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Functional Review of the Health Sector Public Entities (SOEs)

Final Report

May 20, 2014

Poverty Reduction and Economic Management Unit

Southern Europe Program

Europe & Central Asian Region

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CONTENTS

PREFACE

This report was prepared as a part of Cyprus Public Administration Reform (P146719) project lead by Edgardo Mosqueira (Lead Public Sector Development Specialist, LCSPS1).

The report presents the functional review for selected public entities in the health sector: (i) the Cyprus Anti-Drugs Council; and (ii) the Health Insurance Organization.

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The team is grateful for suggestions and advices received during consultations with government officials of the Republic of Cyprus, primarily representatives of the Ministry of Health, the Ministry of Finance, the Office of the Commissioner for the Reform of the Civil service the Health Insurance Organization and the Cyprus Anti-Drug Council. The team acknowledges the comments and guidance received from Daniel Dulitzky (Sector Manager, ECSH1), Adrian Fozzard (Sector Manager, ECSP4) and Dirk Reinermann (Program Manager, Special Operations, ECAVP).

1 Review of the Cyprus Anti-Drugs Council

1.1 Policy goals and objectives

1. **The Cyprus Anti-Drugs Council (CAC) is the national coordinating body in the field of substance dependency and prevention and the national focal point (NFP) of the European Monitoring Center for Drugs and Drug Addictions (EMCDDA)**. The EMCDDA, established in 1993, is the EU decentralized agency responsible to provide the EU and its Member States with a factual overview of European drug problems. The Regulation governing the EMCDDA's work requires that each EU Member State shall establish or designate one NFP. Therefore, the establishment of CAC as a Semi-Governmental Organization (SGO) under the "Prevention of the Use and Dissemination of Drugs and other Addictive Substances" Law 28 (I) of 2000 (subsequently amended by Law 142 (I) of 2002). CAC started its operation in 2001 with the following responsibilities:

- Planning, monitoring and controlling the implementation of the National Strategy on Drugs and other addictive substances.
- Coordinate the activities in the field of addictive substances performed by the various government departments and agencies, the private sector and non-governmental organizations (NGOs).
- Coordinate, monitor and evaluate all relevant programs in the area of substance dependency and prevention implemented by public and private organization.
- Provide financial support to governmental, non-governmental and private programs, aimed at the prevention and treatment of addiction and at the reduction of the use of addictive substances.
- Provide training and share knowledge regarding best practices for the prevention and treatment of substance abuse and harm reduction strategies.
- Collect and disseminate information on the use of drugs and other addictive behaviors in Cyprus.
- Develop cooperation with relevant European bodies and international organizations, in the area of substance dependency.

2. **CAC is in charge of the formulation of national strategies and action plans on drugs and other addictive substances that should complement the relevant European and international strategies**. The National Strategy for dealing with addictions to illegal substances and the harmful use of alcohol for 2013-2020, is the main policy document on addictions and will direct the actions and initiatives of the Cypriot state for the next eight years. It is a coherent and comprehensive policy, which succeeded the National Drugs Strategy for 2009-2012, in order to provide a context to put the policy guidance in practice and coordinate the implementation of efforts and initiatives to address the use and addiction to illegal substances, the management of harmful alcohol use and the management of addiction to licit drugs.

3. **The National Strategy provides the overarching political framework and priorities for the period 2013-20.** The two consecutive Action Plans 2013-2016/ 2017-2020, provide a list of specific actions with a timetable, responsible parties, indicators and assessment tools. By providing a framework for joint and complementary actions, the Strategy ensures related the growth/ human development objective that resources invested in this area are used effectively and efficiently, whilst taking into account the institutional and financial constraints and capacities of the various institutions involved. The Strategy is structured around two policy areas: (i) drug demand reduction; and (ii) drug supply reduction; and three cross-cutting themes: coordination, international cooperation and research, monitoring and evaluation.

4. **CAC plays the overall coordinating role for the implementation of the National Strategies, but it also responsible to implement some actions**. The main achievements of CAC over the past few years could be summarized as follows:

- Financing the operation of a first specialized drug treatment center for women;
- Coordination of interventions and financing of training, resulting in the operation of a treatment center in prison;
- Coordination of interventions and financing of training, resulting in expansion of substitution treatment;
- Introduction of environmental strategies in the National Strategy and new concept of prevention, contributing, through building synergies to the introduction of Health Promotion class in school curriculums;
- Inclusion of alcohol related harm in the National Strategy and Action Plan;
- Financial support of selective programs offering creative occupation to high-risk children and adolescents;
- Establishment, for the first time, of a close cooperation with the National Guard;
- Conduct of the first survey among military conscripts;
- Financing of some of the prevention, early intervention and treatment measures within the army environment;
- Drafting of the National Strategy on Illicit Substances and the Harmful use of Alcohol 2013-2020;
- Operation of an electronic service aimed at a direct communication with drugs users and their families and provision of online support;
- Operation of a central electronic database for the monitoring of drug treatment;
- Introduction and coordination of an early intervention programs aimed at young offenders;
- Financial support of drug users aimed at their social reintegration;
- Co-financing of the operation of a public outpatient treatment center in Limassol;
- Production of best practice guide for journalists;
- Development of electronic services for smart-phones;
- Upgrading of international cooperation;
- Coordination of interventions aiming at an establishment of a cooperation with the Emergency Units of the General Hospitals, aiming at early intervention and overdose prevention;
- Sharing of expertise in the framework of: the Horizontal Group on Drugs of the European Commission, the Committee on National Alcohol Policy and Action of the European Commission, the European Monitoring Centre for Drugs and Drug Addiction of the Pompidou Group of the Council of Europe on Combating Drug Abuse and Drug Trafficking;
- Drafting of the European Drug Strategy, in its capacity as the chair of the Horizontal Drugs Group, of the Council of the European union, in the framework of the Cypriot presidency of the EU;
- Coaching in the framework of the Lithuanian and Greek Presidency of the Council of the European Union.

1.2 Functions and services

5. **The main functions of CAC comprise the strategic planning, coordination, supervision and monitoring in the area of substance dependency and prevention.** According to the Law "Prevention of the Use and Dissemination of Drugs and other Addictive Substances", the main objective of CAC consists in drafting the national strategy and action plan on drugs and other psychoactive substances, and the promotion, monitoring and control of its implementation. CAC activities and tasks are related to policy formulation, advocacy and regulations. CAC does not provide services directly, but finance services aimed at the prevention and recovery of substance dependency. CAC activities are directed to different audiences:

- General population;

- Specific vulnerable groups (including substance users);
- Health care professionals;
- Professionals from law enforcement and other related fields;
- Government and non-government organizations in the field of health care and addictions;
- Educational institutions;
- European and other international organizations.

6. **CAC produces informational and knowledge products that are provided to NGOs and other social organizations (between 10,000 and 20,000 items are provided each year).** In addition CAC finances around 42 programs aimed at preventing the use of addictive substances and around 20 centers for the treatment of substance abuse (the number of programs and centers financed vary from one year to another). The financing provided to the treatment centers ranges from Euros 5,000 to Euros 200,000, for a total of Euros 290,000 in 2013 (including the actions aimed at supporting the social reintegration of former users of addictive substances). Specific products of CAC include (see Annex 1):

- National Strategy for illicit substances and harmful use of alcohol 2013-2020;
- Annual National Report on the implementation of the National Drug Strategy;
- Annual National Report on the drug using phenomenon in Cyprus based on EMCDDA's epidemiological Indicators;
- Annual National Report on Alcohol;
- Research studies and surveys across different populations and environments, such as
    - Epidemiological general population survey
    - European School Survey Project on Alcohol and Other Drugs
    - Survey among the military
    - Social cost of drug use study, etc.
- Prevention and treatment guidelines;
- Monthly Journal, Quarterly News Letter, Leaflets and other information material;
- Online counselling service for substance users and their families;
- Posters targeting medical staff in the Emergency Units aiming at overdose prevention;
- Prevention booklets targeting military conscripts.

1.3 Organizational structure

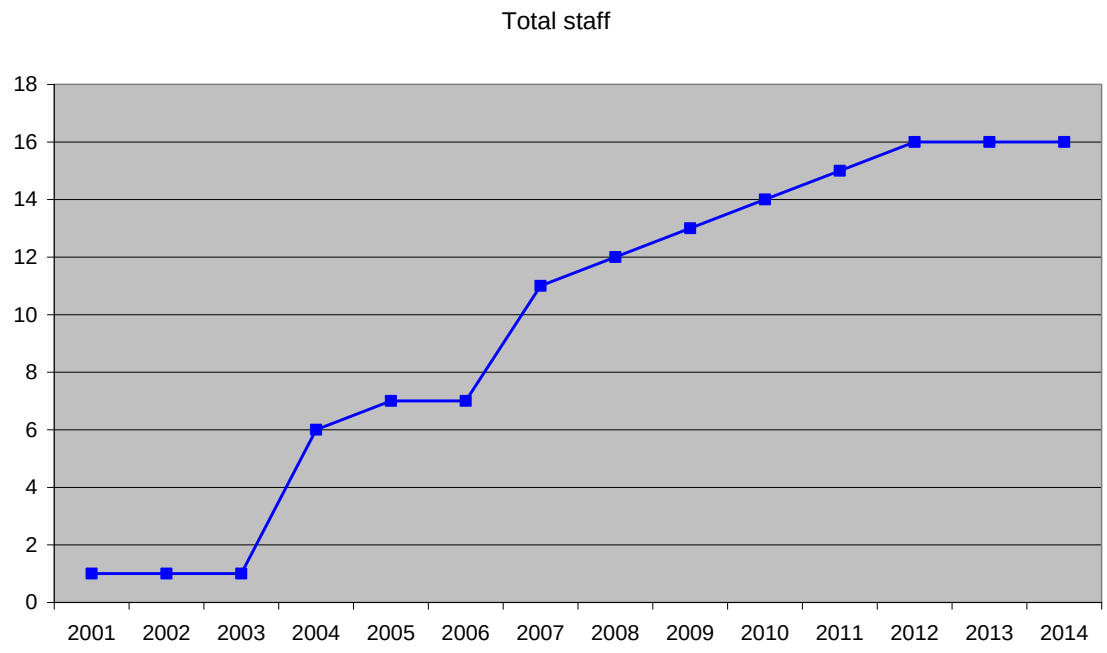
7. **The organizational structure of CAC comprises**: (i) a Management Board with nine members: a chairperson, appointed by the President of the Republic; the President of the Cyprus Youth Board as the vice-chair; and seven members appointed by the Council of Ministers on the basis of their scientific grounding and/or specialized knowledge in the field of drugs; (ii) an Executive Secretary; (iii) two main Departments: the policy department and the monitoring department; and (iv) a support, administrative department (with an accountant; secretaries; and a messenger).

