2. Keynote address

Lobbying at EU level, what kind of trends did we see over the last two decades?

Professor Justin Greenwood

#AIM20yearsBxl
Advocacy & Stakeholder involvement in the EU: 20 years perspective

Justin Greenwood
(1) The EU shall be founded on representative democracy

(3) Every citizen shall have the right to participate in the democratic life of the Union. Decisions shall be taken as openly and as closely as possible to the citizen
Treaty on European Union:
Art. 11, 1-2

- The institutions shall.. give citizens and representative associations the opportunity to make known and publicly exchange their views in all areas of Union action

- The institutions shall maintain an open, transparent and regular dialogue with representative associations & civil society
A ‘Brussels bubble’

- A diverse range of advocacy organisations set up offices in Brussels, for many different causes, acting as a proxy for ‘civil society’

- operating in a ‘market-place of ideas’, a public dialogue with EU institutions

- 1992: An Open & Structured Dialogue between the Commission and Special Interest Groups
A public dialogue between EU institutions & advocates:

- **Funding for NGOs**

- **Transparency regimes:**
  - **Access to Documents**
  - **Transparency Register & code**
    - heavily incentivised by COMM & EP
    - current & future restrictions on non-registered organisations

- **Consultation instruments**
THE EU INSTITUTIONS PERFORM POORLY

When assessed against international standards and emerging best practice, the three EU institutions on average achieve a score of 36 per cent. This is particularly worrying, given that Brussels is a hub of lobbying in Europe and decisions made in the Belgian capital affect the entire region and beyond.

Of the three institutions, the Council of the European Union performs the worst, partly due to the fact that it is not covered by the voluntary EU Transparency Register.

Reform of the Transparency Register is urgently required, not only to increase its coverage to the Council of the European Union, but also to make it mandatory and to ensure that there are meaningful sanctions for breaches of lobbying and transparency rules.

To increase decision-making transparency in all the core institutions, effective “legislative footprints” should be created: a document that details the time, person and subject of a decision-maker’s contact with interest group representatives.

Only when sufficient mechanisms and safeguards are in place to ensure that lobbying across Europe and at the EU-level is done in a clean, transparent and fair manner, can citizens know what interests are behind the legislation that affects their daily lives, safety and well-being.

Co-funded by the Prevention of and Fight against Crime Programme of the European Union
EU institutions need dialogue with civil society

- Information
- Political supporters & messengers
- Approval
The consensual nature of EU politics

- 3 decision making institutions
  - well insulated from pressure
- 8 political parties in the EP
- 28 Member States in the Council
- Diversely constituted Commission
- Consensual outcomes
- Broadly based alliances work well
COMM shift from market making to regulating

capital divided by interests on regulation
  by industry, within industry, within a multinational

EP:
  takes public interest positions on politicised issues
Reflections from key AIM figures
How it all began in 1998

Geert Jan Hamilton
Honorary President of AIM

#AIM20yearsBxl
AIM’s first important Brussels file: cross border healthcare

Willy Palm
AIM Executive Director 1998-2006

#AIM20yearsBxl
20 years AIM in Brussels
AIM’s first important Brussels file: cross border healthcare

Willy Palm, Senior Adviser
Brussels, 15 November 2018
2018: an anniversary year
How it all began in 1998
In Case C-120/95,

REFERENCE to the Court under Article 177 of the EC Treaty by the Conseil Arbitral des Assurances Sociales (Luxembourg) for a preliminary ruling in the proceedings pending before that tribunal between

Nicolas Decker

and

Caisse de Maladie des Employés Privés

THE COURT

in answer to the question referred to it by the Conseil Arbitral des Assurances Sociales by decision of 5 April 1995, hereby rules:

Articles 30 and 36 of the EC Treaty preclude national rules under which a social security institution of a Member State refuses to reimburse to an insured person on a flat-rate basis the cost of a pair of spectacles with corrective lenses purchased from an optician established in another Member State, on the ground that prior authorisation is required for the purchase of any medical product abroad.

