COUNTRY REPORT

CYPRUS

MIPEX HEALTH STRAND

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MIGRATION POLICY GROUP

MIGRANT INTEGRATION POLICY INDEX

HEALTH STRAND

Country Report Cyprus

Country Experts:
Panagiotis Petrou, Chrystalla Pithara and Christina Kouta

General coordination: Prof. David Ingleby

Editing: IOM MHD RO Brussels

Formatting: Jordi Noguera Mons (IOM)

Proofreading: DJ Caso

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International Organization for Migration Regional Office for the European Economic Area (EEA), the EU and NATO
40 Rue Montoyer
1000 Brussels
Belgium
Tel.: +32 (0) 2 287 70 00
Fax: +32 (0) 2 287 70 06

Email: ROBrusselsMHUnit@iom.int
Internet: http://www.eea.iom.int / http://equi-health.eea.iom.int

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READER'S GUIDE TO THE REPORT

This report was produced within the framework of the IOM's EQUI-HEALTH project, in collaboration with Cost Action IS1103 ADAPT and the Migrant Policy Group (MPG). Full details of the research and its methodology are contained in Sections I and II of the Summary Report, which can be downloaded from the IOM website at http://bit.ly/2g0GlRd. It is recommended to consult this report for clarification of the exact meaning of the concepts used.

Sections 5–8 are based on data from the MIPEX Health strand questionnaire, which covers 23 topics, in 10 of which multiple indicators are averaged. Each indicator is rated on a 3-point Likert scale as follows:

0 no policies to achieve equity
50 policies at a specified intermediate level of equity
100 equitable or near-equitable policies.

'Equity' between migrants and nationals means that migrants are not disadvantaged with respect to nationals. This usually requires equal treatment, but where migrants have different needs it means that special measures should be taken for them. Scores relate to policies adopted (though not necessarily implemented) by 31st December 2014. However, some later developments may be mentioned in the text.

To generate the symbols indicating a country's ranking within the whole sample, the countries were first ranked and then divided into five roughly equal groups (low score – below average – average – above average – high). It should be remembered that these are relative, not absolute scores.

The background information in sections 1-4 was compiled with the help of the following sources. Where additional sources have been used, they are mentioned in footnotes or references. It should be noted that the information in WHO and Eurostat databases is subject to revision from time to time, and may also differ slightly from that given by national sources.

Section	Key indicators	Text
1. Country data	Eurostat	CIA World Factbooks, BBC News (http://news.bbc.co.uk), national sources
2. Migration background	Eurostat, Eurobarometer (http://bit.ly/2grTjIF)	Eurostat, national sources
3. Health system	WHO Global Health Expenditure Database[1] (http://bit.ly/1zZWnuN)	Health in Transition (HiT) country reports (http://bit.ly/2ePh3VJ), WHO Global Health Expenditure database
4. Use of detention		National sources, Global Detention Project (http://bit.ly/29lXgf0), Asylum Information Database (http://bit.ly/1EpevVN)

These reports are being written for the 34 countries in the EQUI-HEALTH sample, i.e. all EU28 countries, the European Free Trade Area (EFTA) countries Iceland, Norway and Switzerland, and three 'neighbour' countries – Bosnia-Herzegovina, FYR Macedonia and Turkey.

All internet links were working at the time of publication.

[1] For the definition of these indicators please see p. 21 of the WHO document *General statistical procedures* at http://bit.ly/2lXd8JS

1. COUNTRY DATA

KEY INDICATORS		RANKING
Population (2014)	858.000	●○○○○
GDP per capita (2014) [EU mean = 100]	85	●●●○○
Accession to the European Union	2004	

Geography: Situated in the north-eastern part of the Mediterranean Sea, Cyprus is the largest island in the eastern Mediterranean and the third smallest country in the EU, after Malta and Luxembourg. It is located south of Turkey, west of Syria and Lebanon, northwest of Israel, north of Egypt, and east of Greece. The terrain consists of a central plain with mountains to the north and the south. The largest city is Nicosia with 251.000 inhabitants.

Historical background: A former British colony, the Republic of Cyprus gained its independence in 1960. Its legal system is largely based on English common law.

Since the Turkish invasion of 1974, in response to a Greek-sponsored military coup, Cyprus has been partitioned into a Greek-speaking southern part and a Turkish-speaking northern part, which is internationally recognised only by Turkey. Only the southern part (the Republic of Cyprus, RoC), which extends over two-thirds of the island's area, is considered in this report. For the sake of brevity the RoC is referred to as 'Cyprus'.

Government: Cyprus is a presidential republic divided into six districts: Nicosia, Famagusta, Kyrenia, Larnaca, Limassol, and Paphos.