8. **A total of 16 staff are employed by CAC on a contract basis**. CAC staff includes 1 executive secretary; 1 head of department; 10 officers (one out of them acting as head of department but without any upgrade of the salary); 2 secretaries; 1 accounting officer; and 1 messenger (hourly paid employee) (see Table below). CAC follows the same salary scale as the rest of the public sector.

Table 1. Staff working at CAC

Position	Amount	Employment date	Scale
Executive Secretary	1	2001	A13
Heads of Department	1	2004	A11
Officers	3	2004	A8
Messengers	1	2004	E5
Secretaries	1	2005	A2
Officers	4	2007	A8
Officers	1	2008	A8
Officers	1	2009	A8
Accounting officers	1	2010	A4
Officers	1	2011	A8
Secretaries	1	2012	A2

Figure 1. Staff of the CAC, 2001, 2012



1.4 CAC expenditures and revenues

9. **CAC budget in 2013 was 1.4 million € (up from 1.2 million € in 2012), but is decreasing to 1.3 million € in 2014**. Those figures include 0.1 million € coming from the EU. Expenditures are allocated between the Cyprus Monitoring Center for Drugs and Drug Addition (CMCDDA) that represents the core functions required by the EU Regulation governing the EMCDDA by each member state, and the other functions of the Cyprus Anti-Drug Council (rest-of-CAC). It is worth noting that expenditures for "Financial Grants to Accredited Prevention, Treatment and Harm Reduction Programs",

amounting 500,000 € in 2013 are allocated to the rest-of-CAC (see Table 2). Expenditures by category are summarized in Table 3.

Table 2. CAC expenditures by activity

Expenditure details	2012	2013	2014	2013-2014
Total CMCDDA	**425,887 €**	**420,916 €**	**359,091 €**	**-61,825 €**
Operating Expenses	**343,216 €**	**348,864 €**	**345,464 €**	**-3.400 €**
Personnel expenses	281,112 €	285,039 €	285.039 €	0 €
Transportation	0 €	425 €	325 €	-100 €
Other Operating expenses [1]	62,104 €	63,400 €	60.100 €	-3.300 €
Other Expenses [2]	**82,671 €**	**72,052 €**	**13,627 €**	**-58.425 €**
Total rest-of-CAC	**809,264 €**	**995,484 €**	**961,909 €**	**-33,575 €**
Operating Expenses	**396,249 €**	**399,484 €**	**379,609 €**	**-19.875 €**
Recompense Council members	4,929 €	8,000 €	6.800 €	-1.200 €
Personnel expenses	278,141 €	286,409 €	286.409 €	0 €
Transportation	2,493 €	2,975 €	2.800 €	-175 €
Other operating expenses [3]	110,686 €	102,100 €	83.600 €	-18.500 €
Other Expenses [4]	**413,015 €**	**596,000 €**	**582,300 €**	**-13.700 €**
Non Provisional Expenses and Reserves	**0 €**	**10,000 €**	**5,000 €**	**-5,000 €**
GRAND TOTAL	**1,235,151 €**	**1,426,400 €**	**1,326,000 €**	**-100,400 €**

[1] CMCDDA's Other Operating expenses includes: postages; telephone charges and internet; lighting, heating and fuel; office cleaning; rents; rates and water rates; newspapers and periodicals; advertisements, publications and publicity; photocopying materials, stationery and consumable; sundries; half hourly paid staff (messenger); maintenance of data processing equipment; maintenance of motor vehicles; passages and other expenses for conferences, missions and duty leave abroad; as well as conferences, seminars and other events in Cyprus

[2] CMCDDA's Other Expenses includes: hospitality; purchase of services; design, translation and printings; training abroad; local training; research expenses; purchase of office equipment and furniture; purchase of data processing equipment and software; as well as purchase of books

[3] Rest of CAC's Other operating expenses includes: postages; telephone charges and internet; lighting, heating and fuel; office cleaning; rents; rates and water rates; newspapers and periodicals; advertisements, publications and publicity; photocopying materials, stationery and consumable; sundries; half hourly paid staff (messenger); maintenance of data processing equipment; maintenance of motor vehicles; passages and other expenses for conferences, missions and duty leave abroad; as well as conferences, seminars and other events in Cyprus

[4] Rest of CAC's Other Expenses includes: hospitality; purchase of services; design, translation and printings; training abroad; local training; financial grants to accredited prevention, treatment and harm reduction programs; social reintegration of former addicted persons; purchase of office equipment and furniture; purchase of data processing equipment and software; as well as purchase of books

Table 3. CAC expenditures by category

	2012		2013		2014	
Personnel expenses	559,253 €	45%	571,448 €	40%	571,448 €	43%
Grants to Accredited Programs	320,839 €	26%	515,000 €	36%	515,000 €	39%
Operating expenses	180,212 €	15%	176,900 €	12%	153,625 €	12%
Other expenses	174,847 €	14%	163,052 €	12%	85,927 €	6%
Total Expenses	**1,235,151 €**	**100%**	**1,426,400 €**	**100%**	**1,326,000 €**	**100%**

1.5 International comparators

10. **The EMCDDA has NFPs in each EU member state.** The EMCDDA website (http://www.emcdda.europa.eu/) provides link to the NFPs and this information is summarized in Annex 2. A variety of options have been used to fulfill the function of NFP of EMCDDA. In some countries the function of NFP is allocated to a Public Scientific Organization, in other cases the function is allocated to a Government Department, in other cases the functions are allocated to a specialized public agency, like in case of Cyprus, and finally, in some cases the function of NFP is allocated to a private entity on a contractual base. As can be seen in Table 4, the first model is the more frequent option among EU member states:

Table 4. Different type of national focal point of the EMCDDA

I. Public Health Organization (e.g. National Institute of Health)	II. Governmental Department	III. Specialized Public Agency	IV. Private Entity on a contractual basis
a) Belgium	a) Bulgaria	a) Cyprus	a) Austria
b) Estonia	b) Croatia	b) Denmark	b) France
c) Finland	c) Czech Republic	c) Poland	c) Greece
d) Germany	d) Hungary	d) Romania	
e) Ireland	e) Italy		
f) Latvia	f) Lithuania		
g) Luxembourg	g) Malta		
h) Netherland	h) Portugal		
i) Norway	i) Slovakia		
j) Slovenia	j) Spain		
k) Sweden			
l) United Kingdom			

11. **The NFPs of the EMCDDA have very different staffing levels.** Among the available staffing data, there is not a clear relationship between the number of staff and the model/option, the size of the country or any other characteristic. The available data is listed below ordered by model:

Model I. Public Health Organization (e.g. National Institute of Health)

Estonia. National Institute for Health Development (NIHD). A government research and development institute.

- Staffing: 7 staff in total, but only 5 members are involved with the work of EMCDDA (1 head of department, plus 2 researchers, plus 1 analyst; three out of 5 have master degree in public health while two have PhD).

Germany. German Monitoring Centre for Drugs and Drug Addiction (DBDD). A governmental scientific organization, including different centers for specific related functions.

- Staffing: 9 people (1 director of the center, psychologist by training; 3 psychologists; 2 prevention specialists; 1 treatment specialist; 1 assistant; and 1 student assistant).

Netherlands. Trimbos-Instituut - Netherlands Institute of Public Health and Addiction. A national research institute for mental health care, addiction care and social work.

- Staffing: Total staffing of the Trimbos-Instituut is about 200 people. The exact number of positions currently devoted to EMCDDA tasks is not available

Norway. Norwegian Institute for Alcohol and Drug Research (SIRUS). An independent and publicly-funded research institute.

- Staffing: At the moment, SIRUS has a staff of around 40 people. The director of SIRUS is directly appointed by the Ministry of Health and Care Services.

Slovenia. Information Unit for Illicit Drugs (IUID. A technical unit located at the Institute of Public Health of the Republic of Slovenia (IPH).

- Staffing: at the moment, SIRUS has a staff of around 40 people.

Model II. Governmental Department

Bulgaria. National Centre for Addictions. An inter-ministerial body of the Council of Ministers of the Republic of Bulgaria.

- Staffing: 6 staff (4 sociologists, 1 biologist, 1 expert) plus technical support.

Croatia. Office for Combating Narcotic Drugs Abuse. A specialized service of the Government of the Republic of Croatia, with two departments

- Staffing: 4 staff members (Head of the FP, criminalist; Senior Expert Adviser, social pedagogue; Expert Associate, sociologist; and External Associate, political scientist).

Czech Republic. National Monitoring Centre for Drugs and Drug Addiction. A permanent body of the Czech Republic Government.

- Staffing: 8 people (5 full-time plus 3 part time; 1 head of the FP, plus 4 researchers, plus 1 economist, plus 1 website editor, plus 1 assistant; doctors, economists, social geographers, demographers, other).

Lithuania. Drug Control Department. A specialized department of the government, under the direct leadership of the Prime Minister.

- Staffing: The permissible maximum staff number of the Department makes 38 positions. The exact number of positions currently occupied is not available.

Spain. Delegación del Gobierno para el Plan Nacional sobre Drogas (DGPNSD). A government organization under the auspice of the Ministry of Health and Consumer Affairs in charge of the national Anti-Drugs Plan.

- Staffing: There is a total of 65 staff (civil servants) within the Ministry of Health, Social Services and Equality (MSSSI) ascribed to DGPNSD. Due to the highly decentralized Spanish health system, there is also a (not available) number of additional staff at regional level.