In Case C-158/96,

REFERENCE to the Court under Article 177 of the EC Treaty by the Cour de Cassation (Luxembourg) for a preliminary ruling in the proceedings pending before that court between

Raymond Kohl

and

Union des Caisses de Maladie

THE COURT

in answer to the questions referred to it by the Luxembourg Cour de Cassation by judgment of 25 April 1996, hereby rules:

Articles 59 and 60 of the EC Treaty preclude national rules under which reimbursement, in accordance with the scale of the State of insurance, of the cost of dental treatment provided by an orthodontist established in another Member State is subject to authorisation by the insured person's social security institution.
What healthcare services were meant by the Court?
Is private insurance also concerned?
In what respect can free choice of the patient be applied on a European scale?
Can health systems become out-balanced by an increased mobility of patients?
How can arguments of general interest justify an exception to the principles of free movement?
What will be left of the Member States’ competences in organising health care?

All these questions go beyond the scope of these single cases. They touch upon the relationship between internal market principles and social protection values.
After Kohll and Decker:
Smits-Peerboom, Müller-Fauré, Van Riet, Watts, ...
Cross-border care: a foot in the door
Dans le cadre de la présidence de l’Union européenne, 300 délégués d’une vingtaine de pays ont assisté à la conférence "L’Accès aux soins de santé dans un marché unique".

Le ministère de la Sécurité sociale a organisé en collaboration avec l’Association luxembourgeoise des organismes de sécurité sociale (ALOSS), le Conseil supérieur de la mutualité luxembourgeoise (CSML) et l’Association internationale de la mutualité (AIM), une conférence sur "L’Accès aux soins de santé dans un marché unique", qui se serait sur un rapport établi par le professeur Yves Jorens de l’université de Gand.

La conférence avait pour objectif de présenter une perception précise de l’impact du droit communautaire existant ou projeté sur les soins sanitaires et la protection sociale. Quelque 300 délégués d’une vingtaine de pays étaient présents durant toute la journée.

- "Il s’agit d’un sujet qui passionne et qui polarise des enjeux très importants avec la discussion autour de la directive des services dite directive Bolkestein. La présidence n’a pas caché sa position dans ce domaine.

Nous sommes convaincus que les services de santé représentent un service, mais pas comme tous les autres", explique Mars Di Bartolomeo, ministre de la Santé et de la Sécurité sociale.

Bien que le Conseil européen ait décidé de remodeler le projet de la directive Bolkestein, le problème reste entier.

Libre circulation des patients

"La situation actuelle demande qu’on se mette autour d’une table pour discuter. Les priorités du service des soins sont la qualité, le libre accès et la spécificité des soins", explique Mars Di Bartolomeo. "La libre circulation des patients est dans l’agenda. Nous les voyons dirigées vers les intérêts des patients. Si on ne trouve pas un soin dans son pays, alors on peut se diriger vers un autre pays de l’Union européenne. Ce n’est pas un prétexte pour la libre concurrence dans ce secteur", conclut-il.

Avant d’examiner en détail l’influence du marché intérieur sur les soins de santé, Yves Jorens, professeur de droit de sécurité sociale et de droit social européen, a analysé comment l’Union européenne a réagi, sur un plan politique, aux développements nationaux et européens en matière de soins de santé.

"Les soins sont devenus une activité économique qui pose pas mal de problèmes. L’application des règles du marché intérieur est un grand risque. Comment peut-on garantir des soins qui sont devenus un élément important, si on n’a pas un cadre législatif? C’est le message que nous voulons faire passer. Si on veut garder ce principe de base de la solidarité des services, l’intérêt général, la politique doit définir un cadre législatif pour les principes de base", lance Yves Jorens.

Lütt Stumper

> Le rapport d’Yves Jorens peut être consulté sur le site de la présidence www.ntl.etat.lu

Qu’est-ce que l’AIM?

L’Association internationale de la mutualité, créée en 1950, regroupe 44 fédérations nationales d’organismes autonomes d’assurance maladie et de protection sociale dans 31 pays du monde, tout opérant selon les principes de solidarité et de non-lucrativité.

"En ce moment, nous nous retrouvons face à de nouveaux défis. La population est de plus en plus vieillie et la technologie se développe de plus en plus vite. Le système de santé, peut-il se permettre les dépenses liées à ces phénomènes à l’avenir? Ensuite, les services de santé sont devenus de nouveaux acteurs économiques, ainsi qu’un combat de concurrence entre les différentes assurances. Assurez-vous d’avoir votre part et de ne pas en prendre trop", explique le président de l’AIM.

Pour plus d’informations, consultez www.aim-mutual.org.

