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The health of citizens is a vital factor in growth and development, to which Tunisia has given high priority in its strategic orientations since the earliest days of its independence.

This has taken the form of free access to health care and the establishment of a health infrastructure, which has continued to develop and be adapted to epidemiological changes in the population, its changing needs as well as progress in medical science and techniques.

Moreover, since the beginning of the 1950s, compulsory social security schemes have been established for workers in the public and private sectors. Based on social contributions, these schemes provide a range of benefits in cash and in kind, including those relating to health insurance.

Role of social security in health insurance

The role played by social security funds has developed with a view to adapting to the changes that have occurred on the health care market and the epidemiological status of the population. Following a phase of extension of health insurance coverage, almost exclusively through public health structures in order to achieve optimal primary care coverage, came a second phase of adaptation characterized by new functions being entrusted to the funds with a view to responding to the growing need for secondary care, based on modern medicine and new health care techniques.

The extension of social protection and the public provision of health care

The development of social protection

After a period of metamorphosis, the current social security system took shape in the early 1950s, with the creation in 1951 of the National Pension and Social Insurance Fund (*Caisse*

¹ Report prepared in cooperation with Mr. Mohamed Chiha, Managing Director for health and social benefits, Mr. Fayçal Chebbi, Assistant Chief of Branch at the Main Office and Dr. Riadh Ben Abbes, Regional Doctor.

nationale de retraite et de prévoyance sociale (CNRPS)), which provides social protection for employees in the public sector. In the context of this social protection, the CNRPS administers a compulsory health scheme confined to the care required for long-term illness and surgical operations.

However, since 1972, and still within the framework of the compulsory scheme, insured persons were granted the possibility of selecting between the reimbursement system described above and a system of direct access to care in public health structures. Under the same Act, an optional supplementary scheme was established to enable persons insured under the scheme to benefit from the reimbursement of the cost of the health care required for ordinary illnesses.

The social protection of the active population was completed in 1960 with the establishment of compulsory social insurance for employees in the private agricultural and non-agricultural sectors, which is administered by the National Social Security Fund (*Caisse nationale de sécurité sociale* (CNSS)). This social insurance scheme includes a medical care branch, which provides insured persons with a health card, giving them direct and almost free access (subject to cost-sharing) to all public health structures (in the same way as the system for the direct provision of care under the CNRPS).

The above insurance schemes did not include self-employed workers, irrespective of their occupation, until 1982, when an Act was adopted establishing within the CNSS a compulsory social insurance scheme for this category of workers, with a medical care branch that is the same as for employees in the private sector.

Furthermore, in addition to the provision of medical care in Tunisia, the social security funds cover care provided abroad, which cannot be procured in Tunisia.

Through these schemes, the coverage rate of social security funds attained 84 per cent of the active population in 2001 (not counting the population of 600,000 households benefiting from free medical assistance).²

The role played by the funds in health protection was reinforced in 1995 following the coming into force of Act No. 94-28 entrusting the CNSS with the administration of the scheme for the compensation of injuries resulting from employment accidents and occupational diseases. As a result of this Act, victims of employment accidents or occupational diseases are entitled to benefits in cash and in kind provided by the fund, without any waiting period.

Extension of health care

Since independence, Tunisia has given particular priority to its health care infrastructure, the principal mission of which was to combat a number of health problems, including endemic and epidemic diseases, malnutrition, tuberculosis and maternal and infant mortality. A basic health care infrastructure, principally composed of primary health centres (known as *Centres de santé de base* (CSBs)), was accordingly established progressively in all the regions of the country. Although limited in their role to prevention and the provision of primary care, these centres provided a level of care that was vital for the population and therefore played an essential role in the promotion of health in Tunisia. Moreover, hospitals were established in the major towns.

² Free medical assistance is financed by the State for indigent persons who benefit under this programme from access to public health structures free-of-charge.

The public health infrastructure currently provides its clients with a range of care, including preventive care (such as vaccinations, diagnosis, mother and child protection programmes, family planning, etc.) and curative care covering many fields using modern techniques.

This infrastructure developed rapidly in response to the principal needs of a growing population, particularly through the balanced distribution of first-line structures.

The efforts made by the State in the field of health succeeded in eradicating certain diseases, such as poliomyelitis, malaria and bilharzia, while other diseases have been brought under control.

After a very low-key beginning in the 1960s, over the past 20 years the private health care sector has developed rapidly, largely due to the efforts of the State in the field of education, and particularly medical studies.³

The following table shows the development in the provision of public and private health care between 1987 and 1997.

