



▶ Extending social health protection: Accelerating progress towards universal health coverage in Cyprus

▶ 1. Introduction

The Republic of Cyprus is an island state located in the eastern-most part of the Mediterranean Sea, with a population of less than a million (Eurostat 2023). In 2021, two thirds of the population lived in urban areas, with minimal demographic changes since 2011 (Press and Information Office, Ministry of Interior, Republic of Cyprus 2023). The island enjoys a strategic location that connects Europe, the Middle East, Northern Africa and Asia, situating it as a regional business centre. Cyprus has a high Human Development Index (HDI) of 0.913 in 2023 and a GDP per capita of US\$32,048 in 2022, which is 2.44 times higher than the average among countries in Central and Western Asia (CWA) and slightly lower than the EU average (World Bank 2022; UNDP 2025)

Cyprus has experienced robust economic development in recent decades, fostering investment in social policies, including health care. However, the trajectory of economic growth has changed. Notably, Cyprus was heavily affected by the global economic recession which led to an economic decline from 2009-2014, during which the Government introduced austerity measures, including for the health care system. Despite experiencing a brief recovery phase from 2015-2019 with a 5.3 per cent growth increase, in 2020, as a result of the COVID-19 crisis, another decline of 5.2 per cent in real GDP occurred (ILO 2022; Kontemeniotis and Theodorou 2021).

Historically, Cyprus has allocated a small share of GDP to health, relying heavily on private spending on health through OOP payments (Kontemeniotis and Theodorou 2021). In 2019, the Government of Cyprus launched a new reform of the national health care system named the General Health Care System (GHS), which has unified a previously fragmented system consisting of two parallel and uncoordinated sectors: a for-profit private sector and a heavily regulated public sector (Petrou 2021). The new reform aims to provide equitable access and improved financial protection for all legal residents in Cyprus.

▶ 2. Context

The foundation of the current social health protection system in Cyprus began in the early 1990s, driven by the Government's initiative on the establishment of a universal health coverage system free of charge at the point of service. This effort resulted in the adoption of the General Health

Insurance law¹ endorsed by parliament in 2001, outlining the GHI scheme (GHIS) reform. Despite the establishment of the Health Insurance Organization (HIO) in the same year as a public entity to manage the GHIS fund, little progress was made in terms of the operationalization of the reform. In 2012, the Cyprus Cabinet restated its commitment to the reform in accordance to the recommendations of the European Commission, emphasizing the significance of implementing SHP reforms based on a roadmap that ensures UHC delivery in a financially sustainable manner (Cylus et al. 2013).

Until 2019, the Cypriot national health service system faced numerous challenges, including limited range of services and co-payments, which increased households' reliance on the private health sector. Additionally, inadequate coordination between public and private sectors resulted in inefficient capacity for planning in terms of human resources and infrastructure. The situation was further worsened after the financial crisis in 2013, with a wave of health care professionals leaving the public sector. This led the Government to sign a memorandum for a public sector recruitment freeze until 2016 (Petrou 2021). Before the reform, health care services were provided through the public sector via a network of large district hospitals, small rural hospitals, health centres and rural subcentres. Medical services were also provided through the private sector, consisting of private hospitals, clinical units and hundreds of physicians in private practices, and a considerable share of such expenses were covered OOP by households, which significantly limited equity in access (WHO 2012; 2018).

In 2017, an amendment of the GHIS law was passed, shaping the organization of the provision of health services in the national health system. Furthermore, another structural reform took place aimed at implementing a provider-purchaser split, which led to the establishment of the State Health Service Organization (SHSO), a separate entity from the HIO. Under the new system, the Ministry of Health (MoH) assumes a regulatory function of the national health system, while the SHSO is responsible for health care provision and the HIO acts as a single purchaser managing the GHIS (Petrou 2021).

In June 2019, the Government of Cyprus began the implementation of the GHIS, building upon the foundation laid by the general health care system law of 2001 and its amendments up to 2017.² The 2017 amendment provisions outlined a phased approach for implementation in two phases. The implementation included the establishment of the health insurance fund, relying on contributions levied on wages, incomes, pensions and state revenues as funding sources. The first implementation phase focused on extending outpatient care coverage and improving access for the entire population, associated with small co-payments. These outpatient services included access to general practitioners, specialist medicines and laboratory services. The second phase, which started in June 2020, included extending coverage for hospital care and specialty pharmaceuticals.

Notably, after the implementation of GHIS, financing of the health system shifted from predominantly tax financing and OOP payments to a scheme whereby social contributions and government subsidies finance social health protection, with a reduced share of OOP expenditure. The reform aimed at improving access to services and financial protection through shortening waiting times, improving health service quality and reducing OOP payments, in addition to strengthening the role of the national health insurance agency (HIO) in buying services from both public and private providers (WHO 2021c). The principal objective of the GHIS was to integrate public and private medical services into one unified system under a single-payer umbrella, creating a competitive environment and enhancing efficiency and quality (Petrou 2021). Additionally, the reform efforts were supported by the establishment of an integrated information system for monitoring and evaluation purposes (OECD and WHO 2023). However, as of 2024, a fully integrated digital system has yet to be finalized; existing systems remain disjointed, and the implementation of a national e-health platform is ongoing with expected completion by 2025 (Theodorou, Charalambous, and Williams 2025).

