

HEALTHCARE FINANCING AND REIMBURSEMENT: A GLOBAL REVIEW OF MAJOR TOPICS AND TRENDS

Authors:

Munever Kasif and Eleni Neoptolemou, Harris Kyriakides

e.neoptolemou@harriskyriakides.law and m.kasif@harriskyriakides.law

LAWS AND REGULATIONS ON HEALTHCARE FINANCING AND REIMBURSEMENT

1. Please provide a bird's eyes view on the healthcare economy, indicating, in general terms, the role of the government (public healthcare) and private actors (private healthcare).

The government of Cyprus is a central player in the healthcare system, primarily responsible for providing universal healthcare coverage through the General Healthcare System (GHS or GESY). As of June 2022, 917,000 Cypriots have registered with a general practitioner through the GESY system, which is roughly equal to the current population of the Republic of Cyprus. The system launched its first phase on 1 June 2019, which provided outpatient healthcare services, and this was extended to inpatient services in June 2020.

It is funded by contributions from employees, government officials and income earners, employers (for each employee), the self-employed, the state, and pensioners. Primary care is delivered in both urban and rural areas through public hospitals, a network of private doctors' surgeries, hospitals, centres, clinics, polyclinics and other establishments, sub-centres and dispensaries.

Under GESY, the healthcare insurance model is single-payer: the Health Insurance Organisation (HIO), a government agency, is the sole insurer under GESY. The HIO is responsible for pooling contributions (from taxes levied on employees and employers), contracting healthcare providers, and reimbursing them for services provided under GESY. The GESY is not entirely free of charge. While the fund from contributions (as detailed below) is the main source of financing for the GHS, beneficiaries are also required to make co-payments where necessary on receiving certain services. Where a co-payment is required, the beneficiary will pay the set amount directly to the healthcare provider. For example, a local doctor will allow a patient a number of free visits per year. After that number has been reached, the patient pays €15 per visit.

Private insurers operate alongside GESY, although minimally. Importantly, physicians cannot offer services to private patients unless those services are explicitly not covered by the GESY, in order to avoid the formation of a parallel private market and a potential shift of beneficiaries towards this healthcare pathway.

Nevertheless, there are many private hospitals, medical centres, polyclinics, clinics, and doctors' surgeries. Many private healthcare providers have joined the GHS as contracted providers, enabling them to treat patients under the national system while still maintaining private offerings. Private hospitals, centres, and polyclinics house a variety of specialties, as well as general medicine and surgery.

There are two main forms of private healthcare insurance: international private medical insurance and local private medical insurance. International private medical insurance offers comprehensive protection and a wider range of treatment plans and options but comes with higher premiums. Local private medical insurance is less comprehensive, but has more affordable premiums.

2. Please provide a high-level overview of the legal framework regarding healthcare financing and reimbursement.

The General Healthcare System Law of 2001 (N.89(I)/2001) (the Law), as amended, is the legislative framework that governs GESY. Financing and reimbursement are mainly governed by the Health Insurance Organisation (HIO).

Part II of the Law establishes the HIO, the legal public body which runs the GESY. Regarding financing, the HIO contracts with healthcare service providers to provide healthcare, using funds primarily sourced from the Health Insurance Fund (the Fund). This Fund was set up under Article 18 of the Law and is a special resource established for purposes of gathering the relevant contributions and making all payments to healthcare service providers. The Fund is financed by taxpayer contributions, as outlined in Article 19.

The Law specifies which medical services, therapeutic products, and pharmaceuticals must be covered under the mandatory healthcare system. It defines the conditions for their inclusion in the GHS, the level of reimbursement (tariffs and prices), and the criteria that healthcare providers must meet to be authorised to deliver services covered by the GESY.

The implementation of these provisions is overseen by the HIO, which is responsible for: regulating the inclusion of medical services and therapeutic products under the GHS, defining the structure of financial contributions and co-payments, ensuring risk equalisation and equity, and authorising and contracting of healthcare providers (both public and private) to deliver services under the GESY framework.

