Gender distribution[1]	
			Male	Female
1995	735.9	645.3	321.8	323.5
1996	741.0	651.8	325.0	326.8
1997	746.1	657.9	328.0	329.9
1998	751.5	663.3	330.7	332.6
1999	754.8	666.8	332.4	334.4
2000	759.1	671.3	335.2	336.1

Social Indicators 2000, Department of Statistics and Research.
[1]Government controlled area.

Table 1.4:Population distribution, demographic dependency ratio and population growth rate[*]

Year	Population distribution by age (%)			Demographic dependency ratio[1]	Annual mid-year population growth rate (%)	Natural increase rate (per 1000 inhabitants)
	0-14 years	15-64 years	65 + years			
1995	24.9	64.0	11.1	0.562	1.2	7.7
1996	24.6	64.3	11.1	0.556	1.0	7.2
1997	24.2	64.6	11.2	0.548	1.0	7.1
1998	23.8	65.0	11.2	0.537	0.9	6.3
1999	23.2	65.5	11.3	0.527	0.7	5.2
2000	22.7	65.9	11.4	0.518	0.6	5.2

Social Indicators 2000, Department of Statistics and Research.

[*] Demographic dependency ratio is the total number of persons under 15 years old plus the elderly population aged 65+, over the population of age 15-64 years old.

Table 1.5: Life expectancy

Period	Life expectancy (years)					
	At birth		At age 60		At age 65	
	Male	Female	Male	Female	Male	Female
1994/95	75,3	79,8	20,1	22,9	16,3	18,6
1996/97	75,0	80,0	19,5	22,7	15,6	18,4
1998/99	75,3	80,3	19,8	23,2	15,9	18,9

Source: Statistical Abstract 1999, Social Indicators 2000, Statistical Service

Table 1.6:Birth rate, fertility and reproduction rate, mean age of mother at childbirth

Year	Birth rate (per 1000 inhabitants)	Fertility rate	Net reproduction rate	Mean age of mother at birth of first child	Mean age of mother at birth of any child
1995	15.4	2.1	1.03	25.5	28.2
1996	14.9	2.1	1.00	25.6	28.2
1997	14.2	2.0	0.97	25.8	28.4
1998	13.4	1.9	0.93	25.7	28.4
1999	12.8	1.8	0.89	25.8	28.6
2000	12.6	1.8	0.88	26.1	28.7

Source: Social Indicators 2000, Department of Statistics and Research.

Table 1.7: Emigrants and Immigrants

Year	Emigrants	Immigrants	
		Short-term[1]	Long-term[2]
1997	8000	13234	6149
1998	6800	21206	8801
1999	8500	15812	8524
2000	11268	22187	12764

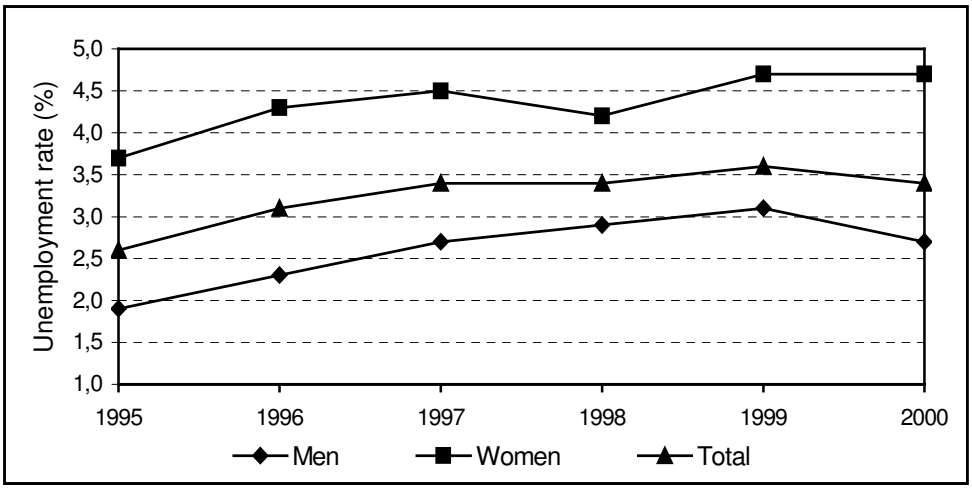
Source: Tourism, Migration and Travel Statistics 2000.

Table 1.8: Immigrants by country of residence and gender (average for 1997-2000)

Country of residence	Short-term immigrants		Long-term immigrants	
	Males	Females	Males	Females
E.U.	4183	2202	2285	1690
Russia, Bulgaria & Ukraine	1019	3733	464	911
Africa	356	106	222	169
America	368	150	214	161
Asia	1700	1142	896	1207
Other	695	2457	331	511
TOTAL	18111		9061	
% on total population	2.72		1.36	

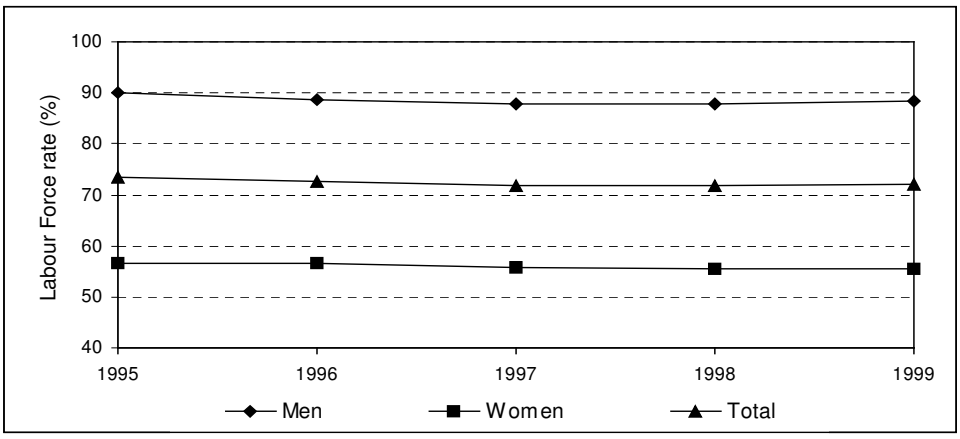
Source: Tourism, Migration and Travel Statistics 2000.

Figure 1.1: Unemployment rate (%), 1995-2000



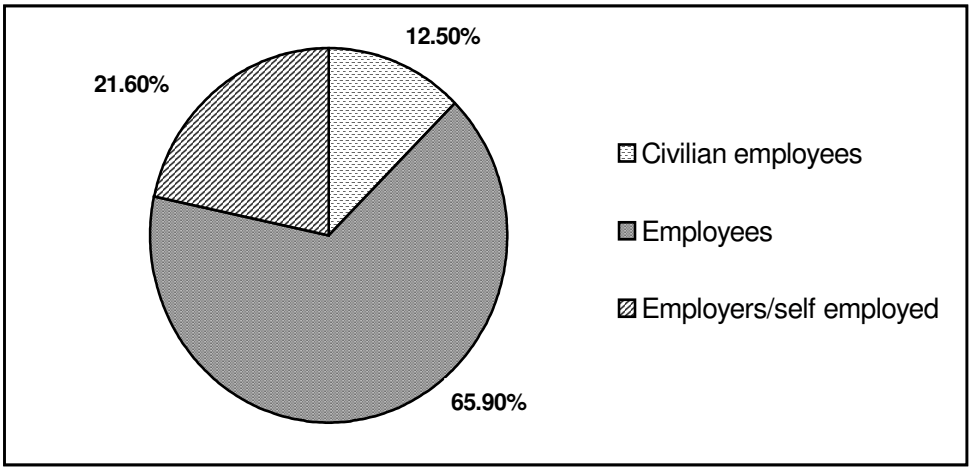
Source: Labour Statistics 2000, Department of Statistics and Research.

Figure 1.2: Labour Force participation rates (%) by Gender, 1995-1999



Source: Labour Statistics 2000, Department of Statistics and Research.

Figure 1.3: Distribution of the gainfully employed population by employment status (1995)



Source: Labour Statistics 2000, Department of Statistics and Research.

Table 1.9: Gainfully employed population by economic activity and gender

Economic Activity		**1995**	**1996**	**1997**	**1998**	**1999**
Gainfully employed population (thousands)		282.0	284.7	284.0	287.0	290.9
Males (%)		60.5	60.4	60.5	60.5	60.8
Females (%)		39.5	39.6	39.5	39.5	39.2
Agriculture, forestry & fishing	Total (%)	10.8	10.5	9.5	9.6	9.5
	Females (%)	4.1	4.1	3.4	3.5	3.4
Mining and Quarrying	Total (%)	0.3	0.3	0.2	0.2	0.2
	Females (%)	–	–	–	–	–
Manufacturing	Total (%)	15.5	14.7	14.3	13.7	13.2
	Females (%)	6.4	5.8	5.5	5.2	4.9
Electricity, gas and water	Total (%)	0.5	0.5	0.5	0.6	0.6
	Females (%)	0.1	0.1	0.1	0.1	0.1
Construction	Total (%)	9.1	8.9	8.8	8.4	8.3
	Females (%)	0.6	0.6	0.6	0.6	0.6
Wholesale and retail trade	Total (%)	15.8	16.2	16.5	16.6	16.5
	Females (%)	7.1	7.3	7.4	7.5	6.9
Restaurants and hotels	Total (%)	10.7	10.5	10.5	10.5	10.6
	Females (%)	5.1	5.0	5.0	5.0	5.1
Transport, storage and communication	Total (%)	6.6	6.6	6.8	6.8	6.8
	Females (%)	1.8	1.8	1.9	1.9	2.0
Finance, insurance, real estate and business	Total (%)	8.0	8.3	8.5	8.7	9.1
	Females (%)	3.8	4.0	4.2	4.2	4.5
Community, social and personal services	Total (%)	22.7	23.5	24.5	24.9	25.2
	Females (%)	10.5	10.9	11.4	11.5	11.7

Source: Labour Statistics 2000, Department of Statistics and Research.

Table 1.10: Deciles of the distribution of net annual income (€), 1996/97

Docile	**Income range (€)**	**Share in total income**
1st	up to 5.435	1.23
2nd	5.436 - 9.222	3.23
3rd	9.222 - 13.099	5.11
4th	13.100 - 16.504	6.74
5th	16.505 - 19.982	8.35
6th	19.983 - 22.963	9.79
7th	22.964 - 26.378	11.22
8th	26.379 - 31.779	13.13
9th	31.780 - 40.424	16.19
10th	40.424 plus	25.01

Source: Family Expenditure Survey 1996-97, Department of Statistics and Research.

Table 1.11: Marriages and divorces

Year	Total marriages	Crude marriage rate[1]	Mean age at first marriage		Total divorces	Crude divorce rate[1]
			Groom	Bride		
1995	6669	10.40	27.7	25.2	757	1.19
1996	5761	8.90	28.1	25.5	725	1.12
1997	7187	11.00	28.1	25.6	851	1.30
1998	7738	11.70	28.8	26.2	852	1.29
1999	9080	13.70	28.8	26.2	1193	1.79
2000	9282	13.82	28.9	26.3	1182	1.76

Source: Social Indicators 2000, Department of Statistics and Research.
[1] Crude marriage and divorce rates are respectively the numbers of marriages and divorces per 1000 inhabitants.

Table 1.12: Percentage of households grouped by demographic characteristics

Type of household	Total	Urban	Rural
One person, aged 65+	7.4	6.9	8.2
One person, aged 30-64	4.4	5.3	2.6
One person, aged less than 30	0.3	0.4	0.1
Couple without children, at least one of the two aged 65+	11.0	9.7	13.6
Couple without children, both persons less than 65 years	10.2	10.3	10.0
Couple with one child only, aged up to 16	7.4	7.9	6.4
Couple with two children only, both aged up to 16	15.3	16.2	13.7
Couple with at least three children, all of them aged up to 16	9.0	7.2	12.5

Source: Family Expenditure Survey 1996-97, Department of Statistics and Research.

Table 1.13: Number and size of households, 1995-2000

Year	Households (thousands)	Average household size
1995	202,8	3,17
1996	205,9	3,15
1997	209,1	3,13
1998	211,7	3,11
1999	214,3	3,09
2000	217,0	3,08

Source: Population Report, Department of Statistics and Research

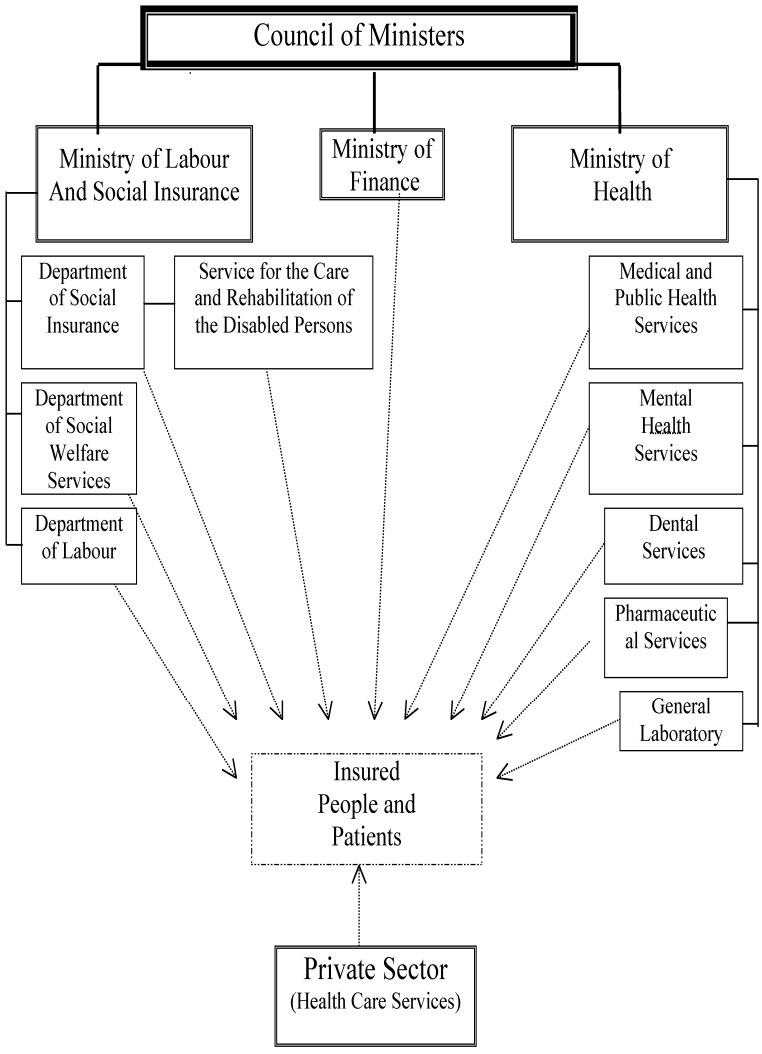
2. OVERVIEW ON THE SOCIAL PROTECTION SYSTEM

2.1 Organisational Structure

2.1.1 Overview of the system

The Council of Ministers has overall responsibility for the State part of the social protection system in Cyprus. It exercises this authority through the Ministry of Health and the Ministry of Labour and Social Security and, to a smaller extent, through the Ministry of Finance. All the parties involved with the administration of social protection in Cyprus, including the private sector, are shown in the organisational chart below.

Organisational Chart of the Social Protection System in Cyprus



Ministry of Labour and Social Insurance

The Ministry of Labour and Social Insurance is responsible for the implementation of government policy for employment, social insurance, social welfare and industrial relations. It is organised into departments and manpower development institutes.

The *Department of Social Insurance* is responsible for:

- the 'Social Insurance Scheme', compulsory for all employed and self-employed persons and providing for maternity allowance, sickness benefit, unemployment benefit (not to the self-employed)[7], old-age pension, invalidity pension, widows pension, orphans benefit, missing persons allowance, marriage grant, maternity grant, funeral grant and benefits for employment accidents (not for the self-employed) and occupational diseases such as injury benefit, disablement benefit and death benefit;

- the 'Social Pension Scheme', providing pensions to persons who have completed the age of 65, and who are not entitled to a pension from another source and satisfy the residence conditions specified in the Law;[8]

- the 'Child Benefit', payable to families having at least four dependent children;

- the 'Mother's Allowance', paid to mothers with four dependent children who were not eligible for child benefit when this benefit was introduced in 1988 because their children were adults[9] and

- the 'Compensation of Victims of Violent Crimes', paid to victims of crimes and to dependants of persons that died as a result of such crimes.

The *Department of Social Welfare Services* is the official agency of the state for the provision and promotion of social welfare services. The main programmes of the Department are the 'Family and Child Services', the 'Community Work', the 'Public Assistance and Services for the Elderly and Disabled' and the 'Staff Development and Programme Planning Services'. It also administrates the following three Laws: (i) the 'Public Assistance and Services Law', guaranteeing a minimum acceptable standard of living in

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7 To the self-employed decease and occupational accidents are treated as incapacity, entitling them to sickness and invalidity benefit.

8 These conditions are: (a) residence in Cyprus for at least 20 years from the date the claimant reaches the age of 40, or (b) residence in Cyprus for at least 35 years from the date the claimant reaches the age of 18.

9 From 1.1.2003 the Child Benefit is paid to all families with children and income below €35000. Responsibility for this benefit is also transferred to the Ministry of Finance.

keeping with human dignity for every person legally residing in Cyprus; (ii) 'Homes for the Elderly and Disabled Law', requiring non-government homes for the elderly and disabled to be registered and inspected; and (iii) 'Children Law and the Centres for the Protection and Recreation of Children Law', requiring non-governmental day-care centres and child-minders to be registered and inspected.

The *Department of Labour* is responsible, among other things, for the 'Service for the Care and Rehabilitation of the Disabled Persons', 'Severe Motor Disability Allowance', 'Special Financial Assistance to the Disabled Persons', 'Financial Assistance Scheme for the Purchase of Wheelchairs for the Disabled'.

Ministry of Health

The Ministry of Health is mainly responsible for the organisation of the health care system in Cyprus and the provision of health care services financed by the state. The ultimate objective of the organisation is to promote and protect people's health.[10]

The Ministry of Health is organised into various departments and manpower development institutes including: (i) *General Laboratory,* providing laboratory analysis services, including the inspection of food, water, medicine, police evidence and drugs investigations (but not services for clinical purposes); (ii) *Pharmaceutical Services,* responsible for the testing, supply and pricing of pharmaceuticals, the inspection of pharmacies etc; (iii) *Medical and Public Health Services,* responsible for services in the fields of precaution, primary, secondary and tertiary health care; (iv) *Dental Services;* and (v) *Mental Health Services.*

The range of services offered through the government health scheme is comprehensive and includes visits to general physicians, specialist consultations, inpatient stays, medical care given abroad in specialist fields not offered in Cyprus and all drugs prescribed.

Also offered are special health care schemes covering specific sections of the population such as:

- medical services (mostly primary health care) provided by Trade Unions to their members through the use of mainly private sector health facilities; and

[10] At the moment this goal is pursued through several intermediary agencies with more focused objectives, leading to a fragmented supply side and no formal system of referral between the various levels. This, however, will change with the National Health Plan, expected to be in place soon. We shall return to this point in Chapter 5.

- various employer-sponsored arrangements providing free medical care, mainly through the health facilities in the private and public sector.

Ministry of Finance

The Ministry of Finance is responsible for the administration of :

- the 'Mobility Allowance', a means tested benefit granted to disabled workers and students to cover travelling expenses for work/college;

- the 'Provisions of Special Grants', where the applicant's entitlement is determined by the degree of his/her blindness; and

- the 'Provision of Financial Assistance to Persons with Disabilities for the Purchase of a Car', for which entitlement is determined by the degree of disability.

Occupational schemes

Many employees in the private and government sectors are covered by occupational schemes which provide benefits, in addition to those of the statutory Social Insurance Scheme.

The occupational schemes take the form of either provident funds or occupational pension schemes. The benefits from provident funds are lump sum money payable on termination of employment, invalidity, retirement or death. A few provident funds (e.g. those for bank employees) also provide a guaranteed lump sum payment against inflation. Provident funds for employees in the private sector are mainly established voluntarily within a system of free collective bargaining. However, once agreed, a provident fund has to be registered and operated in accordance with the Provident Fund legislation.

Occupational schemes are discussed in Chapter 3 of this report.

Private health services

The private sector dominates the health services market in Cyprus, accounting for around 70% of total health expenditure. It treats patients on 'a fee for service' basis and is open to all individuals who can afford to pay.

Private health services are dominated by the practising physician and dentist offering all types of outpatient services. There are also small private clinics in urban areas offering inpatient services. These are supported by all types of diagnostic and other similar services provided by private laboratories and pharmacies. Although the private sector offers a more limited scope of services than the public sector some private clinics have

been able to establish, through amalgamation, highly specialised facilities (kidney transplantation open-heart surgery etc). These facilities are often used by the government to treat eligible patients.

Private sector medical services are normally operated on a profit making basis, however, several palliative institutions exist offering support and rehabilitation services to patients suffering from chronic diseases such as diabetes, cancer, cardiovascular ailments and other illnesses.

2.1.2 Centralisation/decentralisation of the system

Cyprus is a small country with a highly centralised public administration. The public health services are provided through a network of hospitals, health centres, subcentres and dispensaries.

As seen earlier, social security matters are almost entirely under the jurisdiction of the Ministry of Labour and Social Insurance while the Ministry of Health has overall responsibility for the maintenance of public health. The Ministry of Health cooperates with other ministries and municipal authorities (which are under the Ministry of the Interior) to provide preventive health services in the form of health education, inoculations, control of epidemics and communicable diseases, disposal of sewage, quality control of the drinking water etc.