Economy: Cyprus has a market economy dominated by the service sector, which accounts for more than four-fifths of GDP. Tourism, financial services, shipping, and real estate have traditionally been the most important sectors. Cyprus adopted the euro as its national currency in January 2008. After an unprecedented period of deep recession (2011-2014), the Cypriot economy entered the early stages of recovery in 2015. The economy still faces major challenges, such as the high level of non-performing loans, the high unemployment rate, the modest level of lending, and the low level of investment expenditure.[2] However, growth of 2,5% was forecast by the EU for 2017 and is expected to remain robust.[3]

[2] Central Bank of Cyprus, http://www.centralbank.gov.cy/media/pdf/CBC_FSR_30_September_2015_en.pdf
[3] http://bit.ly/2jiNMoR

2. MIGRATION BACKGROUND

KEY INDICATORS (2014)		RANKING
Foreign-born population as percentage of total population	22,3	●●●●●
Percentage non-EU/EFTA migrants among foreign-born population	42	●●○○○
Foreigners as percentage of total population	18,6	●●●●●
Non-EU/EFTA citizens as percentage of non-national population	30	●○○○○
Inhabitants per asylum applicant (more = lower ranking)	492	●●●●○
Percentage of positive asylum decisions at first istance	76	●●●●●
Positive attitude towards immigration of people from outside the EU (Question QA11.2, Eurobarometer)	28	●○○○○
Average MIPEX Score for other strands (MIPEX, 2015)	36	●○○○○

Until the end of the 20th century Cyprus had been a country of emigration rather than immigration, mainly due to its turbulent, conflict-ridden history. Many Cypriots emigrated during times of transition, mainly to the UK, Greece, USA, Canada, and Australia. This trend was reversed in 1990s, during what has come to be known as the 'financial miracle' of Cyprus, which led to a transformation from an agriculture-based to a service-based economy. Rapid economic growth in combination with the large number of women entering the labour market resulted in increased and immediate need for workers. These shortages were dealt with by increased employment of foreign workers, mainly from Asian and Middle Eastern countries, who were given seasonal or up to four-year permits to work in manual occupations linked to specific employers, with the proviso that workers would then return to their country of origin (Christofides et al. 2007). At the same time, work permits for domestic helpers from Asia were introduced in order address domestic labour shortages created by the women entering the labour market (Panayiotopoulos 2005). The number of work permits issued to migrants increased from 7.897 in 1991 to 65.275 in 2007 (Civil Registry and Migration Department, 2010).

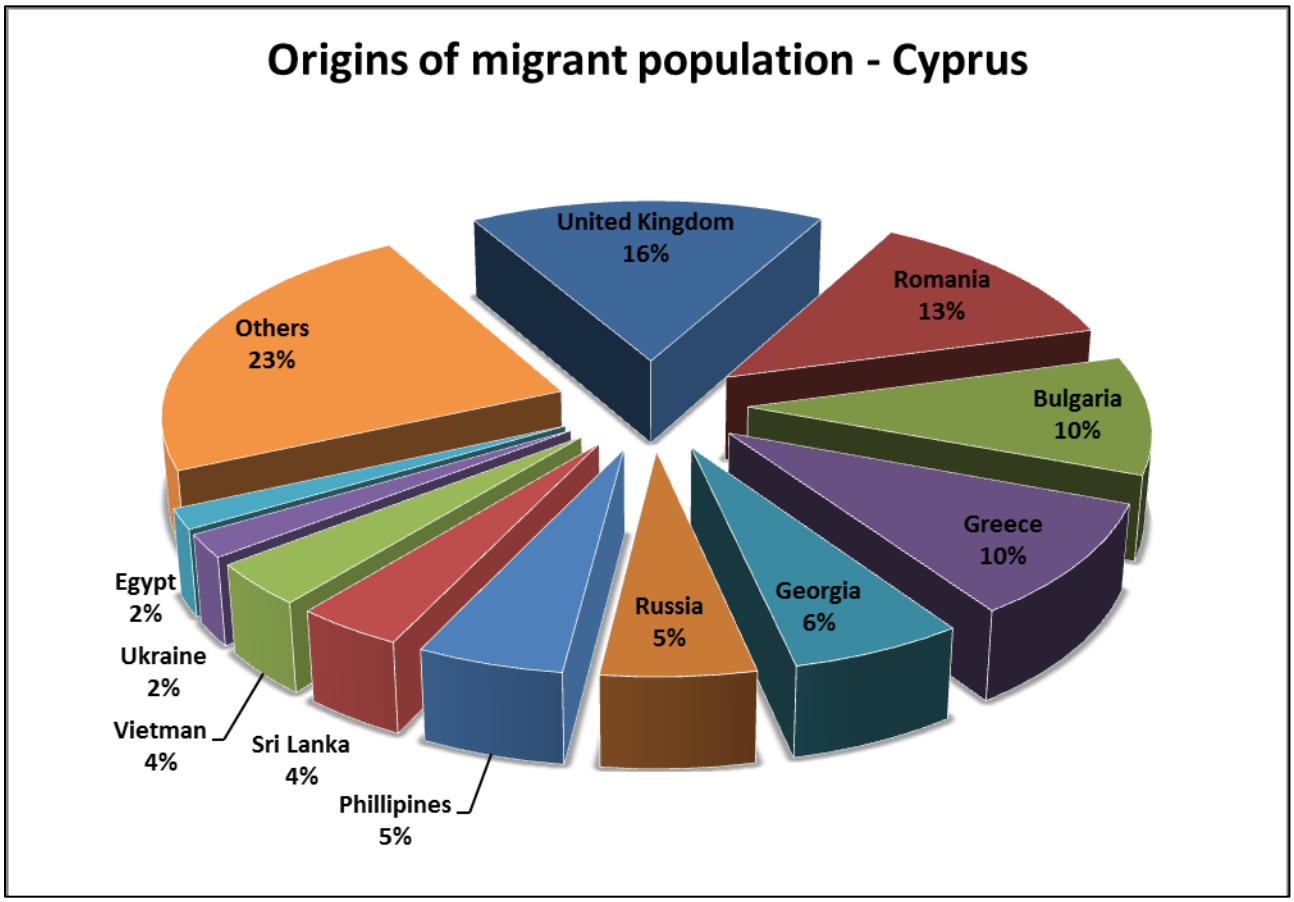
Migrants in Cyprus may fall into several categories with differing rights and circumstances, and are under the control of different ministries. They include migrants on a short-term or long-term residency visa, working visas, domestic helpers and "artist" visas, employees of international companies, and students. Kouta et al. (2013) estimated the number of undocumented migrants at 25-35.000, i.e. 12% - 17% of all migrants.