Development of public and private provision of health care

Year	Public sector			Private sector	
	Hospitals	CSBs	Doctors	Clinics	Doctors
1987	139	1,294	2,299	28	974
1991	146	1,516	2,746	41	1,567
1997	152	1,841	3,486	56	2,978

The financing of health care

In exchange for the health care provided to insured persons and their beneficiaries, the social security funds paid a fixed sum annually to the State budget, in order to cover the cost of both the outpatient care and hospitalization provided by public health structures to insured persons. This financing mechanism is a contribution by the funds to the financing of public health structures, which is mainly covered by the State.

In view of the rapid growth in the number of insured persons as a result, in part, of the extension of social protection, these fixed rate contributions have grown accordingly, reaching 57 million Tunisian dinars in 1996. In the same year a system of flat-rate billing for care was introduced between the funds and public health establishments,⁴ which was then extended to regional hospitals in 1999, while retaining the system of overall fixed-rate financing. This billing system forms part of a global approach intended to ensure that the funds cover the real cost of the care provided to their insured persons.

The process of adapting health insurance

The system of health insurance described above, which was characterized from the beginning by the dominance of public health care provision, particularly in the field of hospitalization, played a determining role in the health care coverage of the population. However, over the years, this health care structure became inadequate to respond to the

³ Tunisia currently has four medical faculties, a faculty of pharmacy and a faculty of dental surgery.

⁴ Public health establishments are university hospitals assimilated to tertiary care structures.

rapid increase in the demand for care arising from the extension of social protection and the more generalized awareness by citizens of their health problems. In parallel with the rise in demand, the private provision of health care underwent a remarkable expansion, with the consequent development of an increasingly assiduous client base, which has resulted in an increasingly important contribution by households to the financing of health care.

The following table shows the development of national expenditure on health care, and its distribution between the various sources of financing.

National expenditure on health care and its distribution between the various sources of financing
(In millions of Tunisian dinars)⁵

Year	Total exp.	Distribution between sources of financing							
		State		Funds		Households		Occ. medicine	
		Amount	(%)	Amount	(%)	Amount	(%)	Amount	(%)
1990	573.5	209.9	36.6	85.6	14.9	273.0	47.6	5.0	0.9
1991	634.6	239.2	37.7	88.9	14.0	300.7	47.4	5.8	0.9
1992	714.6	264.2	37.0	112.4	15.7	331.2	46.3	8.0	1.0
1993	781.9	284.9	36.4	124.2	15.9	364.8	46.7	8.0	1.0
1994	877.7	332.1	37.8	134.4	15.3	401.8	45.8	9.4	1.1
1995	944.7	342.0	36.2	150.2	15.9	442.5	46.8	10.0	1.1
1996	1,040.7	368.2	35.4	172.7	16.6	488.3	46.9	11.5	1.1
1997	1,137.3	392.7	34.5	195.6	17.2	536.8	47.2	12.2	1.1
1998	1,238.1	409.8	33.1	218.5	17.6	596.2	48.2	13.6	1.1
1999	1,366.6	425.7	31.2	266.9	19.5	658.8	48.2	15.2	1.1
2000	1,489.5	460.8	30.9	280.5	18.8	731.3	49.2	16.9	1.1

It is within this context that, starting from the beginning of the 1980s, and despite the clear improvement in health indicators, the public authorities have opted on many occasions for adjustments intended to achieve a better adaptation to the quantitative and qualitative rise in the demand for health care, innovations in medical techniques, the increase in the private provision of care and new priorities in the field of health. In practice, the reaction of the public authorities to the health environment in the country took the form of the creation of CNSS polyclinics, the development within the funds of health and social welfare activities and the strengthening of public health structures.

The creation of CNSS polyclinics

In view of the congestion of public health structures, the CNSS established its first polyclinic in 1980. Five others were then created at the rate of one polyclinic each year. Since 1987, the CNSS has built six polyclinics in areas with a high concentration of insured persons, providing a full range of first-line care, ranging from consultations to the provision of medicines, as well as radiology and biological tests, to the benefit of insured persons and their dependants.

When they were created, the main objective of these polyclinics was to relieve the congestion in public health structures and improve the conditions of access to health care. Since their creation, they have been subject to a series of measures to adapt them to developments in the demand for care and progress in medical techniques. Indeed, the investment in the extension of premises and activities, the renewal of their equipment and

⁵ 1 Tunisian dinar (D) = 0.6789 US\$ or 0,7825 Euro.

their adaptation to technological progress tripled their costs between 1988 and 2000. By way of illustration, equipment only accounted for 30 per cent of their costs in 1988, but currently represents over 60 per cent. Furthermore, the services provided by the polyclinics were extended in 1991 through the creation of dialysis units with a capacity of 50 patients each.

Health care expenditure by the CNSS on its polyclinics has grown rapidly, as shown by the following Table.