2.1.3 Supervision

The body in charge of supervising and coordinating the social protection system in Cyprus is the Council of Ministers. Each of the ministries involved is independently responsible for the supervision of its own departments. An important supervisory role in the field of social insurance is also played by the Social Insurance Board, whose main responsibility is to offer advice on matters pertaining to the Social Insurance Scheme.

2.2 Financing of Social Protection

2.2.1 Financing sources

The financing sources of social protection in Cyprus vary between the different parts of the system. In this section we simply list the financing sources of social protection schemes, as these are discussed in detail in subsequent parts of the report.

Schemes other than health

- *Social Insurance,* financed by earnings related contributions; for employees the contributions to social insurance represent 16.6% of

earnings, for the self-employed persons 15.6% and for voluntary insured persons 13.5%.

- *Social Pension,* paid out of general taxation and reviewed each year to take into account the increase in wages and the cost of living.

- *Child Benefit,* financed out of general taxation and adjusted according to the cost of living index. The same applies to *Mother's Allowance*.

- *Provident Funds* schemes, financed by contributions paid by employees and employers and assessed on employee earnings.

- *Supplementary Pension* schemes, financed by employers.

- *The Termination of Employment Scheme,* financed by employers and covering all persons employed under a contract of service.

Health services

At the moment the government provision of health services is funded out of general taxation, with the exception of a small part financed from charges imposed on some services. As said earlier, the private health sector is open to anyone affording its services.

The state, in its capacity as employer, provides free health care to all civil servants. For others eligibility for free public health services depends on their income and demographic characteristics.[11] At accident and emergency departments medical care is provided free of charge to everyone in need, irrespective of income or nationality.

2.2.2 Financing principles

All contributions are paid to the *Social Insurance Fund* out of which payments of benefits are made. They go to three separate accounts: (i) 6% of total contributions paid on behalf of employed persons are first allocated to the *Unemployment Benefit Account*. The remaining part of these contributions plus the totality of the contributions paid on behalf of self-employed and voluntary insured persons are then allocated as follows: (ii) 9.5/15.5 go to the *General Account*; and (iii) 6.0/15.5 to the *Supplementary Benefit Account*[12].

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[11] Individuals earning less than €10350 pa, households earning less than €17250 pa or with more than three children. Individuals with income between €10350-€15500 pa and households with income between €17250 and €24200 pa are entitled to health care services at 50% of the prescribed rates.

[12] The number 15.5 represents the weighted average of the three contributions (employees 16.6, self-employed 15.6 and the voluntary insured 13.5) to social insurance.

The Unemployment and General accounts of the Social Insurance Scheme are operated on the basis of a *pay as you go* principle, with a reserve sufficient to cover the expenditure of the Scheme for about a year. In case the reserve and income of the Unemployment Benefit Account cannot cover its liabilities, the deficit is covered either out of the general revenue of the government or by the imposition of a special contribution. Short term and employment injury benefits are also financed on a pay as you go basis. The Supplementary Account of the Scheme is operated on the basis of a *partial funding* principle.

2.2.3 Financial administration

Social insurance scheme

The total annual *insurable earnings* of every insured person are divided into two bands: the lower band includes the insurable earnings up to the basic earnings and the upper band includes the insurable earnings above the basic earnings.

- For employees the contribution rate is 16.6% of their earnings (up to a ceiling[13]): 6.3% is paid by the employee, 6.3% by the employer and 4% by the government.

- For self-employed persons the contribution rate is 15.6% of self-employment income: 11.6% is paid by the self-employed and 4% by the government.

- For voluntary insured persons the contribution rate is 13.5% of the earnings from which they opt to pay contributions: 10% is paid by the contributor and 3.5% by the government.[14]

Other social protection schemes

Other social protection schemes include (a) the 'Termination of Employment' scheme, securing redundancy payment and financed by employer contributions at the rate of 1.2% on their employee wages (up to a ceiling) and (b) the 'Protection of Employees Rights in case of Insolvency of Employer' scheme, providing for the establishment of a Redundancy Fund to cover costs for the protection of employees in the event of insolvency of their employer.

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[13] The ceiling, currently at €2839, is annually revised to account for the cost of living increase.

[14] The contribution rate of voluntary contributors in the employment of Cypriot employers abroad is 16.6% (12.6% payable by the voluntary contributor and 4% by the state).

2.3 Overview of Allowances

2.3.1 Health Care

Health services provided by the government include: (i) general out-patient care; (ii) specialist out-patient and in-patients care; (ii) drugs and pharmaceuticals; (iii) diagnostic and paramedical examinations; (iv) hospitalisation; (v) dental care. (vi) medical rehabilitation and provision of artificial limbs; (vii) domiciliary visiting; and (viii) transport of patients.

The current regulations classify the persons who have access to government medical services into the following categories: (i) paying patients, (ii) persons entitled to health services at a reduced charge,[15] and (iii) persons to whom health services are provided free-of-charge (civil servants, families with four or more children, students at the University of Cyprus, war pensioners, and those below a certain level of income[16]).

2.3.2 Sickness

Sickness benefit is payable to insured persons between the ages of 16 and 63 who: (i) are incapable of work; (ii) have been insured for 26 weeks and paid contributions on insurable earnings not lower than 26 times the weekly amount of basic insurable earnings; and (ii) have paid or been credited, in the previous year, with contributions on insurable earnings not lower than 20 times the weekly amount of basic insurable earnings.

The amount of the sickness benefit is: (a) 60% of insurable earnings up to the *basic earnings* level, increased by 1/3 for a dependant spouse and 1/6 for each additional two dependants; and (b) plus 50% of insurable earnings in excess of the basic earnings up to a maximum of two times the weekly amount of basic insurable earnings. The sickness benefit is payable for a maximum duration of one year in each period of interruption of employment. The contribution rate for sickness benefit is set at 0.35% for the lower band and at 0.20% for the upper band.

2.3.3 Maternity

There are two maternity benefits:

- The 'Maternity Grant', currently €360, payable to a woman (either on her own or on her husband's insurance) giving birth.

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15 Single persons with annual income between €10300 and €15700, families with annual income between €17300 and €24300 increased by €10300 for each dependent child.

16 Single persons with annual income less than €10000, families with annual income less than €17000 increased by €1000 for each dependent child.

- The 'Maternity Allowance', payable to a woman insured as an employee or self-employed person for a period of 16 weeks beginning between the 6th and the 2nd week before the expected week of confinement.[17]

As in the case of sickness benefit the claimant must: (i) be insured for at least 26 weeks and have paid, up to the date of birth, contributions on insurable earnings not lower than 26 times the weekly amount of insurable earnings; and (ii) have paid contributions in the previous year on insurable earnings not lower than 26 times the weekly amount of the basic insurable earnings.

2.3.4 Invalidity, Long-term care, Disability

Invalidity pension is payable to persons who have been incapable to work for at least 156 days and are expected to remain permanently unable to earn from work more than 1/3 of their usual earnings. When the loss of earnings capacity is full, so is the invalidity pension. There is also a 'supplementary' part in invalidity pensions (more details are given in Chapter 3).

2.3.5 Old Age

Old age pension is payable at the age of 65 (at the age of 63 for women born before 1/1/1935) and is not conditional on retirement from regular employment (i.e. a person does not have to be retired in order to receive old age pension as long as she/he fulfils certain requirements). The old age pension is composed of the basic pension and supplementary parts, calculated in the same manner as the invalidity pension. Again, old age pension is discussed in detail in Chapter 3.

2.3.6 Survivors

The benefits for survivors are:

- The 'Funeral Grant', payable for the death of: (i) a person who is in receipt of old age, invalidity, widow's/er's pension, death benefit or missing person's allowance; (ii) orphans; (iii) a person whose death is caused by an industrial accident or occupational disease; (iv) a person satisfying certain eligibility conditions; and (v) a dependant of a person specified in (i) and (iv) above.

- The 'Widow's Pension'.

- The 'Orphan's Benefit'.

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[17] This benefit is also payable to step-mothers for adopted children if the adoption took place before the child was twelve years old.

- The 'Missing Person's Allowance'.

All types of pension (invalidity, disability, widows and old age) are discussed in Chapter 3 of this report.

2.3.7 Employment injuries and occupational diseases

The benefits for industrial accidents and occupational diseases are the temporary incapacity (or injury) benefit, the disablement benefit and the death benefit

- The 'Temporary Incapacity (injury) Benefit', is payable to any employed person who is incapable of work as a result of an industrial accident or occupational disease. The benefit is payable for up to 12 months from the date of accident. The rate of injury benefit is the same as for sickness benefit.

- The 'Disablement Benefit' is payable to any employed person, who as a result of an employment injury, suffers loss of physical or mental faculty of a degree of not less than 10%. It may take the form of either a grant (lump sum) or a pension, depending on the degree of disablement.

- The 'Death Benefit' is paid to survivors of an employed person, who dies as a result of an employment injury.

2.3.8 Marriage Grant

For marriages after 6/10/2001, a 'Marriage Grant' is divided equally between the two spouses if either of them satisfies the following eligibility conditions: (i) has been insured for at least 26 weeks and has paid, up to the date of marriage, contributions on insurable earnings not lower than 26 times the weekly amount of the basic insurable earnings; and (ii) has paid or been credited with contributions in the previous contribution year on insurable earnings not lower than 20 times the weekly amount of the basic insurable earnings. The marriage grant is divided equally between the two spouses. The amount of marriage grant is currently at €480.

2.3.9 Unemployment

Unemployment benefit is payable to involuntarily unemployment persons between the ages of 16 and 63. Persons who do not satisfy the eligibility conditions for old age pension at the age of 63 are allowed to draw benefit up to the time when they satisfy the relevant eligibility conditions, but in no case after the age of 65. Unemployment benefit is payable for 156 days for each period of interruption of employment.

Eligibility for the unemployment benefit require the person concerned to: (i) have been insured for at least 26 weeks and paid up to the date of unemployment contributions on insurable earnings not lower than 26 times the weekly amount of the basic insurable earnings; and (ii) have paid or been credited with contributions in the previous year on insurable earnings not lower than 20 times the weekly amount of the basic insurable earnings. Exceptionally, persons over 60 years old are eligible for unemployment benefit if they do not receive a pension under any occupational scheme or a lump sum payment from a provident fund. The weekly rate of unemployment benefit is calculated in the same way as the sickness benefit.

2.3.10 Minimum resources / social assistance

The Public Assistance and Services Law 8/91, secures a minimum standard of living for all persons legally residing in Cyprus. Assistance may be provided in the form of money and/or services to persons whose resources do not meet their basic and special needs as determined by the Law. It makes special provisions for people who are vulnerable to social exclusion (persons with disabilities, single-parents, parents with four or more children and families in risk of dissolution) and may include a rent allowance, home-care etc. Rates for public assistance are reviewed annually to keep in line with the rising cost of living. The Public Assistance and Services Law, is more thoroughly discussed in Chapter 4.

2.4 Summary: Principles and mechanisms of the social protection system

The first Social Insurance Scheme was introduced in 1957, when Cyprus was still a British Colony, and was rooted in the Beverage principles of flat contributions and benefits. However, since then it has undergone several reforms, of which the most drastic ones were in 1964, when the Scheme was extended to cover everyone in employment and in 1980, when it was transformed from a flat rate to an earnings-related scheme. Furthermore, a series of changes following the 1980 reform led the system to a more citizen-oriented rather than employment-centred type.

The development and successful implementation of social insurance in Cyprus has benefited from the extensive practice of ‘tripartism’ involving the government, the employers and the workers. This practice has helped maintain a dialogue between the parties involved and was successful in promoting improvements and in seeing the social protection system through difficult times (e.g. the years following the Turkish invasion in 1974). The successful implementation of social insurance in Cyprus can also be attributed to the fact that the system is not financially strained by the high demographic dependency ratios and large unemployment levels seen in other countries. If unemployment or demographic dependency ratio rise in the future the system will become financially strained.

The reform in 1980 made the social insurance system more citizen oriented as did 'safety net' type features introduced in subsequent years, like the Social Pension Scheme and the Public Assistance Law discussed in subsequent chapters of this report. The fact that most benefits are either means-tested or paid to those who do not or cannot work or have other poverty related characteristics (widows, orphans etc) suggests that the social protection in Cyprus helps towards reducing poverty and income inequality.

The recently implemented tax reform has further removed regressive features of the system such as tax allowances for children and other dependants in the family. These tax allowances are now replaced with benefits payable to families with annual income less than €34500. However, the per capita child benefit in the new system is higher for large families, contrary to the well known fact that the per capita child costs decline with the number of children in the family.

Finally, a striking feature of the social protection system in Cyprus is the very large private/public mix in health care: whereas the overall expenditure on health represents nearly 6% of GDP, a figure close to the EU average, around 70% of this expenditure is for private health care, as opposed to around 25% in EU countries. This feature of the system, however, is likely to disappear when the new National Health Insurance Scheme recently approved by Parliament is in place in 2006.

3. PENSIONS

3.1 Evaluation of Current Structures

3.1.1 Public-private mix

Although in recent years private companies are promoting pension contracts among occupational groups, the pension system in Cyprus is almost entirely public. Therefore very little, if anything, can be said about the public-private mix of pensions.

As mentioned in Chapter 2, there is a Social Insurance Fund into which all contributions are paid, and out of which payments of benefits are made. Regarding the employment sector of contributors (i.e. the percentage of contributors employed in the private sector vs. the percentage of contributors employed in the public sector), Table 3.1 shows the distribution of active contributors to the Fund by category and sex in 1999: the large majority of them, 72.4%, are employed in the private sector, 15.1% are employed in the public sector, 12.1% are self-employed persons and less than 0.5% are voluntary contributors.

Table 3.1: Active contributors to the Social Insurance Fund by category and sex 1999

Category	Total	%	Males	%	females	%
Private employees	207.1	72.4%	110.7	67.4%	96.4	79.2%
Public employees	43.1	15.1%	25.2	15.4%	17.9	14.7%
Self-employed	34.5	12.1%	27.4	16.7%	7.1	5.8%
Voluntary contributors	1.1	0.4%	0.9	0.5%	0.1	0.1%
Total	286.0	100%	164.3	100%	121.7	100%

Source: Labour statistics 1999

Table 3.1 also shows that the percentage of women contributing to the Fund is substantially below that of male contributors, reflecting their lower participation rate and lower earnings (discussed later in Chapter 4). More specifically, 42.5% of the Social Insurance Fund represent contributions paid by women and 57.4% represent contributions paid by men. This It also reflects the fact that, unlike men, women in agriculture are not considered as self-employed persons and do not contribute to the Social Insurance Fund.

Pillars of the pension system

The pillars of the pension system in Cyprus are:

a) the *Social Pensions Scheme*, securing an old age pension to everyone over the age of 65 not entitled to a pension from another source;[18] and

b) the *Social Insurance Scheme*, the pillar for the working population, offering old age pension, invalidity pension, widow's pension, orphan's pension, and disablement pension.

Old age pension

Old age pension is payable at the age of 65 (at the age of 63 for women born before 1/1/1935) and is not conditional on retirement from regular employment (i.e. a person does not have to be retired in order to receive old age pension as long as she/he fulfils certain requirements). A person is entitled to old age pension if she/he: (i) is of pensionable age and satisfies the relevant eligibility conditions; or (ii) has completed the age of 63, satisfies the relevant eligibility condition and has a weekly average of insurable earnings equal to 70% of the weekly amount of basic insurable earnings; or (iii) was entitled to invalidity pension immediately before reaching the age of 63; or (iv) is between the ages of 63 and 65 and would be entitled to invalidity pension if she/he had not completed the age of 63.

The old age pension is composed of the basic pension and a supplementary part, calculated as 1/52 of 1.5% of the total insurable (actual and credited) earnings.

Invalidity pension

Invalidity pension is payable to persons who have been incapable to work for at least 156 days and are expected to remain permanently incapable to earn from work more than 1/3 of usual earnings. Roughly, the eligibility conditions are: (i) paid contributions in at least three years, (ii) weekly average insurable earnings equal to at least ¼ of the weekly amount of the basic insurable earnings; (iii) paid or credited with contributions in the last year not lower than 20 times the weekly insurable earnings.

When the loss of earnings capacity is full, the invalidity pension is 60% of the weekly average of credited insurable earnings (plus increments for dependants). There is also a 'supplementary' part which is 1/52 of 1.5% of the total insurable earnings (actual and credited) of the beneficiary. When the loss of earnings is partial, invalidity pension is reduced as follows:

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[18] The Social Insurance Scheme also covers the following benefits: maternity allowance, sickness benefit, unemployment benefit, missing persons allowance, marriage grant, maternity grant, funeral grant and benefits for employment accidents and occupational diseases i.e. injury benefit, disablement benefit and death benefit. These benefits were described in section 2.3.

Loss of earning capacity	Percentage of full pension
50.0% - 66.7 %	60%
66.7% - 75.0%	75%
75.0% - 99.0%	85%

The widow's pension

The widow's pension is payable to the widow, and under certain conditions to the widower, of a person who on his/her death either (i) satisfied the eligibility conditions for old age pension or (ii) was in receipt of old age pension. A lump sum is also payable to a widow whose husband satisfies the first, but not the second eligibility condition.

The disablement pension

The disablement pension consists of (i) the basic pension and (ii) the supplementary pension. The weekly basic disablement pension for 100% disability is 60% of the weekly amount of the basic insurable earnings, increased in the case of a male beneficiary by 1/3 for the first dependant and 1/6 for each of the second and third dependants. For a female beneficiary not entitled to an increase for her husband, the increase is 1/6 for each dependent, up to a maximum of two.

The weekly supplementary pension is 60% to the weekly average of insurable earnings of the beneficiary, above the basic insurable earnings, in the period beginning with the first day of the second year before the year in which the accident occurred and ending with the day of the accident. The disablement pension for a degree of disablement below 100% is proportional to the actual degree. An attendance allowance of €155 per month is payable for disablement pensioners needing constant care.

The orphan's benefit

The orphan's benefit is payable to a minor whose: (i) both parents are dead; or whose parents were separated and the one, under whose care he/she was, is dead; (ii) one of the parents died and the surviving parent is not entitled to widow's pension; (iii) widowed mother, who was in receipt of widow's pension, remarried.

Occupational pension schemes

Occupational pension schemes are not very common and the majority of employees covered by such schemes are employed in the broader public sector. Furthermore, occupational pension schemes usually are non-contributory on the part of the employee. Their financing, with very few exceptions, is borne solely by the employer.

Mandatory and voluntary contributions

The Social Insurance Scheme is compulsory for every person gainfully employed in Cyprus, as employee or self-employed. For employees the contribution period for wage earners is the calendar week and for salary earners the calendar month. Liability for the payment of contributions to the Social Insurance Fund ceases on the day the insured person attains pensionable age.[19]

Earnings are defined as any remuneration derived from employment excluding ex-gratia payments and bonuses. Insurable earnings, are earnings on which contributions and benefits are calculated. The total annual insurable earnings of every insured person are divided into two bands:

- the *lower band*, the insurable earnings up to the level of *basic earnings,* fixed at €119 a week or €6162 a year in 2002; and

- the *upper band*, the insurable earnings above basic earnings.

As mentioned in Chapter 2 of this report, in the case of employees the rate of contribution to the Social Insurance Fund is 16.6% of their earnings, up to a maximum of €2839 per month. 6.3% is paid by the employee, 6.3% by the employer and 4% by the state. In the case of self-employed persons the rate of contribution is 15.6% of their declared income: 11.6% is paid by the self-employed and 4% by the state.

Voluntary insurance is available to persons who (i) wish to continue paying contributions after the prescribed compulsory period in order to raise their pension benefits or (ii) work abroad in the service of Cypriot employers. In the case of persons paying contributions after the prescribed compulsory period, the contribution rate is 13.5% of the earnings on which they opt to pay contributions: 10% is paid by the contributor and 3.5% by the state. For those working abroad as employees of Cypriot employers the contribution rate is 16.6%, of which 12.6% is payable by the contributor and 4% by the state.

Voluntary continuation of insurance requires the person concerned to satisfy one of the following two conditions:

(i) have regular residence in Cyprus and paid contributions to the basic part of the Scheme on earnings which are not less than 52 times the weekly amount of the basic insurable earnings,

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[19] An insured person who completes the pensionable age without satisfying the contribution conditions for old age pension must continue to pay contributions until these conditions are satisfied. However, in no case contributions can be paid after the age of 68.

(ii) no regular residence in Cyprus and paid contributions to the basic part of the Scheme on earnings not below 156 times the weekly amount of the basic insurable earnings.

Persons working abroad in the service of Cypriot employers can be insured without the above conditions relating to their previous insurance. However, the application for voluntary insurance must be submitted within 12 months from the end of the contribution year for which voluntary contributions are to be paid. Voluntary contributors are entitled to old age pension, widow's pension and orphan's benefit. Voluntary insured persons working for a Cypriot employer abroad are not entitled to benefits for employment injuries.

Tax incentives and alien residents

Contributions to the Social Insurance Fund are tax deductible. Therefore, middle and upper-income groups tend to take advantage of this by saving in supplementary pension schemes. The development of such schemes is also aided by the rising level of earnings.

Cyprus has contracted treaties for the avoidance of double taxation with several countries.[20] Under these treaties foreign pensioners are enabled to remit pensions, free of withholding taxes in their countries. Individual alien residents are taxed 5% per annum on pension and investment income brought to Cyprus. In special circumstances exemptions totalling up to €6896 per person or €13792 per married couple may apply. The total tax burdening of pension and investment income brought into Cyprus by alien residents is around 3%.