According to UNHCR in Cyprus, a significant number of those applying for refugee status are migrants who entered the country legally, mainly as students or on a general employment/domestic helper visa, but find themselves unable to pay their college fees or find new employment and thus become irregular migrants (Officer &Taki 2013).

Women comprise the majority of the TCN population in Cyprus (64% of the total) and tend to be younger than the Cypriot and EU population: 79% of TCNs in Cyprus are between 20 and 49 years of age (50.952) compared to 50% of EU nationals (52.767) and 33,5% of Cypriots (223.661) (CYSTAT, 2012). A gender bias depending on country of origin is evident, as 96,5% and 96% of individuals from Vietnam and the Philippines respectively are women, as were 84% of individuals from Sri Lanka and 64% from Russia. By contrast, 77% of individuals from Syria are men (CYSTAT, 2012). The gender bias is more evident for TCNs than EU nationals, reflecting the high numbers of domestic helpers working in Cyprus from third countries. 41% of the total non-EU workforce in 2014 were domestic helpers (Civil Registry and Migration Department, 2014).) According to the Ministry of Education,[4] 8.540 foreign students were registered as studying in the RoC during the academic year 2011-2012, 7.951 of whom were studying in one of 30 private colleges (Ministry of Education and Culture, 2014). Among them, 2.583 were TCNs.

Attitudes towards third-country migrants are much more negative than the EU average, while according to the MIPEX 2015 survey, integration policies rank second to last in the EU and discourage long-term integration. "Although CY spends EU funds on ad hoc integration policies, its restrictive policies and limited support discourage immigrants and local communities from investing in their integration."[5] Figure 1 shows the country of birth of the largest migrant groups in Cyprus in 2011, the most recent year for which data are available).[6]

Figure 1. Foreign-born population in 2011 by country of origin



[4] Ministry of Education and Culture (2014).
[5] www.mipex.eu
[6] Data not available from Eurostat. Data from the 2011 census are avaiable from CYSTAT (http://bit.ly/2jiLlmb), also from United Nations Statistical Service (http://data.un.org/Data.aspx?d=POP&f=tableCode%3a44)

3. HEALTH SYSTEM

KEY INDICATORS (2013)		RANKING
Total health expenditure per person (adjusted for purchasing power, in euros)	1631	●●○○○
Health expenditure as percentage of GDP	7,5	●●○○○
Percentage of health financing from government National health system (NHS) / social health insurance (SHI)	46	NHS
Percentage of health financing from out-of-pocket payments (higher percentage = lower ranking)	47	●○○○○
Score on Euro Health Consumer Index (ECHI, 2014)	619	●●○○○
Overall score on MIPEX Health strand (2015)	31	●●○○○

Cyprus is the only EU country without a universal health coverage system (Petrou, 2014). The Cyprus Government has been in the process of implementing a General Health Scheme that will offer universal healthcare coverage to the population, and this is expected to come into effect in mid-2020. Due to the financial crisis and consequent austerity measures, health expenditure has plummeted. In 2014 health expenditure was among the lowest in Europe; from 2009 onward it showed an annual reduction rate of 2,5% (World Bank, 2014).

At present, public and private healthcare sectors run in parallel to each other, yet with minimal levels of collaboration or information exchange between them; neither offers universal coverage. Public health policy is designed, organised, and delivered centrally by the **Ministry of Health,** and is guided mainly by exogenous factors such as international and EU policies, guidelines and agreements. Policy changes are usually politically driven by individual governments and ministers, but these initiatives often stall following changes in both. In addition to public health initiatives, the public sector has been the provider of tertiary specialist services such as Mother and Child services, to which the private sector refers high-risk cases requiring specialist care. Semi-governmental institutions provide specialist neurological and genetic services, as well as cancer care. In recent years, however, more private providers have set up tertiary specialist services. The Ministry of Health has some involvement in the running of the private sector through implementation of legislation guiding health institutions and overseeing health, safety and quality protocols and procedures, as well as authorising institution licences.

