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Health Reform Monitor

Healthcare reforms in Cyprus 2013–2017: Does the crisis mark the end of the healthcare sector as we know it?☆

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ABSTRACT

As part of a bailout agreement with the International Monetary Fund, the European Commission and the European Central Bank (known as the Troika), Cyprus had to achieve a fiscal surplus through budget constraints and efficiency enhancement. As a result, a number of policy changes were implemented, including a reform of the healthcare sector, and major healthcare reforms are planned for the upcoming years, mainly via the introduction of a National Health System. This paper presents the healthcare sector, provides an overview of recent reforms, assesses the recently implemented policies and proposes further interventions. Recent reforms targeting the demand and supply side included the introduction of clinical guidelines, user charges, introduction of coding for Diagnosis Related Groups (DRGs) and the revision of public healthcare coverage criteria. The latter led to a reduction in the number of people with public healthcare coverage in a time of financial crises, when this is needed the most, while co-payments must be reassessed to avoid creating barriers to access. However, DRGs and clinical guidelines can help improve performance and efficiency. The changes so far are yet to mark the end of the healthcare sector as we know it. A universal public healthcare system must remain a priority and must be introduced swiftly to address important existing coverage gaps.

1. Background

Cyprus is yet to introduce a universal health coverage system (UHC), and currently features two fragmented and uncoordinated health sectors: A highly regulated public and an unregulated, for-profit private sector [1,2]. The public sector is funded by the Ministry of Health, and the legal basis for attaining a public beneficiary status is Cypriot or EU citizenship, and satisfying one of several socioeconomic or employment status criteria. Public servants are entitled to free public healthcare regardless of income, which provides an indication of the uneven access to free public healthcare [1–3]. People who do not meet these criteria must pay out-of-pocket to finance their health needs at the public or private sector. The aforementioned issues mean that out-of-pocket (OOP) payments are the primary source of healthcare funding (57%), which exceeds public funding (43%) [2,3]. Cyprus' total health expenditure (THE) as a percentage of gross domestic product (GDP) is 7.4%, which is among the lowest in Europe [4].

The fragmentation of the health sector impeded the introduction of supply- and demand-side measures, such as co-payments, integrated clinical guidelines, prescribing behaviour monitoring, medical audit and price regulation of medical activities in the private sector. Moreover, the conundrum of public and private sectors escalated to an inefficient allocation of resources, such as the duplication of health infrastructure and lack of some specialties such as general practitioners [5].

A much anticipated, approved by law National Health System (NHS) has not been enacted, something that has been attributed to a number of factors related to politics and concerns regarding its long-term viability [1]. This long-standing anticipation led to stagnation of further efficiency improvement initiatives such as the introduction of electronic patient records and a Health Technology Assessment (HTA) programme. In particular, low spending on universal prevention programs and public health policies constitute major barriers to efficiency gains [5].

A major drawback of the current system is the impaired capacity to gather and analyse data. Having access to reliable health indi-

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cators is important in any macroeconomic environment, but its importance is magnified during financial recessions, since crises have significant effects on health [6]. In this context, the scope of this paper is to present the recently-implemented changes, assess the reforms and propose future interventions which will increase efficiency. A paper by Cylus et al. [3] provided an excellent approach, analysing the implementation of the health insurance scheme. We build on this to discuss the new measures that have been introduced since its publication, due to the Memorandum of Understanding (MoU) [7]. A recent study by Petrou and Vandoros [8] discussed recent reforms, but focused exclusively on pharmaceuticals. This paper follows up on these previous studies [3,8,], while it discusses the interaction between health, financial crises and mandatory reforms.

2. Policy reforms

In early 2013, the MoU with the Troika came into effect, which mandated several reforms in healthcare [7] (Tables 1 and 2).

