

4 HEALTH SYSTEM ORGANIZATION

4.1 Brief History of the Health Care System

The Constitution of Tunisia clearly states that the prosperity of the nation is based on the welfare of the family and on the right of each citizen to work, to health protection and to education. Health policies, strategies and reforms implemented 50 years ago, shows the main tendencies of the health system:

- Until the 1980 decade, the Tunisia health system have been moved on basis of colonial heritage medical infrastructure, especially hospitals concentrated in the urban area. Authorities have focused its efforts on improving health services supply and health coverage, devoted mainly to :
 - Preventive programs (individual or collective) against communicable diseases, financed only by the State: These efforts have contribute to eradicate same of these diseases and strongly reduce the incidence of others diseases.
 - Geographical access to primary health care affordable to all population categories.
 - Human resources development and training (Medical and paramedical professionals) with recourse to foreign professionals to satisfy population needs.
 - Progressive development of hospital to deal with the need to specialized care.
 - Early setting up of social insurance for a large proportion of population (civil-servant and employees of the formal sector).
- After 1990 decade, authorities have started a new vision of health sector development, based on a strategy that includes¹²:
 - Continuously development of primary health care through a consolidated supply programs.
 - Improving hospital care obtained by reforms of structural and institutional aspects of teaching hospitals.
 - Reforms of legislation of private health care supply.

In term of public-private partnership, we note also two periods:

- First period characterized by an essential public supply, the ambulatory private sector coexisted and provides services to a limited set of the population. This period prevailed until the end of 1980 decade.
- The second period concerns the end of 1980 decade, with a fast development of the private sector, in terms of professionals' number and health care supply. In particular, private inpatient care in surgery has been strongly developed, making available other forms of hospital supply. One of the challenges of the recent health insurance reform is to succeed an efficient public-private partnership.

The extensive growth of the private sector, associated to the quantitative and qualitative changes of health care demand, have contribute to a significant growth of the household expenditures, increasingly requested to direct finance their health expenditures. Knowing the iniquity generated by this situation, authorities have reformed the health insurance system to reduce the costs borne by households.

Given the current context of the health system and the reforms implemented, regulation constitutes the fundamental pillar of the good governance, given the fact that health system is facing deeply constraints and challenges, resulting from its own evolution and reforms undertaken during the last decade and the macro-economic and social environment.

4.2 Public Health Care System

Organizational structure of public system

1. Ministry of Public Health Organization

Organogram of the Ministry of Public Health dates from 1981 (decree n° 81-793 of June 9, 1981) and was submitted to several modifications and adjustments:

- 1984: Creation of the Unit of Organization, Methods & Informatics
- 1985: Creation of the Financial Direction, separating financial affairs from human resources management and Equipment and Buildings administration.
- 1993: Creation, in all the ministerial departments of an office of citizen's relations
- 1998: Creation Emergencies Unit joined to General Directorate of Health
- 2000: Creation of two units, joined to the same General Directorate of Health : Medical Research Unit & Quality of Care Unit
- 2005: The last modification creates:
 - General Directorate of Health Public Facilities, raising the former hospitals' department to a general directorate and modifying its missions and organization.
 - General Directorate of Common Services, coordinating the departments of resources implementation, in substitution of the formal post of General Secretary.

The current organogram of the MoPH is drawn in the annex n°1.

In addition to these central administrations, several public institutions have central prerogatives, helping MoPH headquarters in its general missions:

- Central Pharmacy of Tunisia
- Family and Population Office
- National Center of Blood Transfusion
- National Center of Technical Studies and Bio-medical and Hospital Maintenance
- Informatics Center of MoPH
- National Center of Organ Transplant Promotion

At the regional level, Regional Directorates of Public Health were also created in 1981. They are joined to the Minister and his Office. They are still organized in three services:

- Administrative and Financial
- Basic (Primary) Health Care
- Hygiene and Environment Protection

In addition to their MoPH relationships, representing the Minister of health at the regional level, Regional Directorates of Public Health are closely bound to the regional authority of the Governor. They exert missions of planning, evaluation, supervision, coordination and resources' allocation and distribution at the regional level. The authority

of the regional director covers the private sector, the hospitals (whatever their category) and the primary health care network.

2. Health care provision in the public sector

The pyramid of health public infrastructure has three levels¹³:

- At the first level :
 - An extensive network of 2067 Primary Health Care Centres (including maternal and child health centres, dispensaries and health posts) equally spread throughout the territory, even in the poorest areas.
 - District hospitals (118), based in the main city of rural area, provide primary health care and maternity and general inpatient and outpatient care.
 - These two levels of the public health pyramid cover most of the health needs of the local communities.
- The second-referral level is made up of 34 regional hospitals, located in the main city of each governorate. They provide specialized care in the fields of obstetrics, gynecology, pediatrics, surgery, orthopedics, cardiology and other medical specialties if available.
- At the top of the pyramid, are 22 university hospitals divided in four geographic poles: Tunis, Sousse, Sfax and Monastir. They provide high technology health care for referred patients, and cover the proximity population running needs. These structures host very performing technical platforms and specialized services covering all the specialties, using the most sophisticated equipments.

