European Commission









State of Health in the EU

Cyprus

Country Health Profile 2021

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European Observatory on Health Systems and Policies
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The Country Health Profile series

The State of Health in the EU's Country Health Profiles provide a concise and policy-relevant overview of health and health systems in the EU/European Economic Area. They emphasise the particular characteristics and challenges in each country against a backdrop of cross-country comparisons. The aim is to support policymakers and influencers with a means for mutual learning and voluntary exchange.

The profiles are the joint work of the OECD and the European Observatory on Health Systems and Policies, in cooperation with the European Commission. The team is grateful for the valuable comments and suggestions provided by the Health Systems and Policy Monitor network, the OECD Health Committee and the EU Expert Group on Health Systems Performance Assessment (HSPA).

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Data and information sources

The data and information in the Country Health Profiles are based mainly on national official statistics provided to Eurostat and the OECD, which were validated to ensure the highest standards of data comparability. The sources and methods underlying these data are available in the Eurostat database and the OECD health database. Some additional data also come from the Institute for Health Metrics and Evaluation (IHME), the European Centre for Disease Prevention and Control (ECDC), the Health Behaviour in School-Aged Children (HBSC) surveys and the World Health Organization (WHO), as well as other national sources.

The calculated EU averages are weighted averages of the 27 Member States unless otherwise noted. These EU averages do not include Iceland and Norway.

This profile was completed in September 2021, based on data available at the end of August 2021.

Demographic and socioeconomic context in Cyprus, 2020

Demographic factors	Cyprus	EU
Population size (mid-year estimates)	888 005	447 319 916
Share of population over age 65 (%)	16.3	20.6
Fertility rate[1] (2019)	1.3	1.5
Socioeconomic factors		
GDP per capita (EUR PPP[2])	25 790	29 801
Relative poverty rate[3] (%, 2019)	14.7	16.5
Unemployment rate (%)	7.6	7.1

1. Number of children born per woman aged 15-49. 2. Purchasing power parity (PPP) is defined as the rate of currency conversion that equalises the purchasing power of different currencies by eliminating the differences in price levels between countries. 3. Percentage of persons living with less than 60 % of median equivalised disposable income. Source: Eurostat database.

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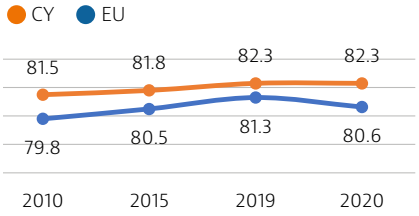
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1 Highlights

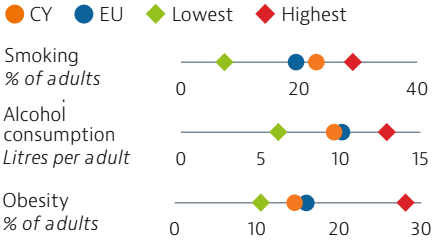
Overall, the Cypriot population is among the healthiest in the EU. As of August 2021, the impact of COVID-19 on mortality and life expectancy had been limited. The population enjoys good health outcomes, despite the prevalence of risk factors such as smoking and obesity. Since 2019, health system reforms to introduce universal coverage and improve overall efficiency have been implemented, despite the ongoing pandemic, and changes to health care financing mechanisms have facilitated surge capacity. As well as improving coverage and resilience, the new General Healthcare System is expected to improve accessibility by cutting waiting times.



Life expectancy at birth, years

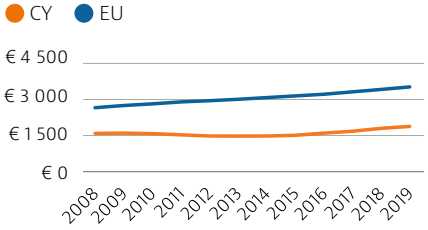
Health Status

As in several other EU countries, gains in life expectancy in Cyprus slowed over the past decade. Notwithstanding the COVID-19 pandemic, life expectancy in 2020 remained stable at 82.3 years. The leading causes of death are circulatory diseases, cancer and diabetes. While the number of people dying from circulatory diseases has consistently fallen since 2015, the cancer mortality rate has remained stable.



Risk factors

Smoking rates in Cyprus are among the highest in the EU and constitute a major public health issue. Although adult obesity rates are close to the EU average, childhood obesity is increasingly common. Alcohol consumption is less of a concern, but all the risk factors are more prevalent in lower-income households, contributing to health inequalities.



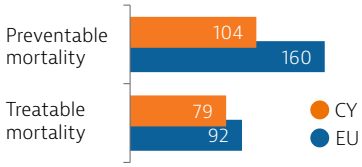
Per capita spending (EUR PPP)

Health system

Spending on health in Cyprus remains consistently below the EU average, at EUR 1 881 per capita in 2019 compared with EUR 3 523 for the EU as a whole. Spending on all components of the system is low. One important goal of recent extensive health system reforms to introduce universal coverage is to reduce what was the highest level of out-of-pocket spending in the EU by improving financial protection.

Effectiveness

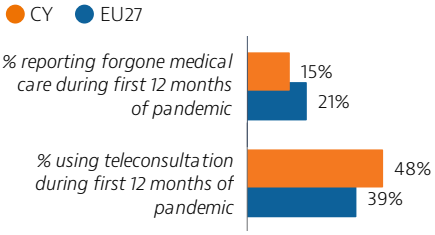
Death rates from preventable causes in Cyprus are among the lowest in the EU. The leading cause of preventable mortality is lung cancer, driven by high smoking rates. Death rates from treatable causes are also below the EU average. Strategies are in place to improve comprehensive data collection on cancer survival rates.



Age-standardised mortality rate per 100 000 population, 2018

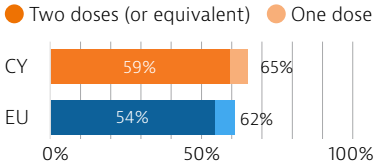
Accessibility

Fewer than one in six Cypriots reported having forgone necessary medical care during the COVID-19 pandemic, a rate consistent with the below-average rates of unmet medical needs reported before the pandemic across the EU. To ensure safe access to care during the pandemic, patients were encouraged to access their doctor primarily by telephone.



Resilience

Financing reforms introduced shortly before the pandemic allowed greater flexibility in planning and contracting with service providers. This facilitated the development of surge capacity during the COVID-19 crisis. Cyprus was also able to roll out its vaccination campaign swiftly. The main capacity constraint is the ongoing shortage of health workers.



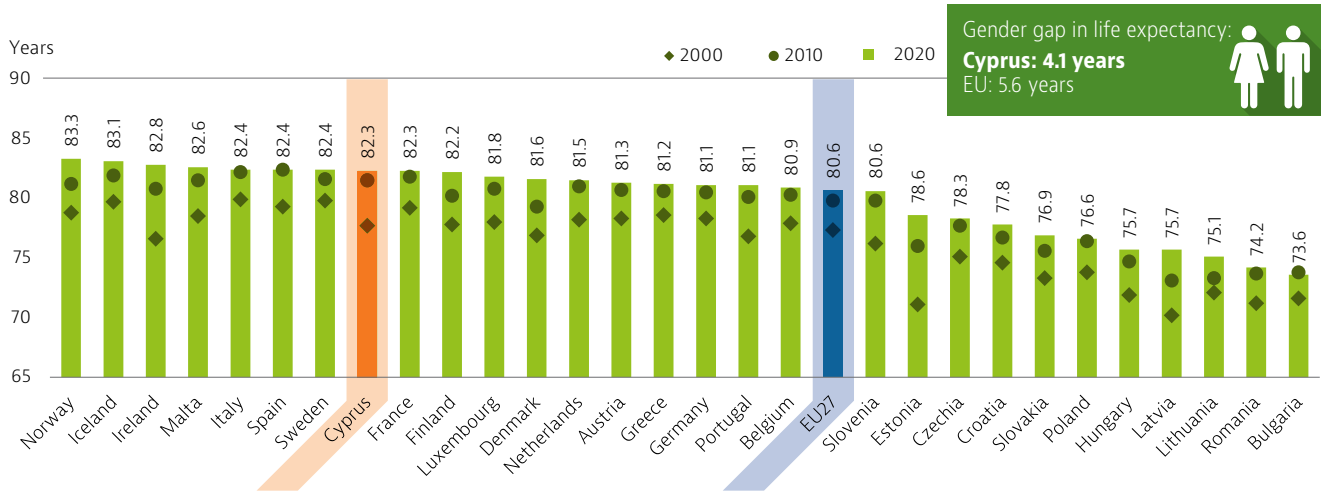
Share of total population vaccinated against COVID-19 up to the end of August 2021

2 Health in Cyprus

COVID-19 did not affect life expectancy in Cyprus as much as in other EU countries

In 2020, life expectancy at birth in Cyprus stood at 82.3 years, 1.7 years above the average for the EU as a whole (Figure 1). On average, Cypriot women live over 4 years longer than men. Gains in life expectancy slowed considerably between 2010 and 2019, particularly among women (increasing by only about half a year between 2010 and 2019 compared with almost 4 years in the previous decade) but also among men (with gains of 1.1 years between 2010 and 2019, down from almost 4 years between 2000 and 2010). While the causes of the slowdown in life expectancy gains in Cyprus in the years prior to the COVID-19 pandemic are not fully understood, it was partly related to an increase in mortality rates from some respiratory diseases, such as chronic obstructive pulmonary disease, among older people. Life expectancy in 2020 did not fall as far as in most other EU countries because the impact of the pandemic was more limited. However, the COVID-19 mortality rate from January to August 2021 was higher, which is likely to reduce life expectancy for that year.

Figure 1. Life expectancy in Cyprus was well above the average for the EU as a whole in 2020



Note: The EU average is weighted. Data for Ireland refer to 2019.
Source: Eurostat Database.

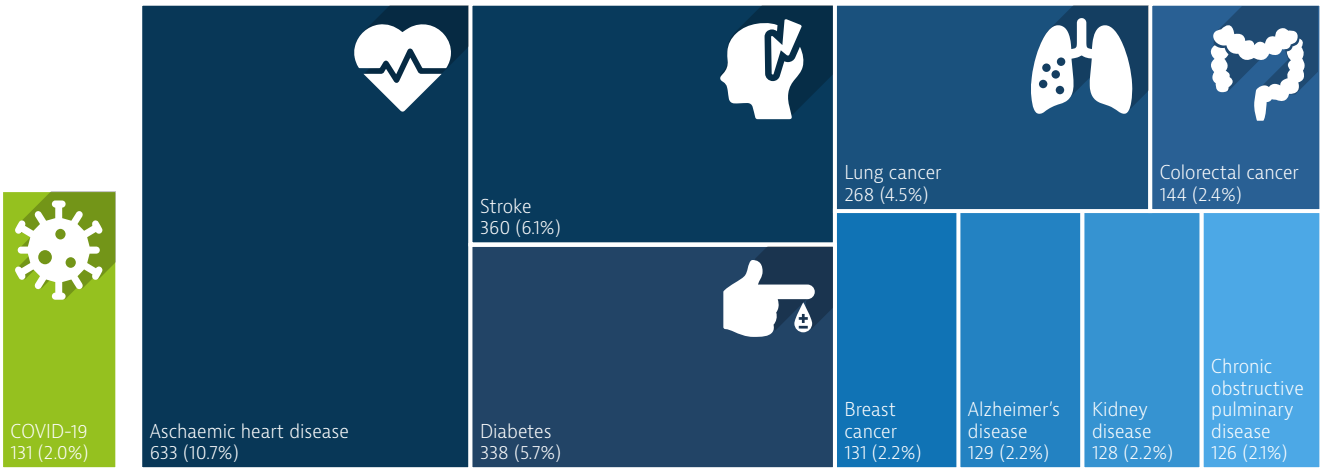
Circulatory diseases, cancer and diabetes are the main causes of death

In 2018, circulatory diseases were the leading cause of death in Cyprus, accounting for 30 % of all deaths, followed by cancer (24 %). While mortality rates from circulatory diseases have decreased substantially in the last two decades, mortality rates from cancer have remained fairly stable. Looking at more specific diseases, ischaemic heart disease was the leading cause of mortality in 2018 (accounting for about 11 % of all deaths), followed by stroke and diabetes. Lung cancer remained the most frequent cause of death by cancer, followed by colorectal and breast cancer (Figure 2).

