

1 EXECUTIVE SUMMARY

Socio Economic Geopolitical Mapping

The Republic of Tunisia has been engaged in economic and sector reform over the past two decades. On the economic level, the country went through the most prospect growth in its history in the late 1990s and early 2000, followed by the application of very comprehensive structural reforms in the last 15 years. Although the five years plan of development has been largely successful from a macro-economic point of view, GDP is still growing at annual rate of 5%, so some impressive growth and poverty reducing is somewhat observed¹.

Tunisia has pursued an ambitious reform program with the collaboration of international agencies to restore macro-economic stability, reduce debt burden, and boost growth. The reform has achieved external and internal balances in an environment of price stability and contributed to economic recovery after a financial crisis and a "stagflation" phase in late 1980s. Furthermore, the reform has resulted in the buildup of foreign exchange reserves and alleviating the debt problem. This broadly positive reform outcome, however, hides wide variations in performance and outcome sustainability. One of the noticeable and most resilient accomplishments of Tunisia's stabilization program is unemployment stability. Also, growth performance and hence poverty profiles, fell below expectations.

In 2000 Tunisia signed the GATTs agreements and made a large number of commitments related to dismantling the limitations on market access to its network industries, which joins the others agreement like GATT, European Union and Maghreb Union. Otherwise, Basic Socials services are usually defined as priority axes of the development policy (human resources development: ensuring the essential food consumption, education, health, social security, poverty reduction, employment...). Public expenditures on social services are evaluated at around 20 % of GDP, where health receives 2.73% from state budget. For the last three years (2002-2004), the percentage increase of health expenditures is evaluated to 5.4% annually.

Health status and demographics

Tunisian's population has increased tenfold since 1956, from slightly over three (3) million to more than ten (10) million today. This increase is accounted for by the high natural population growth rates with high fertility and low mortality rates in the three decades after independency. However, these fertility rates began to decline in the 1990s (2.5). Crude birth rates declined from 50 per 1000 in the 1956s to 25.2 per 1000 in the 1990s to 16.8 per 1000 in 2004. Similar trends are also observed for death rates. These trends have contributed to significant decline in population growth rates from 3.5% in 1956 to 2.4% in 1994 and to 1.08% in 2004. This rate will be, according to United Nations division of population (2004), 0.87 % for the coming period 2020-2025.

The population structure of ages has deeply modified over the last years: Tunisia is going probably to rapidly aging. At the horizon of 2020, given the United Nation division of population estimation (2004), the number of the persons older than 60 years will increase to 12.5% while it was 9.5 % on 2004 and 6.7 % on 1984. Rapid growth made possible a remarkable improvement in social and health indicators and a decline in the poverty rate from 40 percent in 1970 to 3.9 percent in 2004.

Health indicators registered substantial progress to achieve the health and nutrition-related Millennium Development Goals. Life expectancy at birth has reached 73.1 years,

reflecting the epidemiological transition during the past decades. The decline of the infant mortality rate is the most important progress accomplished, decreasing from 41 (1990) to 21 (2002). During the last 44 years, Tunisia has the highest life expectancy at birth when compared to MENA region countries and the gap continues to increase, approaching OECD countries.

The epidemiological profile of Tunisia is not the same, as observed at the end of 1980 decade. We currently observe a net recession of communicable diseases and the eradication, a dominance of non communicable diseases and recrudescence of injuries and accidents. In 2002, non communicable diseases represent 79.7% of deaths and 70.8% of the burden of morbidity. The emergence of chronic diseases is related to social transformations, changes in lifestyle and in socio-economic conditions.

Health System Organization

The Tunisian health system, mainly governed by the MoPH and its regional directorates is dominated by a strong public sector. However, since the end of 1980s, a rapid growth of the modern for profit private sector is registered, especially in the inpatient care.

Tunisian's population of 9.910 million (2004) is served by public health facilities, according to pyramidal scheme: 2068 PHC centers, 118 district hospitals, 32 regional hospitals and 22 teaching hospitals. These facilities are state owned and employ health professionals as civil servants. Private sector is dominated by for single practises physicians and provides ambulatory care. The private facilities have followed credit-worthy demand and have set up in Greater Tunis, central-eastern areas and the coastal regions.

Evolution of public infrastructure is strongly regulated by the five-year plans of economic and social development which define health public sector investments and by the annually investment and operational budgets. In the private sector, few facilities are submitted to certification of needs such as heavy equipments, haemodialysis centres or retail pharmacies. Health sector financing is carried by three stakeholders: the state budget, the social security funds and the households. The budget subsidies cover the public facilities' needs while the private sector is mainly financed by the households increasingly requested to direct finance their own expenditures. The social security contribution is essentially oriented to the public sector although an increasing contribution in the private sector.