Special credits

Under the Social Insurance Scheme every insured person who was over the age of 50 and under the age of 63 on 6th October 1980, is credited with insurable earnings (in the earnings related part of pension) for every weekly contribution paid by or credited to her/him under the repeated flat rate scheme between her/his 50th birthday and 6th October 1980. The amount credited for each week is the weekly average of insurable earnings in the upper band during the period from 6th October 1980 to her/his 65th birthday. The amount credited cannot exceed two times the weekly amount of the basic insurable earnings.

The highest level of protection for an early leaver is the so called *immediate vesting*: a person leaving the scheme after a very short period of

[20] Austria, Bulgaria, Canada, China, Czech Republic, Denmark, France, Greece, Hungary, Ireland, Italy, Kuwait, Norway, Poland, Romania, Russia, Slovakia, Sweden, U.K, USA and Yugoslavia.

service remains entitled to the benefits secured by the contributions paid on her/his behalf. These benefits can remain in the Scheme and be drawn when the person concerned reaches retirement age; or they can be transferred to another pension scheme offered by a new employer or to an approved insurance policy in the employee's name. The benefits are proportional to the pension at retirement.

As mentioned earlier the risks covered by the Social Insurance Scheme are old-age, invalidity, disability, and survivors.

Composition of income in old age

Table 3.2 shows the sources of income for the retired, calculated using a sample of 8637 individuals, out of which 835 (9.6%) were retired.[21] Pensions can be argued to be responsible for placing old age people above or below the poverty line since, in the sense that, as shown in Table 3.2, the main source of income (80%) in old age is pensions.

Table 3.2: Sources of annual income for the retired individuals (1996-97)

Sources of income (mean)	Amount in €	%
Main salary	121.5	1.6%
Pensions	5839.7	78.3%
Rents	225.0	3.0%
Interests	164.1	2.2%
Retirement benefit	650.0	8.7%
Local remittances	111,7	1,5%
Other sources of income*	187,9	2,5%
Income from other benefits**	159.5	2.2%
Total income	7459.5	100.0%

Source: Family Expenditure Survey 1996-97, Department of Statistics and Research.
*Include self-employment, agriculture, shares, transfers from abroad, inheritance, lotteries.
**Unemployment, sickness, maternity, child, government help benefits and other benefits.

Note that local remittances in Table 3.2 represent mostly family financial support, and constitute 1.5% of the income for the elderly. More details on retired people and poverty are giver in Chapter 4.

The capital market

Savings through pensions act as 'consumption smoothers', in the sense that they enable one to obtain a similar standard of living during working and retirement life.[22] The capital market, by offering the mechanism through

[21] The data are drawn from the Family Expenditure Survey 1996-97. The mean value of annual income for all the individuals taking part in the FES 1996-97 was €9461 (CY£5488).

[22] In societies without adequate pension schemes consumption smoothing over time can be achieved by intergenerational transfers, effected through the extended family.

which consumption transfers over time are effected, plays a major role in consumption smoothing over the life cycle.

One can argue that the absence of major private pension funds in Cyprus is due to the capital market being centrally controlled by the government through a fixed interest and exchange rate policy and controls on the free movement of capital. As is well known, private pension schemes are *funded* and need a free and efficient capital market to flourish. An underdeveloped and/or ill-functioning capital market cannot be efficient in performing (through lending and borrowing) the intertemporal transfers required for this purpose. For example, when saving is associated with a very high risk, some individuals may save less than they would under normal circumstances to avoid the excess risk; while others may do the opposite in an effort to insure themselves against the excess risk. In both cases, the capital market imperfection results in a level of savings that is not optimal: eventually, some individuals will find themselves saving either not enough or too much. To the extent that pensions are savings for consumption in old age, an efficient capital market is therefore a necessary pre-requisite for designing and implementing efficient pension schemes.

Cyprus is now gradually abolishing the capital market controls as part of its European harmonisation campaign. In fact, the only government controls still in place relate to the movement of capital in and out of the country.

The banking system

The capital market functions through the banking system. In Cyprus the banking system is privately owned (with the exception of the Cyprus Development Bank) and includes the co-operative societies forming the second largest banking group in terms of total assets.[23] In general, the banking system in Cyprus is considered to be sound financially and competitive in terms of quality and the price of services offered. This is reflected in the 'A/Stable' foreign currency long-term sovereign debt rating awarded to it by the international investment grading company Standard & Poor's.[24] This rating is the highest among the countries which are candidates for EU accession and, according to Standard & Poor's, is not expected to be affected by progress towards a solution of the political problem and unification of the island. In 2000, domestic banks were adequately capitalised, with an average risk adjusted asset ratio of 13.5% (against 11.7% in 1999).

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[23] No village in Cyprus is without a co-operative credit institution. The amount of deposits administered by the co-operative movement reached €4.48 billion in 1999, representing 32% of the local deposits held by banking institutions in Cyprus. The total amount of loans of the co-operative movement in1999 was €3.79 billion, representing 33% of the market.

[24] Reuters, 22 January 2002.

In the area of banking, Cyprus is considered to be at an advanced stage of harmonisation with the EU. The Banking Law of 1997, setting the legal framework within which banking business may be pursued, follows closely the EU banking directives. Regarding the co-operative credit and savings societies, Cyprus has submitted a request for their favourable tax treatment to continue, a position accepted by the EU.

Capital market liberalisation

The capital market in Cyprus is still in the process of liberalisation and the following actions were taken towards this objective in the last couple of years.

- In December 2000 the Central Bank authorised domestic banks to grant loans and credits of any size to non-residents to finance activities in Cyprus.

- In the second half of 2000 the Central Bank abolished the requirement for prior application (and approval by the Central Bank) for the acquisition by foreigners of more than 5% of the share capital of a Cypriot company, other than a bank, listed on the Cyprus stock exchange.[25]

- In May 2001 the Central Bank issued an order under the Exchange Control Law, by which restrictions on the export of certificates of title to any securities were lifted.

- In July 2001, the ceiling on investments abroad by investment companies listed on the Cyprus stock exchange was raised to €35 million or 50% of its capital and reserves (net worth), whichever is the largest.

- An amendment in November 2000 was introduced to implement the EU Joint Action of 3rd December 1998 on money laundering (identification, tracing, freezing, seizing and confiscation of the instrumentalities and the proceeds from crime).

The Central Bank is committed to keeping the exchange rate within the +/-2.25% band in normal times, with fluctuations of +/-15% allowed in the event of 'unusual pressures' in the exchange rate market. It also reduced the interest differential between Euro denominated and domestic loans, thereby reducing the pressure to borrow abroad.

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[25] However, the ceiling of 49 % on the participation of person from third countries in the share capital of such companies is maintained.

3.1.2 Benefits[26]

Calculation of pensions

Pensions are assessed as follows:

- *Basic old age and invalidity pension*: The basic weekly pension is 60% of the weekly average of (paid and credited) insurable earnings in the lower band over the period from 5th October 1964 (or from the contribution year in which the age of 16 is attained, to the last contribution week).[27] For a male beneficiary this is increased by 1/3 for the first and by 1/6 for each of the second and third dependants; while for a female beneficiary not entitled to an increase for her husband the increase is 1/6 for each additional dependent, up to a maximum of two.

- *Supplementary old age and invalidity pension*: The supplementary weekly pension is 1/52 of 1.5% of the total insurable earnings (actual and credited) of the beneficiary in the upper band.

- *Widow's pension*: This is assessed in the same way as old age and invalidity for a male beneficiary.

- *Widow's supplementary pension:* In the case of a widow whose husband was not in receipt of an old age pension, 60% of the supplementary invalidity pension to which the deceased would be entitled on his death if he was treated as invalid on that date, are paid. In the case of a widow whose husband was in receipt of an old age pension, 60% of the supplementary old age pension which was payable to the deceased are paid.

- *Widow's lump sum:* This is payable to a widow whose husband satisfies the first but not the second contribution condition (discussed in 2.3.5). This lump sum is equal to 15% of the total amount of his insurable earnings in the lower band and 9% of his total amount of his insurable earnings in the upper band. In the case of remarriage, the widow is entitled to a lump sum equal to one year's pension, excluding increases for her dependants.

- *Orphan's benefit:* In the case where both parents are dead (or separated and the one, under whose care the orphan was, died) the basic part of the benefit is 40% of the weekly amount of the basic insurable earnings and the supplementary part consists of 50% of the widow's supplementary pension, which was or would had been payable on the death of the

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[26] This section draws heavily on the 'Actuarial Valuation of the Social Insurance Scheme', International Labour Office, Social Security Department, June 1999.

[27] In October 1964 compulsory insurance was extended to every person gainfully occupied in Cyprus including the self-employed.

parent. However, the total benefit can in no case be higher than the said full widow's supplementary pension, where there are more than two dependants. Orphans whose (a) one of the parents died and the surviving parent is not entitled to widow's pension, or (b) widowed mother who was in receipt of widow's pension remarried, receive benefit equal to 20% of the weekly amount of basic insurable earnings for one orphan, 30% for two and 40% for three or more orphans.

- *Basic disablement pension:* The weekly basic disablement pension for 100% disability is 60% of the weekly amount of the basic insurable earnings, increased for dependants as the basic old age and invalidity pensions.

- *Supplementary disablement pension*: The weekly supplementary disablement pension is 60% of the weekly average of insurable earnings of the beneficiary, above the basic insurable earnings, in the period beginning with the first day of the second year before the year in which the accident occurred and ending with the day of the accident.

Indexation

Basic pensions are reviewed at the beginning of each year in accordance with the percentage of revision of the basic insurable earnings. The basic insurable earnings and their ceiling is adjusted to the level of general insurable earnings every year. This adjustment is mandatory if the level of insurable earnings increases by 5% or more.

Supplementary pensions are reviewed according to the increase in the cost of living. This is calculated by comparing the prices in the second half of the year with the prices in the second half of the previous year. Furthermore, every July pensions are increased with the increase of the cost of living index (calculated from comparison of the first half of the year with the first half of the previous year), if the latter is at least 1%.

The above imply that pensions in the lower band are indexed to the increase in the basic insurable earnings, while pensions in the upper band are indexed to the increase in the cost of living. Notably, the fact that pensions in the lower band are indexed to insurable earnings rather than the price level adds 12% to the cost of pensions in this band.[28]

[28] If all pensions are indexed to prices, a gap would gradually appear between minimum pensions in payment and minimum pensions paid to new pensioners. To counteract this, minimum pensions could continue to be indexed to wages and other pensions to prices, with a cost saving of 8% (instead of 12%).

Replacement rate

The average (gross) replacement rate, reported in Table 3.3, is calculated as the ratio of the average pension to the average salary of active contributors. It indicates the part of salary replaced by the pension, assuming that pensions increase in line with the salaries of contributors.

Lower ratios observed in the upper band reflect the fact that this part of the scheme is still young: beneficiaries in 1997 had not accumulated enough since the inception of that band in 1980 and the application of the supplementary benefit formula (1.5% of accumulated earnings) results in a gradually increasing ratio between 1991 and 1997. [29]

Table 3.3: Gross replacement rates

Band	Year	Old age pension		Invalidity pension		Widow's pension
		Males	Females	Males	Females	
Lower band	1991	27%	29%	27%	25%	23%
	1994	28%	28%	26%	24%	23%
	1997	28%	29%	26%	24%	24%
Upper band	1991	8%	6%	11%	12%	7%
	1994	9%	6%	14%	12%	7%
	1997	10%	7%	15%	12%	7%

Source: 'Actuarial Valuation of the Social Insurance Scheme', International Labour Office, Social Security Department, June 1999.

Pension distribution

Table 3.4 presents the distribution of pension payments for the years 1997-2000. As it can be seen from the table, the total amount paid for each kind of pension increased over this period: the widow's pension has increased by 24%, the old age pension by 32%, the orphan's pension by 28%, and the invalidity pension by 31%.

The percentage of old age pensions in total pension payments, at 70%, is significantly higher than other types of pensions. At the other end is the orphan's pension with a percentage of only 0.5% in total pension payments. These percentages, more or less, reflect the number of beneficiaries in each pensioners category, shown in Table 3.5. As expected, the number of old age pensioners is the highest followed by the widow and invalidity pensioners, while the number of orphan and disablement pensioners is the lowest.

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[29] 'Actuarial Valuation of the Social Insurance Scheme', International Labour Office, Social Security Department, June 1999. In addition the scheme provides supplements for dependants, thereby increasing further the effective replacement rate.

Table 3.4: Distribution of pensions, 1997-2000

Pension type	1997		1998		1999		2000	
	€ (mil)	%	€ (mil)	%	€ (mil)	%	€ (mil)	%
Old age	204.1	70.5	219.9	70.8	244.1	71.4	270.5	72.1
Widow's	62.9	21.7	66.3	21.3	71.9	21.0	78.2	20.8
Invalidity	18.8	6.5	20.5	6.6	21.7	6.3	24.6	6.6
Orphan's	1.4	0.5	1.6	0.5	1.7	0.5	1.9	0.5
Disability	2.2	0.8	2.4	0.8	2.6	0.8	-	-
Total	289.4	100	310.7	100	342	100	375.2	100

Source: Cyprus country report "International short training course in economic & financial aspects of ageing in developing countries", Malta, 4-15 March 2002.

Table 3.5 shows that the expenditure of the Social Insurance Fund on old age pensions was €270.4 million in 2000. The number of pensioners that were eligible for old age pension in the same year was 57.7 thousands. The number of pensioners eligible for social pension was 15.4 thousands. As we shall later (in section 4.1.1), the Family Expenditure Survey 1996-1997 provides strong evidence that most people below the poverty line are pensioners (61.7% of retired males and 67.1% of retired females). Among people aged more than 65 years who live alone the incidence of poverty rises to over 90%. These figures suggest that the pension system is not adequate with regard to income security in old age.

Table 3.5: Distribution of pensioners (in thousands), 1997-2000

Year	Old age	Widow's	Invalidity	Orphan's	Disablement
1997	52.3	20.4	4.37	0.77	0.99
1998	53.9	20.6	4.57	0.84	1.00
1999	54.8	20.6	4.56	1.09	1.03
2000	57.7	21.4	5.01	1.12	1.06

Source: Cyprus country report "International short training course in economic & financial aspects of ageing in developing countries", Malta, 4-15 March 2002.

Age conditions for retirement

The old age pension is payable at the age of 65 for men and 63 for women (born before 1.1.1935). Moreover, the pension is payable at the age of 63 if the person satisfies the contribution conditions and has weekly average insurable earnings at least equal to 70% of the weekly amount of basic earnings.[30] For pensions dominated by supplementary schemes in the government and semi-government sector the compulsory pensionable age is usually 60 years, with the right to opt for early retirement between 55 and 60.

[30] Miners are entitled to old age pension one month earlier than the normal pensionable age for every 5 months of work in a mine, but not before the age of 58.

The payment of the pension is not conditional on retirement from regular employment. In fact, the actuarial valuation of 1997 presents evidence that although insured persons tend to claim their old age pension at 63, around 50% of them continue to work and pay contributions in order to claim an upward adjustment of their old age pension for their extra contributions. A person can also ask for postponement of the payment of the pension until the age of 68. In this case, the amount of the pension is increased by 0.5% for each month of postponement.

A person of pensionable age satisfying condition (i) but not condition (ii) of invalidity pension (discussed in section 3.1.1) is entitled to a lamp sum at the age of 68. A person not satisfying the contribution conditions at the age of 65 is allowed to continue the payment of contributions until the age of 68. If at that age the contribution conditions are still not satisfied for the payment for old age pension the person concerned is entitled to a grant equal to 15% of the total amount of insurable earnings if she/he has (paid/credited) contributions for at least three years.

3.1.3 Financing of the pension system

The financing of the system is made on a tripartite basis: employer, insured person and state (the state's contribution is mainly used for the subsidisation of the low-paid insured persons). According to the actuarial analysis sited earlier in this chapter, the mixing of income and expenditures for three different types of benefits (pensions, short-term benefits and employment injury benefits) complicates the setting of an appropriate financing system of pensions in Cyprus. Each of these benefits requires a separate financing system adapted to the nature of its own needs. In addition, the level of reserves to be maintained for each branch should respond to different risks and objectives.

More specifically, since pensions are long-term benefits, the financial obligations that a society accepts when adopting financing provisions and benefit provisions for them are also of a long-term nature. Participation in a pension scheme extends over the whole adult life, either as contributor or beneficiary. During their working years contributors gradually build entitlement to pensions that will be paid even after their death to survivors. All short-term benefits are financed on a pay-as you-go system, leaving long term benefits with the residual financial resources. This situation is not sound, as variation in short-term benefits has a direct impact on the resources available to the finance long-term benefits.[31]

[31] The contribution rates of 8.6% in the lower band 5.7% in the upper band applicable in 1997, are sufficient to meet the financial obligations of the scheme for a certain number of years (estimated up to 2010).

Another problem with the financing of the pension scheme in Cyprus is the fact that self-employed people tend to contribute to the Social Insurance Fund according to their understated declared rather than their true annual income. For example, in 1999 the self-employed contributed as if their average income was €8327. The average income of employees in the same year was €13304.

Table 3.6: Contributions to Social Insurance Fund by type of employment (1997)

Contributions from:	**Employed***		**Self-employed****		**Employers**	
	€	%	€	%	€	%
Salary	1750.9	99.4	47.6	4.9	117.8	8.3
Pension income	2.5	0.1	4.0	0.4	2.4	0.2
Agriculture income	1.6	0.1	149.9	15.6	191.8	13.4
Self employment income	7.6	0.4	760.0	79.1	1111.9	78.1
Total	1762.8	100	961.6	100	1423.9	100

Source: Family expenditure survey 1996-1997

* Some employed people declare deductions from self-employment (and pension) income.

** Some self-employed people declare deductions from employment (and pension) income.

Table 3.6 shows the extent to which the understatement of self-employment income results in inequality between the contributors: the self-employed contribute to the Fund €962 as opposed to €1763 contributed by the employees. Also, the employees contribute more than the employers. The mean amount of contributions is €4148, of which 42.5% is contributed by employees 23.2% by the self-employed and 34.3% by employers.

3.1.4 Incentives

The Social Insurance Scheme in Cyprus encourages people to continue working after reaching pensionable age because, as said earlier: (i) the payment of the pension is not conditional on retirement from regular employment and (ii) contributions to the scheme after pensionable age enables one to claim an upward adjustment of her/his old age pension to take account of the extra contributions. Recently, a new scheme called 'Self-Employment Scheme' has been introduced to keep persons over 63 years actively involved in economic activity as self-employed. Under this scheme grants are provided for the purchase of equipment and/or materials for activities such as agriculture, stock-breeding, home made sweets, embroideries, ceramic work, writing books etc.

3.1.5 Coverage of the system

The Social Insurance Scheme in Cyprus covers compulsorily all the actively employed population. However, self-employed married women in agriculture and unmarried daughters under the age of 35 living with their parents are not covered by the scheme. Although these are elements of

discrimination against women, those not covered by the Social Insurance Scheme, are entitled to a Social Pension. In other words, between them the Social Insurance and Social Pension schemes provide pension cover for everybody in the country.

Furthermore, the Public Assistance and Related Services Law 10/75, (as amended by Law 40/76) gives to every citizen the right to financial assistance for the satisfaction of her/his basic needs (food, clothing, shelter, water, electricity rates). The Law includes provisions intended to also offer assistance to meet special or urgent needs. In addition, social work services are provided to elderly and disabled persons over the age of eighteen not able to look after themselves. Under the social insurance legislation the principle of equality of treatment between nationals and non-nationals is maintained.

There are pension schemes offered by private institutions in Cyprus but opting out from the state Social Insurance Scheme is not allowed. Private pension schemes are additional to the state one for those who wish to increase their pension.

3.1.6 Public acceptance of the system

The Association of Cypriot Pensioners have recently had a meeting with the Minister of Labour and Social Insurance requesting free access to athletic, cultural and other events, and free provision of various government services, such as the issue and renewal of passports etc[32]. During this meeting, the pensioners complained about the lack of education programmes for old age people, especially on the use of computers and the internet. They also raised objections to the eligibility criteria used in relation to the Self-employment Scheme for old age pensioners. According to this scheme eligible for financial support must be at least 63 years old with a monthly income below €430 for one person and €600 for a couple. The pensioners think that these eligibility criteria discriminate against those who receive pension (under the Social Insurance Scheme) because their income (including the pension) is higher than €430 for one person and €600 for a couple.

The government has been working in partnership with communities and voluntary organizations, providing them with technical and financial assistance to help them develop their own programmes for the elderly at local and regional levels. A Coordinating Body for Older Persons (discussed in section 3.3.1), with a wide representation of governmental, private and non-governmental organizations has been operating since 1995.

[32] Also, in a letter to the Minister of Labour and Social Insurance the Association of Cypriot Pensioners ask for an increase in all pensions by 15%. For the basic pension, in particular, the Association asks for an additional rise so as to increase to around €350 (CY£200) per month. Also pensioners living in refugee settlements often complain about the poor quality of their accommodation.

Furthermore, a high level inter-governmental body monitors the policies of various government departments with a view to achieving adequate coordination. Older people also have the opportunity to promote recommendations on all matters that concern them by participating in the Senior Citizen's Parliament, established in 1999, the International Year of Older Persons.