¹ The General Health System Law of 2001 - 89 (I)/2001, available (in Greek) at: https://www.cylaw.org/nomoi/enop/non-ind/2001_1_89/full.html

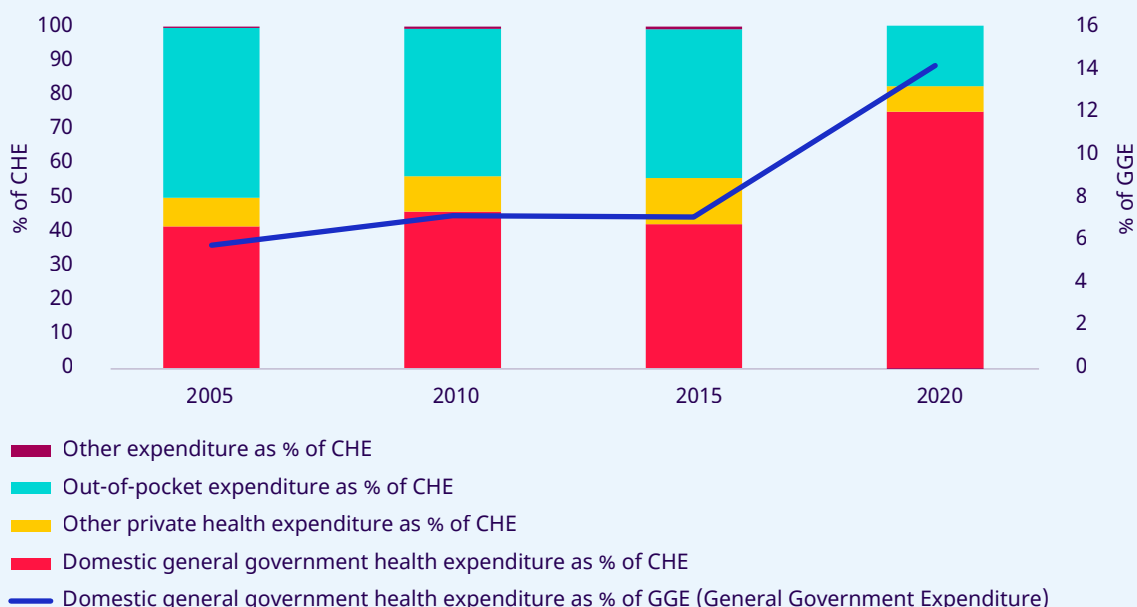
² The General Health Care System Law of 2001 and its amendments up to 2017, available at: https://www.gesy.org.cy/sites/Sites?d=Desktop&locale=en_US&lookuphost=en-us/&lookuppage=hiolegislation

► 3. Design of the social health protection system

Financing

Current health expenditure (CHE) in Cyprus accounted for 9.4 per cent of GDP in 2021. Despite growth in health expenditure over the last few years, it is still behind the EU average (11 per cent), but above the average of Central and Western Asia countries (7.1 per cent) the same year. With the GHIS reform, CHE as percentage of GDP rose from 7.1 per cent in 2019 to 8.41 per cent in 2020, marking an increase from previous years (WHO 2023a). Public financing makes up the largest share of current health expenditure (see figure 32), increased substantially from 42.03 per cent in 2018 to 84.7 per cent in 2021 (WHO 2023b).

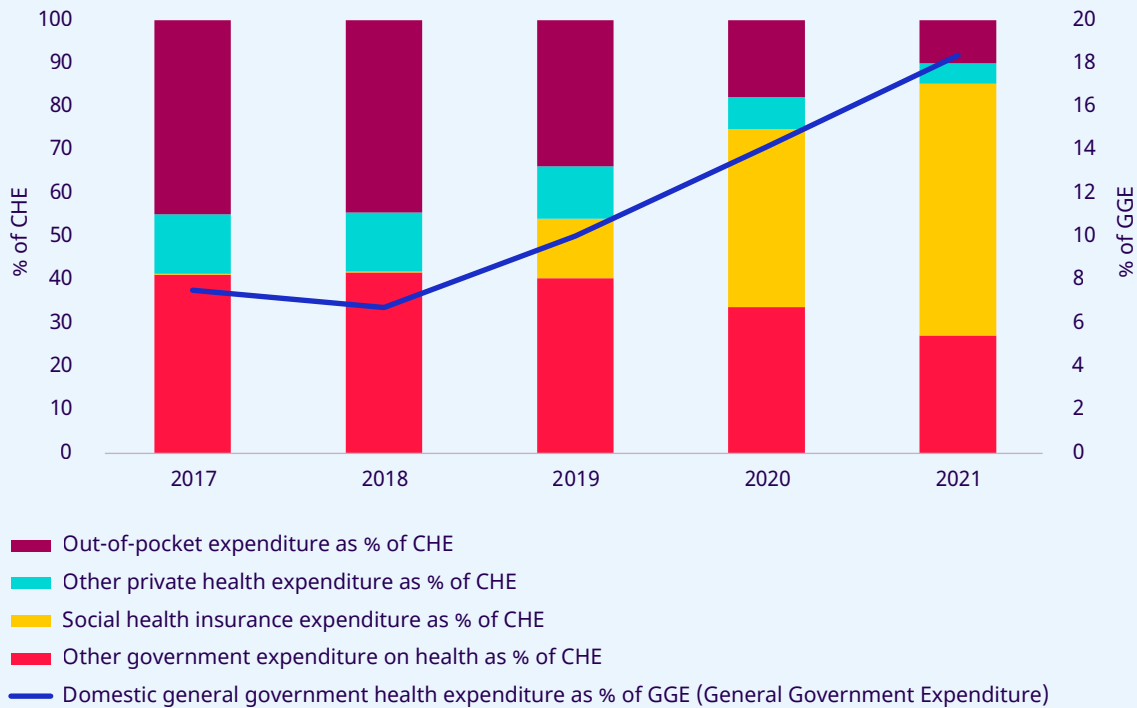
Figure 1. Composition of current health expenditure (CHE) in Cyprus, by source of financing, 2005-2020



Source: Based on data from the WHO Global Health Expenditure Database.