Model III. Specialized Public Agency

Poland. National Bureau for Drug Prevention. A state budget unit subordinated to the Ministry of Health

- Staffing: 5 staff (1 sociologist, plus 2 graduated in political science, plus 2 graduated in psychology).

Romania. National Anti-Drug Agency. An agency under the remit of the Ministry of Administration and Interior.

- Staffing: there is a specific directorate in charge of EMCDDA related tasks, the Romanian Monitoring Centre for Drugs and Drug Addiction, but there is no available data on the specific number of staff devoted to those tasks.

Model IV. Private Entity Contracted by the Government

Austria, Gesundheit Österreich GmbH (GÖG). An NGO funded by the Ministry of Health.

- Staffing: 10 people (sociologists; psychologists; urban and regional planning professionals; ecologists; assistants) The agency also develops a broad variety of tasks and projects funded by EMCDDA / EU, Social Insurance and provinces.

Greece. University of Mental Health Research Institute (UMHRI). Acting as an independent body on the basis of a 3-year contract with the MoH.

- Staffing: 17 staff (4 Psychologists; 4 Sociologist; 3 Statistician; 1 Computer engineer; 2 Secretaries; and 3 External advisers / professors).

1.6 Conclusions and recommendations

12. **According to the documentations consulted and the interviews conducted in the preparation of the report, the CAC seems to enjoy a fair degree of consensus with regards to its functions and role.** The current structure is understood to support the delivery of policy goals rather satisfactorily. The CAC emphasizes in particular the following aspects:
    - Objectivity in evaluating;
    - Flexibility in the decision making;
    - Ability to provide continuity in a highly "politicized" environment; and
    - Perception by the counterparts as catalyst and non-threatening.
    - The CAC also accomplishes its responsibilities as the national coordinating body in the field of substance dependency and prevention and the NFP of EMCDDA satisfactory.
13. **Four models of NFP of the EMCDDA have been identified in the EU**. Four EU countries, including Cyprus set up a specialized public agency to fulfill the role of NFP of the EMCDDA. Ten countries allocated the function of NFP of the EMCDDA to a Government Department (usually in the MoH, but also in the Ministry of Justice or, in some cases under the office of the Prime Minister). Three other countries allocated this function to a private entity under contractual bases. Finally, twelve countries have chosen as the organization fulfilling the role NFP of the EMCDDA a science-based organization, such as the national institute of health.
14. **Two alternative organizational options have been considered for Cyprus: transferring CAC's functions to a Department of the Government of Cyprus (GoC) or to a private entity on a contractual base.**

Table 5. Alternative organizational models for the CAC

	Description	Feasibility	Financial Impact	Expected impact on quality
Transfer CAC's functions to a Department of the Government of Cyprus (GoC)	The functions of CAC could be transferred to a Department of the GoC such as the Ministry of Health or the Ministry of Interior	 The transfer of function to a Governmental Department would reduce the flexibility of the institution, including the capacity to contract NGOs and private sector providers.	 The transfer of function to a Governmental Department is not expected to reduce costs as salary at CAC follows public sector scale.	 The work of the CAC requires coordination with a number of sectors (e.g. health, justice, customs, etc.). The allocation of CAC functions to a specific Ministry (e.g. MoH) may reduce the capacity to articulate other sectors and therefore affect negatively their capacity to coordinate policy in the sector.
Transfer CAC's functions to a private entity	The functions of CAC could be transferred to a private entity such an NGO or a University	 It is not easy to identify a suitable entity in Cyprus	 The option may reduce staff costs, but considering that CAC has only 16 staff, the potential saving are not considered to be important	 A pure private entity may have more difficulties in articulating public entities and in shaping public policy.
Note:	 **Positive**	 **Mainly positive**	 **Neutral**	 **Mainly negative**	 **Negative**

15. On the other hand the option of transferring CAC's functions to a science-based organization, such as a national institute of health, is not considered as feasible in Cyprus as an institution equivalent to a national institute of health was not identified. The two alternatives to the current status of the CAC as a SGO are compared in Table 5. The analysis suggests that both alternatives may have worse results in term of feasibility and impact on quality. The alternative of transferring the functions of the CAC to a Department of the Government of Cyprus (GoC) is not expected to produce any substantial cost-saving; on the other hand the transfer of function to a private entity on a contractual base could produce some small cost reduction if so articulated in the contract, but it seems arguable that suitable candidates could be found. *Thus based on the information currently available, the current status of CAC as a SGO is preferred.*

16. **Even if the alternative options are not superior to the current organization arrangement of CAC, as a SGO, it is desirable to improve the coordination with the MoH.** The MoH should recover the representation it used to have at CAC's Management Board. A formal representation of the MoH in the Management Board of the CAC is justified by the very nature of the activities of CAC and the level of funds that the MoH is providing to CAC's operations.

17. **In addition it would be desirable to enhance the exchange of information and to improve the potential synergies between the MoH and CAC in day-to-day activities**. Opportunities for a better alignment of the work plans of the two institutions comprises:

- The psychosocial, detoxification and substitution treatment services provided by the Department of Mental Health Services;
- The population-based preventive public health services (e.g. health education and healthy life style) provided by MoH;
- The epidemiological surveillance and health information services aimed to monitor drug consumption, drug addiction and substance abuse.

Annex 1: Printed material

1. **National Strategy for illicit substances and the harmful use of alcohol 2013-2020:** Priorities, Action Plan across five pillars: Prevention, Treatment and Social Reintegration, Harm Reduction, Supply Control & Regulation and International Relations
2. **CAC National Reports:** A summary of actions carried out by all the relevant stakeholders according to the National Strategy's Action Plan, submitted to the Parliament once a year.
3. **National report by the Monitoring & Documentation Department**: Annual Report to EMCDDA, a national drug situation.
4. **Annual Reports of the EMCDDA**
5. Drug related information and data: http://www.emcdda.europa.eu/countries/cyprus
6. **Treatment Guide:** this publication provides information on all available treatment services across Cyprus. The guide is available in Greek, English, Russian, and Arabic.
7. **Professionals in the Field of Addictions**
   So as to ensure the provision of high quality services, the CAC has published Treatment Guidelines, which includes the basic principles and good practices that services should adopt.
8. **Parents & Prevention:** this aims to provide important information to parents as regards their parental role and contributing protective factors including prevention programs they could attend to so as to reinforce their parental skills.

9. **Parents & Schools- what you should know**
   Parents and schools may both be a significant contributing factor as regards to prevention in young people's lives. The aim of the leaflet is to provide important information on various aspects as regards to the parental role, as well as provide information on existing mechanisms within the educational system that facilitate treatment or care for those students who deal with substance use related problems.
10. **Alcohol Leaflet:** "What I should know about Alcohol" includes general information as regards to alcohol related harm, alcohol and legislation in Cyprus, myths and facts, tips for sensible drinking and available treatment programmes
11. **Glossary of most frequently used definitions for illicit substances and alcohol**: includes most frequently used definitions which were selected through a literature review. The glossary aims to create a common framework of definition reference and to ensure the use of a common scientific language on a national level in the field of substance use
12. **The phenomenon of illicit substances and alcohol in Cyprus:** a brief on data in Cyprus as regards to illicit substances and alcohol based on the following indicators:
    For illicit substances- the General population Survey (GPS) key indicator, ESPAD Survey (Hibel et al., 2012); Treatment Demand Key Indicator (TDI), Problem Drug Use (PDU) key indicator, Drug related deaths and mortality among drug users (DRD) key indicator, Drug related Crime, drug markets and supply reduction indicator.
    For Alcohol- Treatment Demand Key Indicator (TDI), ESPAD Survey (Hibel et al., 2012), the General population Survey (GPS) indicator, Delinquency indicator, Alcohol and traffic accident related deaths indicator, Somatic symptoms indicator.
13. **Women**

Experts' opinions on available responses to women drug users: this publication records expert's opinions across the EU as regards to available interventions for women drug users, as well as evidence based on scientific literature.

14. **Cocaine, Heroin, Ecstasy, Cannabis, New Synthetic drugs:** These informational leaflets were developed for adolescents and young people. They provide information on the effects of the various substances; substance related harm as well as risks entailed with polydrug use including

alcohol, and information on how to protect from infectious diseases (e.g. HIV/AIDs and Hepatitis).

15. **A Guide for Social Reintegration Services:** thispublication records all available social reintegration services that are provided by governmental and non governmental services in Cyprus, for individuals who wish to seek empolyment and training or receive information on available opportunities.

16. **A Good Practice Manual for the Media:** the good practice manual was developed through a common initiative with the Union of Cyprus Journalists, not so much to guide professionals in the media sector, but to provide a tool of how to objectively deliver substance related information, visually and in writing, based on scientifically proven good practices.

17. **A guide on how to promote and develop European Programs:**
Taking into consideration the current financial situation and the continuous changes in financial grants by the EU, CAC has developed the guide so as to offer relevant stakeholders with information on available European Programs in the field of addictions.

18. A notebook for National Guard: the notebook was developed for all national guards
The notebook, which resulted through a collaboration between the CAC, the National Guard and OPAP, is addressed to all new recruits in the National Guard, and constitutes a useful tool, in which the national guard can find a survival guide with daily objects, basic road safety information, as well as useful contact numbers for information and support help lines.

Research carried out by the Cyprus Anti-drugs Council

1. A synopsis of the general situation in Cyprus (2012)
This publication presents the general situation of substance use in Cyprus, based on key epidemiological indicators, including the prevalence of substance use among the general public and the student population, the characteristics of those who seek treatment, drug related deaths etc.

2. A study of the available interventions for female substance users in the EU (2012)
The study, which was presented at the National Coordinators meeting of the Horizontal Drugs Group during the Cyprus EU Presidency, outlines the views of experts in the EU on available interventions for female substance users, as well as the results based on the review of scientific literature.

3. The European School Survey Project on Alcohol and Other Drugs (ESPAD) (2011)

The overall aim of the with the project is to repeatedly collect comparable data on substance use among 15-16 year old students in as many European countries as possible.