The **public health sector** is financed through a tax-based (Beveridge) system of financing; funding is allocated to the Ministry of Health as part of the government's annual budget (Theodorou et al. 2012). In order to strengthen the sustainability of the funding structure, a 1,5% health care tax was introduced for public servants and public servant pensioners, paid as a proportion of annual gross salaries and pensions. This was implemented as a prerequisite for securing bailout funds according to the Memorandum of Understanding on Specific Economic Policy Conditionality between Cyprus and a team of international lenders known as the Troika (IMF, EU, and European Central Bank).

The **private sector** is organised around private health sector investments made by individuals or companies, and comprises privately owned hospitals, clinics and small practices run by individual practitioners. Services are available to all individuals who are able to pay the full cost at the point of supply. This sector is mainly clustered around specialised (rather than general or family medicine) care with patients able to access any specialty without having to go through primary care first. Because of the autonomy and independent status of private care providers of care where supply is not necessarily informed by need, there is considerable duplication in health infrastructure and running costs for the private market are high, which ultimately places the burden squarely on patients' shoulders.

Health care coverage for the population

The public health care sector is organised around a multi-tiered system of entitlement, with new rules that came into effect in August 2013. At present, those staying in Cyprus can be categorised according to the following entitlement categories:

a. Public health care beneficiaries entitled to a Health Card (who need to fulfil specific criteria)
b. Employment-linked privately insured individuals working for large organisations
c. Employment-linked privately insured transient migrant workers
d. EU citizens using a European Health Card
e. EU citizens permanently living in Cyprus entitled to a Cyprus Health Card
f. Non-insured individuals

Depending on the category they belong to, individuals:

- with a Cyprus or EU health card may access the public sector where there is a co-payment fee at the point of entry;
- pay the full cost of the service using either the private or public sector and go through a reimbursement process with the insurance company;
- pay the full cost of the service as out-of-pocket expense using either the private or public sector;
- use emergency medical services, which are open to all with a standard charge (€10) at the point of entry, except for individuals who belong to specific groups such as the elderly, soldiers and public assistance recipients, among others.

Public Health Service Health Card

In order to be eligible for a Public Health Service Health Card one needs to be a Cypriot citizen, an EU Citizen permanently living in Cyprus, or a migrant with refugee status. The conditions for EU Citizens will not be discussed here, as EU agreements apply for all member states.

In order to be eligible for a health card, individuals must have made social insurance contributions (or if they are public sector employees, have contributed through health tax salary deductions) for at least three years.

Additional eligibility criteria are related to income level, entitlement for public social welfare assistance, age and employment characteristics - i.e. public servants, soldiers serving in the RoC army, the elderly,

low income individuals/families (individuals earning under €15.000, increasing by €1.700 for each dependant), and patients with specific chronic conditions, among others.

Private Health Insurance Schemes

There is no comprehensive or central financing system for the private sector. Access is open to all based on ability to pay, and patients often move from one sector and provider to another. Private insurance companies provide individuals, groups and families with different levels of insurance coverage that enable the insured party to be reimbursed for all or only part of the care received. Packages are available that may cover services received at inpatient services only, outpatient and inpatient services in Cyprus, and specialist services received abroad. Large private or semi-governmental organisations such as banks provide risk-sharing health insurance packages to their employees and their families that enable access to private and sometimes public health services; costs are partially or fully reimbursed by the insurance company. Private insurance companies also offer a variety of different health insurance packages to individuals or groups of individuals.

Individuals may be eligible for health insurance coverage through private insurance schemes organised by employers, which are generally dependent on employment status. These may be comprehensive private insurance packages covering outpatient, inpatient and specialised care for the employee and their family members and provided by large private or semi-governmental organisations, or coverage for outpatient care use provided by large trade unions to their members and their families. These plans cover only outpatient visits in the primary care sector whereby reimbursement takes place following the visit for all or part of the cost of the visit, depending on the insurance scheme.

Impact of the financial crisis on health care services

The financial crisis has increased demand for public health care services, especially for hospital care. An increase of 13,5% was reported in 2011-2012,[7] also in the number of people applying for a health care card enabling them to access services at reduced cost. Austerity measures have put both public and private health services under increased pressure. The public sector has suffered from under-staffing and increased demand, due partly to a recruitment freeze by the government, while government-employed physicians have resorted to the more financially attractive private sector following salary reductions and uncertainty around possible taxation of retirement benefits. These pressures have further increased already long waiting lists in the public sector (Theodorou et al. 2012, Kiliari et al. 2014). At the same time, demand for costly private health services has decreased.