Rise in the cost of health care in CNSS polyclinics, 1996-2000
(In millions of Tunisian dinars)

Year	1996	1997	1998	1999	2000
Expenditure	23.763	25.955	26.486	26.576	28.983

Furthermore, with a view to their adaptation to the growing needs of their clients, the care provided by polyclinics will be extended to provide additional services, which will result in them becoming intermediary health structures situated between first-line care and hospitalization.

The development of health care

Confronted with an almost saturated public sector, since the middle of the 1980s, the funds have found it necessary, in addition to the coverage of primary care, to develop the provision of supplementary care, consisting of the coverage of certain types of health care provided to insured persons in the private sector (such as cardiovascular surgery, dialysis, lithotripsy, functional rehabilitation, medical supplies, prostheses, etc.). Similarly, in the context of these services, the funds cover certain specific types of medicines (which are vital and costly) that are not available through public health structures, such as growth hormone treatment, erythropoietin, interferon and cancer treatments.

The development of this type of health care provision is a partial adaptation to the current situation, which is characterized jointly by a rapidly changing demand for care and the emerging private provision of care, which could no longer be ignored by the funds.

This has occurred at a time of rapid growth in health expenditure, with which the State budget is struggling to cope, and is resulting as a consequence in measures to limit the provision of certain types of care deemed not to be indispensable by the public health authorities.

The benefits and services provided by social security funds in the field of health have undoubtedly made it possible to improve the conditions of access to a number of types of care, which are mainly costly, thereby providing a high level of protection to insured persons. However, it has resulted in a very significant rise in their expenditure on health insurance, which now constitutes a challenge for the funds.

The following table shows the rising expenditure of the CNSS on health care between 1996 and 2000 and its importance in relation to expenditure on health insurance.

CNSS expenditure on health care as a proportion of the cost of health insurance, 1996-2000
(In millions of Tunisian dinars)

Year	Amount	(%)
1996	29.364	27.3
1997	31.217	25.9
1998	46.062	31.7
1999	48.080	28.4
2000	56.038	28.5

The strengthening of public health structures

At another level, and as part of the national policy to limit recourse to health care abroad, since 1992 the public authorities have called upon the funds to finance a programme to strengthen public health establishments. This programme has made it possible for public health structures to acquire the necessary medical equipment for the provision of certain types of care, such as cardiovascular surgery and kidney and bone marrow transplants, and to make savings on their costs.

The expenditure of the funds on the programme to strengthen public health structures has risen, since 1990, to 105 million Tunisian dinars. As a result of this programme, the number of patients sent abroad fell from 1,157 cases in 1987, to 244 in 1996, with this number dropping to no more than a few dozen cases in 2001.

The current system of health protection, as adjusted over the years, has made it possible for Tunisia to achieve a very high ranking among developing countries in the field of health care. The indicators for 2000 show this performance:

- Life expectancy at birth: 72.6 years
- Infant mortality rate: 23.5 per 1,000
- Vaccination rate for children under 5 years: 95 per cent
- Population/doctors: 1,250
- Population/hospital beds: 511

Prospects and challenges

In view of the many changes experienced by the country in such areas as the health, social, economic, demographic and cultural fields, and of their impact on the health care needs of the population, the public authorities have continued to develop health insurance so as to respond to new needs and make the system more effective. However, the adaptations made and the corrective measures taken appear to be no more than partial and palliative, and do not therefore provide a radical solution for a health care system whose shortcomings began to emerge over the past few years. These inadequacies may be summarized as:

- the coexistence of a multiplicity of health insurance schemes, giving rise to higher social contributions for enterprises and to wastage;
- the failure of social security to cover much of the care provided in the private sector;
- the general lack of satisfaction among all the actors: public and private health providers, financing bodies and beneficiaries; and

- the growth in health care expenditure at a higher rate than GDP.

As a result, the State decided in 1996 to reform the health insurance system with a view to establishing a single scheme capable of overcoming the shortcomings of the current disparate schemes. Both in the context of the current schemes and of the planned reform, the funds are confronted with a series of difficulties to overcome.

The principal challenges include:

- making the health insurance system more equitable;
- reorganizing the supply of care and redefining the role to be played by the public and private sectors;
- reorganizing the health insurance sector;
- containing health expenditure; and
- reorganizing social security funds.

Making the system more equitable

The issue of equity in the current health insurance system arises principally at two levels.

At the level of the availability of care

Despite the efforts made by the State with a view to guaranteeing an equitable distribution in the provision of care between the regions, at least in the public health sector, this objective has only been partially attained, since there remains an important gap between coastal zones and the interior of the country, particularly with regard to secondary care. For this purpose, Tunisia is currently seeking appropriate mechanisms to bring health care closer to the people who need it, within the context of a balanced provision of health care, in which the public and private sectors operate in harmony.

At the level of health insurance schemes

In this respect, the inequity is a result of the disparity between the schemes administered by social security funds, particularly with regard to the benefits covered under compulsory schemes.