All these structures, called public facilities, are under direct authority of the MoPH. They offer health care package to all the Tunisian population. Outpatient public facilities provide individual or collective urgent care.

Psychiatric and mental care is available at same regional and university hospitals. National program of mental health have contribute to improve access to this kind of care, by recruiting psychiatrists at regional hospitals and ensuring an adequate training for interested general physicians.

Other structures owned by other ministries are also considered as public sanitary structures and provide care to certain specific categories of the population:

- 03 military hospitals
- 01 hospital of the interior security forces (Police, national guard)
- These structures are classified as teaching hospitals.
- 06 ambulatory care polyclinics of the National Social Security Fund, providing outpatient health services and medical care to social insured patients.

The greater part of the population is served by the public health sector, financed and managed by the State. Indeed, both the private medical sector, and the social security health care services are essentially located in urban areas. So, the public sector remains the first providers, since it accounts more than 80% of all hospital beds' supply, providing inpatient only short or middle term health care. They aren't able to provide long term hospital care.

Evolution of public infrastructure and its development are strongly framed by:

- The five-year plans of economic and social development which define health public sector investments. The year 2007 is the first year of the 11th plan. These plans are prepared on the basis of broad dialogue implying local, regional and national levels

and they are defined after negotiation between ministry of economic development and international co-operation (in charge of national planning), ministry of finances and MoPH.

- The investment and operational budgets are annually allowed after discussion with ministry of finances and it recently introduced a negotiation with social security funds.

3. Health care financing of the public sector

Public sector financing is organized according to three modalities:

- The **state budget** finances investments, professionals' wages and give subsidizes to public facilities as operational budgets. State finances also all preventive programs whose benefit is free of charge for Tunisians.
- **Social security funds (SSF)** finance public sector according to various modes:
 - SSF contribute to finance the investment budget, towards heavy equipment and new technologies. Amounts and objectives are negotiated, implying the ministry for finances.
 - SSF give annually a lump sum to the MoPH, via Ministry of finances, as payment to medical care received by insured patients, at public facilities.
 - A Billing system, introduced since 1996 at university hospitals and 1999 at regional hospitals, is implemented on annual contractual basis. Invoices that give health services received by insured patients and tariffs are transmitted from hospitals to SSF. This system is used in order to improve efficiency and reduce and monitor cost.
 - A Billing system is also introduced on basis of particular conventions, used for some medical acts and pathologies. These conventions concerns also private facilities, except transplantation which remain exclusively allowed at university hospitals:
 - ✓ Kidney and Bone-marrow Transplantation
 - ✓ Cardiovascular surgery and interventions
 - ✓ Lithotripsy
 - ✓ CT Scanner.
 - ✓ Magnetic imagery
- **Households participate** into the direct finance of public facilities, following the three situations:
 - Social insured patients pay a lump sum (moderated ticket) for each service received (consultation, hospitalization and acts). Moderated ticket value varies according to the facilities types and specialized received care.
 - Patients who benefit from reduced tariffs (kind of medical assistance) are treated as social insured.
 - Patients without coverage should direct pay services fees (fee for services), on basis of official tariffs and nomenclature of professional acts. Some of them can be refund if they benefit from private insurances or professional mutual.

4. Public sector administration and supervision¹⁴

As indicated previously, health public sector is under MoPH authority. The MoPH exerts roles of planning and control, through its departments, as direction of planning and study and medical inspections.

Public facilities have a relative autonomy, defined in terms of organization and operating modes. In this context, we distinguish:

- The public administrative unit (PAU) is a legislative and lawful governing the districts and regional and some universities facilities (hospital, centers or institutes). Primary health care centers do not constitute a legal administrative unit and are related, according to their localization, to district or regional hospital. Moreover, these centers can be integrated into only one administrative unit, called basic health group. The PAU has a management autonomy regarding the use of their operating resources. Budget is attached to State budget and it remains governed by the code of public accounts.
- The Public establishments of health (PES) were created under the law n°91-63 of July 29, 1991, relating to the health sector organization. PES has two objectives: increase hospitals' autonomy and ensure a greater participation of the professionals in hospital management. The PES is governed by commerce code.

All these establishments are submitted State supervision, control and monitoring authorities such as the MoPH inspections and the general inspection departments of the Ministry of finances or the primary ministry (Auditing bodies).