In 2020, COVID-19 accounted for 131 deaths in Cyprus (or 2 % of all deaths). An additional 368 deaths were registered by the end of August 2021, by which date the cumulative mortality rate from COVID-19 was about three times lower than the average across EU countries, at about 562 per million population compared with an EU average of about 1 590.

However, the broader indicator of excess mortality – defined as deaths from all causes above what would normally be expected based on the baseline mortality levels registered in previous years – suggests that the direct and indirect death toll related to COVID-19 could be higher. The number of excess deaths from March to December 2020 (567) was four times higher than COVID-19 deaths, although many of these excess deaths may not be connected to the pandemic as they do not correlate with waves of infection. For 2020 overall, both COVID-19 deaths and excess mortality rates were low in Cyprus compared with other countries in the EU, but in 2021 infection rates were much higher.

Figure 2. Lung cancer is the leading cause of cancer mortality



Note: The number and share of deaths attributed to COVID-19 refer to 2020, while the number and share of other causes refer to 2018. The size of the COVID-19 box is proportional to the size of the other main causes of death in 2018.
Sources: Eurostat (for causes of death in 2018); ECDC (for COVID-19 deaths in 2020, up to week 53).

Most Cypriot people report being in good health, but two in five adults have a chronic condition

In 2019, more than three quarters (78 %) of the Cypriot population reported being in good health – a proportion higher than the EU average (69 %). However, as in other countries, people on higher incomes are more likely to report good health than those on lower incomes: 87 % in the highest income quintile reported being in good health compared with 61 % in the lowest.

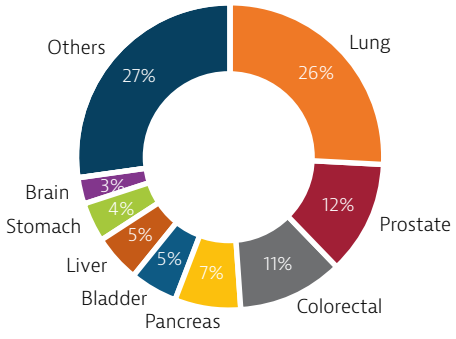
About two in five Cypriot adults (39 %) reported having at least one chronic condition in 2019, a slightly higher proportion than the EU average (36 %), according to EU-SILC. Many of these chronic diseases increase the risk of severe complications from COVID-19. As with self-reported health, there is a gap in the prevalence of chronic conditions by income group: 55 % in the lowest income group report having at least one chronic condition compared with 32 % in the highest.

Cancer deaths in Cyprus are lower than the average for the EU as a whole

The cancer mortality rate has remained stable in Cyprus at a relatively low level since 2004, and in 2018 it was 210 per 100 000 population – lower than the EU average of 265 per 100 000. Figure 3 shows that the main sites of cancer mortality for men are lung (26 %), prostate (12 %), and colorectal (11 %), while among women breast cancer is the leading cause of cancer deaths (20 %), followed by lung (10 %) and colorectal cancer (9 %). Cyprus has a National Cancer Strategy in place that takes a holistic approach to improving both cancer prevention and treatment, in line with Europe's Beating Cancer Plan (see Section 5.1)

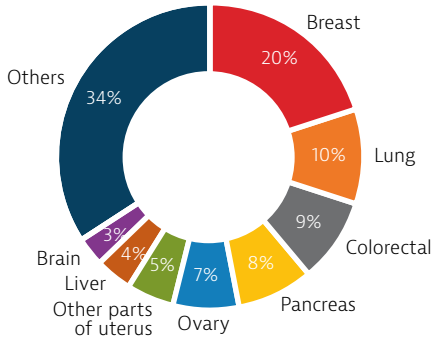
Figure 3. More men than women die of cancer in Cyprus

Men: 800 deaths



Age-standardised rate (all cancer)
CY: 256 per 100 000 population
EU: 336 per 100 000 population

Women: 628 deaths



Age-standardised rate (all cancer)
CY: 164 per 100 000 population
EU: 193 per 100 000 population

Note: The EU average is weighted, calculated by the OECD.
Source: Eurostat database (data refer to 2018).

3 Risk factors

Over a third of all deaths are attributable to behavioural risk factors in Cyprus

Around 35 % of all deaths recorded in Cyprus in 2019 could be attributed to behavioural risk factors such as tobacco smoking, dietary risks, alcohol consumption and low physical activity, which is below the EU average of 39 %. Almost one fifth (19 %) of all deaths in 2019 could be attributed to tobacco smoking (including direct and second-hand smoking) – a share slightly higher than the EU average. Dietary risks (including low fruit and vegetable intake, and high sugar and salt consumption) were estimated to account for about 14 % of all deaths in Cyprus in 2019 – a proportion lower than the average in the EU as a whole (17 %). About 4 % of all deaths can be attributed to alcohol consumption, while about 2 % of deaths are related to low physical activity. Air pollution in the form of fine particulate matter ($PM_{2.5}$) and ozone exposure alone accounted for about 5 % of all deaths (Figure 4).

Figure 4. Tobacco and dietary risks are major contributors to mortality



Note: The overall number of deaths related to these risk factors is lower than the sum of each one taken individually, because the same death can be attributed to more than one risk factor. Dietary risks include 14 components such as low fruit and vegetable intake, and high sugar-sweetened beverages consumption. Air pollution refers to exposure to $PM_{2.5}$ and ozone.
Sources: IHME (2020), Global Health Data Exchange (estimates refer to 2019).

Smoking remains a major public health issue, especially for men

Tobacco consumption remains a major public health concern in Cyprus (Figure 5). More than one fifth (23 %) of Cypriot adults reported that they smoked daily in 2019, a proportion higher than the EU average of 20 %. This is mainly due to high smoking rates among men (33 %) compared to 14 % of women. Some tobacco control policies are in place, but they are relatively weak and poorly enforced (see Section 5.1). On a more positive note, the proportion of 15-year-olds who reported smoking cigarettes was lower than in most EU countries in 2019. However, e-cigarettes have become more popular, and one in ten 15-year-olds in Cyprus reported smoking e-cigarettes in 2019, although this proportion was also slightly lower than the EU average.

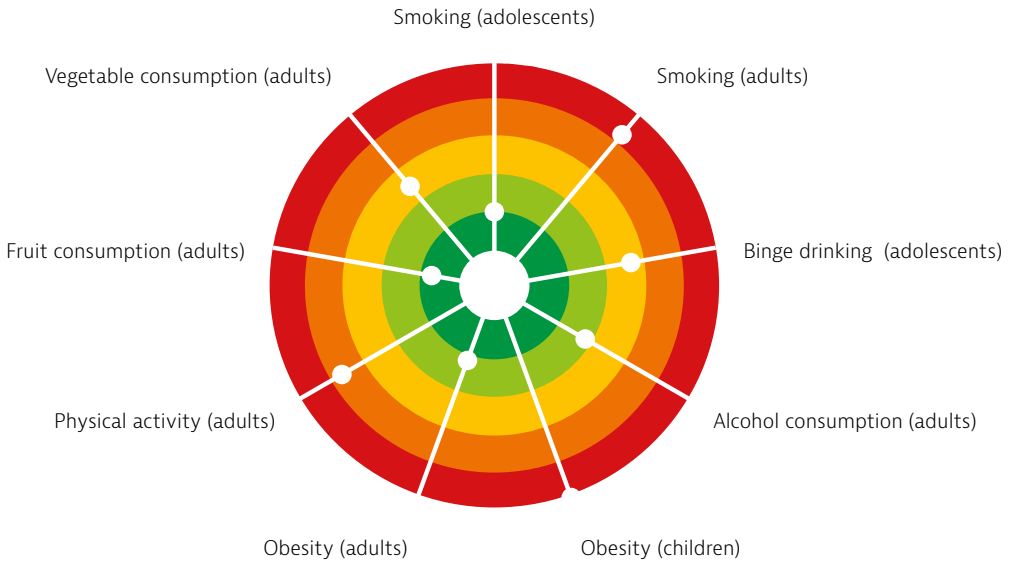
Obesity among children is a public health concern

One in seven Cypriot adults (14.6 %) were obese in 2019 – a share similar to the EU average (16.0 %). Obesity rates among children are higher. In 2015-17, 20 % of children aged 6-9 years were obese – the highest rate among EU countries (WHO Regional Office for Europe, 2018). Low physical activity is an important contributor to overweight and obesity. About 40 % of adults in Cyprus did not meet the WHO recommendation of at least 2.5 hours of moderate physical activity per week in 2014, which is a higher share than the EU average. Poor nutrition is another leading factor contributing to overweight and obesity. Cypriot adults reported that they did not eat at least one portion of fruit (40 %) or vegetables (52 %) per day in 2019 – high shares that are, however, still lower than those in most other EU countries.

Alcohol consumption is lower than in most other EU countries

Alcohol consumption among adults has remained fairly stable since 2000 and is close to the EU average. Only about 4 % of adults reported heavy episodic alcohol consumption (binge drinking[1]) in 2019, which is the lowest rate among all EU countries. However, the proportion of 15-year-olds who reported binge drinking in the past month was much higher, at 37 % in 2019, which is greater than in many other EU countries.

Figure 5. Smoking among adults and obesity among children are important public health issues in Cyprus



Note: The closer the dot is to the centre, the better the country performs compared to other EU countries. No country is in the white "target area" as there is room for progress in all countries in all areas.
Sources: OECD calculations based on ESPAD 2019 and COSI 2015-17 for children and adolescents indicators; and EHIS 2014, EHIS 2019 and national source for adults indicators

4 The health system

Cyprus has managed to implement reforms bringing universal health coverage, despite the pandemic

Cyprus implemented the first phase of the new General Healthcare System in June 2019, which unified a previously fragmented system that had serious problems, including an imbalance of resources between public and private providers, very high out-of-pocket (OOP) payments, large inequalities in access, long waiting lists and inefficiency of the health system overall. The new system is financed by state revenues and contributions levied through wages, incomes and pensions. Under the new System, some responsibilities of the Ministry of Health shifted to the Health Insurance Organisation, which serves as the single purchaser of services from both public and private providers. Some of the Ministry's other responsibilities moved to the new State Healthcare Services Organisation, which is responsible for the development, management, control and supervision of hospitals and health centres in the public sector. Concerted reform efforts meant that, despite the pandemic, the new health system became fully operational on 1 June 2020. The Ministry of Health also played a central role in steering the country's response to the COVID-19 pandemic (Box 1).

1. Binge drinking is defined as consuming six or more alcoholic drinks on a single occasion for adults, and five or more for adolescents.