4. Estimating the social needs of Greek Pontiacs, a vulnerable group in Paphos, evaluating the current situation and developing proposals for the implementation of prevention programs and interventions in the field of social policy and addictions (2010)
The study focuses on the social needs of the Greek Pontiacs in the area of Paphos, the difficulties they encounter in their daily routine, including substance use, and how programs can be developed to meet these needs and facilitate their social reintegration within the Paphos community.

5. General Population Survey (2009)
The study is carried out across Cyprus and it mainly aims to estimate the prevalence of licit and illicit substance use among the general population, investigate existing attitudes and beliefs, and explore socio-demographic associations to drug using behavior.

6. A study of illicit drug use among arrested criminal offenders (2008)
The study aimed to investigate the demographics, social and psychological characteristics of those arrested for drug related criminal offenses. The information gathered contributes greatly towards the development and implementation of specialized programs carried out by the Prevention Office of the Drug Law Enforcement Unit.

7. The prevalence of infectious diseases and molecular epidemiology of Hepatitis C among intravenous drug users seeking treatment
The study indicates the prevalence of infectious diseases among intravenous drug users seeking treatment and high risk behaviors linked to intravenous use, as well as it defines the genotypes and genetic identification of the hepatitis viruses.

8. A study on rave parties, ravers and the use of psychoactive substances
The study suggests that further research is needed to gain an understanding of the rave party phenomenon and ravers, and how these two factors may be related to psychoactive substance use. The study however, did not have an epidemiological approach, in that it did not aim to assess the prevalence of psychoactive substance use among ravers.

9. A study on substance use among middle age people and the elderly
A qualitative study aimed to investigate substance use among middle age users and the elderly (>=40). Autobiographical narrative interviews were carried out in order to identify this population's characteristics and their subjective needs for treatment

Licensed Prevention Programs

Municipal Prevention Unit – Geroskipou Municipality

1. "I feel safe in school"
2. "From me and you to us"
3. "Mental Health: Reinforcing self-esteem"
4. "Everything I need to know for the psychoactive substances"
5. "Open parent meetings"
6. "Parenting Groups"
7. "Intervention for preventing school dropout"
8. Cyprus Lions Quest Foundation
9. "Skills for adolescence"

Institute against drug use (Larnaca)

10. “Prevention for high risk youth”
11. “Early intervention for drug use by parents”

Solomontos Panagide Antidrug Foundation (ASPIS)

12. “Adolescent workshops for adolescents”
13. Prevention for infant aged children: Seminar for nursery staff by private lessons in private nursery schools”
14. “Shield – Youth counseling center”

Pancyprian Psychologists Association

15. “Community psychology: Substance abuse prevention by psychologists”

Prevention Office of the Drug Law Enforcement Unit

16. “Folk stories and tales against addiction”
17. Lions Quest Foundation prevention program for children and parents of 10-14 years of age”
18. “Skills for adolescence”
19. “The garden with 11 cats” program

Prevention and Counseling Center “ITHAKI”

20. “I know, I have an opinion and I choose: if I drink alcohol, I drink responsibly”
21. “Family Council”
22. “The host”
23. “The journey of life”
24. “Schools free of smoke”
25. “Cycling escape”

KENTHEA

26. “The host”
27. “From youth to youth”
28. “Take care”
29. “The life journey”
30. “Schools free of smoke”
31. “Sinedrasi”

Prevention and Counseling Center “Achilles”

32. “The host”
33. “Family Council”
34. “Cyclops and Odysseus”
35. “The life journey”
36. “Schools free of smoke”

Prevention and Counseling Center “Odysseus”

37. “Cyclops and Odysseus”
38. “From youth to youth”
39. “The host”
40. “The life journey”
41. “Schools free of smoke”

Family Violence Prevention Foundation

42. “Children victims of domestic violence hosted in shelters”

Boy scouts

43. “Scouting – living without addictions”

University of Cyprus

44. “BALLONS: Psychoeducation for parents of behaviorally challenging 2-6 year olds”

Social Workers Association

45. “Interventions, practices and social work skills in the prevention of substance abuse”

Cyprus B.M Research and Systemic Applications Center

46. “No one can slip from the net”

Limassol Municipality

47. Social work program “Here 4 youth”

Licensed treatment Centers

1. Therapeutic Community “AGIA SKEPI”
2. Women’s specialized program ‘Panagia I katafygi’
3. Counseling Center “AGIA SKEPI”
4. Low threshold Center “STOXOS”
5. Adolescence and Family Counseling Center “PROMITHEAS”
6. Adolescence and Family Counseling Center “PERSEAS”
7. Prevention and Counseling Center “Achilles”
8. Prevention and Counseling Center “Odysseus”
9. Prevention and Counseling Center “Ithaki”
10. Veresies Clinic - Detoxification Inpatient Program
11. Veresies Clinic - Outpatient Substitution Program
12. Veresies Clinic - Outpatient Rehabilitation Program
13. Veresies Clinic - Naltrexone Implants Program
14. Counseling Center “ApofasiZO”
15. Prevention Center “MESOGEIOS” - Self-help groups
16. Prevention Center “MESOGEIOS” - Outpatient day center
17. Open Therapeutic Community “TOLMI” (Larnaca)
18. Open Therapeutic Community “TOLMI” (Paphos)
19. Substitution Center “SOSIVIO”
20. Substitution treatment center – “GEFYRA”
21. Therapeutic Unit of Addicted Persons – “THEMEA”
22. Detoxification Center “ANOSI”
23. Therapeutic Community “RETO CYPRUS”
24. NA Self Help Groups
25. Multiple Intervention Center (Nicosia)
26. Long Term Psychotherapeutic Rehabilitation Center
27. Drug Users Family and Relatives Foundation

- Open treatment group
- Closed treatment groups

Annex 2: Agencies Responsible for Monitoring Drugs and Drug Addiction in EU countries

Country	Agency responsible for Monitoring Drugs and Drug Addiction.	National drug-related expenditure
Austria	Gesundheit Österreich GmbH (GÖG), an NGO funded by the Ministry of Health	The available information does not allow reporting on the size and trends of drug-related expenditures in Austria
Belgium	Epidemiology Unit of the Scientific Institute of Public Health (IPH), a state (federal) scientific organization	The Belgian drug policy note of 2001 had no associated comprehensive budgets
Bulgaria	National Centre for Addictions	In Bulgaria, the available data on drug-related expenditure remain very limited and are insufficient for analysis
Croatia	Office for Combating Narcotic Drugs Abuse	In Croatia, there is an annual planned drug-related budget, which finances the Action Plan. In 2010, EMCDDA estimations (taken from National report of Croatia, 2011) for total expenditures were 12.090.000 €
Czech Republic	National Monitoring Centre for Drugs and Drug Addiction, within the Secretariat of the Council of the Government for Drug Policy Coordination	In the Czech Republic, the government annually presents drug-related budgets and provides an estimate of the money effectively spent, but no comprehensive estimates of expenditure were provided after 2006
Denmark	National Board of Health (NBH), an autonomous Government agency linked to the Ministry of Health	The available information from Denmark does not allow reporting on the drug-related annual expenditures effectively spent and their evolution over time
Estonia	National Institute for Health Development (NIHD), a research and development institute	The available information for Estonia is not expressed in currency units, but as a fraction of GDP. 2010 estimations were 0.01 % of GDP, showing a decrease since 2007
Finland	National Institute for Health and Welfare (THL), following the merge of the National Research and Development Centre for Welfare and Health (STAKES) and the National Public Health Institute (KTL)	The Finnish Government approves annual drug budgets in line with its drug strategy and action plan; it also provides annual estimates of expenditures. 2009, EMCDDA estimations (taken from National Annual Report of Finland, 2011) for total expenditure were 128.380.000 €
France	French Monitoring Centre for Drugs and Drug Addiction, an independent body funded by an interdepartmental body with representatives of different ministries	The French 2008–11 action plan (extended to 2012) has an associated budget. Its execution has never been assessed in detail
Germany	German Monitoring Centre for Drugs and Drug Addiction (DBDD), including the Federal Centre for Health Education (BZgA, Cologne) dealing with prevention aspects; the German Centre for Addiction Issues (DHS, Hamm) mainly responsible for the working areas ‘addiction treatment’ and ‘harm	In Germany the drug action plans do not have associated budgets and there is no review of executed expenditures

	reduction'; and the Institute for Therapy Research (IFT, Munich) responsible for epidemiology	
Greece	University of Mental Health Research Institute (UMHRI), operating on the basis of a three-year contract within the Ministry of Health	The available information does not allow reporting on trends in drug-related expenditure in Greece
Hungary	National Centre for Epidemiology (NCE), Ministry of Health	In Hungary, there is no specific budget attached to the drug strategy but an overall budget from different Ministries taking into account the main goals of the strategy
Ireland	Health Research Board (HRB), a statutory body with a mission to improve health through research and information	2010, EMCDDA estimations (taken from National Annual Report of Ireland, 2011) for total expenditure were 260.299.000 €
Italy	Drug Policy Department, at the Presidency of the Council of Ministers	The available data do not allow reporting on trends in drug-related expenditures in Italy
Latvia	Disease Prevention and Control Centre of Latvia, a public institution responsible for data collection and monitoring on different public health issues	Latvian drug policy documents do not have associated budgets and there is no review of executed expenditures
Lithuania	Drug Control Department of the Government of the Republic of Lithuania, operating under the direct leadership of the Prime Minister	Information on drug-related expenditures is fragmented and does not allow reporting on the total size and trends in drug-related expenditures in Lithuania.
Luxembourg	Public Health Research Centre (CRP-Santé), a scientific research institute which is partly financed by the National Administration	2009, EMCDDA estimations (taken from National Annual Report of Luxembourg, 2010) for total expenditure were 38.438.000 €
Malta	Ministry for Justice, Dialogue and the Family, operating under the umbrella of the National Commission for the Abuse of Drugs Alcohol and other Dependencies	Available information is very limited and does not allow reporting on the size and trends of drug-related expenditures
Netherlands	Trimbos-instituut (Netherlands Institute of Public Health and Addiction), a national research institute for mental health care, addiction care and social work	In the Netherlands there is no budget associated to the drug policy documents and there is no review of executed expenditures. Thus, available information does not allow reporting on the size and trends in drug-related expenditures.
Norway	Norwegian Institute for Alcohol and Drug Research (SIRUS), an independent and publicly-funded research institute, the director of which is directly appointed by the Ministry of Health and Care Services	A large number of authorities, institutions and organizations are involved in drug policy funding. Total size and trends in drug-related expenditures cannot be estimated in Norway
Poland	National Bureau for Drug Prevention, a state institution established under the auspices of the Ministry of Health	In Poland there are no budgets attached to the national drug program and there is no review of executed expenditures. Thus, available information does not allow reporting on the size and trends in drug-related expenditures
Portugal	General-Directorate for Intervention on Addictive Behaviors and Dependencies (SICAD)	The implementation of the budget for the Portuguese action plan was never fully assessed. Available information does not allow reporting on the size and trends in drug-related expenditure in the country