This inequity is worse when supplementary schemes are taken into account, since they only cover a small proportion of insured persons. The multiplicity of schemes, both compulsory and optional, therefore means that the current system of health insurance leaves room for inequalities.

Reorganizing the supply of health care and redefining the role to be played by the public and private sectors

During the 1960s and 1970s, the public provision of health care was predominant and accounted for nearly all the health care available in the country, based on three levels:

- basic health care centres: primary health structures present in all the regions of the country;

- central hospitals and regional hospitals: secondary health care structures established in all the capitals of governorates (*départements*), as well as in most of the towns in the country; and
- university hospitals: tertiary care structures established mainly in the capital and a number of the major towns in the country.

Since the beginning of the 1980s, and particularly over the past decade, the supply of health care by the private sector has grown very rapidly, firstly in terms of volume, and particularly with regard to doctors, as the number of doctors in the private sector multiplied by five over that period, while the numbers in the public sector only grew by 2.5. Currently, private doctors represent around 45 per cent of all practicing doctors. The reduction in the recruitment capacity for doctors in public health structures and the development of supplementary health insurance schemes have encouraged doctors to set up their own practices.

Moreover, the private sector has focused over the past ten years on the development of certain types of specialized care requiring costly equipment and high-level skills, with the result that private provision has become preponderant in certain fields, such as dialysis, cardiovascular treatment and surgery and lithotripsy.

These developments were encouraged by supplementary health insurance schemes and the agreements concluded between social security funds and certain private clinics for the purposes of the provision of health care.

While the public provision of health care has developed in a planned manner in accordance with national health objectives, the same cannot be said for the private sector, where the rapid expansion has been guided by the laws of the market and the opportunities available in certain fields in which public provision was inadequate due to its slow development in relation to the growth in demand.

Reorganizing the health insurance sector

In parallel with the increased provision of health care in the private sector, most insured persons were obliged, partly due to the regulations governing compulsory health insurance schemes, to turn to public health structures in order to benefit from coverage that was almost free-of-charge. This situation gave rise to the emergence of supplementary schemes covering a broader range of health care, including that provided by the private sector.

Based essentially on the nature of the health care provider, and very little on the actual care provided, supplementary coverage gave rise to a situation of redundancy due to a duplication of the risks covered by compulsory and supplementary schemes, thereby generating additional costs, both in terms of financing (contributions and insurance premiums) and expenditure on health care. In these circumstances, it would be wise to redefine the range of care covered by each of the parties.

Also in the context of the restructuring of health insurance, and applying the principle of the separation of functions between financiers and care providers decided upon by the State in 1996, the CNSS is currently envisaging granting its polyclinics financial and managerial independence.

Containing health care expenditure

As one of the principal objectives of the health insurance reform announced by the Government, the containment of health care expenditure is justified by its alarming increase over recent years. Such expenditure has risen from 359.7 million Tunisian dinars in 1987 to 1,137.3 million Tunisian dinars in 1997, amounting to 4.4 and 5.4 per cent of GDP respectively.

This growth is partly related to natural factors, such as demographic developments, the increasing interest of individuals in their state of health and the efforts made by the public authorities to cover chronic diseases and the introduction of new modern medical techniques, which are often very costly, such as cancer treatments, transplants, dialysis, etc.

Alongside these natural factors, the rise in the cost of health care can also be explained by certain specific features of the Tunisian health care system recalled above, and principally:

- the rapid rise in the supply of care by the private sector, particularly in profitable fields, where coverage is partially or totally assured by compulsory and/or supplementary schemes;
- the duplication of the risks covered by compulsory and supplementary insurance schemes; and
- other factors, such as the fee-for-service for care provided in the private sector, and the particularly common phenomenon in our countries of seeking medical care elsewhere.

Reorganizing social security funds

This also forms part of the project to reform health insurance, with the objective of making the social security funds assume their role as insurers guaranteeing their insured persons quality care adapted to their fundamental needs at a lower cost.

The opening up of funds to the private health sector, which is also envisaged by this reform, explains the interest of the public authorities in restructuring the funds with a view to a clear redefinition of their role and the modernization of their management.

Up to now, the extension of social insurance coverage and the rapid increase in the numbers of insured persons have led the funds to take appropriate measures in terms of their organization and resources, with a view to serving their clients in the best possible conditions. However, the process undertaken focused much more on managerial efficiency than on the level of their performance.

In order to resolve this situation, funds have to be modernized and to optimize their management with a view to achieving an acceptable level of performance, so that they can contain the uncontrolled rise in costs.

The action already undertaken by the funds in this field is intended to:

- simplify procedures without detriment to the internal supervisory rules required for vigilant management;
- modernize their information systems; and
- introduce innovations in their working methods, thereby allowing a better follow up and more effective containment of health care costs.