Yves Jorens (v.l.n.r.), Michel Schmitz (CSML), Ron Hendriks (AIM), Mars di Bartolomeo, Chantal Lepage (ALOSS), Michel Schmitz (CSML), Ron Hendriks (AIM), Mars di Bartolomeo, Chantal Lepage (ALOSS)

27
Finding the right balance between competition that stimulates and solidarity that unites.

(Jacques Delors)
## Milestones

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998</td>
<td>First rulings Kohll &amp; Decker</td>
</tr>
<tr>
<td>2001</td>
<td>Smits-Peerbooms rulings</td>
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<tr>
<td>2002</td>
<td>Revision of the sickness benefits chapter of Reg. 1408/71 on social security coordination</td>
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<td>2003</td>
<td>Müller-Fauré/van Riet ruling</td>
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<td>2004</td>
<td>Report on the application of internal market rules to health services</td>
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<td></td>
<td>High level reflection process on patient mobility and healthcare developments in the EU</td>
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<td>2005</td>
<td>Commission proposal on services in the internal market</td>
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<td></td>
<td>Creation of the high level group on health services and medical care</td>
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<td></td>
<td>Adoption of Reg. 883/04 on social security coordination</td>
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<td></td>
<td>Introduction of the European Health Insurance Card</td>
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<td>2006</td>
<td>EP Report on patient mobility</td>
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<td>2007</td>
<td>Commission draft Regulation implementing Reg. 883/04</td>
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<td>2008</td>
<td>Exclusion of health services from the Services Directive</td>
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<td></td>
<td>Watts ruling</td>
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<td>2009</td>
<td>Council Statement on common values and principles in EU health systems</td>
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<tr>
<td>2010</td>
<td>EP report on the impact of the exclusion of health services from the Services Directive</td>
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<td>2011</td>
<td>Consultation process on Community action on health services</td>
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<td>2012</td>
<td>Adoption of the new proposal by the College of Commissioners</td>
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<tr>
<td>2013</td>
<td>Adoption of implementing Reg. 987/09 on social security coordination</td>
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<tr>
<td></td>
<td>First reading in EP</td>
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<td>2014</td>
<td>Monti Report on Single Market</td>
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<td></td>
<td>Commission/France ruling</td>
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<tr>
<td></td>
<td>Council adopts common position</td>
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<td></td>
<td>Second reading in EP</td>
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<td>2015</td>
<td>Adoption of the Patients’ rights Directive</td>
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<td></td>
<td>Transposition</td>
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</table>

Impact assessment expert panels on cross-border care (Brussels, May 2007)
EU integration and health
What does the European Union mean for health and health systems? More than one would think. The EU’s health mandate allows for a comprehensive set of public health actions. And there are other EU policies, though not health related, which have important consequences for governing, financing, staffing and delivering health services. In other words: EU actions affect the health of Europe’s population and the performance of health systems.

Given how important health systems are, we need an informed debate on the role of the EU and its contribution. But this is not easy because EU health policy is difficult to comprehend. There is no single strategy with a neat body of legislation implementing it; rather, there are many different objectives and instruments, some of which appear in unlikely places.

Understanding the EU role in health is especially important now, when health systems have to deal with a plethora of challenges, the European social model is confronted by the threat posed by the financial crisis, and the EU is facing increasing euro-scepticism in politics.

This short book makes EU health policy in its entirety (and complexity) accessible to political and technical debate. To this end the volume focuses on four aspects of EU health policy:

- the EU institutions, processes and powers related to health;
- the EU action taken on the basis of this health mandate;
- the non-health action affecting health and health systems;
- and, because of its growing importance, financial governance and what it means for European health systems.
REFERENCE to the Court under Article 177 of the EC Treaty by the Conseil Arbitral des Assurances Sociales (Luxembourg) for a preliminary ruling in the proceedings pending before that tribunal between

Nicolas Decker

and

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Raymond Kohll

and

Union des Caisses de Maladie

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Articles 59 and 62 of the EC Treaty preclude national rules under which reimbursement, in accordance with the scale of the State of insurance, of the cost of dental treatment provided by an orthodontist established in another Member State is subject to authorisation by the insured person’s social security institution.
Merci!
Recognition of mutuals, the red thread through 20 years in Brussels (1)

André Arnaudy
AIM Vice President 2000-2002

#AIM20yearsBxl
Recognition of mutuals, the red thread through 20 years in Brussels (2)

Pedro Bleck da Silva
AIM Vice President for Mutual Values
We want that too!