Romania	Romanian Monitoring Centre for Drugs and Drug Addiction, a directorate of the National Anti-drug Agency under the remit of the Ministry of Administration and Interior	Financing drug-related activities in Romania is decided annually by the entities in charge of their implementation. The available information does not allow reporting on the size and trends in drug-related expenditure
Slovakia	General Secretariat for Drug Dependence and Drug Control at the Office of the Government	In Slovakia drug policy documents have no associated budgets and there is no review of executed expenditures. The available information does not allow reporting on trends in drug-related expenditures
Slovenia	Information Unit for Illicit Drugs (IUID), located at the Institute of Public Health of the Republic of Slovenia (IPH).	In Slovenia there are no budgets attached to the national drug policy documents. The available information is only expressed as a fraction of GDP. 2010 estimations were 0.03 % of GDP, showing a increase since 2006
Spain	Delegación del Gobierno para el Plan Nacional sobre Drogas, a government organization under the auspice of the Ministry of Health and Consumer Affairs in charge of the national Anti-Drugs Plan	In Spain the national drug strategy and action plans have no associated budgets and there is no review of executed expenditures. 2010, EMCDDA estimations (taken from National Annual Report of Spain, 2011) for total expenditure were 432.703.000 €
Sweden	Swedish National Institute of Public Health (SNIPH), a government agency operating under the Ministry of Health and Social Affairs	The Swedish government defines a budget every year for some drug-related activities. Nevertheless, prevention and treatment are not budgeted for because they are financed by regional or local authorities. Methods used to estimate expenditures changed over time and it is not possible to report on drug-related expenditures in the country
United Kingdom	Department of Health, England, with support from the North West Public Health Observatory based at the Centre for Public Health, Liverpool John Moores University. It works closely with the Home Office, other government departments and the devolved administrations (Northern Ireland, Scotland and Wales)	There is no central budget under the United Kingdom's drug strategy (Northern Ireland, Scotland and Wales produce budgets associated to strategies). Executed expenditures are published annually in each country, but no comprehensive estimates of expenditure were provided after 2005

2 The Health Insurance Organization (HIO) of Cyprus

2.1 Policy goals and objectives

18. **The mission of the Health Insurance Organization (HIO), as stated in the General Health Care Scheme Law (GHCSL) of 2001 (N.89(I)/2001), is the implementation of the General Health Care Scheme, also known as National Health System (NHS).** The NHS would provide universal health coverage to the entire Cypriot population that would be able to choose freely among authorized health service providers. To finance the NHS a Health Insurance Fund (the Fund) would be established with contributions from employers, employees, self-employed, pensioners, income-earners and government transfers.

19. **The NHS would introduce in Cyprus a Mandatory Health Insurance (MHI) system: a system that pays the costs of health care for those who are enrolled and in which enrollment is required for all members of a population.** MHI systems are quite different from systems in which health insurance is largely voluntary. On the other hand, MHI systems are not very different from those in which health services are provided at little or no cost to the population (e.g. the NHSs of the UK, Italy and Spain), except that in MHI systems the insurance function is generally explicit, provision is more clearly separated from financing and financing is predominantly generated from social security contributions rather than from general taxes. [1]

20. **The HIO would be responsible to administer the Fund to finance the NHS.** The HIO would make the necessary arrangements to secure access to the medical care provided by the Law. For this purpose the HIO would enter into agreement with public and private providers of health services that fulfill the relevant conditions and specifications. It would implement the concept of family doctor as gatekeeper to specialized health services. It would introduce new provider payment mechanisms and set up a comprehensive health information and payment system. In addition, according to the GHCSL, the HIO would carry out annual actuarial reviews on the financial condition of the Fund in relation with its obligations arising from the implementation of this Law. It would be able to utilize resources of the Fund for purposes of research, documentation, further education and training for the better operation and efficiency of the NHS, and would provide incentives and scholarships for postgraduate studies on specialized issues which the HIO considers necessary and worthwhile.

21. **The HIO was established in 2003 but remained substantially inactive until 2006.** Following the approval of its Strategic Plan in December 2006, the HIO formed eight (8) thematic working teams to start the conceptualization, basic principles and technical aspects of the following key aspects of the NHS:

- Family Medicine, that refers to the concept of Family Doctors;
- Specialized Medicine (outpatient care);
- Clinical Laboratories;
- Pharmaceutical Services;
- Accident and Emergency Departments;
- Allied Health Professions;
- Inpatient care;
- System Financing and Global Budgeting;

[1] For a discussion of the arguments in favor and against payroll contribution versus general revenues for health financing see: Savedoff W. (2004). *Is There a Case for Social Insurance? Health Policy and Planning,* 19(3):183–184; Wagstaff A. (2007). *Social Health Insurance Reexamined*. Policy Research Working Paper 411. World Bank, Washington, D.C. January; and Wagstaff A. (2009). *Social Health Insurance vs. Tax-Financed Health Systems—Evidence from the OECD*. Policy Research Working Paper 4821. World Bank, Washington, D.C.

- Ambulance services; and
- Dental Services

2.2 Functions and services

22. **Current functions of the HIO are directed to conceptualize, develop and set up the NHS.** As part of the preparation of the NHS the HIO has drafted the NHS Implementation Strategy Plan and a detailed road map with clearly defined tasks and timeframe. As support functions, the HIO Implementation Strategy Plan also outlines the design of the information technology architecture to support the NHS. In addition, the HIO conducts regular meetings with all involved parties, (primarily Government and healthcare providers), such as:

- Association of Directors of Clinical Laboratories, Biomedical and Clinical Laboratory Scientists;
- Association of the Patients' Rights Protection;
- Cyprus Dental Association;
- Cyprus Medical Association;
- Cyprus Nurses and Midwives Association;
- Cyprus Pharmaceutical Association;
- Ministry of Finance;
- Ministry of Health;
- Ministry of Labor and Social Insurance;
- Private Hospitals Association.

23. **Once the NHS would be established the HIO would have primary responsibilities for the financing (i.e. pooling of health funds and purchasing of medical services) and resource generation functions of the NHS**[2]. The HIO would pool resources from various sources to satisfy the health needs for the entire population. Since financial resources would no longer be tied to a particular contributor, the participants to the pool would share risks. The HIO would utilize the financial resources collected and placed in the Fund to purchase health services from private and public providers. Finally, the HIO would generate resources or inputs necessary for the production of health services (e.g. human resources, physical resources such as facilities and equipment, and knowledge).

24. **The MoH would retain the overall stewardship function of the NHS, therefore a strong coordination between the MoH and the HIO would be required considering the interactions between the stewardship and the purchasing functions**. The stewardship of the health system comprises three key aspects: (i) setting, implementing and monitoring the rules for the health system; (ii) assuring a level playing field for all actors in the system (particularly purchasers, providers and patients); and (iii) defining the strategic directions for the health system as a whole. As the purchaser of the NHS, the HIO will determine the payment system of the health system that determines which providers will be contracted, what to pay them for, how and how much pay them, that in turn affect the behaviors of providers. For this reason the payment system is considered a control knob of the entire health system[3]. Therefore, it is crucial that the payment scheme designed by the HIO and the incentives generated by the payment system would be aligned with the strategic directions of the health system determined the MoH.

25. **There are also interactions between the stewardship function of the MoH and the resource generating function of the HIO.** The GHCSL established that the HIO would finance research and would provide incentives and scholarships for postgraduate studies, therefore the HIO would be able to

[2] Murray CJL, Frenk J. (2000) A framework for assessing the performance of health systems. Bulletin of the World Health Organization. Vol. 78 (6), pp. 717-731.

[3] Roberts MJ, Hsiao W, Berman P, Reich MP. (2008). Getting Health Reform Right: A Guide to Improving Performance and Equity. Oxford University Press.

shape some key inputs of the health system: the human resources of the knowledge. In addition, since the HIO would determine who would be contracted under the NHS it would also determine the supply of physical resources such as facilities and equipment. Therefore the need to ensure the match between supply and demand for health personnel and physical resources; and in the case of research to ensure that the priorities set by the steward of the health system would be followed.

2.3 Organizational structure

26. **The governance structure of the HIO is represented by a Board of Directors with a trilateral representation: Government, Employers' and Employees' Unions and self-employees.** The Members of the Board of the HIO are:

- Christos Patsalides, Permanent Secretary of the Ministry of Finance (alternate Mr Elias Mallis)
- Mr. Kaisis and Mrs.Yiannaki represent on rotation the Ministry of Health (alternate Mrs Elisavet Constantinou)
- Stelios Gregoriou, Government Representative
- Diomides Diomidous, Government Representative
- Costas Georgallis, Employers Representative - Cyprus Chamber of Commerce and Industry
- Vyron Kranidiotis, Employers Representative - Cyprus Employers and Industrialists Federation
- Nikos Moiseos, Workers Union Representative - Cyprus Workers' Confederation (SEK)
- Sotiris Fellas, Workers Union Representative - Pancyprian Federation of Labour (PEO)
- Glaukos Hadjipetrou, Workers Union Representative - Government Employees Union (PASYDY)
- Laris Vrachimis, Self Employed Representative

27. **The evolution of HIO staff is presented in Table 5 and Figure 2.** Table 6 presents the staff of the HIO by type of qualification. Figure 3 presents the organization chart of the HIO.