The introduction of social security contributions earmarked for the HIO allowed for the mobilization of additional resources for health. Since their introduction, social security contributions (which include both contributions from workers and employers and contributions from the general government budget to finance non-contributory coverage of a number of groups), have made up the majority of CHE (see figure 33). The share of OOP in CHE has decreased since the implementation of the GHIS reform. Private health insurance and external health spending play a relatively small role in CHE. Dental care remains the main driver of OOP spending, accounting for up to one third of private health expenditure, due to the exclusion of most dental treatments from the GHIS benefit package and the fact that only 3.8% of dentists are contracted under GHIS (Theodorou, Charalambous, and Williams 2025).

Figure 2. Relative share of social health insurance and other financing scheme as percentage of CHE, 2017-2019



Source: Based on data from the WHO Global Health Expenditure Database

In line with the reform, financing of the GHIS is mainly dependent on state revenues and social security contributions (see table 8). Contributions are collected from employees, employers, the self-employed, income-earners³ and pensioners as a percentage of their wage or income. The responsible bodies for collecting or withholding the contributions (in the case of salaried employees) are the Social Insurance Services (SIS), the tax department and the treasury of the republic. Collected contributions and state funds are then transferred and pooled in the health care insurance fund, managed by the HIO, which in turn, purchases health services from public and private providers (Health Insurance Organisation of the General Healthcare System, n.d.-a). The contribution rates of the insurance system as of March 2020 are as follows:

- Employers – 2.9 per cent;
- workers, government officials, pensioners and income-earners – 2.65 per cent;
- the self-employed – 4 per cent;
- state/government for each employee, self-employed person, civil servant, pensioner – 4.7 per cent.

The above groups must pay contributions based on their gross income. The maximum gross annual income from which contributions are deductible is €180,000 (Health Insurance Organisation of the General Healthcare System, n.d.-a). Moreover, some vulnerable groups of the population such as the unemployed and children are exempt from paying contributions or taxes (European Commission 2023). As of 2024, the HIO and Ministry of Health are currently assessing options for medium-term financial sustainability, including revised ceilings and expanding the risk pool through the integration of additional vulnerable groups (Theodorou, Charalambous, and Williams 2025).

³ Earnings from rent, interest or dividends.

► Table 1. Revenue of the Health Insurance Organization in Cyprus, 2019-2020 (in euros)

	2019	2020
Contributions	454 787 925	855 111 866
Co-payments	16 434 314	35 476 337
Discounts from pharmaceutical companies	13 272 547	35 145 924
Other income items	4 059 789	2 119 139
Other income	395 061	17 101 445
Total revenue	488 949 637	944 954 711

Note: The GHS inception was June 2019, so the financial results (contributions and expenditures) for 2019 presented do not reflect a complete calendar year result.

Source: ILO Actuarial Valuation Report to the Health Insurance Organization (2022).

Governance

The Ministry of Health of Cyprus is responsible for national health policy and ensures that health care standards and legislation are correctly applied by both private and public providers. The Ministry is also responsible for planning, organizing and managing the health care sector, including control over the provision of services in health care facilities. Since the establishment of the GHIS, the Ministry's role has evolved to focus more on strategic regulation and supervision, while operational responsibilities have been delegated to the HIO and the SHSO (Theodorou, Charalambous, and Williams 2025).

As the biggest health care provider, the SHSO is responsible for the development, management, control and supervision of hospitals and health centres in the public sector, which was formerly the role of MoH (OECD and WHO 2021; State Health Services Organisation, n.d.). The SHSO has been granted increasing autonomy in managing the public provider network, including responsibility for quality improvement initiatives and hospital accreditation (Theodorou, Charalambous, and Williams 2025).

The HIO serves as the single purchaser of services from both public and private providers and guarantees access to medical services for beneficiaries. Furthermore, the HIO oversees and monitors the performance of health care providers, ensuring adherence with terms and conditions of the contract, so services are provided in an efficient and cost-effective manner. In 2023, the HIO introduced performance-based elements in its reimbursement mechanisms for personal doctors and is piloting quality-linked incentives in hospital payments (Theodorou, Charalambous, and Williams 2025).

The HIO is an independent public legal entity set up under Law N.89(I)/2001 for the implementation and monitoring of the GHIS system in Cyprus. The HIO is responsible for administering the GHIS fund, pooling the collected contributions and state budget, enrolling beneficiaries, contracting health care providers, and ensuring access to quality health care services for patients (Petrou 2021). It is governed by a board of directors implementing the GHS and managing the HIO's property and resources. The board of directors consists of 13 members, including representatives from the government, employers, workers, the self-employed and patients, all of whom are appointed by the Council of Ministers (The General Healthcare System 2022b).

Legal coverage and eligibility

In Cyprus, Law (1(1)/2005) on the Entitlement and Protection of Patients' Rights⁴ provides for the right to quality health care and the right to be treated unconditionally in emergency cases, in line with Article 4. Article 5 enshrines the right to be treated with dignity and Article 6 stipulates access to health care services that are available and accessible, with acceptable resources.