- In 2003, the Council adopted a regulation for a statute for Cooperatives.
We called with Regina Bastos, member of the EP...

- Public hearings
- Meetings
- Position papers
  - ....
Would the Panteia report be our life line?

- Lobby the researchers
We continued our lobby...

- Luigi Berlinguer, member of the European Parliament, was our next target
- Own initiative report
Lobbying the European Commission...

- Impact Evaluation Study
- New Panteia Report
- Public Consultation

“Pourquoi je n’ai pas ce dossier ?”
Lobbying the European Commission...

• At a hearing in the European Parliament

“I promise you a Statute for mutuals”
Since 2014...

- Strengthen the ties with the Social Economy Europe family
8. Presentation and possible approval of the AIM Declaration on Air Pollution and Health

The Board of Directors is asked to approve the AIM Declaration

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#AIM20yearsBxl

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Annex 3

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Brussels Declaration on air pollution and health

Brussels, 15 November 2016 - We, the undersigned representatives of the International Association of Mutual Benefit Societies, bringing together 59 members from 30 countries, representing 240 million people in the world, and 1.40 million in Europe,

Have adopted the following declaration to European policy makers:

- Taking note that air pollution is the leading environmental risk factor for health;

- Taking note that air pollution is a critical risk factor for non-communicable diseases (NCDs), causing an estimated one-quarter (24%) of all adult deaths from heart disease, 25% from stroke, 40% from chronic obstructive pulmonary disease and 29% from lung cancer;

- Taking note of the World Health Organization "Review of evidence on health aspects of air pollution" (REVHAAP), which concludes that health effects of air pollutants are lower at concentration levels than previously thought, and highlights that there are new associations with conditions such as diabetes, adverse birth outcomes and impacts on cognitive development;

- Taking note that according to WHO, nine out of ten people breathe air containing high levels of pollutants worldwide, leading to an alarming toll of 7 million early deaths from outdoor and household air pollution;

- Taking note that more than 90% of airpollution related deaths occur in low and middle-income countries, mainly in Asia and Africa, followed by low and middle-income countries of the Eastern Mediterranean region, Europe and the Americas, and that many of the world’s megacities exceed WHO air quality guidelines by more than 3 times;

- Taking note that in the European Union, air pollution continues to be an "invisible killer" with 400,000 premature deaths, and that the external health-related costs to society from air pollution are estimated to be in the range of €550-940 billion per year;

- Taking note that admission from coal power plants contribute significantly to the burden of disease, with impacts amounting to more than 13,000 premature deaths, about 8,500 new cases of chronic bronchitis, and over 4 million lost working days each year, and that the economic costs of the health impacts from coal combustion in Europe are estimated at up to €62.8 billion per year.

Brussels Declaration on air pollution and health

UPDATE OF THE BRUGES DECLARATION (27TH OF JUNE 2014)
Brussels Declaration on air pollution and health

Why a renewed declaration?

- Air pollution is the **leading environmental risk factor for health**
  - a critical **risk factor for noncommunicable diseases** (NCDs)
  - new associations with diabetes, adverse birth outcomes
  - an **increased risk of neurological disorders** (stroke, dementia and cognitive disorders)
  - an “invisible killer”: 400,000 premature deaths + **external health-related costs to society** estimated in the range of €330-940 billion per year in the EU alone
  - health effects of air pollutants occur **at lower concentration levels than previously thought**
Brussels Declaration on air pollution and health

Why a renewed declaration?

- Two examples:
  - emission from coal power plants cause more than **18,200 premature deaths**, about **8,500 new cases of chronic bronchitis**, and over **4 million lost working days** each year
  - exposure to **nitrogen dioxide** (NO₂), mainly from diesel vehicles, causes an estimated 75,000 till 229,000 **premature deaths in the EU** annually

- 22 out of 28 countries in the EU are currently in breach of air quality standards for particulate matter or NO₂

- Air pollution and climate change are intertwined

Healthcare mutuals and national health funds are deeply concerned about people’s wellbeing and bear increased health costs from air pollution → threat to the sustainability of healthcare systems as a whole
AIM calls on national and European decision-makers:

- to adopt **comprehensive and strict air quality standards**, in line with the health-based recommendations of WHO
- to adopt measures that **tackle both air pollution and climate change**
- to strengthen efforts to **bring down emissions of air pollutants from all sectors**, but particularly from transport in cities and coal plants
- to become more engaged in clean air efforts and this in all sectors of society according to the principles of **Health in all Policies** → to prevent diseases, to reduce healthcare costs and to improve the quality of life
9. Positive health in Belgium

Positive outcome of the AIM General Assembly in The Hague in 2016

Jean Hermesse,
Christian Mutuals in Belgium

#AIM20yearsBxl
Getting the concept of “Positive Health” alive

Jean Hermesse
Secrétaire Général
AIM Conference 2018
Brussels
Invest more in health care does not necessarily increase health of all because health care impact health, life expectancy with only 10 to 25% maximum.