Gaps in the system and implications for data collection

The segregation of the two health sectors has been the cause of a number of problems in the delivery of care, including making the collection of health and health system related information almost impossible. Because of the stand-alone nature of each service provided and the disjointed nature of the primary sector, it is not possible to collect information from all service providers; further, collating data from major providers, such as large hospitals and clinics which would be more likely to keep service records, entails considerable organisational and time challenges.

[7] CYSTAT; website of NGH http://www.moh.gov.cy/moh/ngh/ngh.nsf/index_en/index_en?OpenDocument

Health data is systematically collected only from the public sector, with the exception of obligatory vigilance registries for infectious diseases and other health conditions such as cancer which are part of international epidemiology observatories and consortiums. Even in the public sector, however, significant systemic problems constrain the collection of data (Petrou, 2015). One of the main problems is the absence of a unified electronic information system running through all institutions of the health system including hospitals, primary and community care and management departments that would enable automatic recording of patient health and care information and would follow patients through their journey(s) in the system. This, combined with the fact that patients 'jump' between the private and public sectors for consultations and treatments, precludes any continuity of care and data recording. Moreover, the triple role of the Ministry of Health as a provider, payer, and regulator further impedes efficiency enhancement, since there are allegations of favouritism towards the public sector.

Lack of universal health care coverage has resulted in skewed distribution of health care access and quality. This is because those not eligible for public health care or covered through employer-linked insurance coverage and who cannot afford private insurance packages face significant barriers to health care access, chief amongst them being the cost of care (28% of respondents raising cost as the main barrier to care, according to Dubois & Anderson 2013). The most disadvantaged groups, including those with seasonal or temporary employment contracts, families whose income is slightly over the income threshold that would qualify them for public sector coverage but who nonetheless experience poverty, migrants and those affected by disability, are the ones most impacted by the current status quo .

4. USE OF DETENTION

Detention of migrants is regulated by the Aliens and Immigration Law. According to this law, the Minister of Interior may issue arrest and deportation orders against anyone falling in the category "prohibited immigrant", and at the same time order his/her detention until deportation measures are enforced. The law does not mention any maximum period of detention (KISA, 2014).

According to the Refugee Law, asylum seekers who enter the Republic of Cyprus irregularly may not be detained solely for their irregular entry or stay, provided that they present themselves without "undue delay" to the authorities and explain the reasons for their irregular entry. Detention under the Refugee Law is permitted on two grounds:

- To establish an applicant's nationality or identity if they have destroyed or falsified their personal documents and do not reveal their real identity during the submission of their asylum application; and
- To examine new elements in the application after the claim has been refused at the initial and appeal stages, and a deportation order has been issued.[8]

Up to 2012, detention of migrants took place mostly in police detention facilities at various police stations all over Cyprus, which had been designed for short-term detention only. Since then, the newly build Mennoyia Detention Centre (capacity of 256 persons) is used for the detention of migrants, including asylum seekers (KISA, op. cit). However, reports indicate that the country continues to make use of police cells.

In its 2014 report, the Cypriot NGO KISA (Action for Equality, Support, and Anti-racism) deplored the absence of medical staff in most detention facilities (KISA, op. cit.).

[8] Asylum in Europe (AIDA), Grounds for Detention Cyprus, n.d.
http://www.asylumineurope.org/reports/country/cyprus/grounds-detention

5. ENTITLEMENT TO HEALTH SERVICES

Score 33 **Ranking** ●○○○○

A. Legal migrants

Inclusion in health system and services covered

There are different categories of legal migrants with different rights and levels of entitlements.

Migrants coming to Cyprus on **worker or student** visas need to show evidence of private health insurance coverage in order to be granted a residence permit and in order for their residence permit to be renewed at the end of four years. Private insurance coverage needs to be renewed annually. This means that in some cases migrants themselves may not realise that the insurance agreement needs to be renewed, sometimes finding themselves unknowingly uninsured, or in other cases employers may knowingly avoid renewing their employees' health insurance agreements because of prohibitive cost until the point when the migrant's residence permit needs to be renewed. In either case, migrants may suddenly find themselves unable to access the care they need or faced with having to pay large sums out-of-pocket.

It should also be noted that private insurance packages specific to migrant workers have a very low reimbursement ceiling, which means not only that migrants need to cover the full cost at the point of access, but that they may also not be reimbursed for the larger part of that cost by the insurance company. Comparison between the ceiling and the minimum potential cost for different types of care provided by the Ministry of Health illustrates that insurance companies place their reimbursement ceilings well below the minimum cost.

Health insurance packages differ between and within insurance companies in terms of costs, terms and conditions for reimbursement (e.g. reimbursement ceiling, services and interventions covered). Basic insurance packages for workers (including and domestic workers) differ from the main health insurance packages offered to individuals or large employers in all of the respects mentioned above. The basic package provides only for inpatient care with the added option to extend it to outpatient care coverage with a higher cost package.

Private colleges and universities tend to affiliate with specific insurance companies, meaning that students may not have a choice in deciding on an insurance provider. In the case of workers, employers tend to decide the insurance plan on behalf of their employees. Migrant workers in this scenario may also not have a choice in terms of the insurance company or package they want to choose. The insurance cost for workers is shared between them and their employers. Students need to cover the full cost of their insurance.