⁴ Law on the Entitlement and Protection of Patients' Rights of 2004 (1(1)/2005), available (in Greek) at: https://www.cylaw.org/nomoi/enop/non-ind/2005_1_1/full.html

Law No (89(1)/2001) of 2001 on the General Health care System and its subsequent amendments up to 2017,⁵ has laid the foundation for Cyprus's social health protection system. The GHS system aims to ensure universal access to health care to beneficiaries without discrimination.

According to the law, GHIS coverage is mandatory for all citizens of republic of Cyprus, EU citizens, legally residing third-country nationals and refugees. A framework of legislative acts, including laws, government regulations and other departmental regulations, provides legal protection for the health care of the population of Cyprus. The system also provides freedom of choice of provider of medical services, which can be accessed from both the private and public sectors (OECD and WHO 2021).

In contrast, asylum seekers (individuals applying for international protection), regardless of their employment status or contributions, are solely eligible for health care access through the system of pre-existing public facilities under refugee law, and they are not included into the GHIS (Council of Europe and European Union 2022). Similarly, undocumented migrants and non-EU students are solely entitled to preventative and curative care for infectious diseases (OECD and WHO 2021).

Benefits

As defined by the GHS law (article 24) and HIO regulations, a comprehensive range of health care services is included in the benefit package, covering primary, outpatient and inpatient care. Additionally, from December 2020, some preventive dental care services are included in the benefit package, but dental treatments such as fillings or extractions remain excluded (OECD and WHO 2021; Government of Cyprus 2022). The GHIS was implemented in two stages, namely Phase I and Phase II. Phase I, initiated in June 2019, includes the implementation of outpatient services (family doctors, outpatient specialists, pharmaceuticals and laboratories). Phase II, which commenced on June 2020⁶ includes all remaining services (inpatient care, accident and emergency, ambulance, allied health services, rehabilitation and palliative care and preventive dental care) (see table 9).

The benefit package includes consultations and interventions with physicians, medicines, laboratory examinations, inpatient care, emergency health care and ambulance services, palliative care and preventive dental services (such as examination and dental cleaning). In addition, assistance from nurses and midwives, clinical psychologists, clinical nutritionists, physical therapists, occupational therapists and speech therapists are included (The General Healthcare System 2022a). Although rehabilitation, long-term care and palliative care are included in the benefit package, there are challenges in ensuring effective coverage due to shortages in contracted health care professionals (OECD and WHO 2023).

▶ **Table 2. Health care services covered by the GHS in Cyprus, by implementation date**

Date implemented	Health care service
1 June 2019	<ul style="list-style-type: none"> • Personal doctors for adults and children • Specialist doctors for outpatient care • Pharmacies and pharmaceuticals for outpatient care • Laboratories for outpatient care
1 June 2020	<ul style="list-style-type: none"> • Inpatient care
1 September 2020	<ul style="list-style-type: none"> • Accident and emergency care and ambulance services
1 December 2020	<ul style="list-style-type: none"> • Dentists for preventive dental care • Nurses and allied health professionals (physiotherapists, clinical psychologists, clinical dieticians, speech therapists, occupational therapists) for outpatient care

⁵ The General Health Care System Law of 2001 and its amendments up to 2017, available at: https://www.gesy.org.cy/sites/Sites?d=Desktop&locale=en_US&lookuphost=en-us/&lookuppage=hiollegislation

⁶ For more details, refer to Annex Table A1.1, Health care services covered by the GHS, by implementation date, of the 2020 Actuarial Valuation report (ILO 2022).

Date implemented	Health care service
1 October 2021	• Midwives
1 January 2022	• Palliative care
1 January 2023	• Institutional rehabilitation services

Source: ILO Actuarial Valuation Report to the Health Insurance Organization (2022).

Cyprus applies cost-sharing arrangements consisting of low co-payments with annual limits. Physician office visits and inpatient treatment are provided free of charge. Co-payments are applied for other types of services and drugs. The objective of the co-payment, which is low and paid directly to the health care provider, is to encourage responsible behaviour from patients and health care providers and to prevent abuse of the system. For example, a consultation with a medical specialist upon referral from a general practitioner costs €6, a laboratory analysis costs €1, prescription drugs cost €1 (regardless of drug price), and a visit to a hospital due to accidents and emergencies costs €10 (see table 10). To access medicines beneficiaries pay a flat co-payment (OECD and WHO 2021). To ensure protection against catastrophic expenses, there is an annual ceiling for co-payments. For the majority of patients, this is set at €150 per year, while for the most vulnerable groups of the population such as low-income pensioners, social assistance recipients and children, it is set at €75 per year (Health Insurance Organisation of the General Healthcare System, n.d.-a).

► Table 3. List of co-payments applied in Cyprus, per health care service

Health care service	Applied	Co-payment amount (€)
Drugs	Per product	1
Medical devices/consumables	Per product	1
Vaccines	Per product	0
Laboratory tests (up to 10 lab tests per lab order)	Per test/test panel	1
Outpatient specialists (except radiology, pathological anatomy, cytology)	Per visit	6
Radiology	Per test	10
Pathological anatomy, cytology	N/A	0
Personal doctors	Per visit	0
Allied health professionals (occupational therapists, clinical dieticians, clinical psychologists, speech therapists, physiotherapists)	Per visit	10
Nurses and midwives	Per visit	6
Accident and emergency departments	Per visit (on triage activity)	10
Dentists	N/A	0
Inpatient services	N/A	0
Ambulance services	N/A	0

Source: Health Insurance Organisation of the General Healthcare System, n.d.-a.