The WHO defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.
Instead of a negative definition of health with health as an aim, a requirement, let us look at health as a mean, a leverage for a life of quality, a meaningful life!

Positive health becomes “the ability to adapt oneself and have control, in face of social, physical and emotional challenges” and this ability, capacity can be exercised in 6 dimensions.
The six main dimensions of health:

- Bodily functions
- Mental functions & perception
- Spiritual-existential dimension
- Quality of Life
- Social & societal participation
- Daily functioning
MY POSITIVE HEALTH

BODILY FUNCTIONS
- Feeling healthy
- Feeling fit
- Having complaints and/or pain
- Sleeping pattern
- Eating pattern
- Physical condition
- Exercise

DAILY FUNCTIONING
- Looking after yourself
- Knowing your limitations
- Knowledge of health
- Managing time
- Managing money
- Being able to work
- Asking for help

MENTAL WELL-BEING
- Being able to remember things
- Being able to concentrate
- Being able to communicate
- Being cheerful
- Accepting yourself
- Being able to handle changes
- Having control

PARTICIPATION
- Social contacts
- Being taken seriously
- Doing fun things together
- Having the support of others
- Belonging
- Doing meaningful things
- Being interested in society

MEANINGFULNESS
- Having a meaningful life
- Being high-spirited
- Wanting to achieve ideals
- Feeling confident about
- Accepting life
- Being grateful
- Continue learning

QUALITY OF LIFE
- Enjoyment
- Being happy
- Feeling good
- Feeling well-balanced
- Feeling safe
- Living conditions
- Having enough money
An old person, a chronic ill patient, a handicapped person can feel oneself well because he/she adapted herself to the situation. One can make progress in other dimensions than only physical and mental.

The individual capacities, abilities can be developed through actions, services, the environment, culture to create space for development toward 6 dimensions, And it seems to work ...
Internal debate on the consequences

- For the priorities of Health Policy
- For strategic development of Sickness Fund
New perspective in terms of Health Policy

- More “health in all policies” (mobility, public transport, work conditions, housing, LEF food, energy, climate, …)
- Integrate « positive health » in health care
- Importance of « non medical » partners
- Creation of an « Institute for Positive Health » open to all partners
From Sickness Fund to Health Fund
Promote services and activities in the six dimensions of Positive Health
Work with local Networks to promote Positive Health
Development of support and coaching with the aim of health and well-being promotion
New associate partner
Inter Mutuelles Assistance (FR),
Martine Carlu-Benasich, Director Healthcare Assistance
PÔLE SANTÉ, BIEN-VIVRE
Assistance routière, voyage ou bien médicale, habitation, santé et prévoyance, le Groupe IMA propose une gamme complète de services pour garantir le bien-être et la satisfaction de vos clients. Et cela toute l’année, de jour comme de nuit.

- Création en 1981 à Niort
- Actionnariat issu de l’économie sociale et solidaire
- IMA, la référence en matière d’assistance...

**LE GROUPE IMA**

- 3 380 collaborateurs
- 6 filiales internationales
- +55 000 prestataires

**DÉPLACEMENT**  **HABITAT**  **SANTÉ, BIEN-VIVRE**

**DE L’ASSISTANCE D’URGENCE À L’ACCOMPAGNEMENT DANS LA DURÉE**
LE PÔLE SANTÉ, BIEN-VIVRE
UNE APPROCHE GLOBALE DE LA PERSONNE

SANTÉ AU QUOTIDIEN
Expertise médico-sociale
Portrait web IMA Santé
Soutien hospitalisation / immobilisation / maladies chroniques
Téléconsultation

PARCOURS DE SANTÉ
Conseil et orientation
Prévention
Évaluation
Coaching motivationnel
Coordination de parcours
Plateforme de services QVT

ASSISTANCE À DOMICILE
Télé-assistance
Soutien vie quotidienne
Adaptation du logement
Aide sociale et financement
Formation et accompagnement des aidants

ARCHITECTE DE SOLUTIONS DE PRÉVENTION ET D’ACCOMPAGNEMENT DES PERSONNES DANS LEUR PARCOURS DE VIE ET DE SANTÉ.