3. What are the key regulators and supervisory bodies regarding healthcare financing and reimbursement?

The HIO is the key supervisory body financing and reimbursement. It is responsible for implementation of GESY, to manage the Fund, to ensure equal access and provision of healthcare services to beneficiaries, without discrimination.

In addition, it is responsible for using the money raised from the Fund to contract with healthcare providers, including personal physicians, specialist doctors, dentists, pharmacists (who provide healthcare services through pharmacies), laboratories, nurses and midwives, and other healthcare professionals.

Article 64 further elaborates on the HIO's role. The HIO sets the procedures and amounts for the remuneration of healthcare service providers. It acts to implement procedures that govern beneficiaries' access to services and how much extra they must pay. It may also draw

up a list of pharmaceutical products, and healthcare items and contact Ministry of Health to ensure the availability of specific pharmaceutical products necessary for the public health.

Finally, the HIO acts as a supervisor of quality standards, ensuring suitable buildings, other facilities and equipment for healthcare use.

Another key supervisory body is the Council of Ministers, Cyprus' executive branch. The Council has two responsibilities relating to HIO: (1) they appoint the members and chair of the HIO; (2) they approve regulations issued by the HIO.

Also important is the Complaint, Audit and Supervisory Commissioner (the Supervisory Commissioner), an independent official who is accountable only to the Council of Ministers. The Supervisory Commissioner is appointed by the Council of Ministers on the recommendation of the Minister of Health. Their job is to investigate complaints related to decisions, acts, or omissions of the HIO, in relation to healthcare providers or with regard to healthcare services or healthcare providers in the context of the implementation of the contract they have signed with HIO.

4. Has there been a change with healthcare financing and reimbursement as a consequence of the Covid-19 pandemic?

The pandemic did not lead to any major change in the general system of healthcare financing, which is still run and financed through the GHS. However, while GHS funding is typically sourced from the Health Insurance Fund, emergency financial injections from the government were required to cover pandemic-related costs. As a result, the public share of health spending increased substantially from 42 per cent in 2018 to 85.3 per cent in 2021.

However, much of this should be attributed to the introduction of the General Healthcare System in 2019. Notably, there has been a large increase in remote medical consultation since the beginning of the pandemic – either online or by telephone – which has increased from 33 per cent in June/July 2020 to 48 per cent in 2021.

5. Who has access to the healthcare system as a patient on the one side and as a medical service provider/supplier of medical goods on the other side? What are the conditions of admission?

Healthcare insurance for basic medical services ensures equal access to the healthcare system in principle. On the patient side, eligibility (governed by Part V of the Law) for the GHS extends to all who have their habitual residence in the areas controlled by the Government of the Republic, who are also citizens of the Republic of Cyprus, European Union citizens who are employed persons or self-employed persons in the Republic, or who retain such status, or have acquired the right of permanent residence, or non-EU citizens with residency status, as well as those who have legally acquired the right to equal treatment under social security provisions. Expatriates, their families, refugees, and protected individuals are also covered, highlighting GESY's universal healthcare approach. Tourists or short-term visitors, however, do not have automatic access to the healthcare system.

In terms of access to the GHS as a doctor, healthcare providers must contract with the HIO. They must also meet the suitable standards of treatment with regards to operations, facilities and equipment as, determined by the Organisation in collaboration with the Ministry of Health, in consultation with the Pancyprian Medical Association.

In cases of non-compliance with the regulations set out in the Law, the HIO reserves the right to suspend or terminate contracts with providers. This will occur in cases of fraud, unethical conduct, unjustified refusal to provide healthcare services, etc. A final requirement is that providers must have insurance against negligence to cover potential damages arising from their services.

HEALTH INSURANCE FINANCING AND COVERAGE

6. How are health insurance carriers financed? How are premiums determined?

The HIO functions as the insurer in GESY by providing healthcare coverage to all eligible residents of Cyprus. The main health insurer, the HOI, collects contributions from tax contributions. These contributions are placed into the Fund (as defined above) which the HIO uses to reimburse healthcare providers (eg, hospitals, clinics, doctors, pharmacies) for services rendered to patients covered under GESY. At least every three years, HIO shall submit an evaluation report on GESY to the Minister of Health, with recommendations for any amendments to the legislation pertaining to participation, co-payments and contributions, which is submitted to the Council of Ministers for approval, following the approval of the Minister of Health and the Minister of Finance.