Certain population groups are exempt from co-payments for outpatient visits, outpatient prescribed medicines, diagnostic tests and dental care (see box 17).

► **Box 1. Groups exempt from co-payment for GHS in Cyprus**

- People with severe mental disorders or mental disabilities;
- Children with special needs staying in institutions;
- Children under the care and supervision of social welfare services;
- Prisoners and people under arrest;
- Uninsured older Greek citizens living in Cyprus;
- Various other smaller groups of the population.

PHC serves as a gatekeeping mechanism and a referral is needed to access health care services such as outpatient specialists, laboratories, pharmacies, nurses, midwives, allied health professionals and hospitals for inpatient services. According to provisions of Part VII, Article 26 of the GHS Laws of 2001-2017, beneficiaries must register with a personal doctor of their choice. The personal doctor is responsible for guiding the beneficiary by referring the patient to the appropriate health care provider. Beneficiaries can be enrolled by a personal doctor, or self-enrolled online. In the case of children, a parent or guardian has to select a physician (paediatrician). When illness occurs, the patient must first reach their personal doctor for an initial diagnosis and provision of appropriate treatment. In more complex situations that require the involvement of specialized medical doctors, a family doctor issues a referral to a medical specialist (The General Healthcare System 2022a). Referrals are not required for dental interventions or in cases of emergency care. Usually, patients can directly approach dental surgeons for preventive dental care without a referral from a family doctor. This exemption is also applied to women above 15 years of age who need medical assistance from gynaecologists and obstetricians (The General Healthcare System 2022a).

When accessing services at a specialist level without referral or when opting for more expensive medicines, co-payments are higher. For example, there is a co-payment of €6 for outpatient visits to a specialist with a referral from a personal physician/paediatrician but it is €25 without a referral and it does not count towards the annual cap (ILO 2022).

Prescribed pharmaceuticals and vaccines are covered and the HIO fully reimburses the lowest cost pharmaceutical, with the beneficiary paying a co-payment of €1 for each prescribed item for outpatient use if dispensed from a public pharmacy. The list of prescribed medicines in the HIO catalogue mainly includes generics and, in some cases, original products when the generic option is unavailable or is still under patent. Moreover, the HIO reimburses certain over the counter products in accordance with medical need. Due to the limited availability of medicines at public pharmacies, individuals often have to pay out of pocket for medicines purchased at private pharmacies (OECD and WHO 2021; Petrou 2021; Cyprus Business News 2024; The General Healthcare System 2022a). In cases whereby beneficiaries choose a more expensive pharmaceutical product than the one reimbursed fully by the GHS, they pay the difference between the price of the pharmaceutical product covered by the GHIS and the price of the pharmaceutical product they chose (ILO 2022).

During the COVID-19 pandemic, all diagnostic and therapeutic services were free (OECD and WHO 2021).

In addition to the GHIS benefits, the Cyprus General Social Insurance Scheme provides payment of cash benefits as a replacement for income during sickness and maternity leave for employed and self-employed persons. Benefits for temporary disability associated with illness are provided to insured persons aged 16 to 63 years for 156 days. The sickness cash benefit consists of basic benefits (60 per cent of annual basic income), and supplementary benefits (50 per cent of the average weekly income). Working women are entitled to 18 weeks of maternity leave. Maternity cash benefits equal 72 per cent of the average weekly basic insurance income for the relevant year. This proportion may be increased

to 80 per cent if the woman has a dependent family member, to 90 per cent in cases of two dependents, and to 100 per cent if there are three dependents. Insurance authorities make these payments from the social insurance fund (ISSA 2018).

Provision of benefits and services

The health care system in Cyprus consists of public and private health care providers. The public providers include eight public hospitals and 37 medical centres across the country (State Health Services Organisation, n.d.), with a small number of hospitals and primary health care facilities providing services in rural and mountainous areas (Lamnisos et al. 2019). Within the private sector, there are approximately 43 private hospital and 75 clinics with many more private hospitals to be issued licenses for operations (Petrou 2021; Cherries Responsible Healthcare Ecosystems 2020; Knews Kthimerini 2024). Overall, few hospitals and primary health care facilities operate in rural areas.

Primary health care services in Cyprus are provided by personal doctors in city health centres and rural health sub-centres, and can be either public or private. In principle, primary health care is provided to communities via a facility close by. Secondary care as a part of GHIS is provided by public and private hospitals, clinics and major health centres that provide specialized outpatient services. Tertiary care is delivered primarily in hospitals and specialized clinics in the capital and major cities.

To enter into a contract with the HIO, all providers are required to register as health care professionals, in accordance with the legal and regulatory frameworks applicable to the provision of each service. Following their request via a provider portal, all applicants must send a signed request form as well as supporting documents to the HIO. Once approved, the enrolment process is followed by on-site contract signing (Health Insurance Organisation of the General Healthcare System, n.d.-c).

Health care providers are reimbursed on a monthly basis, according to their professional category. Providers need to submit their claim via the provider portal to be reimbursed. PHC personal doctors are reimbursed on a capitation fee method depending on the age of each enrolled beneficiary. Most providers⁷ receive reimbursement on a fee-for-service basis, but with some additional adjustments. For instance, outpatient specialists are reimbursed based on the activity list of each specialty and through a point system method. Under the point system method, the services are reimbursed based on the number of points allocated to the specific medical activity and the point value for the specific month (ILO 2022).