Recognised refugees are entitled to a Public Health Service Health Card, subject to the same conditions as Cypriot citizens (Refugee Law N.6 (I)/2000).

Special exemptions

Specific migrant groups who are deemed to be especially vulnerable and in need of support are exempt from restrictions on entitlement, as stated in three legal documents: Recognised refugees [Refugee Law N.6(I)/2000); Trafficking law 13(I)/2012], Ministerial decision 11.11.09(4); Public Medical Institutions and Services (Laws 1978-2013). These groups are:

- pregnant women and minors under 18 (applicable to all persons who do not have medical insurance);
- victims of torture;
- rape;
- psychological trauma, or
- sexual violence including victims of genital mutilation;
- under-age victims of any kinds of violence, abuse or exploitation;
- victims of human trafficking (Law N.87(I)/2007 for the combating of trafficking and exploitation of persons and protection of victims);
- individuals diagnosed with infectious diseases that endanger public health (e.g. TB, HIV/Aids), although in this case the statutory framework is not clearly defined.

Barriers to obtaining entitlement

Problems in the case of private insurance coverage might arise because of (a) language barriers and problems in filling out forms and communicating with administrators, or (b) the presence of "gatekeepers" between transient migrants and insurance companies in the form of employers and college/university administrators.

Some discretionary judgements are present at all levels of healthcare service provision – for example, decisions made by administrators (receptionists, managers or committees) about which treatments/interventions should be reimbursed, entitlement to treatments or benefits that are not explicitly made available to migrant groups within public policy (i.e. in the case of recognised refugees, certain types of specialist treatment or treatment abroad may be denied to refugees, subject to Ministry of Health case-by-case decisions), health workers making clinical judgements about criteria for entitlement such as 'urgency', financial departments deciding how rigorously to pursue unpaid bills (even though in many cases bills are cancelled and not pursued), etc.

All kinds of decisions about the types of treatments that individual migrants are entitled to, as well as the option to waive the full cost of the treatment received in the public sector, fall under the discretion of the Minister of Health. This applies to all categories of migrants on an individual basis, as well as in the case of entitlement to treatments that are given in the context of promoting public health.

B. Asylum seekers

Inclusion in health system and services covered

Asylum seekers are entitled to free healthcare if they have insufficient financial means (Refugee Law N.6 (I)/2000). If their income is below the statutory threshold, they may be entitled to welfare benefits that can take the form of goods, vouchers, or a monetary allowance. If they receive vouchers (instead of an allowance), they are not subject to co-payment when they access healthcare. They are also not subject

to the prerequisite of having a three-year contribution to the social insurance fund before being eligible to receive the public health beneficiary status. Specialist care might be denied, as asylum seekers are only entitled to access emergency services and to receive "necessary" treatment according to the legislation, even though in practice practitioners report that all needed care is delivered to this group.

Asylum seekers are not eligible for reimbursement in cases where specific interventions are not available in Cyprus and patients must seek medical care abroad (whereas nationals are entitled to receive care not available in Cyprus abroad, with the government assuming their costs). They are also not explicitly included in legislation or policy documents as a group entitled to disability and rehabilitation support or adjuvant benefits. However, it is likely that decisions are made on a case-by-case basis for special provision of adjuvant benefits to asylum seekers made by the Ministry of Health.

Special exemptions

Same as for legal migrants.

Barriers to obtaining entitlement

There is a single form submitted by all persons applying for a national health card, and supporting documents required for nationals and recognised refugees and asylum seekers are comparable. All categories, including asylum seekers, need to provide these documents in order to get the health card. Even though both nationals and non-nationals need to supply this documentation, it is potentially more difficult for the non-nationals to obtain (see barriers for legal migrants).

Two forms of administrative discretion apply to asylum seekers:

1. The definition of "emergency" (or "necessary") care is subject to clinical discretion.
2. A bill for publicly provided health care can be waived at the discretion of the Minister of Health. This is applicable to all categories but on an individual basis, in the context of promoting public health.

C. Undocumented migrants

Inclusion in health system and services covered

Undocumented migrants may access emergency care, but there is a €10 co-payment at point of access for all users (some exemptions apply for certain categories such as soldiers, welfare recipients, etc.)

Special exemptions

Same as for legal migrants

Barriers to obtaining entitlement

Same as for asylum seekers.

6. POLICIES TO FACILITATE ACCESS

Score 48 **Ranking** ●●●○○

Information for service providers about migrants' entitlements

Decisions, recommendations, and guidelines are disseminated by the Ministry of Health to hospital administrators, who in turn are expected to keep their staff up to date. However, there are no structured processes for monitoring the dissemination and implementation of guidelines.

Information for migrants concerning entitlements and use of health services

Basic information leaflets addressed to the general population that cover patient rights, services provided by the public sector and information on public health issues (e.g. vaccinations) are made available in the English language within public healthcare settings by the Ministry of Health.