Box 1. The COVID-19 response was centralised and coordinated at the highest levels of government

By law, the Department of Medical and Public Health Services of the Ministry of Health is the main body responsible for prevention and control of infectious diseases. In January 2020, the Department activated a task force at the Surveillance and Control of Communicable Diseases Unit of the Ministry. The response was led by the General Secretary and the Medical Services Directorate of the Ministry of Health, in coordination with the Scientific Advisory Committee, the Council of Ministers and the President of the Republic. The Scientific Advisory Committee consists of independent academics from universities and members of the Surveillance and Control of Communicable Diseases Unit. The Unit coordinates surveillance activities and is responsible for communications with the ECDC, WHO and EU. It also coordinates COVID-19 testing procedures. Analysis of COVID-19 data is the responsibility of the Health Monitoring Unit of the Ministry of Health.

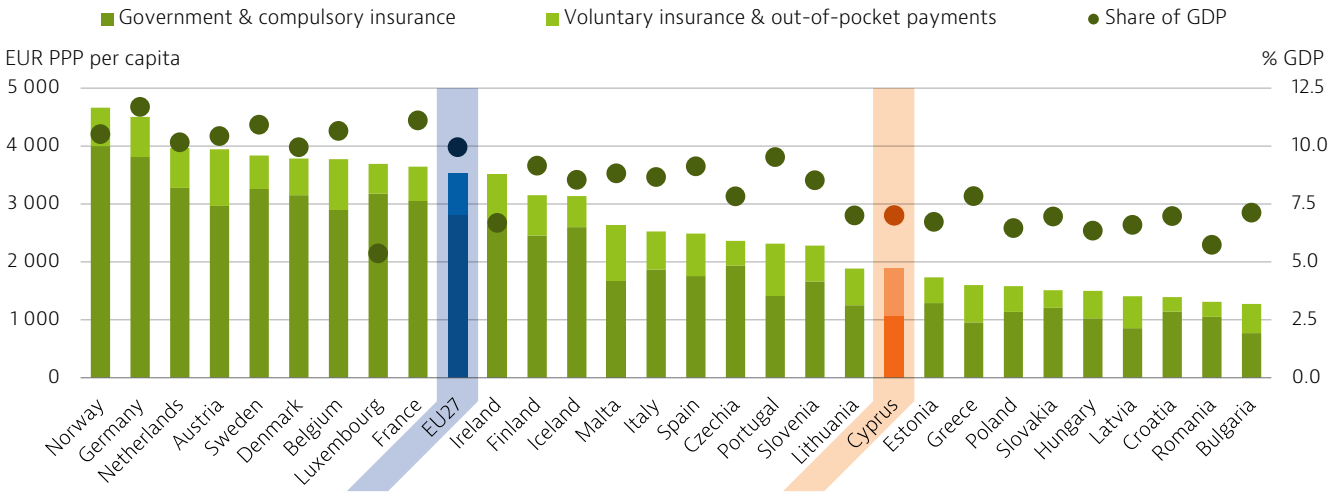
At the highest level, the COVID-19 response is coordinated by the Council of Ministers and Ministry of Health, with the co-operation of the State Healthcare Services Organisation and the Health Insurance Organisation as a facilitator for working with personal doctors.

Source: COVID-19 Health Systems Response Monitor.

Health financing is characterised by high out-of-pocket payments, but this should change

Cyprus spends less on health than most EU countries. In 2019, EUR 1 881 per capita went towards health (adjusted for differences in purchasing power), which is about half the average of EUR 3 521 for the EU as a whole. Despite gradual increases over the past decade, this amount translates to 7 % of GDP, a significantly lower share compared to the total EU average of 9.9 % (Figure 6). In addition, only 8 % of the government budget was spent on health, compared with a 14 % EU average.

Figure 6. Cyprus spends much less on health than the EU average



Note: The EU average is weighted.
Source: OECD Health Statistics 2021 (data refer to 2019, except for Malta 2018).

A significant challenge has been lower household incomes in 2020, leading to a steep reduction in revenues of the Health Insurance Organisation during the COVID-19 pandemic despite increased demand (Box 2).

From 2020, the successful implementation of the General Healthcare System should further reduce OOP payments, which in 2019 accounted for over 30 % of total health expenditure. In 2018 the share was almost 45 %, and Cyprus had the highest level of OOP spending as a proportion of total health expenditure in the EU. Such high levels of OOP expenditure have caused access problems for low-income households, who risk incurring catastrophic health-related expenditure (see Section 5.2). While the old system covered only about three quarters of the population, the General Healthcare System covers the whole population.

Box 2. Early surpluses in the General Healthcare System have been used to cover pandemic-related deficits

In 2020-21, the pandemic reduced revenues for the General Healthcare System that come mainly from health contributions levied on the income of beneficiaries and from employers. It is estimated that in the early months of the pandemic this reduction reached more than 50 % of the Health Insurance Organisation's monthly revenues from private sector wage revenues, due to increased unemployment, reduced wages and the lack of tax on state-funded pandemic-related emergency support allowances, which cover around 60 % of employee-beneficiary wages.

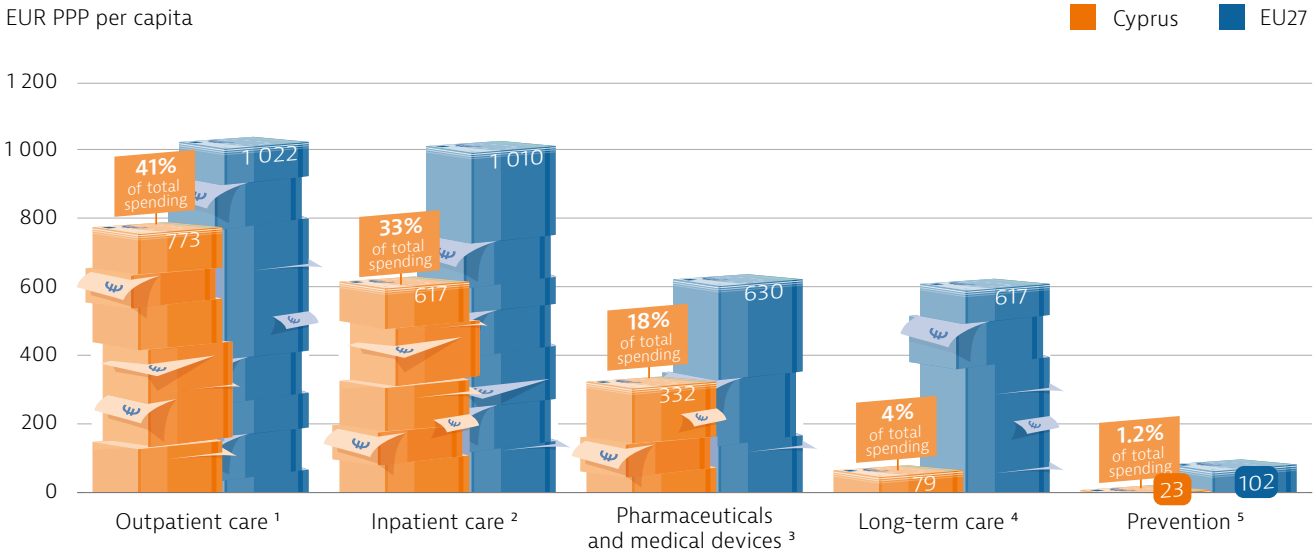
Consequently, the Health Insurance Organisation is now proceeding with a three-year plan in which the surpluses (around EUR 250 million) recorded during the first year of the General Healthcare System (2019) will be distributed to compensate for the deficit created in 2020. New remuneration terms and arrangements with providers were introduced following negotiations in May-June 2020, which take into account the new circumstances.

Source: COVID-19 Health Systems Response Monitor.

Spending on prevention in Cyprus is far below the EU average

Cyprus spends 24 % less per capita on outpatient care, 39 % less on inpatient care and 87 % less on long-term care than the EU averages (Figure 7). This is largely due to the smaller overall health budget available; thus, as a proportion of current health spending, spending on more expensive aspects of care – such as inpatient care and pharmaceuticals – is relatively high. In 2019, 41 % was spent on outpatient care, which is among the highest in the EU, where the average is 30 %. About 18 % was spent on pharmaceuticals, which is equal to the EU average of 18 %, but in absolute terms this translates to just under EUR 332 per capita – about half the average for the EU as a whole. At EUR 23 per capita, spending on preventive services is far below the total EU average of EUR 102 per capita. This amounts to only 1.2 % of health spending (compared to 2.9 % across the EU). Long-term care also attracts low levels of funding, at 4.2 % of current health spending as opposed to a much higher average of 16 % across the EU.

Figure 7. Cyprus spends less per capita on all aspects of health care compared to the EU average



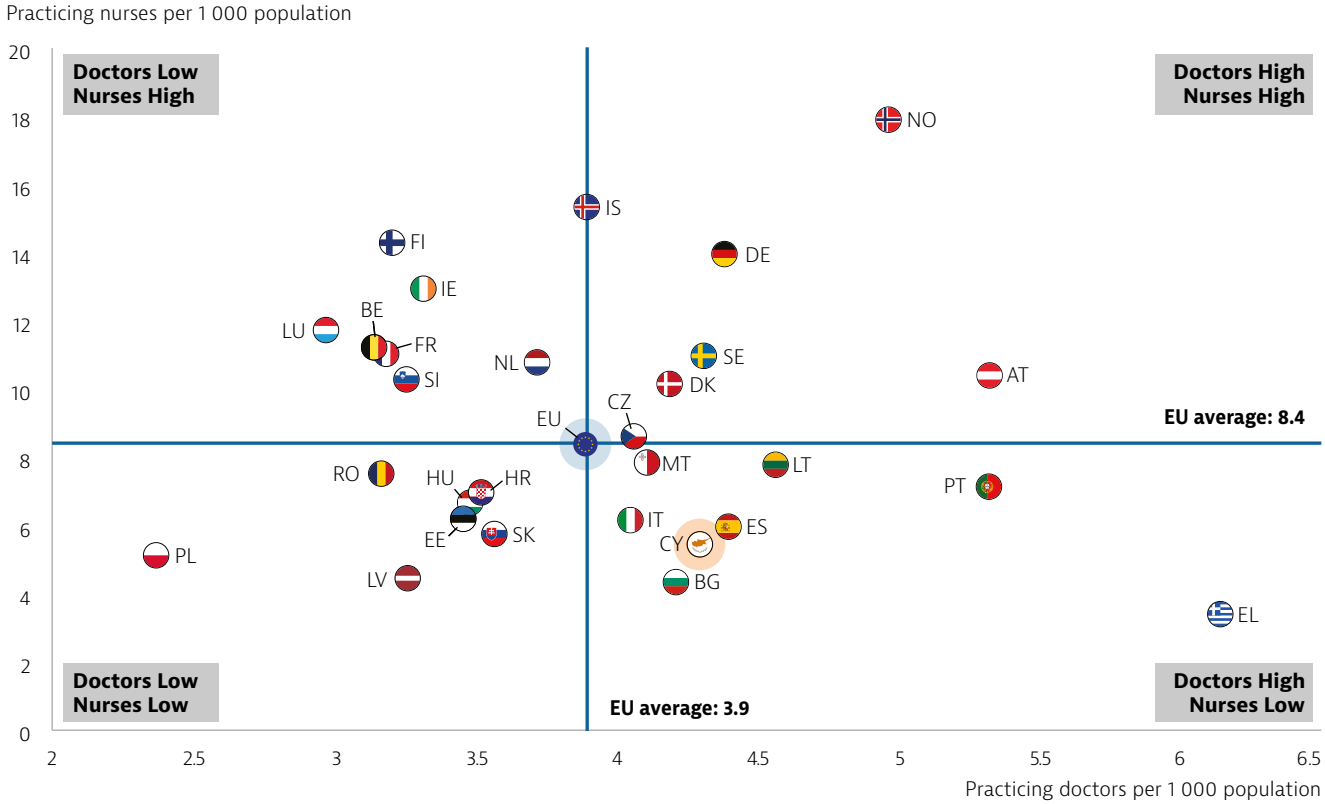
Note: The costs of health system administration are not included.1. Includes home care and ancillary services (e.g. patient transportation); 2. Includes curative-rehabilitative care in hospital and other settings; 3. Includes only the outpatient market; 4. Includes only the health component; 5. Includes only spending for organised prevention programmes. The EU average is weighted.
Sources: OECD Health Statistics 2021, Eurostat Database (data refer to 2019).