Article 19 of the Law sets out the rate at which different actors will be taxed to fund this. Employees are taxed at 2.65 per cent on their earnings; each employer at a rate of 2.9 per cent on the remuneration of each of their employees; every self-employed person at a rate of four per cent of their earnings; the Consolidated Fund of the Republic at a rate of 4.7 per cent on the salaries and pensions of employees, self-employed persons and pensioners. The contributions are capped once a person's salary/pension exceeds €180,000. The Director of Social Insurance Services is responsible for the collection of the contributions (Art 20 of the Law).

In the private sector, private insurers are financed via premiums paid by individuals. These premiums are regulated by the Law on Insurance and Reinsurance Services and Other Related Issues of 2016 (Law 38(I) 2016) by the Superintendent of Insurance. The premiums for private health insurance are covered by contractual freedom and typically depend on several factors, including the age, health status, insurance provider and the type of policy. This means the government does not directly control or regulate private insurance premiums, but oversight ensures compliance with fair competition and consumer protection laws.

7. How is coverage of medical services by health insurance carriers regulated? Are there differences in coverage for in person medical appointments and telemedicine appointments?

The Cypriot government defines coverage for medical services in the Law (and subsequent amendments). The following procedures are protected in the Law, although it says that this

list is not exhaustive: healthcare from personal doctors; healthcare by specialist doctors; laboratory tests; necessary pharmaceutical products, medical devices and sanitary articles; healthcare by nurses and midwives; palliative healthcare; healthcare by other health professionals; in-hospital healthcare; preventive dental healthcare; medical rehabilitation, including the supply, maintenance and renewal of orthopaedic and orthotic items and artificial limbs; home visits; transport of a beneficiary by ambulance; accidents and emergencies. Notably not included is chronic psychiatric institutional or compulsory care which is provided under the provisions of the Psychiatric Hospitalisation Law.

Furthermore, the Board of Directors of HIO may, following an opinion from the Medical Council or the Pharmaceutical Advisory Committee, reject, by its reasoned decision, the provision of healthcare services of limited or questionable effectiveness or healthcare services whose cost is too high and likely to endanger the viability of the System. Because of the breadth of coverage, the main driver of out-of-pocket spending is dental care.

At least every three years, HIO shall submit to the Minister of Health an evaluation report on the System, with recommendations for any amendments to the legislation pertaining to the services provided to the beneficiaries, and any other information deemed appropriate. This report is then submitted to the Council of Ministers for approval, following the approval of the Minister of Health and the Minister of Finance.

Telemedicine appointments are covered in the same way as in-person appointments, and their popularity has increased since the pandemic.

HOSPITAL SECTOR

8. How are services provided by hospitals in the stationary (inpatient) and ambulatory (outpatient) settings financed and reimbursed?

Hospitals are financed through the Fund, with outpatient care (but not inpatient) requiring additional co-payments.

The HIO contracts with public and private hospitals for the provision of in-hospital healthcare. Reimbursement for inpatient services is based on Diagnosis-Related Groups (DRGs), where hospitals receive a predetermined payment for each patient based on their diagnosis, regardless of the actual cost of care. The specific amount of remuneration for each DRG is decided through negotiations between the HIO and hospital representatives. Hospitals contracted with the HIO cannot directly bill beneficiaries for services covered under the GHS.

Outpatient services are generally reimbursed on a fee-for-service basis (eg, GPs, specialists, accident and emergency (A&E)). Fixed fees are pre-negotiated between the HIO and hospitals. While there are no co-payments for inpatient care, there are co-payments for outpatient services. These vary: there is no GP charge, whereas a specialist visit without referral is €25. There are, however, caps: €75 per person per year for people receiving the Guaranteed Minimum Income, low-income pensioners and those aged under 21. The cap is €150 per person per year for the rest of the population.

In the private sector, fees are determined by the free market and depend on reputation of each specific doctor, although an indicator of private sector fees is set by the Medical Council.