In general the pension system in Cyprus is highly rated in public opinion, not considered to be in any way corrupted. An objection, however, is often voiced against the present practice of having nearly all the reserves of the Fund, (amounting to €3.8 billions) deposited in a special account at the Central Bank, earning interest. The argument is that alternative, possibly more profitable, ways of investing some of the reserves should be considered.

3.2 Evaluation of Future Challenges

3.2.1 Main challenges

The well-being of older people is declared as a long-standing objective in government development plans. At the moment, one can argue that Cyprus has done enough to safeguard the right of older people to a decent material standard of living. At the same time, however, the welfare of old age people can be improved on account of other aspects of their lives such as:

- strengthening links with the community,
- promoting their independent social functioning,
- improving the provision of health and social services,
- providing opportunities for active participation in the society,
- placing emphasis on lifelong learning, and
- fostering solidarity and social cohesion between generations.

It is also the case that people in Cyprus need to develop a more positive attitude towards old age pensioners. This, for instance, can be achieved by educating people to reject the perception that older human beings are a frail homogeneous group of individuals that are dependant on others. Instead, the government should promote the ability of people to recognize the needs as well as the capabilities and worth of each individual in society regardless of age.

3.2.2 Financial sustainability

There are strong indications that the aging of population in Cyprus will become an issue of concern with far-reaching implications in the next two

decades. Persons over 65 years of age now comprise 11.4% of the total population. The fertility rate is already below replacement level (1.8% in 2000) and by the year 2028, low fertility and mortality rates are expected to lead to a sharp increase in the share of older people in the population, reaching almost 17.6%. Furthermore, by then the number of people aged 80 years and over is expected to double.

Social Insurance Scheme and the future

At the moment, the Social Insurance Scheme in Cyprus is financially sound and its actuarial equilibrium is guaranteed for the next 18 years or so with the existing rates of contributions.[33] However, the aging of population poses the biggest threat to the long-term financial viability of the Scheme. Under the present retirement age and other social insurance arrangements, the now 30 pensioners for every 1000 contributors is expected to increase to 62 pensioners for every 1000 contributors in the year 2050.

The Government of Cyprus is currently engaged in a dialogue with the 'social partners' with a view to reaching policy recommendations for the restoration of the long-term financial viability of the Social Insurance Scheme. Its actuarial adviser (Chief of the Financial Actuarial and Statistical Branch of the Social Security Department, ILO) has put forward various proposals for discussion with the social partners, including the following[34]:

- Gradual abolition of the right to receive old age pension at the age of 63 and receipt of such pension at the age of 65.

- Diversifying the investment opportunities available to Social Insurance Fund so as to attain the maximum return on its reserves. At present, as said earlier, nearly all the reserves of the Fund, amounting to €3.80 billions, are deposited in a special account at the Central Bank, earning interest.

- Restriction of the right of employees to receive unemployment benefit upon retirement when they also receive retirement benefit from their employer or lump-sum payments from provident funds.

- Establishment of criteria in the legislation for changes in the contribution rates.

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33 'Pension Reform in Cyprus', May 2001, by A. Petasis, Director of the Department of Social Insurance, Ministry of Labour and Social Insurance.

34 'Actuarial Valuation of the Social Insurance Scheme', International Labour Office, Social Security Department, June 1999.

- Adjustment of the basic pensions according to the annual increase in the cost of living index and not the (higher) increase in the level of wages.

- Reduction of the contribution payable by the state to the Social Insurance Scheme in the form of a subsidy and its absorption by other contributing parties.

3.2.3 Pension policy and EU accession

EU is said to be encouraging shifts towards pension schemes that stimulate capital markets, increase public savings and reduce labour costs and public social spending. These schemes (i) reduce the public pay-as-you-go finance, (ii) increase mandatory funded and privately managed schemes and (iii) encourage voluntary private savings for old age. An early policy shift tackling some of these issues may help Cyprus in restructuring its Social Insurance Scheme to guarantee financing. It can also increase labour force participation.

As a consequence of EU accession, Cyprus may have to make the following changes in its Social Insurance Scheme:

- Make voluntary contributions possible for persons not residing ordinarily in Cyprus. This should not have a significant effect on the total cost of the Scheme.

- Consider all females employed in agriculture as self-employed persons. This will also have an insignificant effect on the total cost of the Scheme.

- Extension of dependants supplements to female contributors and performance of a real dependency test.[35]

- Combination of old age and widow's pension. This will increase the general average premium in the lower band from 12% to 12.3%.

- Increase of the pensionable age from 63 to 65 (already mentioned above).

- Increase of the basic pension.

Moreover, the EU accession may cause changes in the demographic structure of the population, e.g. younger people may migrate to other EU countries in search of better employment opportunities, thus reducing the percentage of young people in the Cypriot population.

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[35] This will reduce the amount of spouse supplements by 40% for male beneficiaries and generate a spouse supplement of 20% for female beneficiaries.

3.3 Evaluation of Recent and Planned Reforms

3.3.1 Recent reforms and their objectives

One of the most important reforms of the Social Insurance Scheme in Cyprus took place in 1995, with the introduction of the social pension. Its objective was to provide a pension to all those who were not entitled to an old age pension. This made the coverage of the whole population in Cyprus under the public pension system possible.

The establishment of the Co-ordinating Body for the Elderly in 1995, was a step in the direction of mobilising governmental and non-governmental organisations to work towards improving the quality of life of older people in Cyprus. Furthermore, the establishment of an intergovernmental body was necessary for the policies of various government departments to be adequately co-ordinated.

The Senior Citizen's Parliament, established in 1999 and the so called 'Supreme Body on Policy Making for the Elderly' established in 2000 can form channels for older people to voice their opinion, promote recommendations and shape government policy on matters of their concern.

Activities planned for the future include:

- a study of services and programmes provided to older persons by the Cyprus Development Bank;
- an upgrade of the standards of governmental homes for older persons to improve the quality of life of their inhabitants; and
- a study to establish that older persons do have an acceptable minimum standard of living.

Social Charter and other developments

In January 2001 the Ministry of Labour and Social Insurance, in co-operation with the Co-ordinating Body for the Elderly, issued the *Social Charter* granting privileges to all persons over 63 to participate in social and cultural activities. The Charter entitles these persons to free travel on buses, both rural and urban, and reduced fares for travel on planes and ships. Other benefits included in the Charter are reduced hotel rates and cheaper medical tests. It is estimated that this measure will cost to the government €1.3 millions per annum.

Other changes that have occurred recently include:

- A scheme introduced in February 2001 which provides financial assistance up to €10.3 million for housing alterations or extensions so

as to facilitate the care for the elderly by the family and avoid their institutionalisation.

- Increases in the basic part of the social pensions by 5.2% and in the supplementary part by 2.0%, raising the social pension to €230 per month.[36]

- Increase in the ceiling for insurable weekly earnings from €676 to €710 and for insurable monthly earnings from €2920 to €3000.

- Increase of the self-employment income on the basis of which the social insurance contributions are calculated by 5.21%.

3.3.2 Political directions of future reforms

The tax reform approved by the Cyprus Parliament in the summer of 2002, by increasing indirect taxes to EU levels (e.g. raise the VAT from 10% to 15% and increase the excise duties on tobacco and petroleum products to the minimum EU levels) will also increase the cost of living of households. The government has declared its intention to make the tax reform 'revenue neutral' by making compensating reductions in direct taxes and rises in benefits.

All political parties have put forward proposals emphasising the need to implement adequate compensating increases in benefits to avoid reduction in the standard of living of individuals, who pay no direct taxes because their income is too low and, therefore, will not benefit from reduction in income tax. It is clear from the declared positions of all political parties that there is strong consensus in favour of an increase in the minimum social and basic old age pension from below €260 to €345. Political consensus in Cyprus also exists for the gradual (over 9 years) increase in pensionable age to 65 for all citizens, as a measure to reduce the cost and ensure the long term viability of the Social Insurance Scheme.

The government argues for reduction in its contribution to the Social Insurance Fund from 4% to 2% and for a compensating increase in the employer's contribution by 2%. The government justifies this on the grounds that employers will benefit from the reduction in corporate taxation and abolition of the special defence tax approved in the recent tax reform. The employers and employees, however, oppose the shift in social insurance contributions from the government to the employers arguing that the government must be a contributor to demonstrate the state's commitment to the Social Insurance Scheme.

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[36] Comparable increases in other social insurance benefits have also been implemented.

Changes proposed by the actuarial adviser

The actuarial adviser of the Social Insurance Scheme has recommended the contribution rate schedule under the status quo provisions presented in Table 3.7. The proposed contribution rates are set so as to cover the cost of benefit expenditures and include (in the lower band) a provision for 0.15% of the total salary base to cover administrative expenses.

Table 3.7:Recommended contribution rate schedule under the status quo provisions

Period	Contribution rate			Reserve as a multiple of annual expenditures (end of period)	
	Lower band	Upper band	Total	Lower band	Upper band
1998-2010	8.6%	5.7%	14.3%	2.0	20.9
2011-2020	10.8%	6.5%	17.3%	2.2	11.2
2021-2030	12.5%	7.5%	20.0%	1.5	5.5
2031-2040	14.6%	8.5%	23.1%	1.1	2.2
2041-2050	16.0%	10.0%	26.0%	1.0	1.0

Source: 'Actuarial Valuation of the Social Insurance Scheme', International Labour Office, Social Security Department, June 1999.

Table 3.8 shows a contribution rate schedule that would be sufficient to finance long term benefits in the context of the reform proposed by actuarial adviser. The reform includes an increase in pensionable age from 63 to 65 and the indexation of pensions in the lower band to prices, instead of salaries.[37]

[37] It also includes payment of widower's pensions, a measure suggested in the actuarial valuation.

Table 3.8: Contribution rate schedule under the reform package

Period	Contribution rate			Reserve as a multiple of annual expenditures (end of period)	
	Lower band	Upper band	Total	Lower band	Upper band
1998-2010	8.6%	5.7%	14.3%	3.8	25.1
2011-2020	8.6%	5.7%	14.3%	3.5	12.9
2021-2030	10.1%	5.7%	15.8%	2.2	5.2
2031-2040	11.5%	8.0%	19.5%	1.1	2.0
2041-2050	13.3%	10.3%	23.6%	1.0	1.0

Source: 'Actuarial Valuation of the Social Insurance Scheme', International Labour Office, Social Security Department, June 1999.

Moreover, it suggests stipulation of the following rules:

(i) The Social Insurance Scheme should be considered to be in actuarial equilibrium if, on a valuation date, the expected reserve of the Scheme at the end of year t during a period of equilibrium of 10 years is equal to at least one time the Scheme's expenditures in year t;

(ii) During the maturation phase of the upper band, the level of the reserve ratio k will follow a special schedule for the next five decades, k=11 until 2020, k=5 until 2030, and k=2 until 2040. After 2040, the general rule specified in (i) will apply to the upper band.

The expected impact of this reform is to guarantee contribution rate stability over the next decade. Concerning the increase of contributions of the self-employed, the actuarial adviser suggests the number of professional categories be increased from 10 to 28. Also, it is suggested that new higher insurable earnings should be determined so that the self-employed contribute according to their real rather declared earnings.

Changes proposed in Strategic Plan 1999-2003

According the Strategic Plan 1999-2003, one of the major government objectives is the support of families caring for older family members and the creation of employment opportunities for older persons. For the implementation of these goals the Plan suggests :

- the set up of a support programme for informal care-givers,
- the enhancement of existing programmes for home care-givers, and
- the introduction of a scheme for the integration of older persons in the labour market.

The objective of these measures is to improve the quality of life of older persons, promote their independence and increase their active participation in community life for as long as possible.

3.3.3 Summary and conclusions

The Social Insurance Scheme in Cyprus requires a number of reforms to improve further the quality of life for the elderly and secure the long-term financial sustainability of the system. Notably, some of the measures proposed by the Plan have already been implemented through schemes discussed earlier such as the a scheme for the financial support to families caring for elderly members and other incentives for the provision of home care to help older people avoid institutionalisation and schemes aimed at creating opportunities for them to participate in the labour market and in the community life at large.

Concerning the financial viability of the Social Insurance Scheme, actuarial analysis suggests that the contribution rates are not sufficient to meet the financial obligations of the scheme beyond 2010. The same analysis illustrates the difficulty in setting an appropriate financing system because of the mixing of income and expenditures for three types of benefits: pensions, short-term benefits and employment injury benefits. Each of these branches needs a financing system adapted to the nature of the benefits it provides. Furthermore, the level of reserves for each branch should be maintained at a level adequate to respond to different objectives.

In the case of pensions, benefits are long-term and so should be the design of financial obligations. At the moment, short-term benefits in Cyprus are financed on a pay-as-you-go basis, leaving long-term benefits to be financed by residual resources. This situation is not sound, as any variation in short-term benefits impacts on the resources available for financing long-term benefits.

Another problem of financing the pension scheme is that self-employed people tend to contribute below the level corresponding to their real annual income. For example, in 1999 self-employed contributed as if their average income was €8327 while the contribution of the employees in the same year was at an average income of €13304. It appears that a major part of employee contributions is used for funding pensions for the self-employed.

Finally, the pension system in Cyprus is contaminated with residual elements of gender inequality: women working in the agriculture sector and unmarried daughters under the age of 35 living with their parents are not considered eligible for pension. Also the dependants supplements do not apply to female contributors to the Social Security Scheme. These elements of discrimination against women in the pension system must be eliminated from the Scheme.

4. POVERTY AND SOCIAL EXCLUSION

4.1 Evaluation of Current Profiles of Poverty and Social Exclusion

4.1.1 Social exclusion and poverty within the overall social protection system

Poverty and social exclusion are not considered to be a serious problem by policy makers and public opinion in Cyprus. This can partly reflect the reduced severity of the problem and partly the preoccupation of the government and the people of Cyprus with the 'ethnic problem' created by the Turkish occupation of the Northern 36% of the island.

There is no evidence of widespread social exclusion, in the form of *persistent* income poverty[38], in Cyprus. The opposite, however, is also true, i.e. there is no statistical evidence (no time series data is available) to substantiate the claim that persistent poverty does not exist. All one can say is that Cyprus is a small homogeneous community, by the standards of most other European countries, with small and sparsely located cities and historically low levels of illiteracy and unemployment. It is also a society with strong bonds among relatives resulting in extended families that secure financial support to those in need. Therefore, poverty and social exclusion is more likely to be a problem in Cyprus among those outside 'family networks' such as the immigrants, particularly those who are illegal and work mainly in the 'informal' sector of the economy. In this sense, poverty may be increasing due to the increasing number of illegal immigrants and 'black economic' activity in the island. Again, no direct statistical evidence can be used to document this claim because illegal activities are not included in the official government data used in this report.

In the analysis performed for the purposes of this report using the raw data in the Family Expenditure Survey of 1996-97, we have found high incidence of poverty among the elderly, the divorced and the singles. This is, perhaps, a sign of transformation taking place in Cyprus, away from a society organised around the extended family tradition towards a Western type of society organised around the nucleus family.[39] Although we cannot observe trends using time series data, the evidence from the Family Expenditure Survey of 1996-97 shows a strong negative correlation between poverty and family size. As shown in Table 4.1, one-person and two-persons households concentrate at the bottom deciles of income distribution.

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[38] Persistent income poverty consists of persons that are living in a low-income household for at least three consecutive years.

[39] One can also claim, of course, that the breakdown of family networks is due to their inefficacy.

4.1.2 National definitions of poverty and social exclusion

The relative poverty line before 1996 was officially defined as 50% of the average national per capita income of all households, whereas after 1996 as 60% of the median national *equivalised* income. The income of a household as a whole is converted into income per *adult equivalent* by taking into account the demographic composition of the household (see section 1.1.3).

Table 4.1: Income distribution and household size (in total figures)

Household size	Income deciles										
	1st	2nd	3rd	4th	5th	6th	7th	8th	9th	10th	All
One person	141	92	36	21	10	10	7	6	2	2	327
Two persons	139	126	128	75	45	33	31	29	20	31	657
Three persons	11	11	49	54	57	66	57	45	54	52	456
Four persons	1	8	33	64	75	102	97	109	105	92	686
Five or more persons	1	3	15	51	77	53	73	77	82	87	519

Source: Family Expenditure Survey 1996-97.

Using the data in the FES 1996/97 we have identified the incidence of poverty to be high among the following groups: retired persons (aged over 65), widows (males or females), divorced women, illiterate people or people with elementary education, and single parents (Table 4.2).

Table 4.2: Percentage of persons below the poverty line in various socio-economic groups

Type of person	Below poverty line (%)	% in population
Male 65+	62.0	5.0
Female 65+	65.7	5.9
Retired male	61.7	4.8
Retired female	67.1	4.9
Widow male	54.2	0.8
Widow female	55.6	3.4
Male 25+ without education	58.5	0.8
Female 25+ without education	69.3	1.9
Male 25+ with elementary education	48.9	2.6
Female 25+ with elementary education	49.9	4.7
Single households aged 65+	90.7	2.3
Couples without children, at least one adult aged 65+	64.7	8.0
Single parents with at least one depended child	33.0	1.3
All	25.5	100

Source: Family Expenditure Survey 1996-97.

4.1.3 The 18 EU indicators of Social Exclusion

Table 4.3 shows the 18 EU indicators of social exclusion and the corresponding indicators available in Cyprus. Commenting on the content of this table, Cyprus does not publish matching EU low income indicators for various socio-economic groups (EU indicators of social exclusion 1a to 1e). It does, however, publish mean annual income for these groups.[40]

Furthermore, there are no social exclusion indicators in Cyprus matching the following EU ones: persistence of low income, persistence of low income below 50% of median income, relative mean low income gap, regional cohesion, very long unemployment rate, self-defined heath status, low income rate anchored at a moment in time, and low income rate before transfers.[41]

The indicators of social exclusion which are available (or can be computed from available data) and match the EU ones are: the distribution of income, the Gini coefficient, the dispersion around the low income threshold, long term unemployment rate (≥12 months), long term unemployment share (≥12 months), persons living in jobless households, early school leavers not in education or training, life expectancy at birth and persons with low educational attainment.

Among the EU indicators reported in Table 4.3, those concerning regional cohesion and unemployment are not particularly relevant in the case of Cyprus, due to the small size of the country and the historically low levels of unemployment, respectively. Perhaps, more accurate in profiling Cyprus' poverty and social exclusion can be indicators of population characteristics seen later in this chapter (section 2.2.8) to raise the probability of being below the poverty line, such as old age, single adulthood/parenthood, part-time employment and chronic illness.

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[40] Concerning persistence, annual income would tend to underreport intermittent short-term/seasonal income fluctuations and hence short periods of poverty. Later in this chapter we relate poverty to other more 'permanent' characteristics of the household.

[41] The information required for the calculation of most of these indicators, however, is available in the Family Expenditure Survey (FES) conducted by the Department of Statistics and Research every five years.

Table 4.3 The 18 EU Indicators of social exclusion and the corresponding indicators in Cyprus

	Indicator	**Match CY**	**Comparable indicator**	**Data sources and most recent year avail. for indicators or comp. indicators**
1a	Low income rate after transfers with breakdowns by age and gender[1]	ρ	Mean annual income per adult equivalent by activity status and age of head of household	FES[2.3], 1996/97
1b	Low income rate after transfers with breakdowns by most frequent activity status[1]	ρ	Mean annual income per adult equivalent by activity status and income decile	FES[2.3], 1996/97
1c	Low income rate after transfers with breakdowns by household type[1]	ρ	Mean annual income per adult equivalent by activity status and type of household	FES[2.3], 1996/97
1d	Low income rate after transfers with breakdowns by tenure status[1]	ρ	Mean annual income per adult equivalent by source of income and socio-economic status	FES[2.3], 1996/97
1e	Low income threshold (illustrative values)[1]	ρ	Mean annual income per adult equivalent by activity status and type of household	FES[2.3], 1996/97
2	Distribution of income	✓	—	FES[2.3], 1996/97
3	Persistence of low income	ρ	—	—
4	Relative median low income gap[1]	ρ	—	—
5	Regional cohesion	ρ	—	—
6	Long term unemployment rate (≥12 months)	✓	—	Social Indicators & Labour Statistics[3], 1999
7	Persons living in jobless households	✓	—	Social Indicators[3], 1996/97
8	Early school leavers not in education or training	✓	—	Statistical Abstract[3], 1998
9	Life expectancy at birth	✓	—	Statistical Abstract[3], 1999
10	Self defined health status by income level.	ρ	—	—
11	Dispersion around the low income threshold	✓	—	Social Indicators[2], 1996/97
12	Low income rate anchored at a moment in time	ρ	—	—
13	Low income rate before transfers[1]	ρ	—	—
14	Gini coefficient	✓	—	FES[2.3], 1996/97
15	Persistence of low income (below 50% of median income)	ρ	—	—
16	Long term unemployment share (≥12 months)	✓	—	Social Indicators & Labour Statistics[3], 1999
17	Very long term unemployment rate (≥24 months)	ρ	—	—
18	Persons with low educational attainment	✓	—	Statistical Abstract[3], 1998

[1] This indicator is not available in the publications of the Department of Statistics and Research; we can extract the particular indicator by using the raw data of the Family Expenditure Survey 1996-97.
[2] FES: Family Expenditure Survey 1996-97. [3] Publications of the Department of Statistics and Research.

4.2 Evaluation of Policy Challenges and Policy Responses

4.2.1 Inclusive labour markets

Unemployment as a cause of poverty and social exclusion

Unemployment, in Cyprus has never been as high as in other European countries. Based on *registration data*, the unemployment rate dipped below 2% in 1992, and rose gradually to 3.6% in 1999, falling marginally to 3.4% in the year 2000 (Table 4.4). The rate of unemployment according to the Labour Force Survey (LFS), based on internationally comparable International Labour Office (ILO) definitions, was 4.8% in 2000.