There is a shortage of doctors and nurses in the public health care system

In Cyprus, the density of doctors is 4 per 1 000 population, which is slightly above the EU average, while the density of nurses is around 6 per 1 000 population, which is well below the average (Figure 8). This statistic does not reflect the wider imbalances in the workforce between the public and private sectors, as doctors primarily work in the private

sector and nurses in the public sector. Prior to the implementation of the General Healthcare System, a large number of doctors in the public system switched to work in the private sector. They were then contracted with the new system, either as specialists or as personal doctors, who function as primary care physicians. As a result, public hospitals tasked with ensuring surge capacity for treating COVID-19 patients entered the pandemic with a pre-existing shortage of doctors. In response, new doctors and other health professionals had to be recruited from elsewhere in the public system to respond to the needs created by the pandemic. Cyprus now has four medical schools, so it may be able to train more doctors to fill vacant posts. The system currently relies on medical graduates who studied abroad returning to practise in Cyprus.

Figure 8. The number of doctors is above the EU average, while the number of nurses is well below



Note: The EU average is unweighted. In Portugal and Greece, data refer to all doctors licensed to practise, resulting in a large overestimation of the number of practising doctors (e.g. of around 30 % in Portugal). In Greece, the number of nurses is underestimated as it only includes those working in hospitals.
Source: Eurostat Database (data refer to 2019 or the nearest year).

Primary care plays an important role in the new health system

About one quarter of doctors in Cyprus report that they provide general practice services, although this might not be their specialisation, and gatekeeping has been designed as the backbone of the General Healthcare System. There was concern that private doctors working outside hospitals would not sign on to the new System, as reimbursement rates were considered too low. However, the vast majority did join, as it turned out that the rewards were satisfactory and even beyond their expectations. From June 2019, the General Healthcare System began providing outpatient care services (family doctors and paediatricians, specialists, laboratory tests and medicines), and since June 2020 inpatient care has also been covered, along with emergency care, ambulance services, preventive dental care services and outpatient care by allied health professionals. Before the introduction of the General Healthcare System, utilisation levels and the average length of stay in hospitals (5 days in 2019) were relatively low, but it is not yet known whether they may have increased following the reforms, even without the pandemic, as expanded access may have released pent-up demand for services.

Prior to the pandemic, Cyprus had 3.1 hospital beds per 1 000 people, which is well below the EU average of 5.3 beds in 2019. As part of the pandemic response, the Ministry of Health commissioned beds and staff from private hospitals to increase the capacity available to treat COVID-19 patients in public hospitals (see Section 5.3).

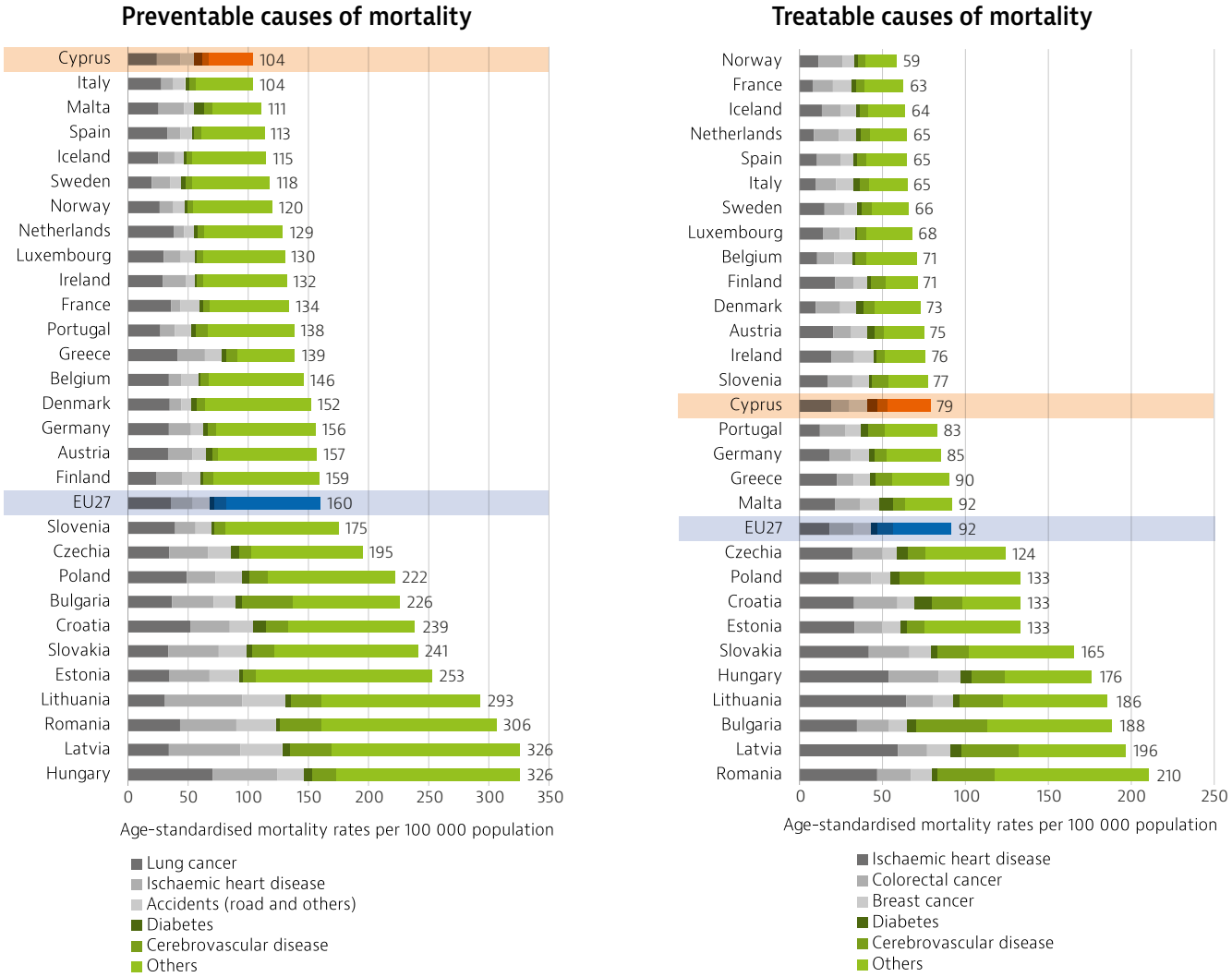
5 Performance of the health system

5.1 Effectiveness

The preventable mortality rate in Cyprus remains low

Among EU Member States, Cyprus reported the joint lowest preventable mortality rate in 2018 (Figure 9). Lung cancer remains the leading cause of preventable mortality, which is consistent with high smoking rates, particularly among Cypriot men. These results suggest the existence of further scope for reducing preventable deaths through more effective public health interventions. The Cypriot government banned smoking in enclosed public places (including bars, cafes and restaurants) in 2017, and there are nominally heavy fines for proprietors and smokers who break the law. However, the ban only applies to fully enclosed indoor spaces, and therefore allows loopholes. Measures to reduce other types of preventable death have also been introduced in recent years. To reduce the number of deaths from traffic accidents, campaigns have been organised to enforce the use of seat belts and child safety seats in cars and helmets for motorcyclists, and to combat drink-driving.

Figure 9. Mortality from both preventable and treatable causes compares well to other EU countries



Note: Preventable mortality is defined as death that can be mainly avoided through public health and primary prevention interventions. Treatable mortality is defined as death that can be mainly avoided through health care interventions, including screening and treatment. Half of all deaths for some diseases (e.g. ischaemic heart disease and cerebrovascular disease) are attributed to preventable mortality; the other half are attributed to treatable causes. Both indicators refer to premature mortality (under age 75). The data are based on the revised OECD/Eurostat lists.
Source: Eurostat Database (data refer to 2018, except for France 2016).

Cyprus stepped up influenza vaccination for older people

Uptake of the influenza vaccine among people aged over 65 years was only 26 % in 2019, which is well below the EU average of 42 % and even further from the WHO target of 75 %. However, in response to the threat of an influenza outbreak during the COVID-19 pandemic, the Ministry of Health procured more seasonal flu vaccine doses than usual for 2020: at least 100 000, compared with 85 000 in 2019 and 55 000 in 2018.

Child vaccination rates are generally higher than EU averages, except for measles. Vaccination is not compulsory in Cyprus, but is provided free of charge to all children in health centres or public hospitals. In addition, at the beginning of each school year, health visitors check whether pupils are up to date with their vaccinations. Vaccination rates for diphtheria, tetanus and pertussis (99 %) and for hepatitis B (97 %) among children compare well to EU levels, but vaccination coverage in children for measles, mumps and rubella in 2019 was 86 % for the first dose (down from 90 % in 2018), with coverage by the second dose steady at 88 %. This is well below the target of 95 % recommended by WHO to maintain herd immunity (WHO, 2020).

Rates of avoidable death from treatable causes in Cyprus are low

Together with its very low rates from preventable causes of death, deaths in Cyprus that should not have occurred in the presence of timely and effective health care were about 79 per 100 000 population in 2018 – well below the EU average of 92 (see Figure 9). The main causes of treatable mortality in Cyprus include ischaemic heart disease, breast and colorectal cancer, diabetes and stroke. The mortality rate from treatable causes has fluctuated around the same level since 2011, without sustained improvement.

More data are needed to assess the quality of care

While data on mortality from treatable causes suggest that Cyprus provides health care of overall good quality compared with the EU average, the performance of specific parts of the system such as primary care or hospital care cannot be evaluated, as data on quality of care are not systematically collected by either the public or private sectors. This lack of data makes it difficult to assess the quality and effectiveness of the health system in greater detail, stifling efforts to strengthen service delivery. Although Cyprus does not have an accreditation system or quality framework for hospitals, there is interest from the Health Insurance Organisation in implementing these in the future. It is also expected that, following the introduction of the General Healthcare System, data on quality will be recorded by the integrated information system, which will be used to assess and improve the quality of services provided.

Almost a quarter of all deaths in Cyprus are from cancer, and lung cancer is the most frequent cause of cancer deaths – this is one of the reasons the high levels of tobacco consumption remain such a major public health concern (see Section 2). However, it is not possible to comment on five-year survival rates for the most common cancers (lung, breast, cervical and colorectal cancers) or childhood leukaemia because cancer registry data are incomplete. Consequently, improving data collection and sharing in cancer care is a key focus of the updated National Cancer Strategy (Box 3).