9. How are the prices of such services determined? How is economic efficiency controlled?

Economic efficiency in the state sector is maintained, firstly, through the DRG system in inpatient care. This assigns a fixed reimbursement amount to specific diagnoses or procedures, regardless of the actual resources used, encouraging efficiency.

Secondly, the HIO monitors the GHS and proposes changes to increase economic efficiency. In early 2024, the HIO introduced quality criteria and linked them to hospital reimbursement in order to improve the quality of inpatient care provided. The quality criteria include the accreditation of hospitals by international organisations, the evaluation of the healthcare services they provide by the beneficiaries, and the collection and submission of data on safety and quality indicators. Hospitals will be able to increase their standard fee by up to 25 per cent based on the new quality criteria. The new agreement also distinguishes between specialised and non-specialised medical cases. This distinction creates a differentiation in the pricing structure between types of cases combined with the level of quality offered by the respective hospitals and clinics, regardless of their capacity. This is unlike the first agreement, where a large proportion of the hospitals' and clinics' reimbursement was subject to the negotiating power and capacity of each provider.

Furthermore, in hospital care, the main challenge to efficiency is overuse of expensive medical imaging for diagnostics. Guidelines and protocols for medical diagnostics are insufficient, and there is a lack of adequate control over contracted private hospitals and their invoicing for services. In response, the quality criteria determining the reimbursement rates for providers include use of diagnostic imaging as one of the criteria.

HEALTHCARE PROVIDERS IN PRIVATE PRACTICE

10. How are services provided by physicians, therapists, laboratories and other service providers financed and reimbursed?

These services are financed through the Fund, with some specialist procedures requiring additional co-payments.

With respect to reimbursement, the GHS distinguishes between personal physicians and specialist doctors. Personal Physicians (GPs) serve as the initial point of contact for beneficiaries. They provide primary care services and can refer patients to specialists when needed. From June 2023, 70 per cent (as opposed to 100 per cent before) of a GP's compensation is based on the number of beneficiaries registered under their care; 30 per cent of a GP's compensation is based on qualitative criteria and performance indicators. The exact amount is decided through consultations between the HIO and the Pancyprian Medical Association, requiring the Minister of Health's approval.

For specialist doctors, therapists, laboratories and other service providers, their remuneration is decided on a ‘fee-for-service’ basis. This means specialists, therapists, and labs are paid a pre-determined fee for each service provided. The exact amount is decided through consultations involving the relevant party and the HIO, with consultation of the Pancyprian Medical Association, and the Minister for Health’s concurrence.

11. How are the prices of such services determined? How is economic efficiency controlled?

The negotiations between government and the relevant healthcare professional body play a role in ensuring economic efficiency. The quality incentives used for GPs further ensure this. One of the biggest impediments to efficiency when the scheme was first introduced in 2019 was the phenomenon of ‘passing patients off’ to specialists, increasing work volume beyond sustainable levels. In 2019, the proportion of primary care visits that resulted in referrals to specialists reached 70 per cent, by 2023, this dropped to 40 per cent. To meet the HIO’s target of 25 per cent, part of the qualitative criteria determining GP’s salaries is the percentage of patients referred to specialists.

Furthermore, the patient co-payments serve a dual function: (1) to alleviate the stress of the GHS on government finances; (2) to remove unnecessary use of the system, resulting in decreased patient inflow and greater efficiency.

There are also broader systems in place to ensure efficiency. Every three years the HIO is required to prepare an evaluation report on the efficiency and functionality of the entire system and submit it to the Minister of Health for information to the Council of Ministers and a decision on any amendment to the framework to improve the efficiency and functionality of the System.

Another large improvement to efficiency is made by requiring all operations to become e-based (Art 32C of the Law). This allows for more transparency, better control, and enhanced communication across and between providers and between providers and the HIO.