Table 4.4 Unemployment rate in Cyprus and EU countries

Countries	1995	1996	1997	1998	1999	2000
Cyprus	2.6	3.1	3.4	3.4	3.6	3.4
EU countries	10.8	10.9	10.7	9.9	9.2	8.4

Source: Economic Outlook 1998, 2000; Planning Bureau.

Unemployment, according to the LFS (in the year 2000), is higher among women (7.4%) than men (3.0%). The gender difference is most marked among people aged 15-24 years (female unemployment of 14% as against 4% for males) and 35-44 years (females 9%, males 2%). Also youth unemployment is higher than adult unemployment (8.1% for those below 25). However, the age-unemployment gap is relatively low by international standards and youth unemployment remains well below the EU average.

Table 4.5: Registered unemployed women by age group and their percentage in total unemployment 1995-2000

Age	Years											
	1995		1996		1997		1998		1999		2000	
	Female	% in total	Female	% in total	Female	% in total	Female	% in total	Female	% in total	Female	% in total
19-	184	80	220	79	224	79	187	76	158	75	95	71
20-24	574	61	669	62	725	59	705	58	697	59	550	51
25-29	559	54	641	57	657	55	614	51	717	56	618	57
30-34	579	59	666	59	648	55	556	49	616	54	614	57
35-39	525	57	628	58	694	55	616	52	686	54	719	59
40-44	450	57	518	57	581	53	587	51	720	54	765	59
45-49	453	59	555	60	579	56	509	50	650	55	642	56
50-54	352	59	489	56	537	53	503	47	622	51	640	53
55-59	380	46	417	42	419	42	377	38	491	41	542	53
60-64	252	31	325	31	349	30	333	27	431	31	473	32
65+	5	22	5	24	4	16	2	13	7	29	11	40
Total	4313	55	5133	54	5417	48	4989	48	5795	50	5668	52

Source: Labour statistics

Table 4.5 shows the registered unemployed women by age group and their percentage in total unemployment for the years 1995 to 2000. For women aged under 54, unemployment is throughout these years significantly higher than that of men. Especially for women aged under nineteen the percentage rose up to 80% in 1995, and declined to 71% in 2000. For the age group of 20-24, there has been a decrease from 61% to 51%. For women older than 54, the percentage in total unemployment is much lower than that of men. However, for women older than 65 the percentage has risen substantially from 5% in 1995 to 40% in 2000.

As shown in table 4.6, in the year 2000 most unemployment was of a relatively short duration: approximately only 30% of the unemployed had been out of work for more than a year in Cyprus (compared to 44% in the EU). The long-term unemployment *rate* (the proportion of long-term unemployed in the labour force) is also relatively low, at 1.4%. Duration of unemployment is longer for women, 36% compared to 21% for men. At 2.7%, the female long-term unemployment rate is almost four times higher than the corresponding male rate.

Table 4.6: Long term unemployment(over 12 months) by sex 1995-2000

Sex	**Years**					
	1995	1996	1997	1998	1999	2000
Male	0,14	0,15	0,19	0,21	-	0,21
Female	0,32	0,36	0,41	0,39	-	0,36
Total	0,21	0,23	0,28	0,28	-	0,30

Source: Social indicators, Labour force survey 2000

Table 4.7 shows the number of seasonal unemployed persons by economic activity and sex. This table provides evidence of the existence of seasonal unemployment, especially in the tourism sector (wholesale and

Table 4.7: Seasonally unemployed persons by economic division and sex 2000

Monthly average		**Winter**	**Spring**	**Summer**	**Autumn**	**Economic activity**
Total	Females					
712	432	2141	1940	1709	2761	Newcomers
154	54	661	585	380	216	Agriculture
17	1	42	49	50	56	Mining
2246	1434	7177	7604	6531	5641	Manufacturing
37	2	122	160	145	14	Electricity
1326	79	4400	4946	3586	2974	Construction
3171	2006	13313	9146	7102	8492	Retail, hotels and restaurants
531	191	2026	1713	1249	1388	Transport
444	287	1416	1386	1235	1286	Financing, insurance, business
2298	1182	6650	6381	8635	5905	Community, services
10934	5668	37948	33910	30613	28733	Total

Source: Labour Statistics 2000

retail trade, hotels and restaurants). More specifically, the total number of unemployed persons in the tourism sector was 13313 in the winter of 2000, while in the summer of the same year this number was only 7102. This is because tourism is much higher during the summer months.

Unemployment is also low in autumn because September is still in the high holiday season. Since the tourist sector is central to the economy of Cyprus, this seasonality in employment spills over to other sectors. Notably, the total monthly average shows that women are slightly more affected by seasonal unemployment (52% are women and 48% are men).

Table 4.8 shows the percentage distribution of households below the poverty line by employment status and gender. The last column in the table gives the percentage of the corresponding group in the population to help the reader understand the order of magnitude of the poverty problem. It is clear that the retired men and women are the most vulnerable groups, with 61.7% and 67.1%, respectively, below the poverty line. For unemployed men and women, the percentage below poverty line is about 15%. This, together with the relatively low unemployment rate suggests that unemployment itself may not be a major cause of poverty and social exclusion in Cyprus.

Table 4.8: Households below the poverty line, by employment status and gender

Gender	Employment Status	Below poverty line	% in population
Male over 16 years old	Employed	3.9	20.6
	Self-employed	11.2	5.1
	Unemployed	15.8	0.2
	Retired	61.7	4.8
	Inactive	10.1	4.7
Female over 16 years old	Employed	4.7	15.4
	Self-employed	10.5	1.8
	Unemployed	15.4	0.3
	Retired	67.1	4.9
	Inactive	17.8	15.5

Source: Family Expenditure Survey 1996-97.

Employment and labour market policies[42]

The government of Cyprus in order to accelerate the economic and social development of the island has adopted a series of Five-Year Development Plans. The latest Plan covers the period 1999-2003 and its major objectives for employment include:

[42] A national report on the labour market profile and employment policy in Cyprus is available at: *http://europa.eu.int/comm/employment_social/intcoop/news/prioritiescyprus_en.htm.*

- the harmonisation of employment policy with the EU, including the terms and conditions of employment and the protection of employees against unfair dismissal;
- gradual relaxation of restrictions on the employment of EU nationals and the removal of obstacles to the free movement of labour to and from EU countries;
- maintenance of conditions of full employment and the increase in the participation of women in the labour force;
- encouragement of flexible conditions of employment through short-term contracts, part-time employment and flexible hours, rational distribution of labour by sector, occupation and region; and
- reduction of differences in the conditions of employment between the private and public sectors.

The Human Resource Development Authority (HRDA) promotes and funds training and other active labour market activities including initial training and continuing training activities. The main initial training activities consist of enterprise-based and institution-based initial training, training for unemployed tertiary education graduates, the Apprenticeship Scheme and practical training for students. Continuing training involves in-company training programmes in Cyprus and abroad and continuing training programmes at training institutions in Cyprus and abroad. Furthermore, the HRDA promotes and funds training for unemployed college graduates (see Table 4.13).

Active labour market activities undertaken by the Department of Labour include: vocational guidance, the 'Scheme for the Self-Employment of Tertiary Education Graduates', the 'Supported-Employment Scheme for Persons with Disabilities', the 'Self-Employment Scheme for Persons with Disabilities, the 'Self-Employment Scheme for Repatriates', and the 'Scheme for the Encouragement of Labour Force Participation by Older Persons'.

The main target of the latest Strategic Development Plan is to increase employment by 1.2% annually and to maintain (registered) unemployment below 3%. The Plan also proposes measures for EU harmonisation and for upgrading and modernising the services provided by the Department of Labour with a view to (i) enabling District Labour Offices to match unemployment registrations with job vacancies in the best possible way, (ii) improving the quality of labour market statistics, and (iii) reducing the cost of routine procedures.

Other measures aimed at enhancing the participation in the labour market of certain groups, particularly women (but also pensioners and the disabled). These measures include the creation of additional private and state nursery schools, the promotion of part-time employment and flexible hours, and the re-training of women who have temporarily withdrawn from the labour market. Emphasis is also given to upgrading the services provided for

vocational guidance, and more efforts are devoted to identifying sectors and occupations with promising long-term employment prospects.

4.2.2 Guaranteeing Adequate Incomes/Resources

Provision of basic subsistence necessities

The right to social protection is guaranteed by the *Public Assistance and Services* legislation, aiming at an annually reviewed, socially acceptable minimum standard of living for all persons legally residing in Cyprus, through a range of social welfare programmes and community services available for families and children, especially the elderly and the disabled. Home care and community development is available through a system of grants, while the National Social Insurance Scheme provides all employees and self-employed nationals and non-nationals with pensions and work related benefits, as explained in Chapter 2 of this report. [43]

In 1996-97, when the last Family Expenditure Survey was conducted, one observes an improvement in house facilities compared to the results of the Census of Population in 1992 (Table 4.9). For example the proportion of households with hot water facilities within the house, already at the high level of 90.3% in 1992, increased further to reach 94.9% in 1997. Over the same period, the proportion of households with bathroom facilities increased from 94.9% to 97.4% and toilet facilities from 97.8% to 99%.

Table 4.9 Percentage of households with basic housing amenities

Housing amenities	1992 (Census of population)	1996-97 (Family Expenditure Survey)
Kitchen facilities	99.0	99.2
Bathroom facilities	94.9	97.4
Toilet facilities	97.8	99.0
Piped water	99.3	100.0
Hot water	90.3	94.9

Source: Census of Population 1992 and Family Expenditure Survey 1996-97.

Table 4.10 shows the percentage of persons, by age and gender, living in houses lacking basic amenities. As one would suspect old age people are the ones experiencing greater difficulties. For example 28.2% of people over 65 lack hot water facilities whereas, only 13.1% of the rest of the population lack the same facilities. It is also interesting to note that, in general, among people over the age of 50 the percentage of women without basic housing amenities is slightly higher than that of men. The opposite is true among people below the age of 50.

[43] The Department of Social Welfare, also provides house equipment, house repairs, allowance for mortgage interest deriving from a house loan etc.

Table 4.10 Percentage of persons in households that lack basic amenities by age and gender

Gender	Age	Kitchen facilities	Bath-room	Toilet facilities	Hot water	Tele-phone	Elec-tricity	Refrige-rator	% in popu-lation
Male	0-15	0.00	0.17	0.17	0.58	1.24	0.08	0.17	13.98
	16-24	0.18	0.71	0.53	1.96	1.60	0.71	0.18	6.51
	25-49	0.14	0.56	0.21	1.18	1.74	0.28	0.21	16.67
	50-64	0.16	1.92	0.96	3.21	1.92	0.64	0.64	7.23
	65+	1.84	5.30	2.07	11.52	7.83	1.15	1.84	5.03
Female	0-15	0.00	0.09	0.09	0.55	1.55	0.27	0.00	12.74
	16-24	0.00	0.36	0.18	0.54	1.43	0.54	0.00	6.46
	25-49	0.06	0.32	0.13	1.10	1.29	0.19	0.32	17.96
	50-64	0.77	2.46	1.08	3.99	2.30	0.61	0.77	7.54
	65+	1.78	7.50	1.97	16.77	11.05	1.78	1.78	5.87

Source: Family Expenditure Survey 1996-97.

Table 4.11 shows the percentage distribution of households without basic housing amenities by employment, marital status, and urban/rural residence. Again, it appears that old people are those in disadvantage: the percentage of retired people without housing amenities is much higher than that of the employed and the inactive. Divorced persons and especially widows are also in disadvantage. For example almost 20% of the widows lack bathroom facilities, whereas the percentage of singles and married that lack bathroom facilities is only 5.4%. Moreover, the percentage of divorced persons without a refrigerator is more than 10%, whereas the corresponding percentage of single and married persons is only 1.6%.

The figures in Table 4.11 also suggest that the frequency of people without basic housing amenities is higher in rural rather than urban areas. In addition, the same table provides evidence that there is an association between low-income and low level of amenities prevalent in older rural housing. At the same time, however, it has to be said that as there are no estimates of the low income effect independent of age and rural status, it is possible that not only low income but also ‘choice’ or expectations can play a role in the observed differences in such amenities.

Table 4.11 Percentage of households without housing amenities, by employment, marital status and residence

Demographic characteristics		Kitchen Facilities	Bath-room	Toilet facilities	Hot water	Tele-phone	Elec-tricity	Refrige rator	% of population
Male 16 +	Employed	0.17	0.96	0.45	1.91	1.63	0.51	0.17	20.62
	Self-employed	0.23	1.14	0.46	3.43	2.97	0.23	0.69	5.06
	Un-employed	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.22
	Retired	1.69	4.82	1.69	9.64	7.23	0.96	1.69	4.81
	Inactive	0.25	1.23	0.98	2.21	1.96	0.74	0.74	4.73
Female 16 +	Employed	0.15	0.60	0.30	1.13	1.95	0.38	0.30	15.41
	Self-employed	0.65	0.65	0.65	2.61	1.96	0.00	0.65	1.77
	Un-employed	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.30
	Retired	2.14	8.81	2.38	18.57	10.00	1.90	1.67	4.87
	Inactive	0.22	1.12	0.37	2.54	2.09	0.45	0.52	15.49
Male 16 +	Single	0.41	1.52	1.10	3.17	2.07	0.69	0.28	8.40
	Married	0.23	1.17	0.36	2.89	2.21	0.45	0.41	25.67
	Widow	5.56	12.50	5.56	13.89	15.28	1.39	4.17	0.83
	Divorced	0.00	4.00	4.00	4.00	12.00	4.00	8.00	0.29
Female 16 +	Single	0.33	1.46	0.65	2.76	2.28	0.65	0.49	7.12
	Married	0.18	1.21	0.36	2.90	2.14	0.40	0.40	25.95
	Widow	2.36	7.07	2.02	14.81	9.76	2.02	1.68	3.44
	Divorced	2.20	4.40	2.20	5.49	5.49	0.00	2.20	1.05
Male 16 +	Urban	0.05	0.61	0.25	1.48	1.48	0.36	0.46	22.72
	Rural	1.00	3.19	1.46	6.28	4.64	0.91	0.64	12.72
Female 16 +	Urban	0.19	0.94	0.19	2.06	1.87	0.37	0.47	24.73
	Rural	0.97	3.63	1.41	7.69	5.22	0.97	0.80	13.10

Source: Family Expenditure Survey 1996-97.

Guaranteed minimum income

As said earlier, the Public Assistance and Services Law secures a minimum standard of living for all persons legally residing in Cyprus. It may be provided in the form of money and/or services to persons whose resources do not meet basic and/or special needs, as determined by the Law. It may include rent allowance, home-care etc. Rates for public assistance are reviewed annually to keep in line with the rising cost of living.

The objective of Public Assistance and Services Law is to safeguard human dignity while promoting social inclusion and long-term independence from public provision. In order to achieve this goal, the legislation incorporates employment incentives together with social support services for people who are thought to be more vulnerable to social exclusion: persons with disabilities, single-parents, parents with four or more children, and families in risk of dissolution. Persons who fall into those categories may be eligible for supplementary public assistance even if they work full-time. Furthermore, persons with disabilities are entitled to an

additional disability allowance, once they meet the criteria for public assistance. Part of the recipient's salary is not taken into account when estimating the monthly allowance for persons with disabilities, older persons and persons with mental illness who qualify for public assistance.[44]

A question pertaining to the guaranteed minimum income legislation is how effective this is in stopping workers falling below the poverty line. To answer this question we have used the FES 1996/97 data to calculate the percentage of low-paid and part-time persons in families below the poverty line.[45] Taking as 'low-paid' those with half the average wage, we have found 14% of male and 7% of female workers to be below the poverty line. For part-time workers the respective figures are 33% and 9%, suggesting that poverty among families with part-time workers is higher than that in families with low paid full-time workers. Notably, the proportion of families with low-paid and part-time members is much higher for males rather than females because males are more often the 'bread winners' in Cypriot families. Therefore, a household is more likely to be below the poverty line when its low-paid and part-time members are males rather than females.

4.2.3 Combating Education Disadvantage

Education as a cause of poverty and social exclusion

Table 4.12 shows the percentage of persons below the poverty line by educational level and gender in the FES 1996-97. Almost all university graduates are above, whereas nearly 2/3 of illiterate people are below the poverty line. Regarding the gender differences, the figures in Table 4.12 show that, with the exception of persons without education, the percentage of females below the poverty line is not much higher than that of males.

Overall, the figures in Table 4.12 suggest that the lack of education is a cause of poverty in Cyprus. However, because of the high incidence of educational qualifications among Cypriots, the number of people affected is likely to be relatively small.

Table 4.12 Percentage of people below the poverty line by gender and educational level

Gender	Education	Below Poverty Line	Percentage in Population

[44] To our knowledge there is no evidence of coverage and effectiveness of the GMI programme, e.g. the level of non-take up – particularly in high risk groups such as elderly households

[45] Temporary work can also be a potential source of low income. However, we could not consider this case because the Family Expenditure Survey 1996/97 has no information about temporary workers.

Male (aged 25+)	No education	58.46	0.75
	Partial elementary	48.89	2.61
	Elementary	22.38	9.06
	Partial secondary	8.85	2.62
	Secondary	4.60	8.82
	College	4.76	1.70
	University	1.03	3.37
Female (aged 25+)	No education	69.28	1.92
	Partial elementary	49.88	4.67
	Elementary	22.92	9.35
	Partial secondary	10.45	2.55
	Secondary	5.41	8.35
	College	5.80	2.40
	University	1.63	2.13

Source: Family Expenditure Survey 1996-97.

It is widely recognised that having a stable job (or the option to work) is a major condition for social inclusion. Table 4.13 shows the distribution of total, male and female employed population by education level in 1999. Over the period 1980 to 1999 the number of employed persons with no secondary or higher education, decreased from 103.7 thousands in 1980 to 66.5 thousands in 1991. As a result, the share of the employed population with no secondary or higher education has declined from 53.8% in 1980 to 24.6% in 1999. In the case of women the corresponding reduction is even higher, from 57.8% to 22.6%. Moreover, in 1980 the share of employed people with university/college education was 9.9% and increased to 19.6% in 1991 and to 26.5% in 1999.

Table 4.13: Registered unemployed and employed people by gender and educational level (1999)

Educational level	**Registered unemployed persons (yearly average)**			**Employed persons (thousands)**		
	Total	Male	Female	Total	Male	Female
No schooling	75	39	36	9.5	5.4	4.1
Primary	3359	1627	1732	57.0	37.0	20.0
Gymnasium (lower secondary) Lyceum (upper secondary)	5832	2939	2893	21.7	12.9	8.8
				110.2	66.8	43.4
College University	2109	975	1134	25.0	12.8	12.2
				46.6	28.8	17.8
Total	11375	5577	5795	270.0	163.7	106.3

Source: Labour Statistics 1999.

The share of illiterate people in unemployment decreased from 1.3% in 1989 to 0.7% in 1999 (Table 4.14), whereas the share of unemployed people with elementary and secondary education has increased. In the case of unemployed people with secondary technical education the increase is substantial, from 4.9% in 1989 to 8.1% in 1999. An interesting observation

here is the large share of university graduates among the unemployed in the early 1990s. Since then there has been a marked drop in this figure, while the share of persons with elementary education in total unemployment has increased.

Table 4.14: Percentage of unemployed persons by educational level

Year	Illiterates		Elementary Education		Secondary Education		Secondary Technical Education		Higher Education	
	Total	Female	Total	Female	Total	Female	Total	Female	Total	Female
1989	1.3	1.7	26.0	23.2	40.8	46.2	4.9	1.4	26.7	27.7
1991	1.1	1.6	24.5	24.5	41.5	45.5	5.5	1.7	27.4	26.8
1999	0.7	0.6	29.5	29.9	43.2	46.9	8.1	3.0	18.5	19.6

Source: Labour Statistics 1999.

The share of unemployed women with elementary and secondary education increased over the period 1989-99. The opposite is true for the share of illiterate women in the labour force. Moreover, it is important to note that the share of unemployed women with higher education decreased from 27.7% in 1989 to 26.8% in 1991 and 19.6% in 1999.

The formal educational system

As argued earlier, using the evidence in Table 4.12, the lack of education is a cause of poverty in Cyprus, but the number of people affected is declining because the educational attainment of the Cypriot population has been rising steadily over the last quarter of the 20th century. According to the Labour Force Survey, 80.9% of people at the age of 20 had upper secondary education, and 28.3% of people at the age of 29 had tertiary education in 2000. On the basis of both these measures, educational attainment in Cyprus is above the EU average.

Formal initial education takes place at three levels: (i) the basic compulsory level lasting 9 years (6 years of primary and 3 years of lower secondary education); (ii) the upper secondary level lasting 3 years and offered free; and (iii) the higher level (college and university).

Public institutions offering upper secondary education are either of general or technical/vocational orientation. As from the school year 2001-2002 the technical/vocational upper secondary cycle is undergoing a major reform, giving emphasis to the acquisition of general skills and abilities in new technology and the needs of the Cyprus economy.

According to data provided by the Ministry of Education and Culture, in 1998-99 about 75% of the pupils in upper secondary schools attended public general education schools, 10% attended private schools and the remaining 15% attended public technical schools. Completion rates at the secondary

education level are relatively high: in the school year 1997-98, 89.6% of the pupils enrolled three years earlier completed successfully the lower secondary cycle; and about 80% of the pupils that first enrolled at secondary level education six years earlier graduated from the upper secondary cycle from one of the types of schools, mentioned above. To our knowledge, there is no evidence relating successful completion of secondary education to family income and poverty characteristics.