Box 3. The National Cancer Strategy has been updated, based on EU guidelines

In 2019, Cyprus launched its updated National Cancer Strategy, based on EU guidelines. It takes the same holistic approach as the European Commission's Europe's Beating Cancer Plan by covering the whole cancer pathway in five areas:

- Prevention
- Early diagnosis/treatment
- Psychosocial support, reintegration and palliative care
- Case reporting and a cancer registry
- Research

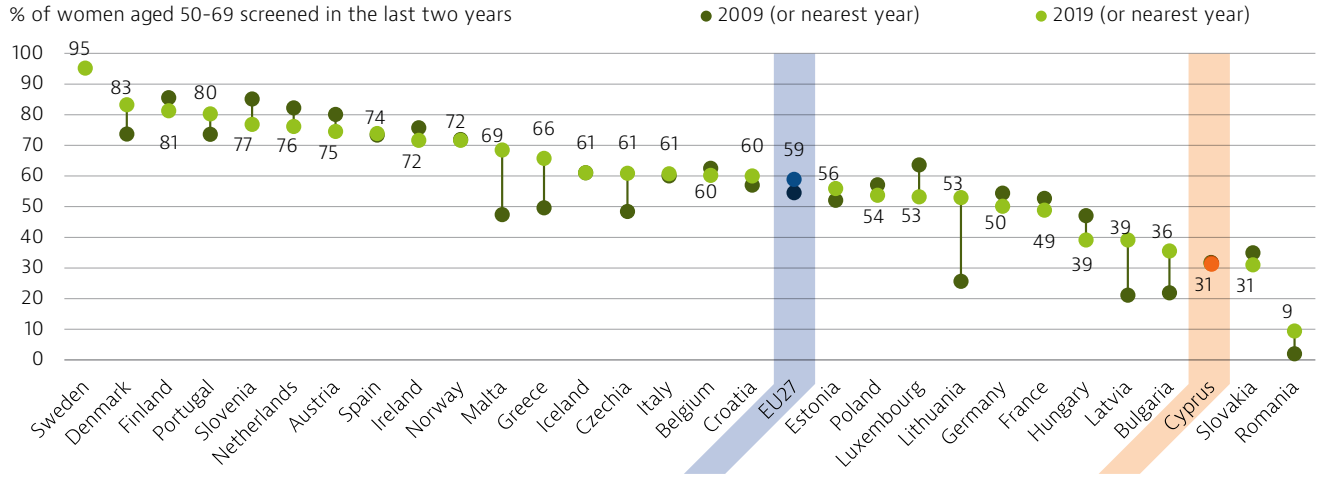
The goal of the Strategy is to organise and utilise all the existing resources and the oncology infrastructure, and to improve data collection and sharing to inform service provision, prevention and research. The Strategy also takes into account the new conditions in the health system following implementation of the General Healthcare System (see Section 4), within which patients are entitled to choose their provider (doctor, clinic or hospital, laboratory and other health allied professionals), if it is registered with the new health care system. The new National Cancer Strategy therefore seeks to improve coordination at all levels of the system.

Sources: Ministry of Health (2019); European Commission (2021a).

Some national cancer screening programmes are in place, but uptake is low

National cancer screening rates have remained stable over a number of years without much sign of improvement, but comparisons are hampered by shortcomings in the data. Since 2007, Cyprus has had a national breast cancer screening programme for women aged 50-69, offered free of charge every two years, with a screening centre operating in each of the major cities. However, in 2019, only about 31 % of women aged 50-69 had been screened for breast cancer in the previous two years – far below the EU average of 59 % (Figure 10). Because of fragmentation in the system, it is likely that many women chose to have mammography screening in the private sector, for which data were not available in 2019 (although data availability could improve under the General Healthcare System). In addition, women may not feel the need to take up the offer of breast cancer screening because gynaecologists unofficially perform a breast examination when patients seek cervical cancer screening. In 2019, 69 % of women aged 20-60 had been screened for cervical cancer at some point in the previous two years, which is higher than the EU average of 58 %, even though there is no national screening programme for cervical cancer. It is too early to say what the impact of the COVID-19 pandemic on cancer screening, treatment and care might be.

Figure 10. Uptake of breast cancer screening is low among women



Note: The EU average is unweighted. For most countries, the data are based on screening programmes, not surveys.
Sources: OECD Health Statistics 2021 and Eurostat Database.

5.2 Accessibility

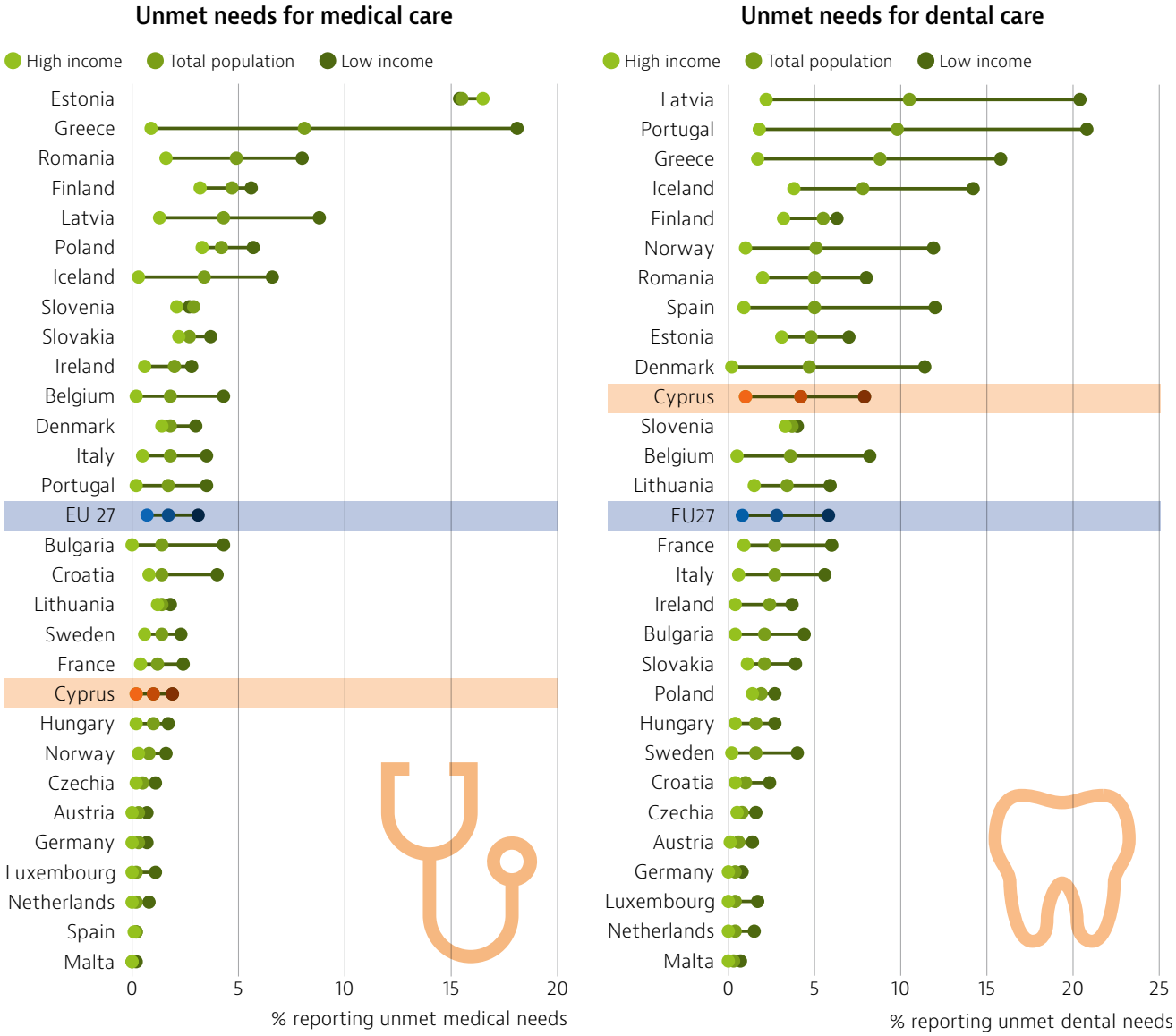
General unmet care needs are low, but are greater for dental care than for health care

Prior to the COVID-19 pandemic and the expansion of coverage under the General Healthcare System, the proportion of the population reporting unmet needs for medical care in Cyprus due to cost, travel distance or waiting times was low. In 2019, just 1 % of the population reported unmet medical care needs. Nevertheless, differences across income groups are significant, with 1.9 % of people in the lowest income quintile reporting unmet needs, but just 0.2 % of those in the highest (Figure 11). The main reported driver of unmet medical needs was the long waiting times in the old public system.

Survey data collected during the first 12 months of the COVID-19 pandemic found that the proportion reporting unmet needs for medical care was 15 %, which is below the average of 21 % for across the EU (Eurofound, 2021)[2]. Unmet needs for dental examinations are higher than for health care, mainly for financial reasons: 4.2 % of the population reported unmet needs for dental care in 2019, but this proportion was much higher among households in the lowest income quintile (7.9 %) than among those in the highest (only 1 %).

2. *The data from the Eurofound survey are not comparable to those from the EU-SILC survey because of differences in methodologies.*

Figure 11. Almost 8 % of low-income households in Cyprus have unmet needs for dental care



Notes: Data refer to unmet needs for a medical and dental examination or treatment due to costs, distance to travel or waiting times. Caution is required in comparing the data across countries as there are some variations in the survey instrument used.
Source: Eurostat Database, based on EU-SILC (data refer to 2019, except Iceland 2018).

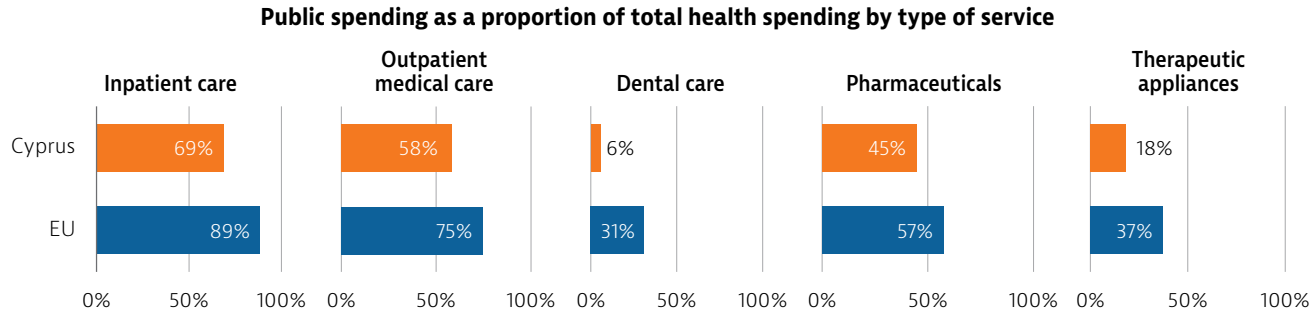
Population coverage in Cyprus is now universal, including services within the COVID-19 response

Cyprus implemented the new, integrated General Healthcare System offering universal coverage on 1 July 2020. The income criteria of the previous system, as well as other prerequisites granting access to the public system, were abolished. Under the previous system, in 2019 only around 83 % of the population were technically considered to be covered free of charge. The General Healthcare System aims to provide universal health coverage for all legal residents, including Cypriot citizens; EU citizens; third country nationals with permanent residence status and their dependents, regardless of income or payment of contributions; and refugees and asylum seekers. For the first time, migrants will have the same health care coverage as all Cypriots and EU citizens, reducing or even eliminating the disadvantages of the previous system, in which people were dependent on private health insurance. All diagnostic and therapeutic services provided as part of the COVID-19 response within the new system are provided free of charge. This also applies to undocumented migrants living in Cyprus, who are now legally entitled to health care and treatment of infectious diseases.