PHARMACEUTICALS AND MEDICAL DEVICES

12. How are pharmaceuticals and medical devices financed and reimbursed?

The HIO covers the vast portion of the cost of pharmaceuticals listed on a ‘list of pharmaceutical products’ from the Health Insurance Fund. There is 100 per cent reimbursement of medicines listed in the positive list based on the lowest reference price. However, a co-payment of €1 per item applies. This list is drawn up and managed by the HIO. However, the Advisory Committee on Medicines evaluates applications for inclusion or removal from the positive list and gives recommendations to its Board (and then to the HIO). Patients opting for a more expensive product not on the list (which usually uses generic brands) are required to pay the difference between the product and the price of the medicine covered by the GHS. In exceptional circumstances, the HIO can request the Ministry of Health to ensure the availability of specific pharmaceuticals considered essential for public health.

13. How are the prices of pharmaceuticals and medical devices determined? How is economic efficiency controlled?

In general, the price of prescription-only medicines for both out and inpatient sectors are regulated using external price referencing (EPR), which is updated annually. Tendering in the inpatient sector is used, although not in the outpatient sector. For prescription-only medicines in the out- and inpatient sectors, generic medicines are priced at 80 per cent of the originator drug's price when they first enter the market. However, for innovative and high-cost medicines, the HIO uses Managed Entry Agreements (MEAs). This involves negotiating agreements with pharmaceutical manufacturers using outcome-based pricing, where payment depends on the drug's effectiveness in real-world use.

LITIGATION INVOLVING HEALTHCARE FINANCING AND REIMBURSEMENT

14. Please provide a high-level overview of major litigation topics and landmark cases regarding healthcare financing and reimbursement.

There has been very little litigation under the new system due to its recent implementation. Much of the old case law centred around whether a specific healthcare provider won contracts to provide services to the Ministry of Health (see: *Vouros Healthcare Ltd v Republic of Cyprus through the Ministry of Health*, case no 997/2015, 4/6/2020 (note these events took place under the 2015 regime); *Vouros Healthcare Ltd v Directorate of Purchases and Supplies, Ministry of Health*, application 8/2017, 21/3/2017).

However, the HIO has initiated some proceedings against hospitals. One big concern with the reimbursement system is the possibility of overtreatment. Much of the litigation has therefore centred on healthcare providers engaging in unnecessary procedures to increase the amount they receive from the HIO. In 2024, the HIO reviewed 12 million claims for reimbursement, rejecting 65,000 claims worth €19 million as being either medically unjustified or exceeding prescribed limits.

With respect to access to orphan drugs or early access products to treat rare diseases, the list of pharmaceutical products that the HIO currently covers is determined by the HIO on advice of the Medical Devices and Healthcare Products Agency. Their decisions are reviewed by the Pharmaceutical Advisory Committee and a Medicines Advisory Committee, with a veto power of the Council.

Non-covered drugs might therefore be obtained through political pressure put on the Council, which has final control over the list. In the event this does not occur, a Committee for Special Requests has been established to examine individual requests which are not covered, or, for the provision of drugs that are not licensed for a certain indication.

In addition, and for the first time, a Vetting Council has been set up enabling Individuals to submit appeals challenging any decisions of the Drugs Committee or of the Committee for Special Requests which, they consider unjust or unfair.

RECENT DEVELOPMENTS AND TRENDS

15. What are the recent developments and trends for the next few years? Please outline any unresolved issues, proposed changes, or trends for healthcare financing and reimbursement and briefly indicate how these may foreseeably affect the medical sector in the near future.

Recent trends indicate an increasing willingness for the Cypriot government to supply orphan drugs. The European Federation of Pharmaceutical Industries and Associations (EFPIA) ranked Cyprus 23rd among 39 countries in Europe in terms of patient accessibility to innovative medicines for the period 2017-2020. Subsequently, efforts are being made to increase the availability of innovative drugs: 130 innovative drugs had been added to the GHS by the end of January 2023.

The primary issue the WHO raised in its report on healthcare in Cyprus is health workforce shortages. These are a key capacity constraint and are the focus of many policy efforts. The Capacity Master Plan for Health considers the recruitment, retention and reskilling of the health workforce as part of its long-term objectives. Upskilling opportunities for health workers are also part of the Recovery and Resilience Plan. Furthermore, whereas previously many doctors left Cyprus or did not return after completing training abroad, the implementation of the GHS and the reduction in bureaucratic workload and rigid hierarchies should help combat this problem.