In the academic year 1999-2000, 69% of upper secondary school graduates (approximately 55% of all young people in the relevant age-cohort) continued their studies beyond the secondary level (the remaining 45%, did not continue to attend higher education). Again, there is no evidence relating entry to higher education to family income and poverty characteristics. Out of the total number of tertiary students in the same academic year, 46% were studying in Cyprus and 54% abroad. The country with the highest percentage of Cypriots attending tertiary education abroad is Greece (53%), followed by the United Kingdom (23%) and the USA (14%).

In public tertiary institutions in Cyprus tuition is free and students receive a annual grant of 1730 Euros. Since 2001 the same annual grant is also paid to students in tertiary institutions abroad. Scholarships to study abroad are provided through the Cyprus State Scholarship Authority. Priorities as regards the study subjects are set on the basis of the economy's needs and scholarship holders are required to return to Cyprus on completion of their studies.

Training and continuing education

The so called *Apprenticeship Scheme* and other short courses organised by the Human Resource Development Authority (HRDA) are considered as active measures to reduce youth unemployment and social exclusion. The Apprenticeship Scheme is designed for persons over 15 years of age who have completed the three years of compulsory secondary education and have a vocational outlook. Apprentices are employed in industry and receive general education and vocational training, on a day release basis, for a period of two years. The wage costs for the days that apprentices spend in school are subsidised by the HRDA. The programme combines technical training with practical experience in industry and aims at facilitating the transition from schooling to the workplace.[46]

The main initial training activities of the HRDA include:

[46] In recent years the Apprenticeship Scheme has faced a number of operational and structural problems, including the lack of opportunities for instructors to adopt modern teaching techniques, the insufficient infrastructure in technical schools to cover the needs of the enrolled students and the lack of adequate company facilities to provide on the job training.

- Enterprise-based 'Initial Training', including design, organisation and implementation programmes.

- 'Accelerated Training programmes' mainly for unemployed school leavers and focusing in occupations with significant labour shortages.

- Management training of tertiary education graduates

Note that most training programmes are offered to individuals already employed and the enterprises select graduates for employment and training. Therefore, the efficiency of the HRDA programmes cannot be assessed by looking at the number of individuals who found work as a result of their training.

In addition to the programmes supported by the HRDA, there are other possibilities for adult/continuing education through both public and private educational institutions. In the case of public education institutions of this type include evening secondary and technical schools, state institutes of further education and adult education centres offering programmes in a very broad range of topics like music, dance, etc.

4.2.4 Family solidarity and protection of children

Family bonds in Cyprus are still very strong, dominated by traditions harboured by the extended family arrangements. This is shown by the high percentage of young persons living with their parents after the age of 18. For example, only 2% of Cypriots aged 18-23 are heads of family, according to figures drawn from the FES in 1996-97 (Table 4.15).[47]

[47] Moreover, a high percentage of old aged relatives, particularly grandparents, live with their children.

Table 4.15 Percentage of household heads by age

Age group	% of age group in population	% of family heads in age group
18-23	6.6	2
24-29	7.1	22
30-35	8.6	42
18-35	22.1	66

Source: Family Expenditure Survey 1996-97.

Table 4.16 shows the percentage of people in households with certain demographic characteristics that fall below the poverty line, together with their corresponding percentage in the population. Persons over 65 living in one adult households is the group exhibiting by far the highest incidence of poverty, with over 90% below the poverty line. Female widows, divorced women and single parents follow with 55.6%, 35.1% and 33% below the poverty line. On the other hand, family size does not appear to be associated with a high incidence of poverty.

Table 4.16 Percentage of people in households with certain demographic characteristics that fall below the poverty line

Demographic Characteristics	Percentage below poverty line	Percentage in Population
Male child: aged 0-15	5.39	13.98
Male aged 16-24	5.52	6.51
Female child: aged 0-15	4.64	12.74
Female aged 16-24	4.30	6.46
1 person h/h, aged 65+	90.67	2.24
2 adults + 3 or more children	4.74	17.12
Single parents	33.03	1.26
Divorced women	35.16	1.05
Female widow	55.56	3.44

Source: Family Expenditure Survey 1996-97.

Social developments in recent years are challenging the traditional family roles in Cyprus. Increasing family violence, separation and divorce are becoming more and more noticeable in the society, as are the repercussions of the mass media and modern technology influences. To deal with these problems a service for families and children operates under the Department of Social Welfare Services with the objective to (i) support family members to effectively exercise their roles and responsibilities, and (ii) prevent and treat delinquent behaviour, family violence etc. The declared objective is to provide counselling and other services, such as home-care and child day-care services, to families at risk at the earliest possible stage.[48]

[48] Cyprus is already harmonised with the European Union as regards issues of social protection. Nevertheless, there is a continued effort to improve the standards of democracy, human dignity and social cohesion. Legislation with international and legal instruments ratified by Cyprus include: basic legislation for the protection of

The Department of Social Welfare Services also offers services helping older persons and persons with disabilities to promote independent social functioning for as long as possible within the family and the community at large. Residential care on a 24-hour basis is offered when other solutions are not sufficient to meet individual needs. There are governmental, non-governmental and private home-care and day-care programmes and the government pays for these programmes in full or in part through the Public Assistance Law.

Preventive and child protective services offered by the Department of Social Welfare Services include adoption, foster care (temporary placement in a family other than the child's biological one), residential care for children and juvenile delinquency.

In the case of divorce the rights of the wife depend on whether she worked during the marriage. If both spouses worked then both of them are entitled to their share of the assets acquired by the couple during the marriage according to their financial contribution. In the case where the wife was a housewife and her contribution to the marriage cannot be defined in financial terms, then she is entitled to one third of her husband's assets. There are no benefits targeting divorced women who have no adequate means to support themselves or their children, other than the income support that applies to all individuals. The divorced wife is also entitled to an alimony if she has no adequate financial means to support herself after the divorce.

4.2.5 Accommodation

Cyprus does not experience the problems caused by homelessness found in other countries, as no homeless people exist officially. Furthermore, as seen from the figures in Table 4.17, the percentage of households living in poor quality accommodation is low. More precisely, the percentage of households that lack, bathroom, hot water, or telephone facilities is less than 5%, while the percentage of households that lack, kitchen, toilet, electricity, or refrigerator facilities is less than 1%. Furthermore, Table 4.17 shows that approximately half of the households below the poverty line are households that lack these basic housing amenities.

The data in the Family Expenditure Survey 1996-97 suggest that most Cypriots own the dwelling where they live: 40.5% are owner-occupiers without and 26.2% are owner-occupiers with outstanding loan/mortgage. Moreover 7.6% of the households acquired their dwelling free, either from their parents or through inheritance. Households expelled from their homes

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families and children; The Children's Law, Cap. 352, the Parents and Children Relations Laws of 1990-1998; the Public Assistance and Services Laws 0f 1991-1999; the Homes for the elderly ad Disabled Persons Laws of 1991-1994; and the Violence in the Family Law of 2000.

by the Turkish army and still living in refugee housing estates and other types of government accommodation amounts to 16.5%. The proportion of households renting their dwelling is only around 7%.[49] The average number of rooms per dwelling is 5.26.

Table 4.17: Households below the poverty line lacking basic housing amenities

Households without:	% below the poverty line	% in population
Kitchen facilities	50.22	0.79
Bathroom	53.47	2.61
Toilet facilities	50.31	0.98
Hot water	57.52	5.07
Telephone	55.67	4.24
Electricity	49.60	0.72
Refrigerator	50.57	0.98

Source: Family Expenditure Survey 1996-97.

There are governmental, non-governmental and private homes for older persons and persons with disabilities. The government encourages local communities and NGOs to develop supportive services at the local level to increase the flexibility and efficiency of services. The Department of Social Welfare Services meets the cost of residential care fully or partly, depending on the resident's income.[50]

Furthermore, the government provides the following benefits to persons with disabilities:

- people living in rented dwellings are given a rent allowance equal to 50% of the amount deemed by law as necessary to meet their basic needs. In special cases (e.g. death of the household head) this figure can go up to 100%;

- households living in owner-occupied dwellings receive an allowance for mortgage interests equal to 50% of the basic benefit; and

- households living in owner-occupied dwellings are also entitled to a house equipment and house repair allowance of up to £500.

Moreover, the Service for the Care and Rehabilitation of Disabled People provides special funds for the purchase of equipment aiding the disable to move easier inside their homes.

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[49] These figures do not include foreign nationals who generally rent their houses.

[50] The legislation governing these services is: the Homes for the Elderly ad Disabled Persons Laws of 1991-1994, the Homes for the Elderly ad Disabled Persons Regulations of 1992-1995 and the Private Children's Homes Regulations of 1982.

Although no official data exist about the accommodation circumstances of foreign workers, it is well known in Cyprus that this category of workers live in the most poor, run down city areas of the country. This reflects the fact that foreign workers are amongst the most poorly paid people living in Cyprus. Again, no official statistics exist about differences in pay between indigenous and foreign workers, however, indirect evidence supports this conjecture: according to estimates based on econometric analysis foreign workers lower the wage level by around 15% in the tourist and other sectors of the economy where they are mostly employed.[51]

4.2.6 Ethnicity

Since the Turkish invasion of Cyprus in 1974 and the move of the Turkish Cypriots into the northern part of the island, now occupied by the Turkish army, the population living in the government controlled area is dominated by Greek Cypriots. The only other officially recognised ethnic minorities are the Armenians, Maronites and Latins. These minorities represent a very small proportion of the population of Cyprus and most of their members are socially and financially integrated in the community with the Greek Cypriot majority. In this sense, ethnicity is not a factor influencing poverty in the government controlled part of the island.

The Ministry of Justice as well as of the Department of Social Welfare Services, are required by law to safeguard the right of to a decent standard of living for all persons legally residing in Cyprus. Very little is known, however, about poverty among the large contingent of around 30 thousand foreign workers legally resident in Cyprus. They represent around 12% of the total work force and mainly work either as domestic servants or as blue-collar workers in agriculture, manufacturing and the tourist sector (hotels and restaurants). Furthermore, it is estimated that another 10-15 thousand immigrants live and work in Cyprus illegally. It is likely that the majority of illegal and a large number of legal immigrants live below the poverty line.

4.2.7 Regeneration of areas

Cyprus is a small country and the only sensible geographical grouping of households for social policy purposes is the urban/rural one. As shown by Table 4.18, the percentage of persons below the poverty line is higher among households living in rural areas. Having said this, however, one should add that defining poverty on income alone in this case can be misleading because people living in rural areas probably benefit more from consuming goods produced by themselves than households living in urban areas. Table 4.18 also provides evidence that there is a higher percentage of

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[51] Pashardes P, L Christofides and P Nearchou, Labour Market in Cyprus: Foreign Workers and Structural Problems, Department of Economics, University of Cyprus, Nicosia, 2000 (in Greek).

women below the poverty line than men, regardless of whether they live in rural or urban areas.

The small size of the country is also convenient for visits to welfare offices: the longest distance from one of these offices is hardly an hour away by bus. Furthermore, welfare officers are assigned (on a geographical basis) people incapable to go to a welfare office due to either living in remote areas or disability. In these cases the people concerned have home visits by their welfare officer.

Table 4.18 Percentage of persons below the poverty line by gender and area of residence

Gender	Area of residence	% below poverty line	% in population
Male aged 16+	Urban	11.32	22.72
	Rural	17.94	12.72
Female: aged 16+	Urban	15.88	24.73
	Rural	23.25	13.10

Source: Family Expenditure Survey 1996-97.

4.2.8 Other factors influencing poverty and social exclusion

In the absence of reliable official statistics identifying factors influencing poverty and social exclusion, the individual household data in the Family Expenditure Survey 1996-97 were used to estimate the probability of being below the poverty line associated with various observable characteristics.[52] The empirical results obtained from this estimation and shown in Table 4.19 suggest that, other things being equal, pensioners and chronically ill persons have 58.8% higher probability of being below the poverty line than non-pensioners and not chronically ill persons. Part-time employees have a 36.1% higher probability of being below the poverty line than full time employees, while being unemployed this probability is only 17.8% higher than being employed. Elderly heads of household (over 75 years old) also have a relatively high probability of being below the poverty line, and so do single adult and single parent households.

Table 4.19 Characteristics ranked by their effect on the probability of being below the poverty line

Characteristics associated with poverty	Probability of being below the poverty line
Pensioner	58.3%

[52] The empirical estimates are obtained using the Probit model where the dependent variable is 1 when the person is below and 0 when the person is above the poverty line.

Chronically ill	58.3%
Part-time employee	36.1%
Household head aged over 75	30.8%
Single adult household	28.2%
Single parenthood	20.3%
Unemployed	17.3%
Household head aged between 61-75	14.4%
Primary education	12.7%

Source: Family Expenditure Survey 1996-97.

Interestingly, being a female is not itself a characteristic associated with a higher probability of being below the poverty line. This does not contradict the results reported earlier (Table 4.18) but suggests that poverty tends to have a higher incidence among women than men in Cyprus because women tend to have certain characteristics associated with poverty for everybody, such as part-time employment, single parenthood. There are also more women pensioners than men.

As noted earlier (end of section 4.2.5), indirect evidence suggests that being a foreign worker is a characteristic associated with poverty; however, we could not include foreign workers in the econometric analysis because no data exist for them in the FES.

4.2.9 Administration, access to and delivery of services

The Department of Social Welfare operates through six District Welfare Offices and a branch Welfare Office covering the government controlled area of Cyprus. It also encourages the supply of social welfare services by third parties through community work and public sensitisation to local needs. This decentralised provision of welfare services aims at providing the same level and quality of such services to all citizens in all areas of the country. Furthermore, given that poverty and social exclusion drivers are better identified at the local community level, the decentralisation of welfare services helps towards meeting diversified needs.

Local community welfare councils and NGOs are financially and technically assisted to:

- operate day-care centres for older persons and persons with disabilities,
- operate residential care for older persons and persons with disabilities,
- provide home-care, and
- provide group support services to persons with a mental or physical illness, persons who abuse substances, persons who are victims of family violence etc.

To the extent that old age and chronic illness are seen in the previous section to be the two most important drivers of poverty, the policies above

are appropriately targeted. At the same time, however, one cannot be certain about the effectiveness of such policies because the government does not collect data documenting poverty and monitoring progress vis-à-vis its social welfare services. Yet, data collection and monitoring are integral parts of an effective policy to combat poverty and social exclusion.

4.3 Evaluation and Future Challenges

4.3.1 Main challenges

As said earlier, while the family bonds harboured by the extended family are still strong in Cyprus, social and economic developments are challenging the traditional role of the family. The Cypriot family now is more child-centred (see Table 4.15), providing social insurance to young people until they are able to set up and provide for their own family, while the elderly are gradually left out of these arrangements. Single parents and divorced women are also affected, perhaps in the sense that support for them can be seen as granting approval to 'attitudes' that are still considered outside the social norm.

The main challenge of the social insurance system and social inclusion in Cyprus is to catch up with the new problems created by rapid changes in society and focus on the groups of people who bear the consequences of these problems. Single parents, divorced women and especially old people (retired persons, widows) are groups becoming more and more vulnerable as the extended family and the traditional social values in Cyprus are giving in to western influences.

4.3.2 Links to other social protection policies

Future developments of the social insurance system in Cyprus are linked to the expected reform of the pension, national health and taxation system. These reforms are expected to affect poverty and social exclusion.

The pension system has to be reformed to meet the increasing funding needs due to the expected future increase in the demographic dependency ratio. The current view is that sooner or later either the social insurance contribution will have to increase to meet the increasing number of old age pensioners or the retirement age limit will have to be raised (from 60 to 63) so as to reduce the number of retirees. If the latter solution is applied, the percentage of old people below the poverty line is likely to decrease.

The expected introduction of a National Health Insurance Scheme is also likely to benefit those in need because medical care will be universal and all citizens will have free access to the same quality of health services. At the moment the less privileged Cypriots do have free access to public health care, however, the service received at the primary level of such care is not of

a quality level comparable to that offered by the private sector at out-of-pocket cost. Furthermore, as the National Health Insurance Scheme will be funded by employee, employer and government contributions, the elderly (who are the most poor section of the population in Cyprus) will also gain from not having to contribute to its cost; as they do under the present system where public health services are funded by general taxation.

The tax reform that took place in June 2002, is claimed to be *revenue neutral*. Its objective was to reduce direct and increase indirect taxation. More precisely, there was a reduction of income and corporate tax rates and an increase in VAT and excise duties. At the same time child benefit, previously paid to households with three or more children, now is paid to all households with an annual income below €34500. Overall, the tax reform has increased the burden of people at the lower end of income distribution who will not benefit from the reduction in the income tax rates (because they are already below the threshold) but will be paying the increased VAT and excise duties. There is, however, a compensating increase in pensions and other benefits protecting the old and other vulnerable groups.

4.3.3 Political directions and future reform

At the moment political directions in Cyprus are motivated by the need for EU harmonisation and preparation for accession. Therefore, most measures taken to combat poverty and social exclusion originate from this motivation, as described in the next section. The prompt adoption of EU social welfare policies is aided by the political consensus in Cyprus in favour of improving the social insurance system: all political parties openly declare readiness to raise benefits, particularly pensions. In fact, one finds it difficult to separate the left from the right in Cyprus when looking at their manifested positions about social insurance matters.

In its haste to effect all the required changes for EU harmonisation and accession, however, the Cyprus government often overlooks the need for monitoring the effectiveness of the measures introduced to improve its social welfare system. As argued earlier in this chapter, there is a need for data collection and monitoring progress in this area, perhaps by setting up an ad hoc unit in the Department of Social Welfare. As this Department is already over-stretched the government should allocate more resources for this purpose, a point also made in a recent EU assessment of Cyprus progress towards harmonisation.

4.3.4 Social exclusion, poverty and EU accession

Currently, measures and actions are being taken in order to promote equality of opportunities between the two genders in view of the need to satisfy the EU harmonisation requirements for accession. These include:

- Expansion and improvement of child care facilities, through a government grant scheme to NGOs providing such facilities; the provision of special allowances to working people with elderly parents at home; and the promotion of part time employment and other flexible forms of employment.

- Encouragement of women to participate in initial and continuing training programmes and to enter new fields of occupations.

- Raising awareness of equality issues through appropriate training of staff and through the education system, the promotion of special campaigns and the encouragement of the media to contribute to this effort.

- Subsidisation of NGOs and women rights organisations to promote and implement gender equality programmes.

- Introduction of a Gender Management System, to serve as a tool for the integration of women issues into all government policies.

- Improvement of equality in the legal framework through the legislative transposition of the acquis and its effective implementation.

Moreover, a number of additional measures are introduced in order to improve the employability of certain categories of the labour force:

- The self employment Scheme for tertiary education graduates, providing financial incentives in the form of interest rate subsidisation for loans undertaken with a view to creating self-employment.

- The self-employment scheme for older persons, aims to keep older persons (63 years and over) actively involved in economic and social activities. The scheme provides grants in order to engage in activities such as agriculture and stockbreeding, home made sweets and jams, embroidery, ceramic work etc.

- Employment support scheme for people with disabilities (mental or multiple disabilities) was introduced in 1996 to further facilitate their employment in the open labour market. Support is provided in the form of job-coaching. These programmes are run by voluntary organisations and financed to the tune of 75% by the government.

The law against homosexuality was abolished a few years ago in a further effort to eliminate any kind of discrimination against homosexuals. This, however, was fiercely opposed by the Orthodox Church in Cyprus and no active measures are taken to encourage the social inclusion of homosexuals.

In addition to the changes in the tax system discussed earlier, several legal reforms affecting the social insurance system have also been ratified by Cyprus, with a view to satisfying the EU harmonisation requirements for accession.

- *The European Social Charter of 1961* (Laws 64/67, 5/75, 31/88 and 203/91). Among other things, this gives the right of special protection at work to employed women, e.g. in case of maternity. Moreover, everyone has the right to vocational training and to social and medical assistance. Furthermore, disabled persons have the right to vocational training, rehabilitation and resettlement. Family is recognised as the fundamental unit of society with the right to appropriate social, legal and economic protection. Mothers and children, irrespective of marital status and family relations, have the right to appropriate social and economic protection.
- *The European Convention for the Protection of Human Rights and Fundamental Freedoms of 1950 and the Relevant Protocol of 1952* (Law 39/62). The aim of this law is the maintenance and further realisation of human rights and fundamental freedoms through an effective political democracy and by a common understanding and observance of the human rights.

These, together with other legal reforms motivated by participation in international conventions[53], are expected to benefit vulnerable groups and assist Cyprus to fight social exclusion.

4.3.5 Summary

The Cyprus government has introduced legislation to deal with poverty and social exclusion problems in the country and secure a minimum standard of living for all persons legally residing in Cyprus. At the same time, it has taken action to promote long-term independence from public provision, e.g. incentives for employment and for participation in training and continuing education schemes. Direct measures to alleviate poverty, such as family support and counselling services, have also been introduced.

The lack of data and monitoring procedures, however, do not allow one to assess the effectiveness of these policies. Only a small number of EU indicators of social exclusion are compiled by the government of Cyprus and in general, there is lack of up to date information for the calculation of these indicators. There is, therefore, an urgent need for setting up systematic data

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[53] *The 1966 U.N. International Covenant on Economic, Social and Cultural Rights* (Law 14/69); the 1966 U.N. International Covenant on civil and Political Rights (Law 14/69); the 1989 U.N. Convention on the Rights of the Child (Law 243/90); and the 1993 Hague Convention on Protection of Children and Cooperation in Respect of Intercountry Adoption (Law 26(III)/94).

collection and monitoring procedures to follow progress and implement changes to improve the provision social services.