Beneficiaries are entitled to a comprehensive package of care

The General Healthcare System provides a comprehensive package of benefits covering primary, outpatient and inpatient care. Figure 12 shows the situation in 2019, which demonstrates that under the previous system public spending on all types of health services was much lower than the average for the EU as a whole. As of 1 December 2020, some preventive dental care services are also included in the package of benefits, but dental treatments such as fillings or extractions are still excluded. Alongside this, the main gaps in the publicly financed benefits package are long-term care, rehabilitation and palliative care (Kontemeniotis & Theodorou, 2020). These have been integrated into the new system, but there is insufficient capacity to meet all needs. To ensure access to medicines, under the General Healthcare System beneficiaries pay a flat co-payment of only EUR 1 for the cheapest generic equivalent of a prescribed medicine. The current list of non-hospital medicines covered includes 1 510 products. If patients wish to obtain the brand-name medicine, they need to pay the price difference between the generic and the branded product. However, Cyprus has the highest pharmaceutical prices in the EU when prices are adjusted for individual income (Box 4).

Figure 12. The public share of financing in Cyprus is lower than the EU average across all areas



Note: Outpatient medical services mainly refer to services provided by generalists and specialists in the outpatient sector. Pharmaceuticals include prescribed and over-the-counter medicines as well as medical non-durables. Therapeutic appliances refer to vision products, hearing aids, wheelchairs and other medical devices.
Source: OECD Health Statistics 2021 (data refer to 2019 or nearest year).

Box 4. Access to medicines is an important policy priority in Cyprus

The affordability of medicines is an important issue in Cyprus because OOP payments for outpatient medicines have grown over time and are the key driver of catastrophic healthcare costs. Medicines reimbursed through the General Healthcare System are dispensed according to a limited positive list of approved medicines, which frequently mandates the use of generics or the cheapest product.

There are fixed co-payments of EUR 1 for each electronically prescribed item for outpatient use, if they are dispensed in one of these public pharmacies, but the limited range of medicines available there pushes many people to pay out of pocket in private pharmacies.

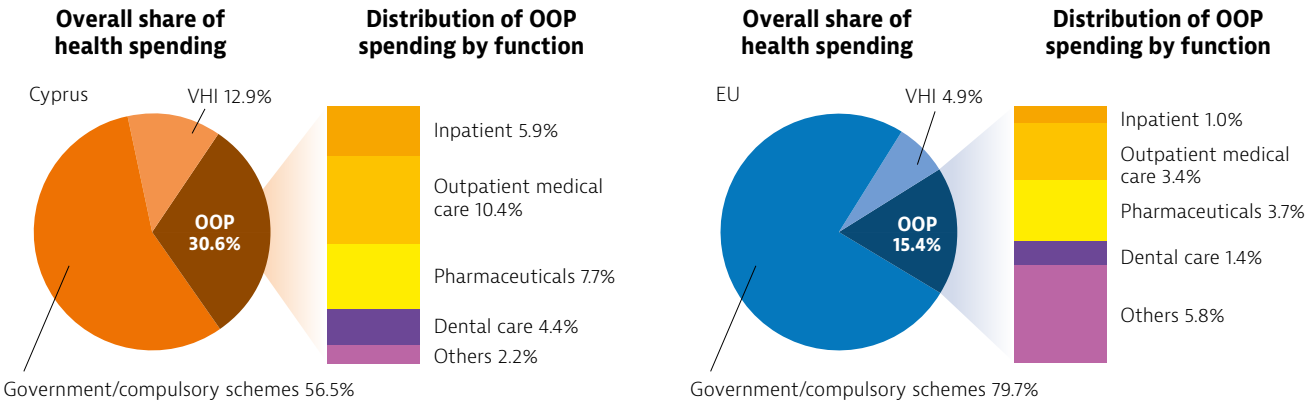
As part of attempts to contain costs and strengthen access to medicines, Cyprus was an early signatory of the Valletta Declaration in which 10 EU Member States have committed to work together to ensure affordable access to medicines. This collaborative approach aligns with the European Commission's pharmaceutical strategy for Europe (European Commission, 2020).

Source: Kontemeniotis & Theodorou (2020).

Cyprus has high levels of out-of-pocket expenditure

In 2019, a high proportion of health spending in Cyprus was financed out of pocket: at 30.6 % it was almost double the average of 15.4 % for the EU as a whole. This high level was mainly due to paying for services in the private sector and lack of universal coverage prior to implementation of the General Healthcare System in 2019 and 2020. Outpatient medical care accounted for the highest share (10.4 %) of OOP spending on health, compared to just 3.4 % on average in the EU (Figure 13). OOP payments for pharmaceuticals also constituted an important share of health spending, at 7.7 % in Cyprus compared to 3.7 % in the EU.

Figure 13. Out-of-pocket spending on health in Cyprus was mainly on outpatient care and medicines

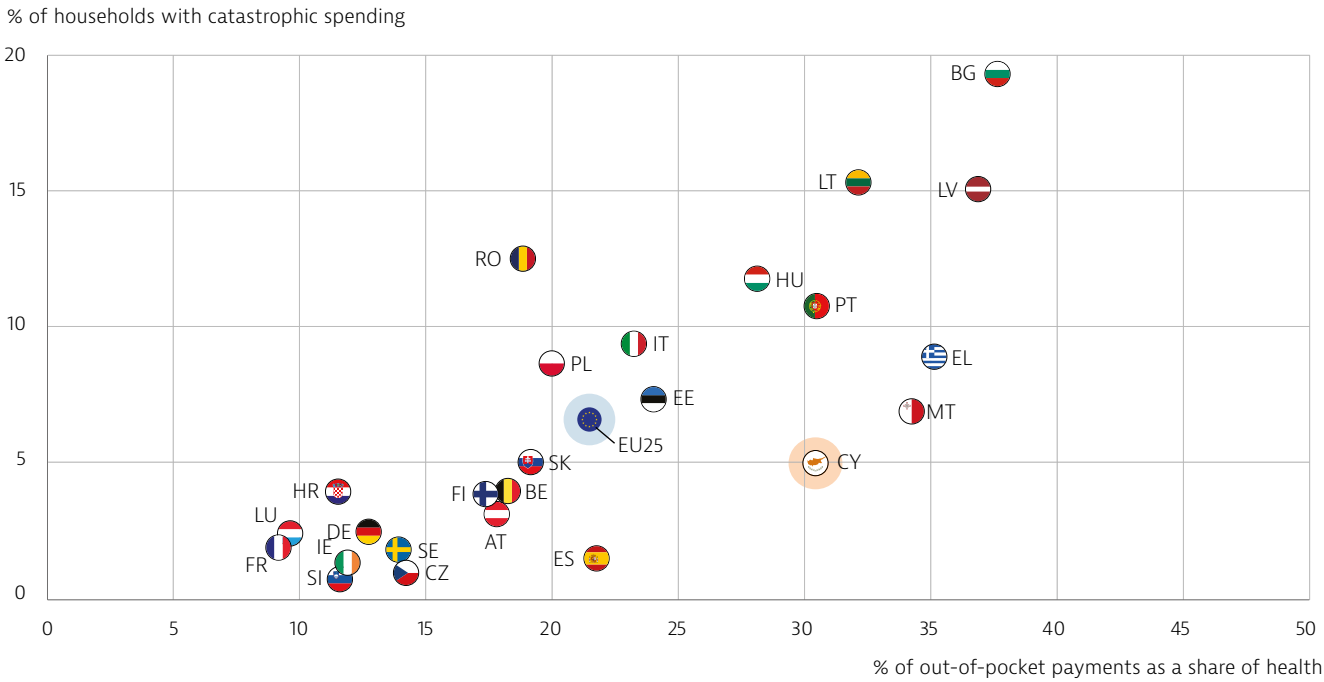


Note: The EU average is weighted. VHI = voluntary health insurance, which also includes other voluntary prepayment schemes.
Sources: Source: OECD Health Statistics 2021; Eurostat Database (data refer to 2019).

When measured as a share of final household consumption, OOP medical spending in Cyprus was 3 %, which is almost the same as the EU average of 3.1 %. Despite relying significantly on OOP spending to cover medical costs, only 5 % of Cypriot households incurred catastrophic health spending in 2015. This was below the EU average of 6.6 % and much lower than for other European countries that also relied to a large extent on OOP to finance health care (Figure 14).

Catastrophic spending may have been low historically because the public system acted as a safety net, meaning that most people who could not afford to pay for private services were able to obtain public sector services at minimal or no charge. Protection against user charges was strengthened under the General Healthcare System, and the user charges policy was simplified. For example, exemptions now apply to almost all co-payments, and there is an annual cap, which is set at a more protective rate for children and low-income households. Previously, user charges were applied to outpatient prescribed medicines, diagnostic tests and emergency department visits – largely without exemptions (Kontemeniotis & Theodorou, 2020).

Figure 14. Cyprus was an outlier, with low levels of catastrophic spending despite high out-of-pocket spending



Note: The EU average is unweighted.
Sources: WHO Regional Office for Europe data, 2021.

Previously long waiting times for care have been relieved

Waiting times for some services, especially for elective surgery and diagnostic tests, have historically been long in Cyprus. This was the result of longstanding budgetary pressures and staff shortages in the publicly financed part of the system. Since the introduction of the General Healthcare System, the ability of the Health Insurance Organisation to contract with private providers has relieved most of the capacity constraints in the system and the backlog of patients on waiting lists.

Staff shortages in the system were exacerbated in 2013, following the economic crisis, as the health budget was cut and salaries of health workers were reduced, while their workload increased. In response, many doctors moved from public to private facilities (Kontemeniotis & Theodorou, 2020). As noted in Section 4, the number of doctors per 1 000 population is above the EU average, while the number of nurses is well below the EU average: doctors choose to work mainly as specialists in the private sector and nurses generally work in the public sector.

Despite initial fears about the willingness of private health care facilities and doctors to provide contracted services in the General Healthcare System, most private doctors, clinics and hospitals, allied health professionals, dentists and all private pharmacies and laboratories have agreed to contract with the Health Insurance Organisation. It is estimated that the new system has at its disposal 80 % of the available hospital beds, and this positive development is expected to relieve pressure on overcrowded public hospitals and reduce waiting times (Kontemeniotis & Theodorou, 2020). Also, although many elective surgeries were cancelled during the pandemic, access to regular emergency care could continue with contracted private providers, while emergency capacity in public hospitals was used to care for COVID-19 patients. Telehealth services were developed mainly for the remote care, including psychological support, of COVID-19 patients.

5.3 Resilience

This section on resilience focuses mainly on the impacts of and responses to the COVID-19 pandemic[3]. As noted in Section 2, the COVID-19 pandemic had a major impact on population health and mortality in Cyprus, with 499 COVID-19 deaths recorded between March 2020 and the end of August 2021. The first wave of the pandemic in 2020 had a smaller impact on population health and mortality in Cyprus than that in most other EU countries, but the second wave that began in October 2020 was more severe. Most COVID-19 deaths in Cyprus occurred in 2021 (see Section 2). The measures taken to contain the pandemic also had an impact on the economy, as GDP in Cyprus fell by over 5 % in 2020, compared to an EU average fall of 6.2 %.

