POLITICAL ECONOMY OF SOCIAL HEALTH INSURANCE REFORM IN TUNISIA

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Population Health Care Coverage

- The majority of the population (65-70%) is covered by a social health insurance scheme, covering health care services provided by public sector.
- The poor (7-8% of the population) are completely exempted from payment of fees in the MoPH facilities.
- The remainder of the population (#25%) benefits of reduced fees in MoPH facilities.
## HEALTH EXPENDITURES FINANCING

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<tr>
<td>GOVERNMENT</td>
<td>51%</td>
<td>38%</td>
<td>37%</td>
<td>32%</td>
<td>26%</td>
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<tr>
<td>SOCIAL SECUR.</td>
<td>13%</td>
<td>15%</td>
<td>16%</td>
<td>19%</td>
<td>23%</td>
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<td>HOUSEHOLDS</td>
<td>36%</td>
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Rapid increase in private financing, mostly through out of pocket expenditures.
HEALTH INSURANCE REFORM
Basic Principles

• A single, basic, and mandatory scheme with a basic benefits package, managed by social security
• An optional complementary scheme, managed by private insurance companies
• Increase and standardization of contribution rates for the basic scheme
• Contracting with providers, and competition between public and private providers
HEALTH INSURANCE REFORM

- Basic benefit package design
- Financing
- Relationships with providers

- Law 2004-71 of August 2, 2004
- Creation of a Health Insurance Fund (CNAM): subdivision of the social security by risk group
- Discussions, negotiations of agreements with health care providers
• The Government
• The General Union of Tunisian Workers (UGTT), representing employees
• The Tunisian Union of Industry, Trade and Handicraft (UTICA), representing employers
• The Tunisian Union of Agriculture and Fishing (UTAP): employers in the agricultural sector
• The private providers
• Development partners: EU, WB, WHO
Contentious Issues: Coverage and Benefits

- Content of basic scheme
- Ambulatory (outpatient) care and hospitalizations in private health care facilities gradually implemented; implementation speed determined by the public section
- Preservation of previous rights and privileges

ALLIANCE between UGTT&ROVIDERS
Contentious Issues: Financing and Cost Sharing

- Contribution rates needed for fiscal viability of the scheme and actuarial studies:
  - 6.75% ? 8.25% ?
  - Spiraling increases?
- Financing: Employers + Employees
- Coverage of low-income persons
- Insurance levels, user fees and access to healthcare
- Drugs: Reference prices and substitution
Contentious Issues: 

**Provider Payment Methods**

- Capitation
- Fee for services & Nomenclature
- Hospitalization: DRGs & technical feasibility and timeliness

ESP = Private facilities of inpatient care
Contentious Issues:

Reimbursement to Providers

- Reimbursement for expenditures ≠ payment abilities
- Third party payer // Pharmacists ≠ Technical Management
- Ceilings

Providers
UGTT
MoPH
Contentious Issues: Provider Options in Basic Scheme

- Public providers only
- Refund of expenses without limits on choice of provider
- Private provider with family physician acting as gatekeeper
  - Certain Specialties excepted
  - Third party payer
Contentious Issues: Provider agreements and Fees

- Sectoral agreements and medical ethics
  - Freedom of choice and of prescription
  - Control and medical referrals
- Non-participating physicians
- Fee schedules
  - gPs AND SPECIALISTS
  - Lumpsum payments to ESPs
Contentious Issues: *Public Sector Upgrading*

- Keeping up the competition with the private sector
- Management of the public sector and the public-private mix
- Human resources:
  - Number and norms of distribution
  - Stability of the employment and careers evolution
  - Working conditions
  - Continuing education and retraining
  - Remuneration and incentives
- Rehabilitation of the infrastructure
- Financial resources
- Evaluation of performances

UGTT  MoPH  MSA  MF  CNAM  ..........
ENVIRONMENT

- **Ideological**: Liberalization of the «health market» and «disengagement» of the state
- **Economic**: Competitiveness, reduction of the public expenses of the government and impact on the social services
- **Epidemiological**: transitions and impact on supply, demand and costs of healthcare
- **Cultural**: Foreign experiences
- **Social**: Influence of the reform partners and their relationships to the State and the Government; other influences
CONCLUSIONS

• The health insurance reform has mobilised several partners all with their ideological, intellectual differences and stakes and ability to act

• It requires:
  – An ability to carry out long, difficult and delicate negotiations,
  – The capacity of the Government to mediate among the various partners,
  – Strong governance and strategic management of the health system.
QUESTIONS?

• Can reforms of such a size be designed by one of the parties?

• How can the Ministry of Public Health at the same time play the role of the regulator of the system and serves as a provider of healthcare?

• Is the public-private competition possible given the current conditions resulting from public sector management and governance of the health system?

• What consistency and coherence of the bodies of international organization?