Hospitals providing inpatient services are paid per hospitalization case in accordance with the diagnosis-related groups (DRGs). Pharmacies dispensing pharmaceutical products to outpatients are paid per package supplied by the pharmacists to beneficiaries. The choice of fee-per-pack for pharmaceuticals aims to separate the payment method from a potential reduction in pharmaceutical prices and to encourage usage of generic medicines.

To ensure the financial sustainability of the scheme, the HIO established a pre-determined annual global budget for each category of service provided by GHS. Regardless of the volume of service provided, health care providers cannot surpass the allocated budget per service during a fiscal year. The HIO determines the annual assigned budget after consultation with respective representatives of the health care providers (Health Insurance Organisation of the General Healthcare System, n.d.-a). Reimbursement fees are subject to monthly adjustments for inpatient and outpatient services, depending on the volume of service, to align with the allocated global budget. This approach aims to ensure that the actual cost does not exceed the budget cost allocated for each category of service (Health Insurance Organisation of the General Healthcare System, n.d.-b).

The HIO is preparing to transition to a performance-based reimbursement model for primary and inpatient health services. For primary health care, this entails moving from the current capitation payment method and integrating reimbursement linked to quality indicators. As for inpatient care, the

⁷ Providers include: Outpatient specialists for health care services to outpatients; laboratories; nurses, midwives and allied health professionals; dentists; ambulance services; accident and emergency departments; medical rehabilitation centres (and/or per diem); and palliative care centre (and/or per diem).

plan involves shifting from a volume-based reimbursement approach to implementing a pre-determined unit price for each hospital (Government of Cyprus 2022).

► 4. Results

Coverage

Since the reform initiated in July 2020, over 99 per cent of the population of Cyprus, including citizens, legal residents and refugees have been covered by the scheme. The reform focused on addressing gaps in the previous system. Before the introduction of the GHS, in 2013 only 85 per cent of the population had access to the publicly financed system, with entitlement tied to citizenship and income, and individuals were subject to user fees when accessing services. Between 2013 and 2019, additional eligibility criteria were put in place (linked to tax and pension contribution payments) and coverage dropped to 75 per cent of the population during this period (Kontemeniotis and Theodorou 2021).

Between 2013 and 2019, additional eligibility criteria were put in place (linked to tax and pension contribution payments) and coverage dropped to 75 per cent of the population during this period (Kontemeniotis and Theodorou 2021). Some marginalised groups such as undocumented migrants and certain non-EU students still face limitations in access, mainly due to their exclusion from GHIS eligibility criteria (Theodorou, Charalambous, and Williams 2025).

Adequacy of benefits/financial protection

Before 2019, the share of OOP in CHE was high due to gaps in population coverage, long waiting times, high user fees and accessing services in the private sector out of pocket. This created gaps in access and financial protection levels, particularly affecting poor and vulnerable households who faced hardship resulting from health costs, impacting their ability to meet other basic needs. Through the reform, with the extension of coverage and the integration of public and private health care providers under the same umbrella, OOP spending decreased significantly. OOP spending as percentage of CHE fell dramatically from 44.36 per cent in 2018 to 33.73 per cent in 2019, and then to 14.01 per cent in 2020, before dropping to less than 10 per cent in 2021 (WHO 2023c).

Additionally, public spending on outpatient care, inpatient care and pharmaceuticals increased. Prior to the GHS reform, outpatient treatment represented the most substantial share of OOP (10.4 per cent) alongside pharmaceuticals (7.7 per cent) (OECD and WHO 2021). Currently, the main driver of OOP spending is dental care, comprising up to one third of OOP expenditure. This is because only a few preventive dental services are included in the GHIS benefit package (OECD and WHO 2023). In addition to dental services, other gaps are long-term care, rehabilitation and palliative care. These services have been integrated into the new system, but there is insufficient capacity to meet existing needs.

Households in Cyprus spend approximately 3 per cent of their total consumption on health care. In 2015, despite relying heavily on OOP spending to cover medical costs, only 5 per cent of Cypriot households incurred catastrophic health spending (OECD and WHO 2021). The Government of Cyprus introduced various initiatives under the GHS to protect the population against catastrophic expenses, mainly by simplifying the co-payment procedure. For example, all co-payments have an annual cap set for everyone, with lower caps for children and low-income households.

Previously, outpatient medicines, diagnostic tests and emergency department visits were subject to user fees – mostly without co-financing from the state budget or exemptions (Kontemeniotis and Theodorou 2021). Patients would pay around €20-60 on average for a specialist appointment and around €100 for x-radiography and ultrasonography. Today, these services are free of charge with a low co-payment of €6-10. Moreover, the cost of vaccinations for children previously ranged from €50-100, whereas now, essential vaccinations are entirely free. Increased uptake of outpatient services has been observed since the reform, particularly among low-income groups and those with chronic condition (Theodorou, Charalambous, and Williams 2025).

According to the latest EU-SILC survey, the level of unmet needs for health services in Cyprus is low. Only 0.1 per cent of respondents in 2022 reported an inability to access health care services due to costs, distance or waiting time, compared with 1 per cent in 2019. However, it is worth noting that there are significant discrepancies between income groups. For example, 1.9 per cent of persons in the lowest income quintile reported unmet needs, whereas only 0.2 per cent of respondents in the highest income quintile reported that their needs were not met. Prior to the implementation of the GHS, long waiting times in public facilities constituted a significant barrier to access, which was attributed as the primary reason for unmet health needs (OECD and WHO 2023).

