Health Financing and Social Health Protection in Tunisia

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Health Sector Profile

- Epidemiological, Demographic Transitions
- Mix-financing system
- Health care coverage (Social Health schemes, free and reduced tariffs for poor, Supplementary insurances schemes (mutual vs. private) / Not covered persons
- Benefits: Generally speaking, patients have access to all types of health care, without the limitation of a particular benefits package.
Health Sector Profile

Financing/Contributions

- Health finance sources are grouped into three major types of financing agencies: the state, Social Health Insurance and households.
- Private sources of financing include individual expenditures (reimbursed or not, by private or mutual insurance companies), occupational health and other expenditures for curative services provided by companies.
- **Public sources:**
  - State provide grants to MoPH and others ministries
  - Social Health protection schemes are available for employees and employers, both mandated to participate (contribution rate is 6.75%).

Provider Payments

- Primarily fee-for-service but payment options and procedures vary by health care scheme: direct patient reimbursement, direct provider reimbursement, payment in-kind, annual lump sum payment, billing, and grants.

Delivery System

- Health care is delivered through public, parastatal, and private facilities.
  - The public sector is predominant, with 80 percent of hospital beds and more than 55 percent of all medical personnel. Tertiary health care services are the main public sector providers.
  - Private delivery of health care, especially for hospitalization and basic medical services has grown rapidly, and private bed capacity has doubled in the past five years.
- Access/ Equity/Quality/ Efficiency
Trends of Health Expenditures

- 1980-2008, total health expenditures (THE in current dinars) have increased by 21.5 with a AAGR of 12%.
- AAGR of health expenditures:
  - 15% for the period 1980-1990
  - 10% for the period 1990-2000
  - 9.6% for the period 2000-2008
- THE/ GDP
  - 3.2% on 1980 to 5.9% on 2005 and 6.2 for 2008.
Financing Sources of Social Health Insurance

(Social Contribution)

Source: NHA report (2007) and Estimation for 2010
## Social Health Insurance (CNAM)

### Expenditures

<table>
<thead>
<tr>
<th></th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public facilities</td>
<td>59.99%</td>
<td>56.61%</td>
</tr>
<tr>
<td>Private facilities</td>
<td>38.86%</td>
<td>42.32%</td>
</tr>
<tr>
<td>Treatment abroad</td>
<td>1.15%</td>
<td>1.07%</td>
</tr>
</tbody>
</table>

### Private Facilities

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>AAG (2007-2010)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic Diseases</td>
<td>31.7%</td>
<td>37.4%</td>
</tr>
<tr>
<td>Ordinary Diseases</td>
<td>20.0%</td>
<td>46.0%</td>
</tr>
<tr>
<td>Supplementary health services</td>
<td>37.2%</td>
<td>17.7%</td>
</tr>
</tbody>
</table>

88.9%

Source: DES/CNAM 2011
Financing Sources of MoPH / University Hospitals

<table>
<thead>
<tr>
<th>Year</th>
<th>Grants</th>
<th>CNAM</th>
<th>Others Revenues</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>72%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2006</td>
<td>72%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2007</td>
<td>73%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2008</td>
<td>72%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2009</td>
<td>71%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>70%</td>
<td></td>
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</tbody>
</table>
Out-of-pocket Payments for Health

- Private facilities (78.8% in 2000, 80.9% in 2005) vs. Public facilities (18.6% in 2000, 17.3% in 2005)

- Private facilities:

<table>
<thead>
<tr>
<th></th>
<th>2000</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient</td>
<td>19.8%</td>
<td>17.7%</td>
</tr>
<tr>
<td>Inpatient</td>
<td>9.8%</td>
<td>9.0%</td>
</tr>
<tr>
<td>Drugs and pharmaceuticals products</td>
<td>37.9%</td>
<td>37.6%</td>
</tr>
<tr>
<td>Chronic Diseases</td>
<td>14.8%</td>
<td>15.2%</td>
</tr>
<tr>
<td>Others</td>
<td>17.7%</td>
<td>20.5%</td>
</tr>
</tbody>
</table>

Source: Households’ National Survey 2005
Raisons and consequences of the rapid growth of Health Expenditures

- **Raisons :**
  - Demographic transition, epidemiological factors
  - Rapid development of Private sector
  - Gradual extension of health coverage on the private sector

- **Consequences :**
  - Additional increase on health expenditures will continue to be mainly supported by households if mechanisms of prepayment is not reinforced.
  - +++ Health inequity
Principal findings: At catastrophic threshold 10% about 12% of households are found to be exposed to CHE. While CHE appears to affect all socioeconomic groups, it tends to be more concentrated on the lower-income groups, the insured and those who were supposed to benefit from free or subsidized care.

Policy Implication: Extending the breadth of health insurance and state-subsidized coverage may not necessarily lead to better financial protection in health. Reinforcing the supply capacity of the healthcare system seems to be an inevitable prerequisite step for expanding effective coverage of financial protection mechanisms.

Conclusion: Reinforcing the effective, rather than the nominal, coverage of social protection mechanisms to the lower-income groups of the population is firmly recommended.
Paper 2. Fairness in Health Care Finance and Delivery: The Case of Tunisia

- **Principal findings:**
  - Out-of-pocket payments, which constitute a sizeable share in the current financing-mix, emerge to be a progressive means of financing health care in Tunisia. Such progressivity pattern does not hold across all income deciles in the population: the share of health care expenditure attests to be statistically significantly different from the share of ability-to-pay only for the richest half of the population.
  - Distributions of need for - and utilization of - outpatient and inpatient - reveal that the observed progressivity is rather an outcome of the heavy use, but not need, for health care at the higher-income levels.

- **Policy Implication:** Reinforcing the supply capacity for underserved regions and effective coverage for poor
Challenges

- Extend the breadth and depth of Social Health Coverage (CNAM and Free Medical Assistance)
  - Health coverage of total medical fees for chronic diseases and surgeries at either public and private facilities.
  - Enhance prepayment schemes under mandatory and supplementary (or complementary)
  - Improve health resources pooling through cross-subsidies from rich to poor (and vulnerable groups) and healthy to unhealthy
- Strengthen the health-delivery systems (PHC) and adequate human resources for health and health information systems, in order to ensure that all citizens have equitable access to health care and services
- Investment (efficient use of resources) in Public facilities through a rigorous upgrade (Quality, hospital capacity, Human Resources, management of drugs, waiting list...).
Concluding Remarks

- Health financing system wasn’t more adapted: it is important to regulate and maintain the core functions of risk pooling, purchasing, and delivery of basic services...for the Entire Population
- It is possible to move quickly towards the goal of universal coverage by choosing an appropriate financing systems and changing consumer behavior.
- Pursuing the goal of universal coverage:
  + Technical details of the various health financing mechanisms
  + Financing health care is a political matter.
THANK YOU FOR YOUR ATTENTION