Table 6. Staff working at the HIO

	Number of employees										
	2003	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
Director General	1	1	1	1	1	1	1	1	1	1	1
Directors	0	0	0	2	3	3	4	4	4	3	2
Senior Officers	0	0	0	2	5	15	14	14	14	14	14
Officers	0	0	0	9	9	28	25	24	22	22	22
Secretarial Officers	0	0	0	0	1	1	1	1	1	1	1
Secretarial Assistant	0	0	1	4	9	9	13	12	12	11	11
Messenger	0	0	0	1	1	1	1	1	1	1	1
Cleaners	0	0	0	1	1	2	2	2	2	2	2
TOTAL	**1**	**1**	**2**	**20**	**30**	**60**	**61**	**59**	**57**	**55**	**54**

Figure 2. Staff of the HIO, 2003- 2013

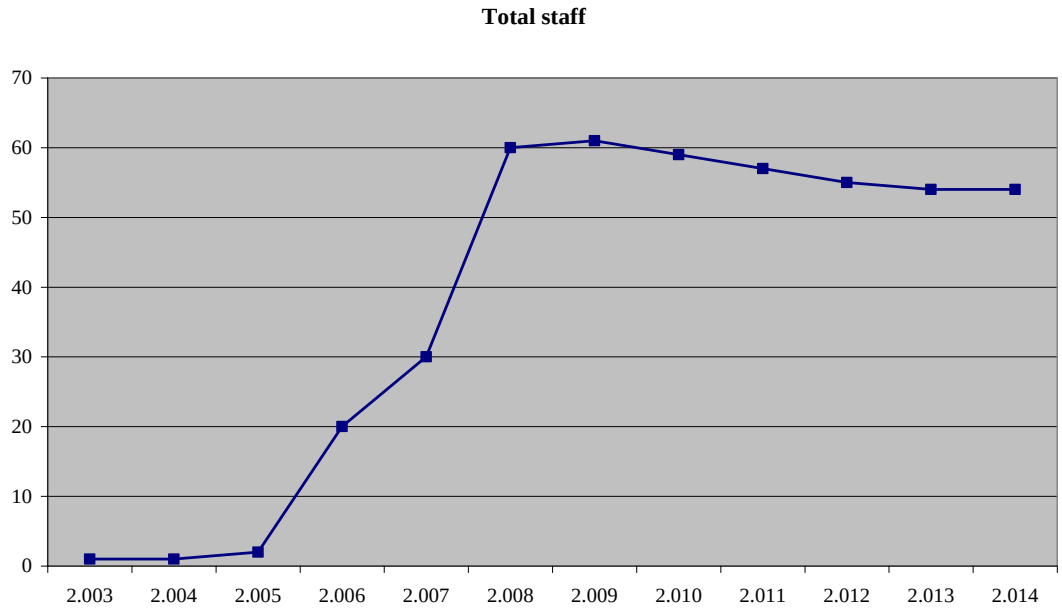
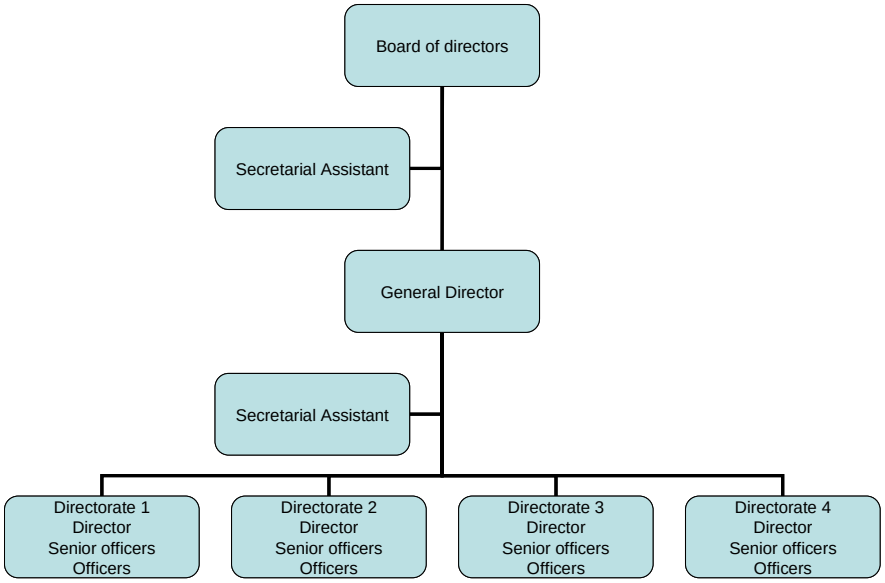


Table 7. Total number of HIO staff by qualification

	Certificate/Diploma	Bachelor Degree	MA/MSc/MBA	PhD	Total
General Director	n/a	n/a	n/a	n/a	**1**
Directors	0	0	1	1	**2**
Senior Officers	0	1	12	1	**14**
Officers	0	2	19	1	**22**
Secretarial Officers	1	0	0	0	**1**
Secretarial Assistants	7	4	0	0	**11**
Messengers	n/a	n/a	n/a	n/a	**1**
Cleaners	n/a	n/a	n/a	n/a	**2**
TOTAL	**8**	**7**	**32**	**3**	**54**

Figure 3. Organization chart of the HIO



2.4 HIO expenditures and revenues

20. The 2013 total expenditure of the Cyprus HIO was approximately 3.2 million €. Table 8 shows the evolution of the expenses as reported by the HIO.

Table 8. HIO expenditures

	2013	2012	2011	2010	2009
Cost of services	2,763,985 €	3,023,783 €	3,122,218 €	4,103,554 €	4,687,959 €
Administration costs	440,957 €	474,581 €	495,869 €	398,620 €	414,502 €
Finance costs	79 €	2 €	2,009 €	226 €	6,372 €
TOTAL COSTS	3,205,021 €	3,498,366 €	3,620,096 €	4,502,400 €	5,108,833 €

	2008	2007	2006	2005	2004	2003
Cost of services	6,394,307 €	1,730,085 €	1,522,767 €	152,892 €	135,472 €	33,015 €
Administration costs	406,195 €	347,646 €	215,502 €	191,288 €	206,124 €	30,030 €
Finance costs	5,700 €	2,331 €	446 €	0 €	0 €	0 €
TOTAL COSTS	6,806,202 €	2,080,062 €	1,738,716 €	344,181 €	341,596 €	63,046 €

21. Staff costs are the largest expenditure item, followed by consulting services and rent. Most of the costs are included under the heading Costs of services (staff costs and consulting services), while the main categories under Administration costs can be grouped in the following topics: rent and other costs related to HIO venue; depreciation; special defense contribution; travel costs; and training, conferences, seminars and events, Specific figures are presented in Table 9 below. Staff costs and the relative shares of staff, consulting services, rent and other costs are presented in the figures below.

Table 9. HIO expenditures by category

	2013	2012	2011	2010	2009
COST OF SERVICES					
Staff costs	2,713,914 €	2,750,037 €	2,806,721 €	2,709,154 €	2,647,428 €
Consulting services	50,071 €	273,746 €	315,497 €	1,394,400 €	2,040,531 €
	2,763,985 €	3,023,783 €	3,122,218 €	4,103,554 €	4,687,959 €
ADMINISTRATION COSTS					
Rent and other costs related to HIO venue	346,385 €	372,739 €	329,082 €	222,171 €	209,199 €
Depreciation	65,000 €	64,666 €	70,603 €	74,791 €	70,967 €
Special Defense Contribution	10,552 €	11,869 €	8,702 €	18,314 €	27,535 €
Travel costs	6,015 €	11,367 €	18,223 €	37,987 €	69,540 €
Training, conferences, seminars, events	3,186 €	2,797 €	12,584 €	8,548 €	11,498 €
Other administration costs	9,819 €	11,143 €	56,675 €	36,809 €	25,763 €
	440,957 €	474,581 €	495,869 €	398,620 €	414,502 €
Interest	79 €	2 €	2,009 €	226 €	6,372 €
TOTAL COSTS	3,205,021 €	3,498,366 €	3,620,096 €	4,502,400 €	5,108,833 €

	2008	2007	2006	2005	2004	2003
COST OF SERVICES						
Staff costs	1,806,933 €	960,731 €	486,895 €	147,845 €	130,691 €	31,050 €
Consulting services	4,587,374 €	769,354 €	1,035,872 €	5,047 €	4,781 €	1,965 €
	6,394,307 €	1,730,085 €	1,522,767 €	152,892 €	135,472 €	33,015 €
ADMINISTRATION COSTS						
Rent and other costs related to HIO venue	196,517 €	148,020 €	121,603 €	109,217 €	87,660 €	152 €
Depreciation	62,670 €	58,757 €	44,176 €	43,766 €	38,367 €	14,325 €
Special Defense Contribution	0 €	0 €	0 €	0 €	0 €	0 €
Travel costs	61,254 €	41,278 €	20,023 €	11,439 €	15,306 €	1,258 €
Training, conferences, seminars, events	51,099 €	59,570 €	6,508 €	16,691 €	52,967 €	13,669 €
Other administration costs	34,655 €	40,021 €	23,193 €	10,175 €	11,825 €	627 €
	406,195 €	347,646 €	215,502 €	191,288 €	206,124 €	30,030 €
Interest	5,700 €	2,331 €	446 €	0 €	0 €	0 €
TOTAL COSTS	6,806,202 €	2,080,062 €	1,738,716 €	344,181 €	341,596 €	63,046 €