83M€ CHIFFRE D’AFFAIRES
+350 COLLABORATEURS
90,6% SATISFACTION GLOBALE
PÔLE SANTÉ, BIEN-VIVRE
New associate partner
Cyprus Health Insurance organisation, HIO
Athos Tsinontides, acting Director General
The Cyprus General Health System
Athos Tsinontides
Acting Director General

AIM Board of Directors Meetings
Brussels, 14-16 November 2018

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Where we are!
Health Insurance Organisation (HIO)

HIO is a public legal entity. Its mission is the implementation of the General Health System (GHS) and its main responsibilities include monitoring and managing the System in order to promote social solidarity, equal access and efficient use of resources.

HIO is governed by a 13 member Board of Directors, with quadrilateral representation (Government, Employers, Employees and Patients):

- Chairman*
- Director General, MoH
- Director General, MoF
- Government - 2 members
- Employers - 3 members
- Employees - 3 members
- Self employed - 1 member
- Patients - 1 member

The composition of the BoD provides autonomy and protection from political interventions and promotes consensus in decision making.

* Appointed by the Ministerial Council
**Main Characteristics**

**Universal**
- Coverage of the whole population regardless of income and health status

**Social**
- Contributions based on income

**Solidarity**
- Healthy population for the sick
- The affluent for the poor

**Accessible**
- Equity in the access of beneficiaries
- Free choice of providers in public and private sector

**Comprehensive**
- Provision of complete health care package
GHS Beneficiaries

Republic of Cyprus Citizens
who have their ordinary residence in the areas controlled by the government of the Republic of Cyprus

European Union Citizens
who have their ordinary residence and work in the areas controlled by the government of the Republic of Cyprus or have acquired the right of permanent residence.

Third Country Nationals
Who have their ordinary residence in the areas controlled by the Republic of Cyprus and meet the provisions of the Cyprus National Law.

Other categories
under certain conditions
Financing the GHS

- Employees
- Employers
- Self-employed
- Pensioners
- Other income earners
- Officials
- State
- Patients

GHS Fund

- Personal Doctors
- Outpatient Specialists
- Laboratories
- Nurses, midwives, clinical psychologists, clinical dieticians, physiotherapists, occupational therapists, speech language therapists
- Hospitals
- A&E
- Ambulance
- Pharmaceuticals

Contributions- Co-payments

Claims

Global Budget
The GHS contributor categories and the contribution percentages

<table>
<thead>
<tr>
<th>CONTRIBUTORS</th>
<th>March 2019*</th>
<th>March 2020**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employees</td>
<td>1.70%</td>
<td>2.65%</td>
</tr>
<tr>
<td>Pensioners</td>
<td>1.70%</td>
<td>2.65%</td>
</tr>
<tr>
<td>Any other income</td>
<td>1.70%</td>
<td>2.65%</td>
</tr>
<tr>
<td>Officials</td>
<td>1.70%</td>
<td>2.65%</td>
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<tr>
<td>Self-employed</td>
<td>2.55%</td>
<td>4.00%</td>
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<td>Employers</td>
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<tr>
<td>Government</td>
<td>1.65%</td>
<td>4.70%</td>
</tr>
</tbody>
</table>

There is a maximum annual income of €180,000 on which contributions are payable.

* Contribution percentages which will apply from 1st March 2019 for outpatient services
** Contribution percentages which will apply from 1st March 2020 for the full GHS implementation
With the General Health System we achieve:

- Financial protection,
- Equal access,
- Free choice of doctor,
- Quality healthcare services,
- Reduction of waiting lists,
- Prevention and detection of disease
- Comprehensive package of healthcare services,
- eHealth

The right to Universal Health Coverage
GHS implementation timeline

1st Phase
June 2019

Outpatient health services
- Personal Doctors for adults and children
- Outpatient Specialists
- Pharmacies and pharmaceuticals
- Laboratories

2nd Phase
June 2020

Full GHS implementation
- Inpatient care
- Accident & Emergency and Ambulance
- Nurses, Mid-wives and Allied Health Professionals
- Palliative care and Rehabilitation