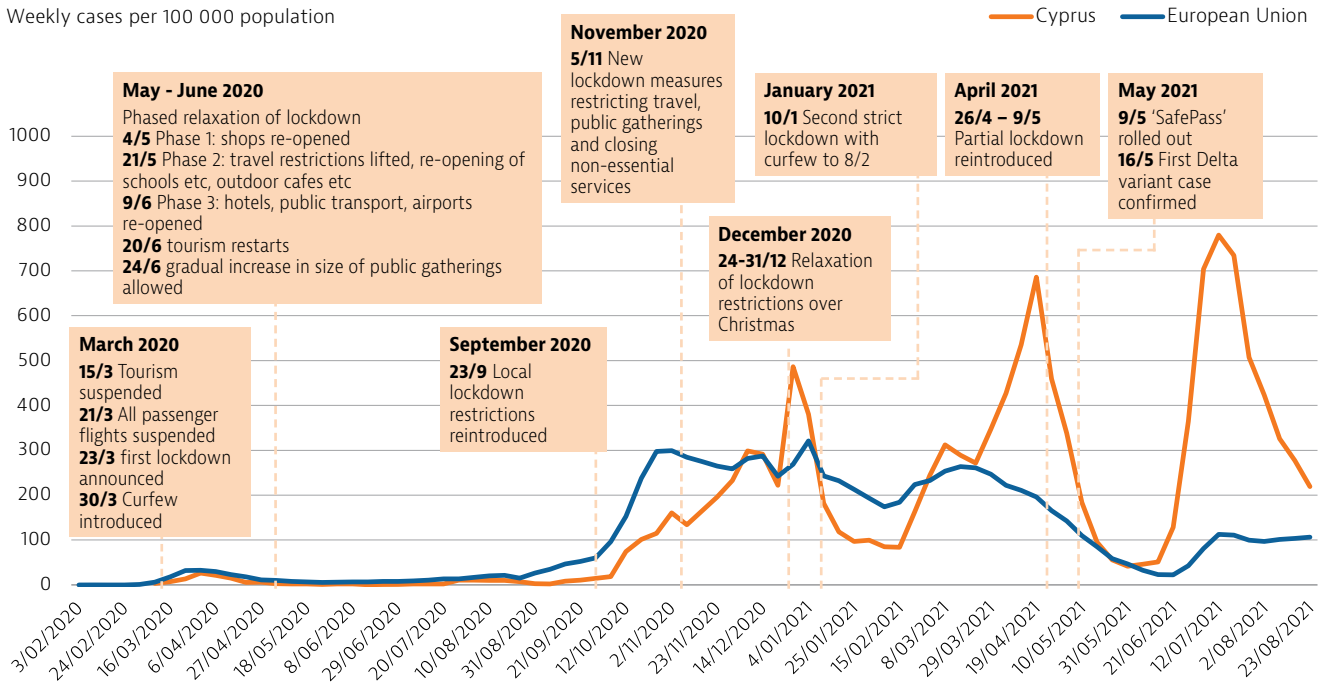
Cyprus responded to the pandemic with a variety of containment measures

Official advice regarding the necessary personal preventive measures against COVID-19 – such as hand hygiene, respiratory etiquette and social distancing – was issued in January 2020, before the first cases in Cyprus were recorded on 9 March 2020. After this, international travel restrictions were implemented, schools closed and mass events cancelled. The first lockdown was announced on 23 March 2020, with restrictions on unnecessary travel and the closure of most shops, but as these rules were widely flouted, a much stricter curfew was introduced from 30 March 2020.

After the first wave peaked in April 2020 (Figure 15), a phased gradual lifting of restrictions began in May 2020, and the country reopened to tourists from low-risk countries in June 2020. Despite the implementation of new emergency measures in November 2020 (including limiting indoor gatherings to 10 people) the rise in new cases continued until early January 2021, when Cyprus went back into full lockdown. Schools and shops reopened at the beginning of February 2021. Despite the continuation of many other restrictions, the number of new cases remained consistently high, with increasing numbers of hospitalised patients pushing the health care system very close to its limits, especially in terms of availability of intensive care beds. In response, a two-week partial lockdown was introduced on 26 April 2021. This lockdown was replaced by the "safe pass" system, whereby entrance to hospitality venues was dependent on showing a pass confirming that the recipient had had a negative test in the past 72 hours, had recovered from COVID-19 in the past six months or had received at least one dose of vaccine. This system was due to be in place until 31 May 2021, but the Delta variant was also detected in Cyprus in May 2021. As infection rates continued to grow, the safe pass was made a longer-term measure and extended beyond hospitality venues – for example, it was required to use public transport.

3. *In this context, health system resilience has been defined as the ability to prepare for, manage (absorb, adapt and transform) and learn from shocks (EU Expert Group on Health Systems Performance Assessment, 2020).*

Figure 15. Cyprus managed to contain the COVID-19 infection rate initially



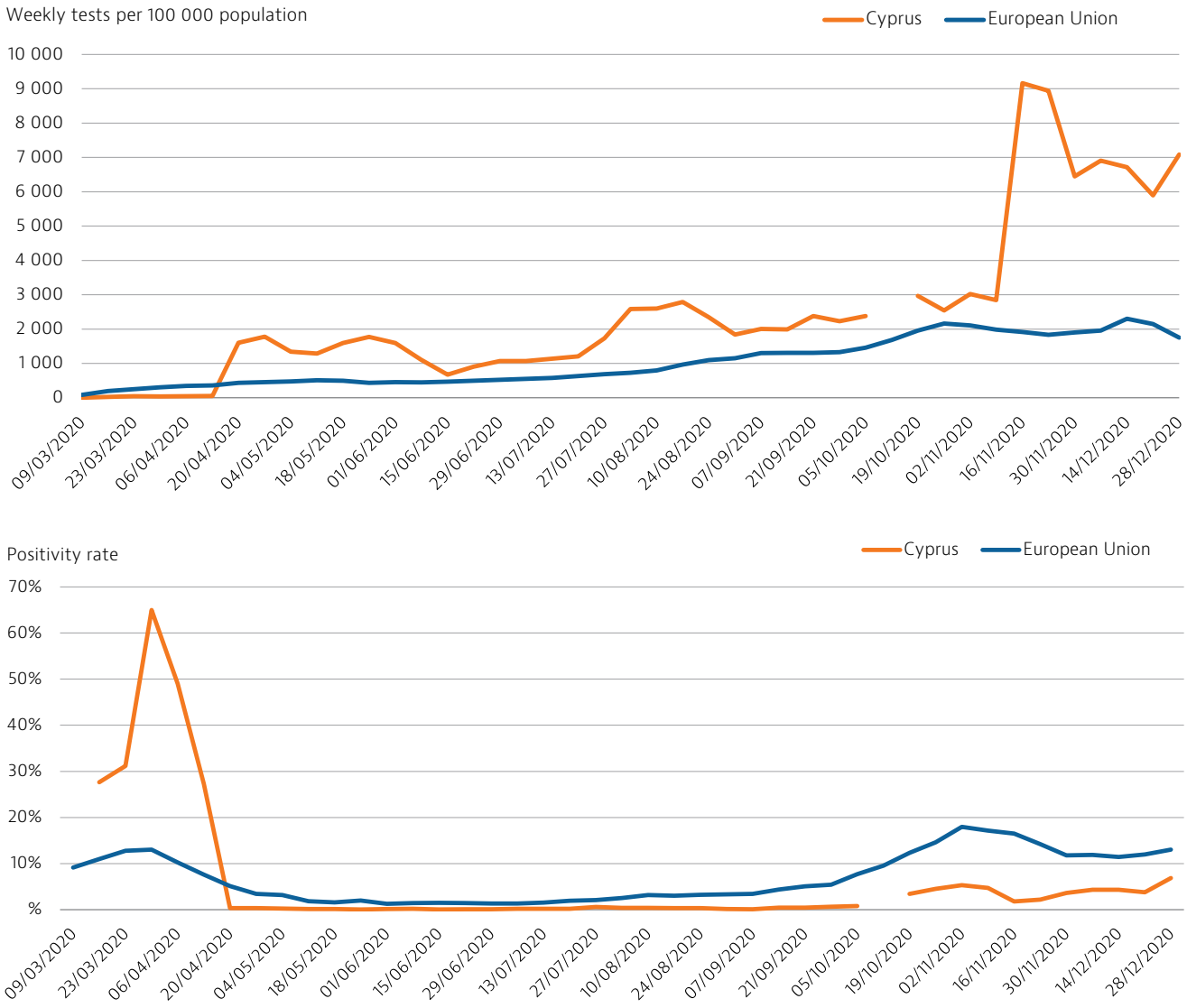
Note: The EU average is unweighted (the number of countries used for the average varies depending on the week).
Sources: ECDC for COVID-19 cases and authors for containment measures.

Cyprus managed to find the resources for testing, tracing and surge capacity in the health system

It was necessary to increase laboratory capacity rapidly in response to the COVID-19 pandemic. Initially, all tests were conducted in one centre – the Cyprus Institute of Neurology and Genetics in Nicosia – but testing capacity was expanded using the hospital network: one public hospital laboratory and 11 private ones were swiftly contracted to perform PCR testing. By mid-April 2020, Cyprus had one of the highest testing rates per capita in the EU (Figure 16) – much higher than other EU countries with small populations such as Malta and Estonia. Once testing had been scaled up, the positivity rate dropped accordingly. As of 24 May 2020, 12 % of the population had been tested. In the second wave, laboratory testing was supplemented by widespread use of rapid testing and random sample testing to identify local outbreaks in particular settings. In August 2020, random sample testing was conducted by mobile laboratory units. Cyprus also shared samples with the ECDC to monitor which strains and variants of COVID-19 were in circulation.

The strategy for the gradual easing of restrictive measures from 1 February 2021 was based on the three pillars of testing, tracing and vaccinating. As with testing, surveillance capacity had to be scaled up rapidly alongside expanded testing capacity. The Ministry of Health worked alongside municipalities to investigate outbreaks at the local level, and recruited many people to assist the Epidemiological Surveillance and Control of Infectious Diseases Unit with contact tracing and further testing. Through this tracing and surveillance work, they found that many of the chains of transmission started at social gatherings and events, such as private parties and weddings. By October 2020, as case numbers increased, it had become difficult to maintain contact tracing for every new case. In response, people who tested positive were asked to inform their close contacts themselves and tell them to isolate. If a close contact developed symptoms before the Unit had traced them, they were instructed to contact their personal doctor in the first instance.

Figure 16. Testing rates were so high in the second wave that the positivity rate remained low



Note: The EU average is weighted (the number of countries used for the average varies depending on the week).
Source: ECDC.

Primary care providers played an important role in detecting and treating COVID-19 cases

Personal doctors were the first point of contact in the system; they referred patients for check-ups and testing at one of six special COVID-19 clinics that were set up across the country as part of the pandemic response, which operated by appointment only. Personal doctors also provided remote care (by telephone) at home for COVID-19 patients who did not require inpatient care. From November 2020, if a personal doctor was concerned about worsening symptoms, they could refer the patient to special COVID-19 clinics that were opened in all public hospitals. Patients were assessed and either received outpatient treatment and returned home or were sent by public ambulance to the reference hospital for admission if required. Health workers in these clinics had the necessary personal protective equipment (PPE) to treat COVID-19 cases safely.

Flexibility in the system enabled the development of surge capacity during the pandemic

The introduction of the General Healthcare System in 2019 provided much more flexibility in planning surge capacity and contracting with private providers to maintain access to routine emergency care while coping with the extra demand for inpatient care (see Sections 4 and 5.2). Availability of acute care and intensive care unit (ICU) beds was not at risk during the first wave of COVID-19. As in many countries, Cyprus increased its ICU capacity during the first and second waves of the pandemic. In May 2020, a new ICU was constructed at Nicosia General Hospital,

with a capacity of 28 beds, increasing the operational capacity of the public system in intensive care. In the second wave, 54 beds were available in ICUs for COVID-19 cases, and usage reached 39 beds around mid-January 2021. Consequently, a revised plan was formulated in February 2021 for deployment of more beds and recruitment of staff so that the system could be ready to face a possible third wave. This plan addressed the worst case scenario, with a large number of cases. It provided for the deployment of 100 beds in addition to the current 200 in wards and around 65 active beds in ICUs allocated to the treatment of COVID-19 patients. Nurses would be redeployed from other departments and doctors would be contracted from the private sector to provide surge capacity as needed.