Responsiveness to population needs

Accessibility and availability

According to WHO Global Health Observatory figures, in 2021, the UHC index in Cyprus, representing the level of coverage of essential health services, reached 80.7 points (SDG 3.8.1), surpassing that of 2010 by 11 points. In this regard, Cyprus demonstrates better results compared with the average among Central and Western Asian countries (74.6 points, 2021) and the average for the European region (77 points, in 2021) (WHO 2021d). Indicators on reproductive health, maternal, newborn, child and adolescent health reached 84 points; for infectious diseases the figure is 90 points; for non-communicable diseases, the figure is 65 points; for access to services, the figure is 86 points; and for availability of primary data for the UHC index, the figure is 56 points. Overall, these rates demonstrate significant achievements in Cyprus with regard to the provision of and access to health services.

However, some challenges remain. Despite cancer being one of the main causes of death in Cyprus, cancer screening rates have not improved in recent years. Breast cancer is the only form of cancer subject to a national screening programme for the general population, targeting women aged 50 to 69 years old. The screening service is provided free of charge within facilities located in major cities within the country. According to surveys conducted in 2019, approximately 65.8 per cent of women have accessed the service in the last two years, which is close to the EU average (59 per cent in 2019). However, there are notable disparities in access based on income levels. In 2019, only 53 per cent of women in the lowest income quintile reported having undergone screening, which is significantly lower than the rate among those in the highest income quintile (79 per cent) (OECD and WHO 2023).

In Cyprus, the density of doctors amounts to five persons per 1,000 inhabitants, slightly exceeding the average among CWA countries and the EU region (WHO 2021b). The density of nurses amounts to approximately 5 nurses per 1,000 inhabitants, well below the average in the EU, but similar to CWA countries (OECD and WHO 2023). However, these figures fail to capture the broader imbalance in workforce distribution between the public and private sectors, with physicians concentrated predominantly in private health facilities and nurses concentrated in the public health sector (see table 11). Before the introduction of the GHS, doctors were incentivized to migrate to the private health sector due to higher salaries and better working conditions, which was exacerbated by government austerity measures following the financial crisis.

► **Table 4. Public and private medical and nursing personnel in Cyprus, 2021**

	Physicians	Nursing officers
Public	797	3 375
Private	3 636	1 524
Total	4 433	4 899

Source: Statistical Service of Cyprus 2021.

Previously, the national health care system heavily relied on medical graduates who studied abroad and returned to practice in the country, mainly because Cyprus lacked medical schools prior to 2013. However, the landscape has since changed, with an estimated 10 per 100,000 inhabitants having graduated from medical school by 2021, demonstrating a consistent rise since 2019. Currently, Cyprus has four medical schools with the capacity to train more doctors per year, improving the medical workforce situation (OECD and WHO 2021; 2023). As of 2023, over 60% of new doctors entering practice were trained in Cyprus-based institutions (Theodorou, Charalambous, and Williams 2025).

To address the increased demand during the COVID-19 pandemic, public hospitals recruited additional medical personnel. Physicians and nurses working in the private sector were hired to work in public hospitals as a part of the standby capacity required to cope with the COVID-19 burden (OECD and WHO 2023). Before the pandemic, Cyprus had 2.2 hospital beds per 1,000 persons, which is lower than the average in CWA countries (3.9 beds on average in 2019) and significantly lower than in the EU (5.3 beds on average in 2019) (WHO 2021a). Responding to needs during the pandemic, the Ministry of Health also organized the transfer of hospital beds from private hospitals to public hospitals (OECD and WHO 2021).

Quality and acceptability

In Cyprus, life expectancy increased by around 11 per cent from 1978 to 2020 (ILO 2022). In 2022, the average life expectancy at birth was 81.7 years, and women had a longer life expectancy (83.6 years) compared to men (79.9 years). The preventable mortality rate was 112 per 100,000 inhabitants in Cyprus in 2020, while the mortality rate from treatable causes was 70 per 100,000 inhabitants (OECD and WHO 2023). The under-five mortality rate fell by more than 0.5 per 1000 live births, reaching a ratio of 2.80 in 2020 (WHO 2020b). Cyprus enjoys high levels of routine child immunization coverage (except for the case of measles) and a low infection rate of HIV/AIDS (WHO 2020a). In 2022, treatable mortality decreased slightly to 67 per 100,000, while under-five mortality remained stable. However, maternal mortality remains a concern with three deaths reported in 2022, keeping the ratio above the EU average (Theodorou, Charalambous, and Williams 2025).

These figures indicate some improvements to the level of access to quality health care, yet the absence of systematic data collection on the quality-of-care indicator poses a limitation in evaluating the effectiveness and quality of the health system. For instance, between 2000 and 2020, maternal mortality worsened (from 33 to 68). The country had four maternal deaths in 2000, three maternal deaths in 2005, four maternal deaths in 2010, six maternal deaths in 2015, and nine in 2020 (WHO, 2020b). The shift of focus of health care providers towards the COVID-19 response is one of the potential explanations for the sudden doubling of the maternal mortality ratio, which is one of the highest in the world.