One information package available in electronic and printed format (disseminated to government agencies and NGOs) was created by a private research organisation using government funds allocated from the EU Integration Fund. This package contains information specific to the CY health care system and migrants' social welfare and health care entitlements in English and four migrant languages (Arabic, Hindi, Moldovan and Ukrainian.[9] This is the only publication with content modelled and adjusted to target the needs of the migrant population.

The Ministry of Interior has put out some information on migrant rights and integration, and this includes leaflets in the four migrant languages listed above. A policy paper on the integration of legal migrants was published for the period of 2010-2012, and it laid out targets related to the provision of information to migrants; actions are being implemented on an ongoing basis, based on available funding.

This information, which is mainly available through websites, caters primarily to the needs of legal migrants, including refugees and asylum seekers.

Health education and health promotion for migrants

Information on health education and health promotion specific to migrants is primarily available through websites. Specific campaigns that have been set up include an NGO collaboration with the MoH where a female genital mutilation awareness campaign was specifically directed at health professionals.[10]

It is worth noting that health education and health promotion campaigns targeting only migrants are not regularly or consistently implemented, and according to MOH officials, to date there is no comprehensive plan to do so. Training material for the above-mention campaign is only available in Greek and English.

[9] http://cyprus-guide.org/en/the-guide/item/15-health-care-services
[10] http://www.endfgm.eu/

Health education and health promotion initiatives are specifically directed towards the majority population, and take place within the school health realm or within mainstream healthcare services. Health education leaflets are therefore available in the Greek language to those who access public health services. Children of legal migrants and asylum seekers who attend public schools may also be reached by health education and health promotion initiatives targeting students. Regrettably, none of these campaigns address the needs of undocumented migrants.

Provision of 'cultural mediators' or 'patient navigators' to facilitate access for migrants

Not provided

Is there an obligation to report undocumented migrants?

The threat of being reported by health professionals to immigration services is an important barrier to accessing public health care services for undocumented migrants. In Cyprus there is no relevant legislation or overt professional codes of conduct regarding the reporting of undocumented migrants. In practice, however, it is noted that migrants are required to present their ID and residence permit card in order to register and be seen by healthcare professionals in public A&E departments; the A&E electronic databases of two hospitals are linked to civil registry department databases and can verify residence status but (theoretically) cannot denounce undocumented migrants since input of other details beyond name, age, and sex is not explicitly obligatory (Public Medical Institutions and Services (Laws 1978-2013). An organizational culture of excluding undocumented migrants through these practices and covert obligation to report undocumented migrants might be present, which might or might not vary according to individual hospitals. A&E departments of private hospitals do not require identifying documents in order to be seen.

Are there any sanctions against helping undocumented migrants?

There are no specific sanctions against healthcare professionals or organisations assisting undocumented migrants. However, organisational practices such as the requirement for migrants to present ID and residence permit and the tie-in between electronic databases in A&E departments and the civil registry department databases might create pressures on healthcare professionals, even though no such cases have been reported so far.

7. RESPONSIVE HEALTH SERVICES

Score 17 **Ranking** ●●○○○

Interpretation services

Not available

Requirement for 'culturally competent' or 'diversity-sensitive' services

No standards or guidelines are available

Training and education of health service staff

There is some training and education of health service staff meant to enable professionals to provide services responsive to the needs of migrants, but it is on an ad hoc basis. There is no mandatory training on providing culturally competent health care services organised by the Ministry of Health.

Training on diversity and quality of service provision, guided by the 2010-2012 migrant integration policy, is organised centrally by the Cyprus Academy of Public Administration and delivered to all public servants, including health care professionals. This department offers training about twice a year, and all hospitals are informed directly about class availability and schedules. Participation is mainly limited to professionals working in the A&E and less often to outpatient departments. Participation is voluntary and 1-2 individuals are put forward to attend by each staff supervisor.

Nicosia General Hospital has a learning hub, which is responsible for identifying learning and training needs of staff once a year, and follows up with organising training to fill identified needs. Other hospitals are not as organised and it falls on supervisors to identify training needs and opportunities, and to encourage their staff to attend.

Involvement of migrants

There is no organised involvement of migrants in information provision, service design and delivery.

Encouraging diversity in the health service workforce

There is no organised attempt to achieve a more diverse health service workforce. Access to employment in the public sector (the only sector under direct government control) is essentially closed to migrants, as the criteria for even being considered are by their nature very restrictive: Cypriot or EU nationality and excellent knowledge of Greek.

Development of capacity and methods

In terms of health delivery and the development of capacity and methods to treat migrant groups, no attempt has so far been made in adapting diagnostic procedures and treatment methods so they become more sensitive and responsive to the diverse sociocultural backgrounds of patients.

Some attempts have been made to develop additional capacity among health professionals in dealing with health problems specific to certain migrant communities. For example, there is a female genital mutilation policy in the context of which medical and nursing staff of A&E departments have been

trained on how to deal with such cases in a way that is appropriate to migrant population needs. Action points in this policy inform professionals on how to adapt their practice and adopt new approaches. The Ministry of Interior has also sponsored training (delivered by a private educational organisation) on assessing and treating torture victims for a small number of healthcare professionals.