To secure sufficient health workers, the Ministry of Health used a variety of strategies, including reallocating health professionals within the public health sector; recruiting doctors in specific specialties; recruiting final-year medical and nursing students to support health professionals; loosening requirements and accelerating procedures for faster recruitment of additional staff on short-term or temporary contracts; and deployment of volunteers in contact tracing, telephone inquiries and appointment scheduling for PCR testing at public health centres. To maintain staffing and capacity for the treatment of COVID-19 patients, planned elective care in both private and public hospitals was also rescheduled. In the first wave, a key challenge was also ensuring adequate staffing levels when so many health workers were becoming infected with COVID-19. Covering for health workforce absences was therefore a priority in planning the vaccination strategy for Cyprus.

Cyprus put mechanisms in place to ensure that stocks of personal protective equipment did not run out

Cyprus entered the pandemic with sufficient stocks of PPE, but as global shortages became apparent in February 2020, the government purchased and imported medical equipment, PPE and other consumables directly from Chinese suppliers. It took advantage of donations from many private companies and individuals, and the Ministry of Health also participated in the EU Joint Procurement initiative for PPE and other equipment. In an effort to avoid shortages of PPE, in mid-February 2020, the Ministry of Health set specific guidelines regarding the appropriate use of PPE, and established a central management team to coordinate, monitor and control national supply and demand. Both stock and distribution are centrally controlled through the Ministry.

The rollout of the COVID-19 vaccination programme started at the end of December 2020

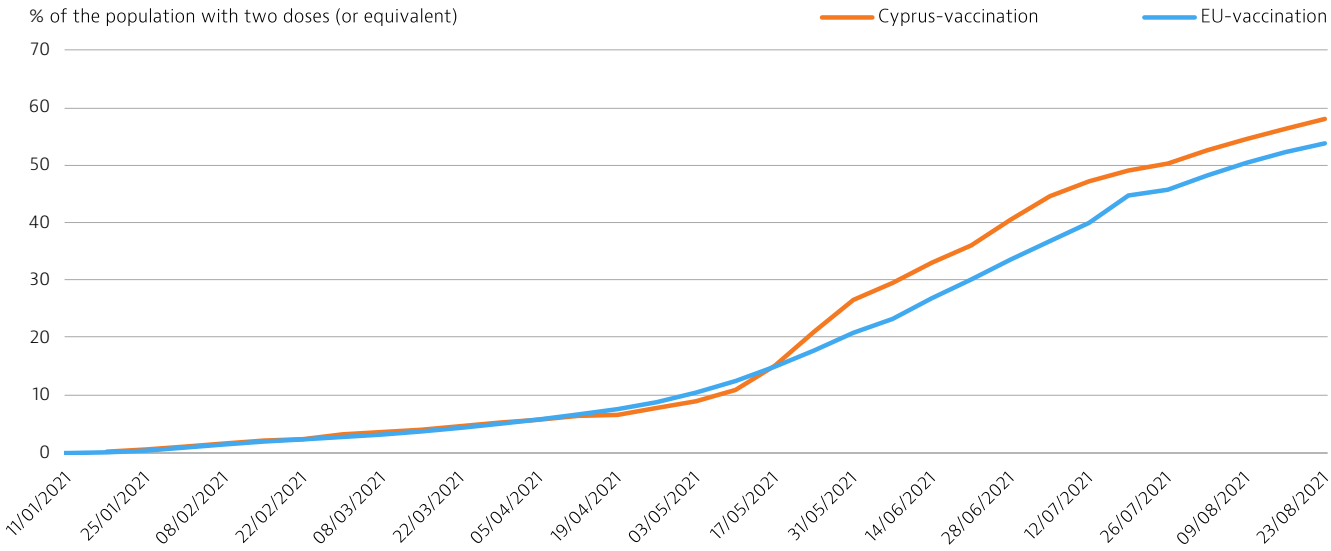
After testing and tracing, the third pillar of the strategy for gradual easing of restrictive measures was vaccination. The government sought to procure enough vaccines to cover the whole population of the island. The main goal was to reach vaccination coverage of over 40 % by the end of the first half of 2021, provided vaccines were received as planned. Cyprus joined the central procurement procedures of the European Commission for pre-purchasing, and started to receive vaccines following licensing by the European Medicines Agency. By 17 April 2021, over 200 000 people had received at least the first dose of a COVID-19 vaccine (about 24 % of the total population). By the end of August 2021, 59 % of the population had received two doses of vaccine or equivalent, which is above the EU average (Figure 17). The National Vaccination Plan set out the priority groups based on the epidemiological situation, with those most at risk vaccinated first (Box 5).

Box 5. COVID-19 vaccinations were rolled out by priority group

In late December 2020, COVID-19 vaccination began with residents and staff in nursing homes and long-term care facilities, as well as for health professionals working in reference hospitals for COVID-19, ICUs, emergency departments and the ambulance service. This was followed by age groups - those over 80, then those over 75 – and then people with a high risk for severe disease. Next were people working in health services, then residents in prisons and other closed structures, followed by the rest of the population.

Source: COVID-19 Health Systems Response Monitor.

Figure 17. Vaccination coverage in Cyprus was above the EU average at the end of August 2021



Note: The EU average is unweighted (the number of countries used for the average varies depending on the week).
Sources: Our World In Data.

Vaccination is voluntary and free of charge to all – even those not covered by the General Healthcare System. The National Vaccination Plan provided for 38 vaccination centres in primary health care centres and other designated facilities. Mobile units supported the onsite vaccination of health professionals (in both private and public facilities), and could travel to remote areas and closed structures. The opening hours of vaccination centres were extended, with all health professionals working overtime to increase the vaccination rate and coverage. In mid-February 2021, procedures for the voluntary vaccination of bedridden patients also began. All COVID-19 vaccines are administered by trained health professionals (usually health visitors), who are also responsible for administering the routine vaccination schedule.

Health information systems still need strengthening, but have coped well

Despite problems with the collection of data and analysis of quality indicators in the health system (see Section 5.1), the COVID-19 response in Cyprus and vaccination rollout show that the General Healthcare System has succeeded in reducing fragmentation in the system and enabled greater flexibility in meeting the demand for health services. The Health Insurance Organisation began development of a new health information system in 2017, which is an important part of this process.

Data flows are all centralised in the Ministry of Health – the Epidemiological Surveillance and Control of Infectious Diseases Unit is responsible for testing and contact tracing, as well as international reporting. The information systems used for public health monitoring and surveillance have also been shown to be robust and responsive. Real-time data were available for the development of COVID-19 response policies and decision-making. Improving data completeness and data quality will support more in-depth health system performance assessment. It would also enable Cyprus to engage more fully with the European Health Data Space initiative (European Commission, 2021b), which aims to promote health data exchange and support research on new preventive strategies, as well as on treatments, medicines, medical devices and outcomes.

Following the pandemic, substantial investment in the Cypriot health system is planned

As part of its National Recovery and Resilience Plan for the period 2021-26, which will be funded by the EU Recovery and Resilience Facility and the state budget, Cyprus has targeted areas of investment to modernise key elements of the health system (Republic of Cyprus and European Union, 2021). The plan consists of EUR 1 billion in grants and EUR 200 million in loans, including major investments in the public health information system (EUR 5.7 million), upgrading of both public and private hospitals (EUR 46.1 million) and support to facilitate accreditation as part of quality assurance measures.

6 Key findings

- The Cypriot population enjoys good health overall, with one of the highest life expectancies in the EU. However, increases in life expectancy had slowed even prior to the pandemic, especially for women, and they stalled in 2020, although in most other EU countries life expectancy fell in 2020. Overall, official COVID-19 deaths accounted for 2 % of all deaths in 2020, but the higher number of excess deaths recorded in Cyprus that year suggests that the impact on mortality may have been larger.

- While death rates from cancer are lower than in the EU they still account for a considerable share of overall deaths. Lung cancer is the most common cause of cancer mortality among men, with tobacco consumption undoubtedly playing a major role in this. The National Cancer Strategy aims to improve data collection, prevention and service provision for cancer patients.

- Although mortality rates from preventable and treatable causes are relatively low overall, there are variations in access to different services that affect health outcomes. For example, although cervical cancer screening rates compare well with the EU average, despite the existence of a national screening programme, only about 31 % of women aged 50-69 had been screened for breast cancer in the past two years in 2019 – far below the 59 % screening rate across the EU.

- Cyprus has been successful in implementing long-awaited reforms bringing universal health coverage. These unified a previously fragmented system that had serious problems, including an imbalance of resources between public and private providers, high out-of-pocket payments, large inequalities in access, long waiting lists and inefficiency of the health system overall. Concerted reform efforts meant that, despite the COVID-19 pandemic, the new health system became operational in 2020 and out-of-pocket payments have reduced considerably.

- The implementation of the General Healthcare System from 1 June 2019 provided much more flexibility in planning surge capacity by being able to contract freely with private providers to maintain access to routine emergency care while coping with the extra demand for inpatient care in the public sector. Doctors and nurses working in the private sector were also contracted to work in public hospitals as part of the surge capacity needed to cope with the burden of COVID-19.

- While reported levels of unmet needs are slightly lower than the EU average, they are much higher for low-income groups than for high-income groups, indicating barriers to access for those who cannot afford to pay privately and instead have to join a waiting list. Both reducing high levels of out-of-pocket spending and tackling long waiting lists were key drivers for the introduction of the General Healthcare System.

- To get back to normal and fully reopen its borders for tourism, Cyprus has focused on a policy of testing, tracing and vaccinating. The vaccination campaign started in late December 2020 and initially focused on the highest-risk groups, but subsequently expanded to all adults. Coverage kept pace with the EU average and then surpassed it.

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Country abbreviations

Austria	AT	Denmark	DK	Hungary	HU	Luxembourg	LU	Romania	RO
Belgium	BE	Estonia	EE	Iceland	IS	Malta	MT	Slovakia	SK
Bulgaria	BG	Finland	FI	Ireland	IE	Netherlands	NL	Slovenia	SI
Croatia	HR	France	FR	Italy	IT	Norway	NO	Spain	ES
Cyprus	CY	Germany	DE	Latvia	LV	Poland	PL	Sweden	SE
Czechia	CZ	Greece	EL	Lithuania	LT	Portugal	PT		

European Commission

State of Health in the EU
Country Health Profile 2021

The Country Health Profiles are an important step in the European Commission's ongoing *State of Health in the EU* cycle of knowledge brokering, produced with the financial assistance of the European Union. The profiles are the result of joint work between the Organisation for Economic Co-operation and Development (OECD) and the European Observatory on Health Systems and Policies, in cooperation with the European Commission.

The concise, policy-relevant profiles are based on a transparent, consistent methodology, using both quantitative and qualitative data, yet flexibly adapted to the context of each EU/EEA country. The aim is to create a means for mutual learning and voluntary exchange that can be used by policymakers and policy influencers alike.

Each country profile provides a short synthesis of:

- health status in the country
- the determinants of health, focussing on behavioural risk factors
- the organisation of the health system
- the effectiveness, accessibility and resilience of the health system

The Commission is complementing the key findings of these country profiles with a Companion Report.

For more information see: ec.europa.eu/health/state

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