Although, the reasons above suggest that one cannot make strong claims about the success of government policy, there are indications that the problem of poverty and social exclusion is not a pronounced one in Cyprus: unemployment has been very low over the past two decades and the benefits from the fast economic growth over the same period are spread among all socio-economic groups in the country. Furthermore, Cypriots still appear to uphold the values of 'sharing' between family members and members of the community.

There are, however, categories of people not adequately protected by the 'safety net' of the state, the extended family and the community. Groups of people in these categories, like the immigrants, are likely to be suffering from poverty and social exclusion. In other words, hidden poverty may exist and be deep in Cyprus. Furthermore, poverty and social exclusion may become a more widespread phenomenon in the future due to social and economic developments causing the fading out of the extended family bonds, especially those centred around small family businesses forced to close down by increasing foreign competition.

Funding for the pension system has to increase to meet the needs of an ageing population. The establishment of a National Health Insurance Scheme in the country will also require additional funding for the social insurance system. Furthermore, changes required for EU harmonisation can make social insurance in Cyprus an expensive commodity. It remains to be seen how strong the resolve of the Cypriot people will be to cope with the new social insurance challenges and whether they will be as successful in containing the problem of poverty and social exclusion in the future as they can claim to have been so far.

5. HEALTH CARE

5.1 Evaluation of Current Structures

5.1.1 Organisation of the health care system

Structure of the health care system

Cyprus has not yet introduced a comprehensive National Health Insurance Scheme (NHIS), therefore the provision of health services is not concentrated on one central authority. Instead there are five types of coverage:

- public health provision,
- private health provision,
- funds for medical care by employers and trade unions,
- the scheme for sponsored patients abroad, and
- private health insurance schemes.

Public health provision in Cyprus was first introduced by the British colonial administration in the 1940s, ensuring free of charge provision of health services to everyone in need who do not have the means to pay for it or suffer form chronic life threatening decease. Government hospitals also provide medical treatment free of charge to people with disability or in need for treatment for contagious and life threatening diseases (thalassaemia, AIDS etc). The government, however, as employer, also provides free medical care free to all civil servants and their families. The public health provision to both the poor and the public sector employees is financed by general taxation. Within the public health services the structure for the delivery of health care is highly centralized.[54]

Persons that are not public servants and are not otherwise entitled to free medical care or to publicly provided medical care at reduced cost, purchase health services from the private sector. Very often, however, public servants (especially those at high salary scales) also seek medical care in the private sector to secure a more personalised treatment, i.e. select the physician who will administer their treatment, arrange convenient appointment and treatment times, have a private room if hospitalised etc. Hence, there is a high degree of out-of pocket payment relationship between providers and purchasers (patients). There is also some indirect financing from private

[54] Furthermore, in cases where the illness cannot be diagnosed or treated in Cyprus patients are flown for diagnosis and/or treatment in other countries, mainly UK, Israel and Greece. In such cases the Ministry of Health and private health insurance companies (where applicable) cover a substantial part, if not all, of the cost.

medical insurance companies, but at a relatively small level. Private health care providers focus on primary and secondary services.

In some cases, there are joint public-private ventures, e.g. the government purchases health services from the Oncological Centre, an independent non-profitable institution established through donations from the private sector. There are also various small scale medical funds operating under special agreements with the private sector. These funds are mostly organised by semi-government and private companies on behalf of their employees and their families and allow beneficiaries to buy health care services from doctors and hospitals of their choice at a low cost. Some labour unions even operate their own medical centres providing their members with medical care either free or at very low cost.

There is no evidence of the existence of an 'informal' health sector in Cyprus, in the form of patients bribing physicians to secure a higher level of health care in the public sector. However, it is generally thought that physicians, dentists and other medical practitioners in the private sector behave like most other self-employed people in Cyprus in not declaring their full income.

The health "insurance" system

Cyprus is in the process of implementing a comprehensive NHIS. This Scheme is expected to be in place by the year 2006. At the moment, the government as an employer provides medical insurance to its employees through the public health sector, as discussed elsewhere in this chapter. There are also employer and trade union sponsored schemes that provide medical insurance to their members, such as those organised by semi-government organisations and large private companies (e.g. banks), offering health care coverage (including at least in-hospital insurance) to their employees and members of their families.[55] Furthermore, there is the so called 'Government Regular Employees Health Care and Welfare Scheme' administered by trade unions and governed jointly by representatives of the Ministry of Health, workers unions and others. In part, this scheme is funded by contributions (1% on the basic salary paid by the worker and 1% paid by the government) and covers expenses for sick leave (up to 80 days, after which expenses are covered by the Ministry of Labour and Social Insurance) and health care.

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[55] Comprehensive health care provision is not mandatory for the private employers or the self-employed. However, in 1997 the employers' liability insurance covering employment related accidents and sickness became mandatory.

Primary, secondary and tertiary health care

Public sector primary health care is provided at five outpatient departments of hospitals, seven suburban outpatient departments, five urban and twenty three rural health centres (with a large number of subcentres) and three small rural hospitals. It is estimated that no place in Cyprus is further than 10 miles away from a health centre (straight-line distance), although in some cases the actual travel distance probably exceeds this. These health centres are staffed with specialists and general practitioners providing curative, promotive and preventive services as well as 24-hour on call services.

General hospitals (with the exception of Nicosia general hospital), offer only specialist out-patient primary care. Treatment of common diseases and injuries is available practically to all Cypriots. Almost all the citizens of the republic have access to primary health care and to all the Casualty Departments of the main hospitals. Secondary and tertiary public sector health care is provided by the district hospitals and by specialized centres (Thalassaemia Centre, Cyprus Institute of Neurology and Genetics).

The private sector offers mainly primary and secondary health care by doctors from the private sector, having their own surgeries mainly in towns and large villages. However, through amalgamation, private clinics have established specialized facilities[56], which are often used by the government. The government also purchases private sector facilities for specialised treatment (i.e. heart operations, oncology, kidney transplant).

Health promotion and prevention

Health promotion and education are now seen as a lifelong benefit for the health of the population. Awareness of the health risks associated with unhealthy lifestyles is growing amongst the population in Cyprus. This is partly the result of government policies and practices and partly the result of the diffusion of information at schools and other places and via the media.

Health promotion and education are established as an important tool towards the achievement of the goal ‘health for all’ declared by the Cyprus government. There is also intersectoral collaboration and community participation with more than 50 non-governmental organizations actively involved in health promotion activities.

Actions concerning health promotion include:

a) data collection and research (cancer register, participation in the *Interhealth* project etc);

[56] Facilities for kidney transplantation, and open heart surgery.

b) information and health education (awareness raising campaigns, participation in the ENHPS programme, training courses for doctors, nurses, teachers etc); and

c) early detection and screening (mass screening for cancer, screening school children for chronic diseases, mandatory national thalassaemia screening etc).

The Ministry of Health runs the School Health Services Scheme for the prevention of disease and promotion of healthy lifestyle among school children. Health education for older adults is provided through adult education centres organized by the Ministry of Education and Culture. The government also has education policies concerning ageing, maternal and child care, nutrition, alcohol abuse etc. More details about health promotion, information, education and training are given in section 5.2.1.

5.1.2 Health care benefits

As said earlier, the current health care system in Cyprus is modelled on the basis of the Beveridge principle, with statutory benefits funded through general taxation. The health care benefits provided are means tested (except for government employees, families with four or more children, those in need of emergency treatment and certain categories of chronically ill persons) and include hospitalisation, prescription drugs, lab tests and radiology, dental services and physician visits. Moreover, the Ministry of Health sponsors treatment abroad for patients that cannot be treated in Cyprus, provides public health and preventive services, mental health care and services for the treatment of thalassaemia.

Provision

The provision of public health care services is governed by the 'Government Medical Institutions and Services General Regulations of 2000'. The public health sector has a hierarchy of services starting from primary health care delivery in urban and rural health centres and sub-centres. The outpatient system has recently been expanded to include community mental health care services, providing basic outpatient medical, diagnostic and pharmaceutical services.

The public sector is dominated by four District General Hospitals (Nicosia, Larnaca, Limassol and Paphos) with that in Nicosia being at the top of the pyramid of health care provision. The Nicosia General Hospital acts as the overall referral hospital for certain specialities not provided elsewhere in the country. There are also three small rural hospitals in relatively isolated areas, with a comprehensive set of services including specialized in-patient services. The public sector also runs a Mental Health Hospital and a specialized Hospital for Children and Women. Overall, the

range of services offered through the government health care scheme, is comprehensive and includes all drugs prescribed, visits to general physicians, specialist consultations and inpatient treatment, and medical care abroad in specialities not offered in Cyprus.

Private health provision in Cyprus is characterised by a large number of physicians in individual practices, although recently a number of *polyclinics* have been established in urban areas with a number of physicians offering a range of medical services, from outpatient consultation to inpatient surgery. The type of services offered, depends upon the specialization of the physicians working in each clinic. Complicated cases, particularly those requiring special equipment are referred to the government sector, usually the Nicosia General Hospital.

Coverage

The private health sector plays a major role in care provision in Cyprus. It treats patients on a fee for service basis and is open to all individuals who can afford to pay. Normally, those providing private health services do so on a profit making basis.

As said earlier, the public sector provides health services free of charge to government employees (including police and full-time military personnel), families with four or more children and certain categories of chronically ill persons; everyone else receives free of charge health care on the basis of means testing, based on income criteria. Emergency treatment is also provided free of charge by the public sector to all persons living in or visiting Cyprus.[57]

On the basis of income criteria, entitled to publicly provided free medical care are individuals earning less than €10300 per annum, households earning less than €17300 per annum (increased by €10300 for each dependent child), and households with more than three dependants. Individuals with income between €10300 and €15700 and households with income between €17300 and €24300 (increased by €10300 for each dependent child) have health care provided at a reduced cost. On the basis of these criteria about 55% of the population has access to free or reduced rate public health services.

In general, little information is available about private health insurance schemes, but is believed that not many such schemes exist due to the absence of tax incentives. A small number of such schemes sponsored by employers and trade unions for the benefit of their employees and members

[57] The health services provided include the following: out-patient care by general practitioners and specialists care to out-patients and inpatients; drugs and pharmaceutical material; diagnostic and paramedical examinations; hospitalisation; dental care; medical rehabilitation; domiciliary visiting; and transport of patients.

offer comprehensive health care coverage and benefits. In most other cases, however, the health care coverage and benefits are limited. All private medical insurance schemes rely on the private sector for the provision of health services.

It is also important to note that, given the small size of the market for health in Cyprus, some highly specialized tertiary medical treatment is not financially viable and patients seeking such treatment have to do so abroad. The government provides funding for this through a scheme covering costs fully or partly for anyone in need of health treatment abroad.

5.1.3 Financing of the health care system

As mentioned previously in this chapter, publicly provided health services in Cyprus are financed from general taxation, while privately provided health care services are financed from out of pocket payments. A small percentage however, (5%-8%) is financed from revenue received from the sales of goods and services. Also a small proportion (3%) of the system represents medical insurance arranged by employers on behalf of their employees.

Health expenditure in Cyprus has increased during the last few years reaching 5.7% of GDP in 2000 (from 4.1% of GDP in 1990). Public expenditure has risen to reach almost 2.5% of GDP in 2001 and this reflects increases mainly in medical, public health and pharmaceutical services expenditure. Yet, the overall share of health expenditure in GDP is still low in Cyprus compared to the EU average. This is believed to reflect various factors including the relatively younger structure of the Cypriot population, the absence of a National Health Service system, the absence of a medical school, the limited resources spent for medical research activities, and the favourable climatic and environmental conditions. However, given that soon a NHIS will be introduced, a medical school will be in place at the University of Cyprus and the population dependency ratio will start rising, the health expenditure is likely to rise in the future.

Tables 5.1 and 5.2 show the private and the public expenditure on health services in Cyprus, respectively, in 1999. Notably, most of this expenditure is realised in the private sector: 3.7% of GNP compared to 1.8 % of GNP in the public sector. The dominance of the private sector also appears in the distribution of doctors and dentists, with more than three quarters of them working in the private sector. The public sector, however, has a 70% share in the employment of nurses, mostly working in the four large District General Hospitals. In contrast, the distribution of hospital beds is evenly balanced between the two sectors. However, while in the public sector the beds are concentrated in the four large District General Hospitals and the three smaller rural ones, in the private sector these are spread in a large number of small clinics, with an average bed capacity of about 15.

Table 5.1: Expenditure on health services in Cyprus (in millions €, 1999)

Expenditure category	€	% in GNP
1. Government (excl. investment & laboratory)	157.9	1.8
2. Private	314.1	3.7
(1) Medical and pharmaceutical products	130.4	
(2) Therapeutic appliances and equipment	15.5	
(3) Physicians, dentists and other medical services	111.5	
(4) Hospital care	51.5	
(5) Service charges on accidents	5.2	
3. Total	472.0	5.6

Source: Health and Hospital Statistics, Department of Statistics and Research, 2000.

Table 5.2: Public expenditure on health services in Cyprus: 1999-2001 (in millions €, current prices)

Year	1999	2000	2001
Government expenditure (excl. invest & laboratory)	157.9	173.6	192.6
% in GNP	1.8%	1.8%	1.9%
(1) Medical and public health services	99.5	112.4	121.6
(2) Mental health services	14.2	14.9	15.1
(3) Dental services	2.4	2.8	2.8
(4) Pharmaceutical services	41.8	43.5	53.1

Source: Ministry of Health.

Table 5.3 presents the major categories of expenditure by the Ministry of Health in Cyprus. As the table shows, expenditure on each category increased significantly between 1999 and 2000. In 2001, there was a small decrease in the expenditure on contributions to institutions and on the treatment of patients abroad, while expenditure on non-governmental medical treatment almost doubled. Expenditure on laboratories, x-rays, drugs and medical supplies increased considerably. This probably reflects

Table 5.3: Major categories of expenditure by the Ministry of Health:(in millions €,1999-2002)

Year	1999 Actual	2000 Actual	2001 Actual	2002 Budgeted
Total ordinary budget	180.7	197.8	219.8	222.8
Subscriptions/contributions to institutions in Cyprus	1.4	2.3	1.8	2.1
Sponsored patients scheme abroad	15.1	16.4	15.0	13.8
Medical treatment in Cyprus (non-governmental)	1.2	3.2	5.9	5.9
Laboratory and x-ray expenses	2.3	2.7	2.9	3.2
Drugs and other medical supplies	33.9	34.8	43.7	35.0
Employment of officers & hourly-paid staff	116.2	126.0	133.6	142.9

Source: Ministry of Health.

the trend in the use of advanced medical equipment and expensive pharmaceuticals in health care provision.

Social insurance

At present the public health sector in Cyprus receives no funding from health insurance contributions and provides health services free of charge only to the groups specified in section 5.1.2. This, of course, will change when the NHIS becomes law in 2006. Then, the public health system will receive funding from compulsory health insurance contributions and will also provide comprehensive medical care to the entire resident population at all levels of health care.

Utilising concepts from the Canadian and German schemes, the NHIS proposed for Cyprus aims at equity in finance and universal provision of health care, efficient delivery with high standards and containment of cost. Every person will be registered with a private doctor (General Practitioner) of her/his choice. In each case the doctor will prescribe any health service deemed necessary. The choice of specialist and hospital by the patient is possible but limited by the required treatment. As long as the patient complies with the system parameters there should not be out-of-pocket cost.

The health services planned under the NHIS include:

- primary and specialist care to outpatients,
- diagnostic services, lab tests, and other investigations,
- prescription drugs,
- hospital care of both secondary and tertiary (including acute mental) illness,
- dental care for children up to 15 years of age, and
- domiciliary visiting and transport of the patient, physiotherapy and rehabilitation services, including provision of prosthetic and orthopaedic appliances.

Private insurance

The development of local insurance companies started in the 1980's. However, the private medical insurance sector in Cyprus has not grown at a fast pace. Most companies offering health insurance do so mainly to complement other businesses and the health products included in their packages tend to be simple. With medical costs rising and demand for comprehensive cover growing, a specialist touch has been added by a small number of select companies, the most prominent being BUPA (UK).

Private medical insurance contracts offer local hospital indemnity cover or hospital plus outpatient indemnity cover on an annually renewable basis and, in some cases, international cover. Employers' liability insurance,

recent addition to the Cyprus insurance market, is growing rapidly since 1997 when it became mandatory. It has now stabilised around €8.62 million spread over 26 insurance companies, with the highest volume at almost €1.72 million (in 2002).

Premium income of private health insurance is difficult to estimate, as separate reporting is not yet required by law. Premium volume could range between €5.2 to €10.3 million with an annual premium per person of €258 in 2002. In general there are 33 companies writing accident & health insurance in Cyprus, totalling just over €27.60 million in premium income and representing 15.2% of non-life market or 5% of the total market. BUPA, the only specialized health care insurer, is ranked fourth with €2.6 million in premium income. Long-term care insurance is not available at the moment.

Private medical insurance in Cyprus is mainly organised collectively through trade unions and funded through membership subscriptions and/or deductions from salaries by the employer. Membership in the medical insurance scheme is mandatory for some trade union members. Recently increasing medical costs have led to serious budget deficits and streamlining of benefits, raising concern about the long term viability of these medical schemes. In any case, the private medical insurance market in Cyprus will change substantially in terms of both products and volume in the near future, when the new NHIS is introduced.

5.1.4 Incentives

In general, Cyprus appears to have a adequate supply of physicians and hospital beds. Therefore, it is safe to assume that the overall (public and private) supply of health services is adequate, at least in terms of quantity, and meets the increasing demand. For example, while the number of general practitioners, specialists and nurses increased by 6.9% over the period 1997-99, the number of outpatient attendances in general and special hospitals grew only by 2.1% (Table 5.4, public only). This may be due to the policy of improving rural health services by assigning physicians to rural health centres.

The number of outpatients in rural hospitals and health centres has increased by 10.3% between 1997 and 1999 therefore the transfer of medical personnel to rural areas can be seen as an improvement in the geographical allocation of population per doctor. According to the Department of Statistics and Research, the number of persons per doctor has decreased from 379 in 1997 to 357 in 1999.

Table 5.5 shows the distribution of doctors, nurses and beds in the public and the private sector. The public sector dominates in the number of nurses, while the private sector dominates in the number of doctors. The number of hospital beds is almost the same in both sectors. The public sector, however,

has exhibited a decrease in the number of hospital beds between 1980-1999 (due to the reduction of beds in the mental health hospital and the shifting services to the mentally ill from hospitals to the community), while the number of doctors and nurses has increased. It is interesting to note that the private sector has developed more rapidly and effectively than the public sector.

Table 5.4: Outpatient attendances, inpatient discharges and medical personnel in the public sector, (in thousands,1997-1999)

Patients	Medical Institution	1997		1998		1999	
		No.	%	No.	%	No.	%
Out-patients	General Hospitals	884.3	69.4	930.7	69.5	903.8	67.8
	Special Hospitals	4.0	0.3	3.6	0.3	3.5	0.3
	Rural Hospitals	86.8	6.8	87.6	6.5	94.9	7.1
	Rural Health Centres	299.0	23.5	317.7	23.7	330.7	24.8
	Total	1274.1	100.0	1339.5	100.0	1333.9	100.0
Casualty	Total	345.2	100.0	356.9	100.0	367.6	100.0
In-patients	General Hospitals	53.1	97.1	53.5	97.0	54.5	96.8
	Rural Hospitals	1.6	2.9	1.7	3.0	1.8	3.2
	Total	54.7	100.0	55.2	100.0	56.2	100.0
Medical personnel	G. practitioners/specialists	1.7	36.5	1.8	36.7	1.9	36.9
	Nursing	3.0	63.4	3.1	63.3	3.2	63.1
	Total	4.7	100.0	4.9	100.0	5.1	100.0

Source: Health and Hospital Statistics, Department of Statistics and Research, 1999.

Table 5.5: Distribution of doctors, nurses and hospital beds

Doctors, nurses and beds	1980	1999
Doctors	560	1863
Public Sector	234	490
Private Sector	326	1373
Nurses	1707	3189
Public Sector	1427	2196
Private Sector	280	993
Hospital Beds	3438	3072
Public Sector	2087	1527
Private Sector	1351	1545

Source: The System of Health Care Delivery 2000, Symeon Matsis, Ministry of Health.

5.1.5 Coverage of the system and access to care

Since its introduction the public health care system by the British colonial administration in the 1940s retained its feature of securing free of charge provision of health services to everyone in need who cannot afford to pay

for treatment in the private sector. As said earlier, in addition to civil servants and a few other groups, free access to the public health care system are individuals with income below €10300 per annum and households earning less than €17300 per annum. Furthermore, individuals with income €10300 to €15700 and households with income €17300 to €24300 (increased by €10300 for each dependent child) have health care provided at a reduced cost.[58]

Fees for paying patients, in-patient care:

- Accommodation and nursing: €103, €86, and €60, for 1st class, 2nd class and 3rd class ward, respectively. For intensive care units the fee is fixed at €172.
- Medical attendance €17.2 daily.
- For operations, tests and other services, the fees increase by 30%.

Fees for paying patients, out-patient care:

- Visit to a specialist €17.2.
- Visit to a general practitioner €12.
- Drugs, x-rays and laboratory examinations are charged extra.