Figure 4. HIO staff costs

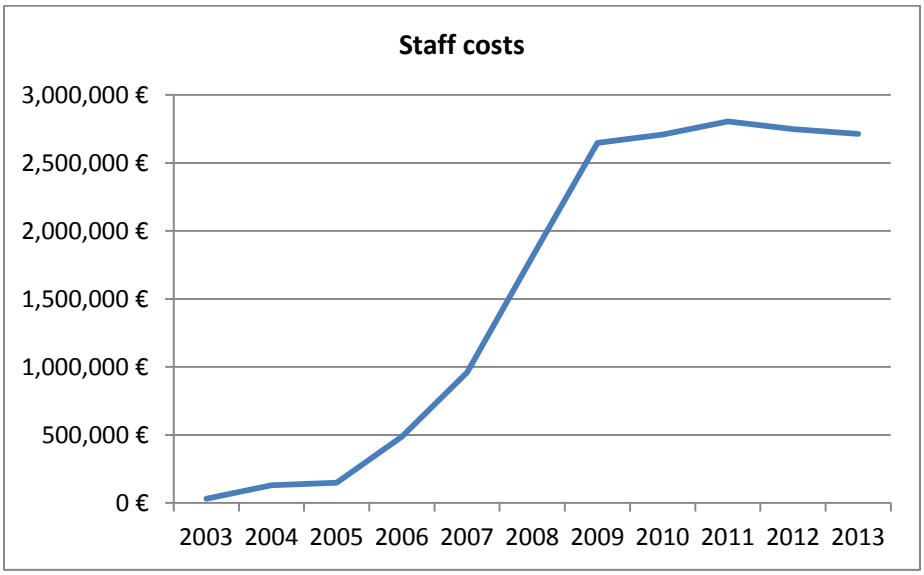
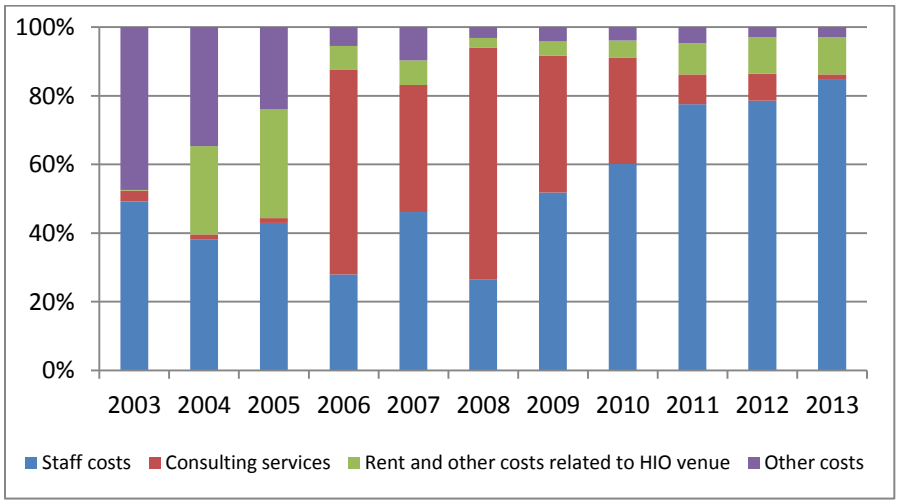


Figure 5. Staff costs, consulting services, rent costs and other costs as % of total costs



28. **Once the Fund of the NHS would be established, the HIO could utilize up to 5 percent of the annual Fund to cover its administration expenses**.[4] Based on the estimated of the Mercer Study, the administration costs of the HIO could not be more than €43.9 million in the first year of operation and could increase up to €60.9 million after 10 years in parallel with the estimated increase in the annual budget of the Fund.

[4] Article 4(g) of the GHCSL of 2001 (N.89(I)/2001). The GHCSL establishes that this percentage can be increased after a decision taken by the Council of Ministers.

2.5 International comparators

Costs comparison

29. **It is not possible to identify suitable comparators to benchmark the HIO with respect to the limited functions that is currently performing: conceptualization, development and setting up of the NHS.** Therefore, rather than benchmarking the current HIO, we compared the expected administrative expenditures of the HIO once the NHS would be set with the expenditure for health administration and insurance observed in other OECD countries.

30. **The administrative expenditures of the HIO once the NHS would be in place are expected to be on the higher end of other OECD countries.** As indicated in the previous section the GHCSL established that up to 5 percent of the annual budget of the Fund could be used to cover the administrative expenditure of the HIO. This percentage would classify Cyprus among the countries with high expenditure for general health administration and insurance (EHAI) as a percentage of public health expenditure (see Figure 6).

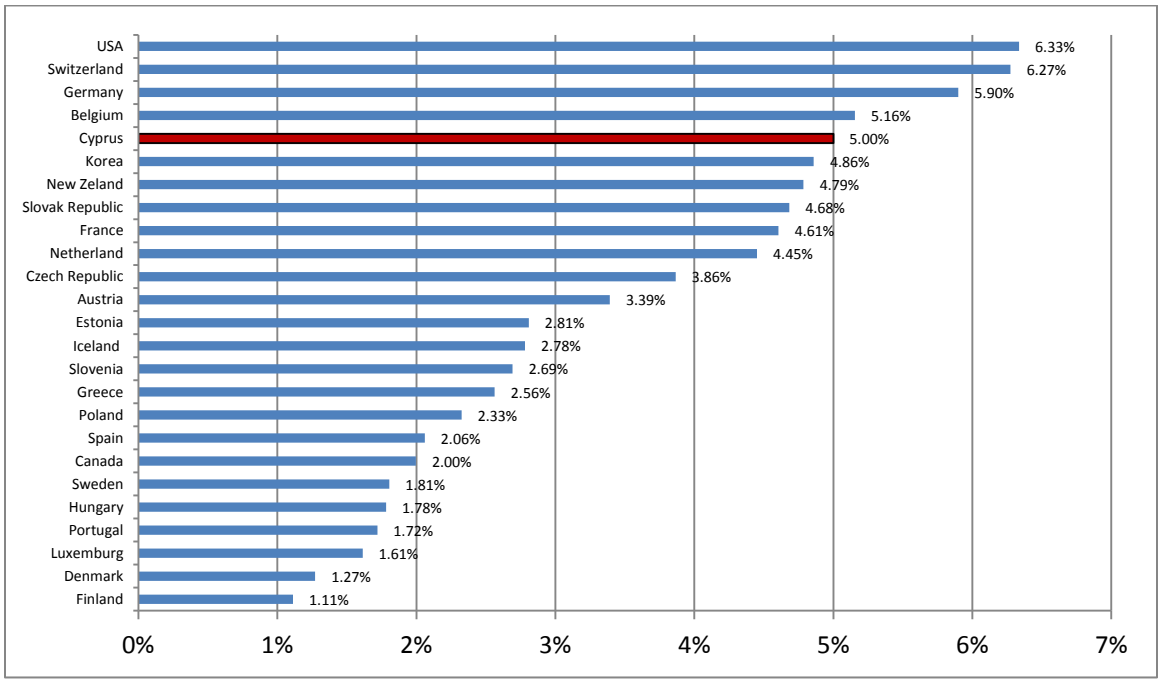
31. **Cross-countries comparison of the health sector administrative expenditure is confounded by a number of factors.** The most important factors comprise: (i) differences in definitions, reporting and methodologies used; (ii) country context determinants that could affect health insurance administrative costs (e.g. the geography, the development level, the administrative capacity, etc.); (iii) if administrative costs are the same or similar, an insurer with a higher average claim amount per insured would appear to have lower administrative costs, when reported as a share of total expenditure or claims; (iv) the ratio of administrative costs over total insurance expenditure is affected by cost-containment activities as, cost-containment activities may imply additional administrative and health expenditure, and with a smaller denominator, the share of administrative costs in total expenditure would increases; and (iii) the institutional design of health insurance that comprises the set of institutions and rules (i.e. legal provisions and regulations) that prescribes how health insurance undertakes its resource mobilization, pooling and purchasing functions.[5]

32. **The estimate is probably conservative as in addition to the administrative expenditure of the HIO we should also consider the costs to fulfill the stewardship function of the health system provided by the MoH** (see paragraphs 1.13-1.15 of the report "Analysis of the Function and Structure of the Ministry of Health of the Republic of Cyprus"). Therefore the combined expenditures for health financing functions provided by the HIO and the stewardship functions provided by the MoH are likely to put Cyprus near the top of OECD countries in term of expenditure for general health administration and insurance (EHAI) as a percentage of total public health expenditure. It is worth mentioning that the increase in the administrative costs of the health sector in the context of health financing reforms that have introduced a division between financing and provisions has been observed in other countries.[6]

[5] See: Nicolle E, Mathauer I. (2010). *Administrative costs of health insurance schemes: Exploring the reasons for their variability*. HSS/HSF/DP.E.10.8. WHO, Geneva.

[6] For example the doubling of the cost of administering primary care in England in real terms between 1989/1990 and 1994/1995 has been attributed to the administrative burden associated with internal market reforms introduced in the 1990s (see Giuffrida A, Gravelle H, Sutton M. 2000. Efficiency and Administrative Costs in Primary Care. *Journal of Health Economics.* 19(6):983-1006).

Figure 6. Expenditure for general health administration and insurance (EHAI) as a percentage of public health expenditure, 2011.



Source: OECD Health data 2013 and estimate based on the provision of the GHCSL of 2001 (N.89(I)/2001)

A framework for assessing the good governance of the NHS

33. **The literature identifies five important dimensions for the governance of MHI systems**.[7] Even if the NHS is still at a preparatory stage, it is useful to identify the relevant elements of good governance that would be relevant to the NHS: coherent decision-making structures; stakeholder participation; transparency and information; supervision and regulation; and consistency and stability. Within each dimension, indicators can be defined and rated to assess the contribution to the specific dimension to the overall governance structure (see Annex 3).

34. **In order to be coherent, decision-making structures require those responsible for decisions to possess the discretion, authority, tools, and resources to fulfill their responsibilities**. The structures must also establish consequences for decisions that align incentives with achieving good performance of the overall system. Explicit indicators to describe some features of coherent decision-making structures that affect the quality of governance are:

- Responsibility for MHI objectives must correspond with decision-making power and capacity in each institution involved in the management of the system
- All MHI entities have routine risk assessment and management strategies in place.
- The cost of regulating and administering MHI institutions is reasonable and appropriate.

35. **Stakeholder participation influences the flow of information and accountability relationships of the actors within the system**. The representation of stakeholder interests can be functional or dysfunctional depending on which groups it includes and in what proportion. To be successful, representation should attempt to achieve inclusiveness, participation, and consensus

[7] Savedoff W, Gottret P. (2008), *ibid*.

orientation. Indicators used to describe features of stakeholder participation that influence the quality of governance include:

- Stakeholders have effective representation in the governing bodies of MHI entities.