Over the last years, public sector sets up many organisational measures, where the MoPH tried to develop and enhance higher levels of management autonomy, especially in the teaching hospital's, targeting more flexibility in day-to-day operation and strategic planning, associating closely the health professionals. Later, MoPH implemented accompaniment measures focusing on emergencies' management, quality assurance, information system, payment mechanisms with social security funds and incentives to specialist physicians to exert in prior regions.

Governance/Oversight

For the private sector, there are a many legal rules which set standards and norms for equipment, buildings and staff, as well as norms of facilities functioning. The control and respect of norms is ensured by MoPH inspection departments. Cabinets for health professionals' practice, including laboratories and medical imaging, as well as inpatient care facilities aren't submitted to certification of needs.

MoPH supervise the health sector, through its departments of planning, of legal and juridical procedures and inspection. However, professional orders of medical doctors, dentists and pharmacists are also allowed to supervise in some defined activities. The National Health Insurance Fund will have competences of monitoring of health care

services provided to social insured patients and it will introduce new contractual rules with health providers, worked out and implemented with MoPH collaboration.

In Tunisia, until now there are no accreditation mechanisms for both public and private sector. However, various factors and reasons (mercantile) have motivated some private facilities to get "certifications" from foreign organizations. Generally, the management of health sector is centralized, even with the multiple attempts to decentralization at regional departments of public health or hospital level. It remains delegation of tasks than a real delegation of power. The mechanisms of accountability in the Tunisian health system are relatively weak due to two main reasons: the scarcity of professional's norms of practice and the absence of a dedicated institution for autonomous evaluation, recognized by professionals and authorities.

The current legislation authorizes public health facilities to use private suppliers of services or engineering. These suppliers can be private health professionals, private health facilities or private companies specialized on non technical fields. Outsourcing of non clinical activities: cleaning, housekeeping, meals and others activities is allowed and practised in a large scale.

Health Care Finance and Expenditure

Total health expenditures per capita are evaluated around 150 USD per capita (2004) and around 5.6% of the GDP. The Tunisian health care financing system is a combination of social insurance, general revenue, and out-of-pocket payment. In the 2000s, the household and state share is estimated respectively to 50% and 26% while social security contributes with 24% of total health financing. Private insurance plays only a very limited role.

Until the end of 1980s, the health expenditure was mainly supported by State budget (50%) and incidentally by social security funds (15%). During this period, the expenditure share of public funds is nearly 65%. The financial crisis (second half of 1980s decade) and the socioeconomic programs of structural adjustment plan have reduced the expenditure share of the State, relayed firstly stage by an important increase of household expenditures and secondly by a small increase on social security expenditures. For the period 1995-2004, health expenditure is equally supported by public funds (State and Social security funds) and private funds (out of pocket -direct payment of households- and complementary and private health insurance).

User fees were instituted, in the public sector, since 1983 and constitute ever since a financial resource in the running budget of health facilities. Their amounts were revised with an upward tendency, especially in the 1990s. For the poor population, as identified by social affairs departments, care in public sector facilities is free of charges. Paying these fees, patients have access to medical and nursing care, drugs and other pharmaceuticals, and all complementary examinations such as medical imaging, laboratory tests and so on. Government also provides social assistance and health coverage to protect vulnerable groups of population, not classified as poor and not covered by social security. They benefit of reduced tariffs after justifying low income (in accordance with official minimum salary guaranteed by the law) and investigation by social affairs department.

Private financing of health is increased since the beginning of the last decades and it causes problems of equity and accessibility. Increasing public funds for health is included into the new prospect regime of health insurance. State budget devoted to MoPH will be more used to improve provision and quality of primary health care. Knowing the inequity generated by this situation, authorities have reformed the health insurance systems to

reduce the health cost supported by households. The reform of social health insurance has been decided and the National Fund of Health Insurance was created on 2004. This reform will be implemented at mid 2007, for meadows 65% or 70% of population.

Human Resources

For 100 000 Tunisian citizens, the health system offer nearly 100 physicians and 300 paramedical staff, including nurses, midwives and other technicians (anesthesia, radiology, laboratory, etc.). This human resources' capital is locally trained in four (4) medical schools, 19 nursing schools and 5 health technicians' schools. Human resource policy is focused on firstly training of general physicians to satisfy the health care needs as regards to basic health and secondly training of specialists. These second stages are often followed by the development of training capacity of university hospitals.