8. MEASURES TO ACHIEVE CHANGE

Score 25 **Ranking** ●●○○○

Data collection

The Ministry of Health has designed a structured patient information electronic database with outcomes related to demographic, socio-economic, as well as health characteristics. Nationality is part of this database but so far it has not been included in formal collation and analysis of data, and annual reports of the Ministry of Health do not segregate data based on nationality. This indicator is frequently left out, as it is not a mandatory field at the time of patient registration at public sector health care centres.

Nationality data is also collected as part of the Cyprus Cancer Registry with information for all individuals diagnosed with cancer in the public and private sectors. For the cancer registry, there are eight nationality options when collecting case data: Greek, Turkish, Cypriot, Maronite, Armenian, EU, Other (Non EU), and Unknown. It is therefore not possible to break down this data into individual nationalities other than the ones already specified by the system.

Migrants entering Cyprus for employment or study are required to present test results for infectious diseases such as HIV, HBV, syphilis, and tuberculosis –data records of which are kept on file. The infectious disease (HIV, HBV, HCV and TB) registry also requires nationality; nevertheless, this data is not included on national health surveys.

Support for research

In the context of integration policy action, one already funded research project analysed migrant healthcare access (Theodorou et al, 2010). This study also looked at the reasons for accessing healthcare, focusing on specific health problems (Ministry of Interior). A study looking into the sexual and reproductive health knowledge levels of migrant female domestic workers and providing educational interventions was also funded by the Cyprus University of Technology (Kouta et al, 2013).

"Health in all policies" approach

Thus far, the RoC government has not adopted a “health in all policies” approach, and no consideration is given to the impact on migrant or ethnic minority health of policies in sectors other than health.

Whole organisation approach

Migrant or ethnic minority health is clearly not a priority throughout service provider organisations and health agencies, since so far no policies have been implemented specifically targeting minority health issues.

Leadership by government

The RoC government has published a migrant integration policy plan targeting all legal migrants. Even though specific actions and interventions have been introduced in sectors such as education, the majority of actions in the area of health are not targeted actions but fall under the broader category of public health actions aimed at the general population. No specific new plans have been elaborated

targeting specific ethnic groups or conditions that have increased prevalence among migrants or ethnic minorities. There is no continuity in the implementation of these policies.

Involvement of stakeholders

One particular policy design gap is the fact that no formal or informal policy exists to systematically involve external stakeholders in the design of migrant health policies. Usually, NGOs take part in advisory bodies only after they are explicitly asked for participation. There is no official and permanent collaboration between health authorities and NGOs.

Migrants' contribution to health policymaking

There is no contribution from, or consultation with, any migrant groups or organisations in health policy design.

CONCLUSIONS

Cyprus is the only European country without a health system aiming to provide universal coverage, an attribute that has permeated all layers of health care settings in Cyprus. This has led to inequities in access to health care and to the fragmentation of health services into a volume-driven public sector and a value-driven private sector. There is a strong correlation between the current flawed structure of the health system and the numerous documented examples of inequity and inertia. Therefore, it is expected that the long-anticipated National Health System, whose introduction has been constantly postponed through the years, could move things forward, mitigate inequities, improve access and promote change.

The unification of the two fragmented health care sectors could also enhance the health system's responsiveness and enable data collection at an early stage, thus rendering it proactive rather than reactive. This could also facilitate the introduction of evidence-based guidelines, initiatives and actions, which among others, could constitute the primary steps in reaffirming support to vulnerable groups.

Due to a political stand-off, the introduction of the NHS is now not scheduled until mid-2020, which several stakeholders dispute since the blueprint for the NHS has been hotly debated, primarily on fiscal feasibility grounds.

The introduction of the NHS could promote the provision of universal access, the backbone of any contemporary health system. All United Nations Member States, including Cyprus, have pledged to try to achieve this goal by 2030.[11] Currently, migrants from outside the EU/EFTA can only contract with private insurers, nevertheless the breadth and scope of the coverage offered clearly does not overlap with the current charges of private sector physicians and in any case, provide only basic coverage.

The ramifications of the unprecedented fiscal crisis are jeopardising the affordability of care for patients, especially those on lower wages. By reducing the number of beneficiaries of publicly-financed health services in accordance with the requirements of the team of international lenders (the Troika), Cyprus has done the opposite of what was needed to move towards a universal, equitable health system. This comprises a potential public health hazard, since the crisis has been acknowledged to constitute a health risk in itself, thus compounding the threat to health.

In the run-up to the implementation of the NHS, measures need to be taken to increase the responsiveness of the system to the needs of the population – including migrants – and to make it more inclusive.

[11] See http://www.who.int/universal_health_coverage/en/

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International Organization for Migration

Regional Office for the European Economic Area (EEA), the EU and NATO

40 Rue Montoyer—1000 Brussels—Belgium—http://www.eea.iom.int

Tel.: +32 (0) 2 287 70 00— ROBrussels@iom.int