36. **Transparency is a means to hold public decision makers accountable and to control corruption.** There is less opportunity for authorities to abuse a system in their own interest when laws, rules, and decisions are available for everyone to see, when critical meetings are open to the public, and when budgets and financial statements may be reviewed by anyone. Indicators that describe some features of transparency and information that affect the quality of governance are:

- The objectives of MHI are formally and clearly defined.
- MHI relies upon an explicit and an appropriately designed institutional and legal framework.
- Clear information, disclosure, and transparency rules are in place.
- MHI entities have minimum requirements in regard to protecting the insured.

37. **It is important that supervisory and regulatory arrangements are consistent with the structure of the NHS system.** While it is important for the behavior of institutions to be transparent, it is necessary for them to be answerable and responsible for their actions in order to achieve accountability. Visibility is important for supervision and the presence of consequences—reward or sanction—for the performance of the health insurance funds is key to regulation. The following indicators describe some features of supervision and regulation that affect the quality of governance:

- Rules on compliance, enforcement and sanctions for MHI supervision are clearly defined
- Financial management rules for MHI entities are clearly defined and enforced
- The MHI system has structures for ongoing supervision and monitoring in place.

38. **Finally, consistency helps to avoid uncertainty around rule-making and enforcement through time and through periods of political change.** If regulations are consistent then people and institutions can make long-term decisions with the assurance that the rules will not change or, at least, will not change arbitrarily. Stability is of particular importance for MHI systems because insurance necessarily entails commitments over time, because MHI must be financially sustainable over generations, and access to health care and financial protection has to be maintained in the face of political change or economic downturns. The following indicator is one feature of consistency and stability that affects the quality of governance:

- The main qualities of the MHI system are stable.

39. **This framework could be used to qualitatively measure the governance performance of the NHS and to monitor its evolution though time**. Even if some indicators could be evaluated on the base of the existing legal framework provided by the GHCSL (e.g. stakeholder participation) it is important to consider how effective the provisions of the law would be. In addition the assessment of several indicators would be possible only once the NHS would be implemented (e.g. the effectiveness of the regulatory and supervisory framework). Indeed some dimensions (e.g. consistency and stability) would require an additional period of time to be evaluated.

2.6 Conclusions and recommendations

40. **The functions of the HIO are currently limited to the conceptualization, development and setting up of the NHS.** Once the NHS would be established, the HIO would have key responsibilities for the financing (i.e. pooling of funds and purchasing of medical services) and the resource generation of the

new health system. However, it is difficult to assess the HIO under the current setting, as there are not comparable institutions that provide the same functions.

41. **The HIO has been providing these limited functions for more than ten years since it was created under the 2001 GHCSL**. For reasons outside the control of the HIO the Cyprus NHS has not been implemented. However, the current limited role and functions of the HIO represents a waste of important resources (both financial and human resources) that could be better used by the health system. Therefore, it is recommended to proceed rapidly with the operationalization of the NHS. On the other hand, if it would appear not possible to implement the NHS system, the HIO should be dismantled as the need for its functions would disappear.

42. **HIO administrative expenditure is capped to a maximum of 5 percent of the NHS' budget. However, the total expenditure for general health administration and insurance (EHAI) in Cyprus is expected to increase significantly**. The sum of the administrative expenditures of the HIO and the MoH would put Cyprus among the countries with high level of EHAI as a percentage of total public health expenditure. Even if international comparisons of health sector administrative expenditures is not without limitation, it is recommended to perform a detailed assessment of HIO costs to the scope for reducing some of its costs.

43. **A framework to assess qualitatively the good governance of the NHS is proposed.** The proposed framework would measure governance along five dimensions - coherent decision-making structures; stakeholder participation; transparency and information; supervision and regulation; and consistency and stability – using a total of 12 indicators. The period application of the instruments would allow monitoring the evolution and identifying opportunity for improvements.

44. **Because of the strong interactions between the stewardship, purchasing and resource generating functions, a strong coordination between the MoH and HIO is required.** One practical recommendation is to ensure the participation of the MoH in the working teams that are defining the technical aspects of the NHS (e.g. Family Medicine; Specialized Medicine; Clinical Laboratories; Pharmaceutical Services; Accident and Emergency Departments; Allied Health Professions; Inpatient care; and System Financing and Global Budgeting). Moreover, additional working groups would be desirable; in particular in the area of capacity planning to ensure that sufficient capacity is well utilized and duplications between public and private providers are reduces. Finally, sharing of documents, data and information systems between the two institutions should be fostered.

45. **Current governance structure does not ensure an effective control of the Government of Cyprus (GoC) over the HIO.** Currently only 4 of the 11 members comprising the HIO's Board of Directors are appointed by the Government of Cyprus (GoC). The fact that GoC's representatives are a minority at HIO's Board, raises the question whether, under current arrangements, the GoC is able to exercise an effective control over the HIO. The insufficient control of the GoC over the HIO could lead to a misalignment between GoC's policies and HIO's operations; and to an insufficient access to data and information that are crucial for the formulation of strategic, policy and financial decisions by the GoC. Therefore a revision of the current Governance structure of the HIO, with the objective of ensuring a clearer and more effective control by the GoC over the HIO should be considered.

Annex 3: Dimensions, features, and indicators of good governance in mandatory health insurance

Dimensions	Features	Indicators
Coherent decision-making structures	1. Responsibility for MHI objectives must correspond with decision-making power and capacity in each institution involved in the management of the system.	Yes/No Examples: • The institution responsible for the financial sustainability of the system must be able to change at least one of the parameters on which it depends (e.g. conditions of affiliation, contribution rate, benefits package, ability to act a strategic purchaser, or tariffs). • The institution in charge of the supervision of sickness funds has the capacity to fulfill its responsibilities (i.e. it has enough skilled staff, it has access to the necessary information, and legal texts give it the authority to fulfill its role vis-à-vis sickness funds).
	2. All MHI entities have routine risk assessment and management strategies in place.	Yes/No Examples: • Clear regulations on MHI entities' continuous risk assessment and risk management are in place. • Strategies are in place, i.e. MHI entities follow and analyze the evolution of expenditures and contributions. • MHI entities have the capacity to manage risks, i.e. to take corrective action in order to ensure the financial sustainability of the system by modifying some of the parameters influencing it (contribution rate, composition of the benefits package, etc.).
	3. The cost of regulating and administering MHI institutions is reasonable and appropriate.	Yes/No Examples: • Maximum administration costs for MHI entities are set in legal texts or regulations.

		• Administrative costs are monitored by the regulator. • Provisions for covering the costs of the MHI regulator are stipulated in legal texts. • Before new regulations are put in place, a cost-benefit assessment is conducted.
Stakeholder Participation	4. Stakeholders have effective representation in the governing bodies of MHI entities.	Yes/No Examples: • Governing bodies of regulatory oversight and institutional governance (board of directors, oversight body) have representatives of government agencies, regulatory bodies, MHI entities, unions, employers' organizations, beneficiaries, providers, and independent experts. • Representation is effective, i.e. different stakeholders' views are considered in decision-making.
Transparency and Information	5. The objectives of MHI are formally and clearly defined.	Yes/No Examples: • Objectives are stated in a high-level legal text (e.g. the Constitution or a law). • Objectives are publicized and easily accessible to the public. • Objectives are clearly defined and easily understandable.
	6. MHI relies upon an explicit and an appropriately designed institutional and legal framework.	Yes/No Examples: • The main characteristics of the system are defined in legal texts (coverage, benefits package, financing, provision, regulatory oversight, and institutional governance). • The framework is appropriate given the country MHI context (i.e. it is not too restrictive, considers special local circumstances, and does not ignore important parts or players in the system).

		• The status and responsibilities of each MHI institution in the system are clearly defined and transparent. Yes/No Examples:
	7. Clear information, disclosure, and transparency rules are in place.	• Explicit disclosure regulations exist in the law or regulations of the law. • Business activities, ownership, and financial positions are regularly disclosed (i.e. the rules are followed). • Beneficiaries have access to the financial information of sickness funds. Yes/No Examples:
	8. MHI entities have minimum requirements in regard to protecting the insured.	• Consumer protection regulations exist in law, including consumer information, and independent mechanisms for resolution of complaints, appeals, grievances, and disputes. • The insured can obtain timely, complete, and relevant information on changes in benefits, premiums, length of coverage, etc. • Consumer complaint mechanisms exist and are being used. • Appeals and grievance mechanisms exist and are being used. • Independent dispute resolution mechanisms exist and are being used.
Supervision and regulation	9. Rules on compliance, enforcement and sanctions for MHI supervision are clearly defined	Yes/No Examples: • Rules on compliance and sanctions are defined in legal texts. • Corrective actions are imposed, based on clear and objective criteria that are publicly disclosed.

		• Adequate capacity for the execution of these functions is provided. • Cases of rule violation and subsequent actions by the regulator are publicized. Yes/No Examples: • Financial standards for MHI entities are defined in legal texts or regulations.
	10. Financial management rules for MHI entities are clearly defined and enforced	• Clear financial licensure/market-entry rules are defined (minimum capital requirements). • Ongoing reserve and solvency requirements are defined. • Regulations of assets and financial investments are defined. • Audit (internal and external) rules are defined. • Rules for financial standards are enforced. Yes/No Examples: • Clear nonfinancial licensure/market entry rules are defined.
	11. The MHI system has structures for ongoing supervision and monitoring in place.	• Insurance product filing/registration is defined and regulated. • Adequate on-site inspections and offsite monitoring are in place. • Ongoing financial reporting rules are defined and provided information is accurate and timely. • Clear market exit/dissolution rules are in place.
Consistency and stability	12. The main qualities of the MHI system are stable	Yes/No

	Examples: • Objectives have remained substantially the same in the recent past • Fundamental characteristics of the MHI system (e.g. benefits package, rules for affiliation, contribution requirements, basic protection rights for the insured, and basic institutional requirements for operators) are defined in law. • The law has remained substantially the same in the recent past (i.e. independent of political elections or economic crises).

Source: Savedoff WD and Gottret P. (2008). *Governing Mandatory Health Insurance*. The World Bank, Washington DC.