Every person entitled to free medical care pays a fee of €1.72 per out-patient visit payable by. Also, the daily fees payable by state officials and civil servants for in-patient treatment are: €17.2, €8.6 and €5 for 1st class, 2nd class and 3rd class ward, respectively.

The fact that the public sector provides free (or at reduced cost) medical care to low-income people and its employees, leads to the obvious conclusion that middle- and high-income groups that are not civil servants are excluded from the system. Moreover, access to the public health care system, does not occur through the choice of general practitioners (GPs). Only the private sector gives to the patients the option to choose a GPs.

5.1.6 Public acceptance of the system

In an interview survey of 2501 households (8270 individuals) that took place in 1996, people were asked to rate the quality, waiting time, courtesy and amenities of public and private sector health services[59]. Table 5.6 presents the service user's evaluations of certain aspects of outpatient and inpatient services. The results reported in this table suggest the following.

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[58] The right to free medical care is waived for treatment of condition caused under circumstances creating legal liability for damages, by a third person. (In such cases the fees will be claimed from the person liable for the damages).

[59] Cost Estimation of the National Health Insurance Scheme, Harvard School of Public Health and Cyprus Development Bank, 1997.

- Households rate higher their ability to choose their own doctor in the private rather than the public sector. This is thought to be a major factor motivating patients to seek medical services in the private sector.

- There is no significant difference in the average rating of physician's ability in the two sectors; yet the public performs better than the private sector on the availability of up-to-date medical equipment.

- Overall, the general public (both outpatients and inpatients) gave similar ratings to the public and private sector providers, with the public sector provider usually receiving a slightly lower rating. This is also reflected in several individual aspects of the service.

Table 5.6: Service user's evaluations of certain aspects of outpatient and inpatient services (1=very poor; 10=excellent); mean rating, standard deviation in parenthesis

Patients	**Outpatient**		**Inpatient**	
Sector	Public	Private	Public	Private
Ability of doctor to give correct diagnosis/treatment	9.21 (1.4)	9.45 (1.0)	9.29 (1.6)	9.48 (1.3)
Cleanliness and comfort of waiting/consultation areas	9,08 (1.3)	9.55 (0.8)	9.10 (1.6)	9.63 (0.8)
The outcome of medical services	9.04 (1.4)	9.37 (1.0)	9.18 (1.6)	9.49 (1.2)
Courtesy and helpfulness of your doctor	8.80 (1.8)	9.57 (0.9)	9.00 (1.7)	9.52 (0.9)
The ability to choose your doctor	7.69 (2.8)	9.74 (0.8)	7.55 (3.1)	9.82 (0.7)
The availability to up-to-date medical equipment	-	-	9.52 (1.0)	9.34 (1.2)
Your overall impression	8.92 (1.5)	9.52 (0.9)	8.96 (1.7)	9.53 (0.9)

Source: Report on the 1996 cost estimation of the proposed national insurance scheme

In the same interview survey, however, the respondent's perception of waiting time in the physician's office was 129 minutes in the public and 25 minutes in the private sector. The perception of waiting time for a non-emergency hospital admission was 110 days in the public and 3 days in the private sector. Many people also described health care delivery in Cyprus as 'a non-system', apparently because health provision in the country has no underlying coherent philosophy, no sense of direction and no effective management. Yet, health standards in the island can be claimed to be high: World Health Organisation, in its evaluation of health systems performance in the year 2000, places Cyprus among the top 25 performers in the world.

Regarding changes over time, portion of households who would never use the public sector for their health care increased significantly between 1992 and 1996. This has not, however, led to a decline in the demand for public medical care: as shown in Table 5.7, the number of outpatient and inpatient attendance at government medical institutions increased.

Table 5.7 Outpatient attendance and inpatient, discharged from general hospitals

Year	1995	1997	1998	1999
Outpatient	871739	884302	930689	903810
Inpatient	50185	53097	53536	54457
Total	921924	937399	984225	958267

Source: Health and Hospital Statistics, Department of Statistics and Research, 1999.

At the same time, the Cyprus country report published by the European Committee of Social Rights (1999), notes that attendance at public sector maternal and child health centres has dropped significantly due to preference for gynaecological and paediatric services in the private sector. This suggests that the private health sector is preferred when it comes to the provision of certain health care services, while the public sector dominates in other aspects, especially in secondary and tertiary medical care.

5.2 Evaluation of Future Challenges

5.2.1 Main challenges

The Cyprus health care system faces a set of very specific challenges, mostly having to do with structural weaknesses, including the following.

- The absence of NHIS and the inequitable distribution of health services arising from the large number of patients paying out of their pocket for medical care.
- Highly centralized structure of health care delivery and lack of adequate management resources for public hospitals.
- The absence of medical school, inadequate facilities for continuing medical education and almost non-existent medical research.
- Inadequate inspection and control of private sector services and lack of data regarding its use by patients, types of diseases treated etc.
- Lack of a proper anti-drug strategy and of facilities for treatment of drug-users.
- Further harmonization with the EU, requiring new legislation and the establishment of new infrastructure.

Plan of action

In order to accomplish goals arising from these challenges, Cyprus adopted a fairly ambitious list of objectives and prepared actions in the context of the five-year Development Plan 1999-2003, including:

- the improvement of public health and preventive activities,
- integration of policies and coordination between the public and private sectors,
- reform and restructuring of the Ministry of Health and its services to improve efficiency,
- creation of a medical school and encouragement of medical research, and
- introduction of changes aimed at the harmonization of the Cyprus health system with the EU.

To achieve such an ambitious list of objectives, the Ministry of Health has prepared an extensive plan, the most important element of which is the introduction of the NHIS. The legislation required for this has been approved by Parliament and implementation will begin shortly with a to having a functioning NHIS by 2006.

A reform of the Ministry of Health is also on its way, through the establishment of new departments and decentralization of the administration of public hospitals on the basis of modern systems of management and medical audit. The budget allocated to public health and preventive activities is increased and a study for the creation of a medical school is being prepared in consultation with the University of Cyprus. Furthermore, more funds are earmarked for research and for upgrading the existing system of training and education, including equipment and other facilities for computerization.

Health promotion and prevention programmes

As said earlier, awareness of the need to adopt a healthy lifestyle is growing amongst the population in Cyprus. Health promotion and education are now considered as tools of government policy and actions taken in this detection include:

- INTERHEALTH project for the study of risk factors contributing to the development of cardiovascular diseases. This includes data collection and research, e.g. Cyprus participates in the on the smoking habits.
- Information and health education through: (i) raising awareness campaigns i.e. cancer, smoking, heart disease etc; (ii) participation in the European Network for Health Promotion at Schools (ENHPS) programme; (iii) training courses for doctors, nurses, teachers and parents etc; (iv) introduction of the smoking Control Law in 1980 and subsequent amendments; (v) production of health education materials; and (vi) introduction of health education in the school curriculum.

- Early detection and screening including: (i) mass screening for cervical cancer; (ii) screening of schoolchildren 8-12 years of age for all risk factors contributing to cardiovascular and other chronic diseases; (iii) mandatory national thalassaemia carrier screening[60]; and (iv) screening of pregnant women for the detection of chromosomal abnormalities.

The Ministry of Health operates the 'Health Services School' whose main duty is educating schoolchildren about the prevention of disease through the promotion of healthy lifestyle. It also offers immunization and screening services to schoolchildren for various diseases or abnormalities and delivers lectures on health risks (smoking, AIDS, accidents, nutrition).

Regarding diet, the traditional Mediterranean eating habits are low in fat and high in complex carbohydrates (pulses, brown bread). Unfortunately this diet is gradually abandoned in favour of fast-food based dietary habits, high in animal protein, saturated fat and cholesterol and low in fibre. This has led to 60-70% obesity rates among Cypriots. The Ministry of Health organises activities to encourage people to adopt a healthy diet and lifestyle, including the action programmes 'healthy children', 'promotion of Mediterranean diet', 'fibre for a healthy life', 'school cantinas' and 'TV and radio'.

For maternal and child care, the government offers advice on family planning, breast-feeding advantages, nutrition, postnatal and antenatal care, child guidance and advice on childcare education etc. All hospitals for maternal and gynaecological care operate child health centres and provide family planning services. Furthermore, during their pregnancy women are attended by either midwifes or obstetricians.

Health promotion activities are also organised by non-governmental organizations, for instance, the Cyprus Society of Medical Informatics (CSMI), a non-profit, non-governmental organization based on the voluntary work of computer scientists with an interest in medical informatics. The purpose of the CSMI is to promote the use of telecommunications and information technology in medicine to improve the services offered by the health care delivery system. Their activities also include organising seminars, conferences and discussion groups, promoting research and enhancing the application of information technology in medicine.

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[60] Thalassaemia is the most frequent genetic disorder in Cyprus (one of the highest frequencies around the world). A programme of mandatory screening and counselling for prenatal diagnosis in heterozygote marriages is operated by the Thalassaemia Centre, also offering laboratory investigations, treatment and follow-up.

5.2.2 Financial sustainability

Cyprus exhibits the demographic characteristics of an ageing country with decreasing fertility rate, sharp decline in the birth rate, rising life expectancy and decreasing infant mortality. At the same time, the rate of active doctors per head is low in Cyprus compared to other European countries, as is that of available hospital beds.

As already mentioned, Cyprus is in need of a national health system, a medical school, more research on health, more inspection and control of the private sector, upgrading of public hospitals and health centres etc. On the basis of the increasing needs likely to be encountered in the future, Cyprus should be prepared to increase the currently low share of GDP devoted to health care. The planned NHIS, in particular, will place the funding of health care in Cyprus on a completely different footing.

The cost of National Health Insurance Scheme

The cost of the proposed NHIS has been studied by a team of experts, under the direction of Professor W. C. Hsiao[61]. The results of this study, summarised in Table 5.8, suggest that the total cost of the NHIS scheme would be €306 million (in 1996 prices). Compared to current level of public health expenditure (€115 million), then the net additional cost of the NHIS to the public would be €191 million (or 5.4 percent of total wages and salaries).

According to the above estimates the government budget will be burdened by €181 million (€10 million will be raised from other sources) in 1996 prices, out of which €162 million is the general public contribution and €19 millions the contribution by the government as an employer. Thus, the government will cover 59% of the NHIS cost. Additionally, the government will continue to fund and supply public health services that are not covered by the NHIS scheme, like psychiatric and dental services.[62]

Table 5.8: Total cost of NHIS, (in 1996 prices)

Item of Expenditure	€ (in millions)	% of total earnings

[61] In 1996 a consultancy team comprising Prof. W.C. Hsiao (Harvard University), Ms. Kara Hanson (Harvard University), Prof. W. Yip (Harvard University), Ms. Jacqueline Arzoz (Harvard University) and members from the Cyprus Development Bank, Ministry of Health and Ministry of Finance submitted a report 'Report on the 1996 Cost Estimation of the Proposed National Health Insurance Scheme', describing the principles for the design and implementation of a National Health Insurance Scheme in Cyprus.

[62] The aforementioned cost estimation is based on some crucial assumptions. The authors assumed that the NHIS would be adopted in its entirety and the whole plan would be implemented properly. If Cyprus only adopts a universal health insurance scheme without implementing the proposed system reforms, the total cost could be much higher than the estimated 1996 total cost of €306 million.

Cost of NHIS services currently funded by the government	115	3.3
Net additional cost	191	5.4
Total Cost of NHIS (1996)	306	8.7

Source: Report on the 1996 cost estimation of the proposed NHIS.

The cost of NHIS will be funded from contributions paid out of salaries, self-employment income, pensions and other income. The government will also contribute. The proposed contributions are presented in Table 5.9. Overall, it is envisaged that the financing of NHIS will be tripartite: the government will contribute 50%, the employees 25% and the employers 25%. It is anticipated that the scheme will be fully implemented by the year 2006.

Table 5.9: Contribution (%) to the total cost of NHIS

Category	**Personal contribution (%)**	**Employer*** **(%)**	**Government (%)**	**Total (%)**
Salary-earners	2.00	2.55	4.55	9.10
Self-employed	3.55	-	4.55	8.10
Retired	2.00	-	4.55	6.55
Fund-holders	2.00	-	-	2.00

Source: House of Parliament, Y.Y. 25.3.09(17).
* For civil servants, employer is the government.

5.2.3 Health care and EU accession

In relation to the 31 chapters required for Cyprus harmonisation with the EU acquis, health related matters were considered in the following chapters:

Chapter 1: Cyprus has amended and implemented the legislation required for the harmonisation of foodstuffs, pharmaceuticals, cosmetics, precursors and medical devices. Enforcement of 'Food Control and Sale Law' is carried out by the Ministry of Health. The administration has been upgraded to meet the new requirements and the personnel is undergoing training. The State General Laboratory has successfully become accredited.

Chapter 2: Legislation amendments will soon be approved by the House of Parliament for (a) the free movement of doctors, dentists, pharmacists, nurses, midwives and paramedical professionals and (b) the medical treatment of European citizens.

Chapter 7: The Health Inspectors of the Ministry of Health are assigned responsibility for the control of food (imported and locally processed) intended for the local market, as well as for the animal origin of foods.

Chapter 13: Cyprus legislation is now in line with the directives on labelling, tar yield and advertising of tobacco products.

Chapter 22: The Ministry of Health implemented a strict monitoring programme for water supply. Regarding bathing water, the a monitoring programme is introduced to address the requirements for the microbiological and chemical parameters in the coastal areas.

Chapter 24: An 'Anti-Drug Council and Fund' was set up in July 2002, for the preparation and implementation of a National Drugs Strategy and for the co-ordination of public and private initiatives in the filed of drug supply and demand reduction.

In spite the substantial progress, Cyprus needs to do more for EU harmonisation.

- A health monitoring and information system needs to be developed in order to obtain health data and indicators comparable to the EU system. Although the computerization of the public health services has started some time ago, still no Health Information System is available.

- In the case of veterinary and phytosanitary legislation (including food safety) harmonisation with the EU is partial as six framework bills aimed at covering all Community Veterinary Legislation still need to be enacted.[63]

Furthermore, there are various reforms required such as the training of GPs in general medicine, the introduction of information technology in the health sector, the upgrading and completion of the legislation concerning public health, and the introduction of quality in health care.

5.3 Evaluation of Recent and Planned Reforms

5.3.1 Recent reforms and their objectives

The Nuffield Institute (Oxford, UK) was assigned in 1993, a study to propose a new organizational structure for the Ministry of Health and to assist with the reorganization of the public hospitals. Although some progress is made the health care system in Cyprus is still in need of major improvement. The Strategic Plan 1999-2003 sets the reform of the organizational structure and financial infrastructure of the health care system a priority. So far, the progress made in the context of the Plan include: (i) the creation of an authority at District level for decentralisation, (ii) administrative separation of the primary from the secondary heath care, (iii)

[63] These are the areas of importation and trade, animal health, hygiene of foods of animal origin, animal welfare, veterinary pharmaceutical products and animal genetic material. Cyprus also needs to implement the directive on fees for veterinary inspections, set up an animal identification and registration system and upgrade the food-processing establishments .

extension of the working hours of health centres, and (iv) increase of programmes for health promotion and prevention of diseases.

Furthermore, there have been some improvements at the secondary and tertiary level of health care provision such as (i) the completion of the Institute of Neurology and Genetics, (ii) the completion of the new Limassol General Hospital, (iii) the completion of plans for the new Nicosia General Hospital expected to be operational by the middle of 2004 and (iv) the completion of plans for the Famagusta General Hospital expected to be operational by the end of 2004.

The National Health Insurance Scheme

The introduction of NHIS, scheduled for 2006, is the most crucial and important planned reform, as it will have many implications.

- It will provide general medical care services, specialised medical services, inpatient care (except chronic mental health care), diagnostic tests, drugs, rehabilitation services and dental care for children up to 15 years old and medical treatment abroad.

- It will help improve institutional capacity, organizational structure and human resources through changes expected to take place in order to provide the necessary infrastructure for the implementation of the NHIS.

Therefore, in addition to providing adequate and equitable access to a substantial and comprehensive health care system for all citizens, the proposed NHIS, should also improve the efficiency of health provision in Cyprus at both the macro- and micro-economic level. At the same time, however, the introduction of the NHIS will lead to an increased demand for health services, especially by those now paying out-of-pocket for their medical care.

Under the NHIS every family will be registered with a GP and there will be a uniform pricing policy for the public and private sector. At the primary health care level, it is expected that there will be (i) improvements in the efficiency of health care provision, (ii) decongestion of the departments of casualties and emergency cases and (iii) a more effective prevention of diseases at an earlier stage.

The new Nicosia General Hospital will be established as the centre of tertiary health provision for all district hospitals, and in some cases for the private sector. There will be a reduction in the number of patients sent abroad for medical treatment and the quality of services, pharmaceuticals and training of personnel will be enhanced.

5.3.2 Political directions of future reforms

Since 1992, many top-level consultations have taken place, in order to inform all political and social partners about the planned introduction of the NHIS. During these consultations the Ministry of Health had meetings with more than 35 organizations. The general conclusion of these consultations is that most parties approve of the proposed NHIS. Those opposed to it are mainly semi-government and banking employee organisations that have their own private medical insurance schemes. They are asking to be excluded from the proposed NHIS because they pay lower contributions under their own current medical insurance schemes than those they will be paying under the NHIS.

Concerning the financing of the NHIS:

- Trade unions have been arguing for an increased government contribution to enable reduction the employees contribution from 2% to 1.5% of salaries.
- Employers argue that their should be greater than the contribution of employees.
- Trade unions and employers argue that the self-employed should contribute in proportion to their real (not declared) earnings.
- All social partners want to have an increased participation in the management of the NHIS.

Health care providers support the proposed NHIS. The Cyprus Medical Association has agreed to the authority of the family doctor to refer patients to specialists.

Expected impact of the reforms

The introduction of the NHIS is likely to cause significant system and behavioural changes. The main system changes expected are as follows.

a. A system of family physicians paid on a capitation basis will produce savings of approximately €25.86 million per annum (in 1996 prices)[64].

b. The pharmaceutical costs will increase due to all primary care being delivered by independent contractors.[65]

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[64] This is calculated from the fact that in 1996 the cost per capita for primary care was €77.60, and the capitation rate would be set at a level to produce a net income of €55170 for a family physician with a size of 1550 registered patients. Under these assumptions, the capitation rate would be approximately €45 per person per year.

[65] At the moment, public hospitals prescribe generic drugs and use bulk purchasing of medicine; consequently the cost per prescription in the public hospital pharmacy was

c. There will be an increasing of laboratory and radiology costs because primary care will be delivered by independent contractors.

d. Shifting public hospital based family physicians to the private sector will increase the examination costs.

e. Purchasing drugs in bulk and establishing a drug list is estimated to produce savings of €10.35 million (in 1996 prices).

f. There will be a shift in the use of over the counter drugs to prescription drugs because under the NHIS the cost of prescription drugs will not be covered. This is estimated to add €6.89 million to the cost of NHIS.

g. There will be savings from purchasing laboratory and radiology services in bulk and in cost based pricing.

h. The NHIS agency will be able to reduce fees paid to specialists and hospitals by 10% resulting in €3.45 million savings for the NHIS.

i. Services provided by the public sector (and costs) will be reduced because public hospitals will be forced to compete with private hospitals.

The behavioural changes expected to result from the introduction of the proposed NHIS are mainly in relation to insurance and the level of demand.

a. People covered by private insurance and those with no insurance are expected to increase their utilization of public health provision to the level of those who are now fully covered by the government plan.

b. Those currently paying out-of pocket health care costs are expected to increase their demand.

c. An increase in demand for health care provided by the private sector is also expected, because those now using the public sector will take advantage of the shorter waiting time in the private sector.

In the 1996 cost survey, it was estimated that there would be a 10% increase in quantity demanded by those patients who were currently using the public hospital inpatient services and the outpatient specialists services.

5.3.3 Conclusions

The public health system in Cyprus is based on the principle of health services financed from general taxation and supplied (in addition to

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46% of the cost per prescription in the private pharmacy. Shifting public hospital based family physicians to the private sector would increase the drug costs of their patients.

government employees and a few small other groups)) to everyone in need. However, the organisation and management of the system is outdated and inefficient. This has created opportunities for the private health sector to expand. In many cases even those eligible for free medical care from the public sector choose to purchase health services from the private sector. Demand for private health care in Cyprus is particularly strong at primary level. In recent years there is also increasing demand for private secondary health care, leading to the creation of private clinics with facilities for specialised treatment.

The situation described above is reflected in the fact that public health provision in Cyprus accounts for less than 40% of the overall health expenditure in the country, a very low proportion compared to EU countries. Weaknesses of the health system in Cyprus include among others the lack of a developed market for health insurance, inadequate facilities for continuing medical education, poor medical research record, lack of a comprehensive health data collection mechanism and inadequate inspection and control of private sector services. This situation is expected to improve soon as a result of new legislation regulating the establishment and operation of private hospitals.

In spite of these problems, however, health care standards Cyprus appear to be relatively high in international rankings. A plausible explanation for this can be that the private health sector is efficient in making up for the inadequacies in primary and secondary health care in the public sector, while the public sector inadequacies in tertiary health care are covered by the treatment abroad of patients in need of specialised medical care.

The main problems arising form the structural weaknesses of the public health care system in Cyprus are expected to be cured when the planned NHIS is introduced in 2006. Then, public health provision will be supported by the necessary infrastructure, the funding will be secured through compulsory insurance contributions, the entire resident population will have adequate and equitable access to medical care which will be comprehensive at all levels of health services.

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