One of the first measures in 2013 was the introduction of an annual fee for all beneficiaries in order to strengthen the sustainability of the funding structure. This was combined with the requirement to update and align the prices of the public health sector with actual costs incurred to the system, and to revise the criteria for public beneficiary status. Moreover, as a tool to address tax-evasion (one of the contributing factors to the financial crisis), the public beneficiary status was linked to a person's social insurance contributions. However, this led to the exclusion of several patients' categories from free public health care. Such categories include new entrants in the labour market and refugees, since obtaining beneficiary status requires a minimum of three years' consecutive contribution to the social insurance fund. The Troika also mandated wage cuts and a freeze in recruitment in order to constrain public expenditure, which were at first implemented in 2012, prior to the MoU [9]. However, a reduction in income and unemployment (as a result of the crisis), sparked a gradual shift of patients towards public healthcare services [10], which peaked in 2011–2012 for inpatient care, demonstrating a 13.5% increase versus the previous year [11,12]. Additional workload and reduced resources impaired the functional capacity of the public health care sector [1]. Consequently, many patients have to choose between long waiting lists in the free public sector [13,14], or paying out-of-pocket for instant access to the private sector. Relatively high out-of-pocket payments, in the context of the financial crisis, emerged as a barrier to indicated medical care for a 28% of the population, second only to Greece [10]. In 2013, there was an increase in the number of patients who were reimbursed by the MoH for treatment in the private sector by 21.7%, due to excessive waiting times. On an individual basis, patients may be referred- and reimbursed by the MoH- to the private sector if the public sector cannot provide timely care and/or if the condition does not fall within the competencies of public sector. This practice was criticised as being financially damaging [15]. A downward trend was noticeable by 2015, indicating efficient monitoring [16].

Regarding rational and efficient prescribing, the value of clinical guidelines in providing summarised guidance to physicians [17] had previously been ignored in Cyprus. The presence of an ageing population, which shifts the pattern of health delivery from acute care to chronic disease management, further augments the importance of integrated, chronic-patient oriented, guidelines [9,18]. This resulted in the preparation of 20 clinical guidelines for an array of health conditions in 2013. A recent survey on these demonstrated high satisfaction rates among physicians [19]. In addition, clinical algorithms aiming to regulate laboratory ordering were introduced for nine high volume and per-unit cost laboratory tests.

Traditionally, governments in Cyprus, lulled in a false sense of fiscal security due to above-EU average economic growth, avoided demand-side measures. An increase in demand, without corresponding improvement in health outcomes is associated with an increase in health expenditure as well as waste, and may expose patients to unnecessary and potentially harmful interventions. Prior to the crisis, the lack of demand-side measures was prominent in all layers of the public health care sector, especially pharmaceuticals, emergency care and laboratory test ordering [7], while inefficient practices were previously not changed, due to lack of clinical guidelines and HTA.

A co-payment, in the form of a fixed uncapped amount was introduced in 2013 (three and six euros for family doctors and specialists, respectively). Results varied depending on the setting: the co-payment reduced visits to primary care physicians, but mental health visits proved inelastic [20,21]. In the laboratory sector, a co-payment in the form of 0.5 euros per test – capped at 10 euros per visit – was introduced, after which, paradoxically, there was an increase in the number of tests prescribed per patient in the emergency services [22]. Nevertheless, a recent study reported that the co-payment reduced the utilisation of cholesterol tests, without any negative impact on lipidemic control [23]. As a lack of demand-side measures had led to emergency services overuse [3], a 10-euro fixed co-payment fee was introduced for all emergency room visits, which led to a significant reduction of (primarily non-emergent) visits [24] thus reducing an often unnecessary burden. This is expected to facilitate faster provision of health care when needed the most.

Despite the reduction in the number of people covered by public healthcare, the Troika also prioritised the introduction of the NHS, which will reduce the currently high out-of-pocket payments and safeguard access to healthcare for the whole population. Towards this direction, the tender for the electronic IT system, which is necessary for an NHS to function effectively and efficiently (and another Troika request) was awarded in late March 2017, showing that there are steps taken in this direction.

In the hospital sector, Cyprus is also working on the replacement of the per-diem reimbursement scheme with DRGs, which can increase hospital efficiency [25,26]. This sector merits additional attention as hospital care accounts for the largest proportion of total health expenditure in Cyprus [3,4]. In line with striking differences between the public and private sectors, the product mix composition of these sectors varies significantly: the private sector features a large number of relatively small hospitals (16 hospitals, plus 21 polyclinics and 39 clinics totalling 1455 beds), in contrast to only nine public hospitals with 1435 beds. Currently, public hospital management teams follow rather administrative tasks and can only marginally influence the centralised resource allocation and decision-making process. The MoH announced interventions to promote competition between private and public hospitals in the context of the NHS, including restructuring and public hospital autonomy, so that they can operate as independent entities on a decentralised level. Ultimately, this aims to minimise politically motivated resource allocation and interventions, which impair their productive efficiency [7,27].

The cumulative impact of the reforms and the austerity measures led to a decline in health expenditure per capita, and as a result, health expenditure per capita ranked among the lowest in Europe in 2014 (2266 PPP$ per capita) demonstrating a 2.5% annual average reduction rate, from 2009 onwards [4].

3. Future challenges and responses

There is still great potential to further minimise waste while improving quality of and access to healthcare through further dis-

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