In the past, waiting times for accessing services in public facilities posed a significant issue that affected quality of care. This was largely caused by the imbalance of the health workforce distribution between the public and private sector, and the shortage of physicians and nurses in the public sector. The introduction of GHS has drastically improved this issue through the contracting of private providers and reduction of waiting lists of patients, especially for inpatient care (OECD and WHO 2021). Additionally, during the pandemic telehealth services rapidly expanded to compensate for lockdown conditions. This led to an increased reliance on phone and online telehealth care, which rose to 48 per cent in 2021 from 33 per cent in 2020 (OECD and WHO 2023). By 2023, teleconsultations accounted for 38 per cent of total outpatient contacts, a slight decline from pandemic levels but well above pre-2020 rates. New legislation is under development to formally regulate telehealth practices (Theodorou, Charalambous, and Williams 2025).

Currently, Cyprus does not have an accreditation system or quality framework for hospitals, except for a basic system available in a few hospitals and laboratories. The design and development of a robust accreditation programme should aim for simplicity, minimal costs, and the involvement of all stakeholders, including patient representatives. Furthermore, there is a need to establish dedicated entities responsible for overseeing the quality of care, while involving patients in quality improvement activities (Pallari et al. 2020; OECD and WHO 2021). As of 2023, Cyprus has initiated a pilot accreditation programme for public hospitals, accompanied by the introduction of quality-linked financial incentives for providers under GHIS. This marks the country's first steps toward formalising a national quality framework (Theodorou, Charalambous, and Williams 2025).

As part of its National Recovery and Resilience Plan for the period 2021-2026, Cyprus set out targeted areas to improve and modernize public hospitals within the framework of the GHS. Key investments include not only the provision of support to facilitate an accreditation plan for public and private hospitals, but also the upgrading of the public health information system (Directorate General Growth, Ministry of Finance 2023). Following the introduction of the GHS, data on service quality is expected to be recorded by the integrated information system, which will be used to assess and improve the quality of services provided by either the public or private sectors (OECD and WHO 2021). However, as of 2024, the integrated IT system is still under phased development, with full functionality expected by the end of 2025. Currently, provider-level quality indicators are collected manually and supplemented with selected electronic records (Theodorou, Charalambous, and Williams 2025).

The health technology assessment (HTA) framework in Cyprus is in its early stages and is overseen by the HTA unit of the Ministry of Health (EUnetHTA 2017). Its primary objective is decision making and reimbursement processes for integrating cost-effective new technologies and protecting against the adoption of harmful technologies in the health system. However, given its nascent stage, the current focus is predominantly on assessment rather than appraisal. This approach is internally conducted and might lack transparency, as recommendations are not publicly reported. Nevertheless, there are ongoing efforts to promote the development of a formal system with an appropriate structure and related legislation (Fonrier et al. 2022; European Commission 2017; Panayiotopoulou et al. 2019). The European Conformity marking (CE marking) tool is used to guarantee the safety and performance of medical devices. Specific health technologies such as MRI, CT scanners, gamma cameras and X-ray units are operated under the protection of Ionizing Radiation laws (N.115(I)/2002); responsibility for this legislation lies with the Department of Labour Inspection under the Ministry of Labour and Social Insurance (WHO 2012).

While migrants and refugees are included legally in the GHIS, there is some evidence of perceived discrimination in access to health care services among migrant and refugee populations, mainly due to language barriers (Gil-Salmerón et al. 2021).

► 5. Way forward

The development and implementation of the new ambitious GHS reform took many years to be operationalized. Through reform efforts, the previously fragmented system was consolidated and serious problems were addressed, including an imbalance of resources between public and private providers, high OOP payments, large inequalities in access and long waiting lists. The improvements were made particularly evident as a result of (and despite) the COVID-19 pandemic in 2020, during which time the new health system became operational and OOP payments were reduced considerably (OECD and WHO 2021).

Moreover, the Ministry of Health, the HIO and State Health Services Organizations have launched an ambitious programme for the digitalization of the provision of medical services and the development of a comprehensive monitoring system for electronic health care (Ministry of Health of the Republic of Cyprus 2021; G-NUIS, n.d.).

Despite universal coverage of GHIS, some groups of the populations still face barriers to access, such as language barriers for migrant and refugee populations, and equity in access to a range of services across income groups remains a concern (Gil-Salmerón et al. 2021).

▶ 6. Main lessons learned

- ▶ The implementation of reforms, including the extension of legal coverage of the population, increased public spending on health and the introduction of a provider-purchaser split, led to the successful extension of a comprehensive health system reform and, within it, expansion of a unified national health insurance scheme. This approach enabled the successful integration of previously fragmented, inefficient schemes. This led to better financial protection, with decreased OOP payments and increased coverage.
- ▶ Approaches to increase public resources for health and to improve financial sustainability include the shift from an under-financed public health system and high reliance on OOP spending, to a scheme financed by social security contributions and government subsidies; a move towards low and simplified risk-sharing mechanisms; and the establishment of a pre-determined annual global budget for health services provided by the GHS.
- ▶ Remaining challenges include inequities in access to health care services reflective of social inequalities and other forms of discrimination linked to migration status. Looking forward, the inclusion of additional services (such as rehabilitation, palliative care and long-term care) may be needed to ensure the system remains responsive to population needs.

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This country profile was prepared by Constantinos Stavrakis, Artiom Sici, Mathilde Mailfert and Salma Elgamel with the collaboration of Yesle Kim and Marie Stijns (ILO).

Contact details

International Labour Organization
 Universal Social Protection Department
 Route des Morillons 4
 CH-1211 Geneva 22
 Switzerland

T: +41 22 799 7239
E: socpro@ilo.org
W: www.ilo.org
www.social-protection.org