In the public sector, MoPH is the only employers and no recent changes have been made. All health personnel are governed by the national law of civil-servants. Procedures of recruitment and dismissal interfere have a limited role on affecting professionals. However employment is subject to national exam of recruiting general practitioner and specialist physicians, according to previous criteria of needs of region (general physicians) and specialities. Data on health professional unemployment are unreliable. The possibility of working in the private sector is being always opened but undeclared. The real unemployment concerns superior technician's categories (nutrition, physiotherapists) and general physicians and pharmacists (numerus clausus). Generally, it doesn't exist, on national level, official standardized mechanisms to evaluate personnel performances. However, these mechanisms are developed on university hospitals dealing with their mission of training and development of competencies. This evaluation is also made at basic health care level using mechanisms of supervision on local and regional level. In all cases, inspection and disciplinary proceedings are used to reduce aberrant practices; but did they have impact on the performances?

Three reforms, impacting human resources are planned:

- First, the consequences of health insurance reform on human resources: (i) New opportunities of employment in the private sector, (ii) New distribution of health professionals between sectors, and (iii) New role of GP as gatekeeper,
- Reform of Medical Education was introduced in 2005, aiming: (i) Adaptation of programs, curricula and length to specialty, and (ii) Strengthening of GP training especially by introducing the "family practitioner".
- Reform of Nursing Education, introduced in 2006, aiming: (i) Adaptation to international standards aligning Bologna agreement, and (ii) Recruitment of baccalaureate graduates and training at the high education schools.

Health Service Delivery

95% of population have access to health facilities within at least 5 Km distance. In the public sector, the only valid restrictions are related to user fees that citizens must pay to get curative care. All the personal preventive care is freely delivered to all Tunisian citizens. For medical emergencies, patients can reach all public levels of care, without any restriction.

Access to specialists is direct for ambulatory care delivered at primary health care centres, in particular in the urban centres which offer certain categories of specialized ambulatory care. Elsewhere, patients examined at the first line are referred to specialists in hospitals. The access of the citizens to in the private sector is direct. It is subjected to no constraint and the patient has the whole freedom of choice of the doctor. He also chooses the private medical facility if a hospitalization is required. GP gate keeping, non-

existent in the private sector, will be gradually set up within the framework of the health insurance reform, but strongly disapproved by the medical community. Tunisia never explicitly defined package of health services. In public sector, all citizens have access to all categories of care. Nevertheless, the refund regime (complementary insurance) limits the access to only long term diseases and surgical interventions and by ceilings. Private insurance regimes make the same with the restricted refunding.

The hospital sector is essentially public, being a matter for the MoPH (85% of the beds). The non-profit private sector doesn't exist. The majority of public hospital beds is beds in acute hospitals, and doesn't include long term care institutions yet. Inpatient operating indicators indicate a decrease of average length of stay in the teaching hospitals where a high occupancy rate is registered and a low average length of stay and occupancy rate in the regional hospitals. A national regulatory authority of pharmaceuticals is managed by the MoPH, through its drug and pharmacy unit coordinating its activities with the national lab of drug control. Central Pharmacy of Tunisia, public body related to MoPH, is the sole entity allowed to import drugs for the country, dealing with international tenders.

Health System Reforms

After an exhaustive analysis of health sector problems, new strategy has been implemented, encompassing the three following objectives:

- The continuously development of primary health care through a program to consolidate the provision of primary health services.
- The improvement of hospitals' inpatient care by reforming structural and institutional aspects of teaching hospitals.
- The reform of legislation rules related to private providers.

Major reforms in the public sector concerned the management modes of teaching and regional hospitals, associated with several measures devoted to the entire sector and the primary health care level. These reforms are at the same time pursued by a legislative reform encompassing the both private and public sectors.

In matter of insurance, an important reform will be progressively implemented since July 2007 and it is in the last phase of its preparation. It aims to improve health insurance coverage of the population, to increase the efficiency of health services, to reduce wastes of resources and health expenditures and to insure a best social equity. The health insurance reform aims also to prevent transitions' consequences and pursues three major goals:

- Set up and implement a sole mandatory basic regime, to be managed by one health insurance body, the National fund of health insurance.
- Implement optional complementary regimes in order to bear the costs that remain uncovered by the basic regime.
- All health care providers should be involved, whether they are public or private through contracts that include and determine quality standards of care delivery, mechanisms of cost containment, tariffs and provider payment methods.