Key organizational changes over last 5 years in the public system, and consequences

Up until the recent devolution initiative the health sector was not subject to major organizational and management reforms. There were some isolated attempts at reforms

Over the last 5 years, public sector sets up many organizational measures, defined on the programs of socio-economic development plans, in particular on their components initiated with the World Bank. These measures can be summarized as follows:

- Strategy for improving emergency care has been implemented in order to reinforce resources and management of these departments, through for example, specific training to various professionals categories. Despite the improvement of emergencies procurement, these measures are not scientifically documented or objectively evaluated.
- Strategy for improving health care quality and setting up a continuously assurance quality, in partnership with WHO. Tunisia is still in experimentation stage at pilot sites level and no results that can be currently identified.
- The social security funds payment mechanisms of health care received at public hospitals have been at many times revised in order to get a new financing schema, based on pathologies. The technical complexities of this approach have slow down the process. However, we succeed on better assessment of the real care costs.
- For various reasons, State has allowed some university physicians to get a private activity, called "Complementary Private Activity-CPA-". Strongly regulated, this activity has been at several times modified. It's estimated that procedures must be softened to allow to these doctors improving their incomes, but under serene conditions. It's also, stressed the negative consequences in terms of (i) presence of these doctors at their original workplace: public facilities, (ii) training of new doctors and (iii) the unfair competition observed with the private sector.
- In order to improve the territory coverage from Tunisian specialists doctors, the State have implement an incentive system, based on an increase of professionals wages and authorization to practice on private sector (ambulatory care) if the specialists doctors accept to get a full time job on public facilities, located at priority

defined regions. Since the implementation of this system (1995), it's observed better country coverage from Tunisian specialists, but it remains under the assigned objectives. Coverage does not seem dependent on these incentives. These organizational measures are currently under review.

- Two processes of reform are implemented in the human resources training:
 - A reform of medical studies aimed to better adapting the course of training to specialist and promoting training of general practitioner dealing to the need to "the family physician".
 - A reform of nurses studies, revises access conditions to studies and the training schemes - which will be attribute a university diploma adapted to the internationally recognized standards.

Planned organizational reforms

Since 1996, a reform of social health insurance has been decided and The National Fund of health insurance was created on 2004. Really, it will be implemented at mid 2007, for meadows 65% or 70% of Tunisian population.

This reform¹⁵ will improve the access of social insurance patients to all public and private providers, on preliminary defined contracts. The public sector, which is often protected, will be submitted to competition with private sector that has clearly developed its ambulatory and hospital services during last years. Public sector should improve quality of its services; cost monitoring and continue its roles of health population safety and of last recourse, because it should keep its public service mission. Partnership between public and private sector is currently under development.

In addition, the following conceived organizational measures should be taken at short times:

- The review of central department of the MoPH organization seems still pressing, despite the changes introduced during the year 2005.
- The review of missions, prerogatives and organization of public health regional directions, (in the context of decentralization and regional directions reinforcement) is to be defined at the same time as the MoPH headquarters organization, for a real delegation of power.
- Beside the introduced improvements for university and regional hospitals, organization and management of public facilities still requires enhancement to re-organize district hospitals and basic groupings.

4.3 Private Health Care System

Private health sector have various development stages, as it's always exist beside the dominant public sector. The private sector includes:

- Doctor's practice: it's initially limited to individual practice at single cabinet; but currently it includes private outpatient centers of medical imagery and laboratories.
- Dentists practices
- Pharmacists, drugstores (retail sale) or wholesalers
- Liberal practice, individual or collective, private ancillary practice (physiotherapists, opticians and nurses).

Private sector has realized a significant development, until the end of the 1980 decade and has several impacts:

- Improvement of population's purchasing power has allowed certain categories to demand health care offered by private sector.
- High numbers of professionals were trained on several medical specialities.
- The reduced state expenditures in health care, as consequence of structural adjustment plan, have strongly reduced employment in public health sector.
- The financial solvency of the social insured patients, for heavy medical acts, have encouraged to privately invest more on some lucrative crenels such as cardiology, cardiovascular surgery and heavy equipment (CT scanner and MRI).
- State incentives and subsidies to private investment in general were undertaken at private health sector.
- The increase interest of private investors from non professionals to the health care sector.

Modern, for-profit

Single practice physicians (specialists and generalists) dominates private sector and provides ambulatory care. Inpatient care at the private sector has been developed since the last decade, as shown at the following table:

Number of private health facilities and beds (1995-2004)

Year Facilities	1990		2004	
	No	Beds	No	Beds
Clinics	33	1142	81	2379
Multi-disciplinary	25	1060	49	2175
Mono-disciplinary	8	82	32	204
Dialysis Centers	18	205	99	986

Source: MoPH

Overall, the private sector has been growing rapidly since the 1990s. The sector employs 83% of the country's pharmacists, 72% of dentists, but only 7% of paramedical professionals¹⁶. It has most of the country's heavy medical equipment. It is mainly financed by households, absorbs about half of all health expenditure and its development is likely to accelerate with the health insurance reform. The private sector has followed credit-worthy demand and has set up in Greater Tunis, central-eastern areas and the coastal regions.

The main regulation mechanisms driving the private sector are shown in the table below. Any significant change was registered out of replacing of previous authorization of the MoPH by rules defined on the book of duties

Main regulation mechanisms of the private sector

	Previous Situation	Current situation
Liberal Practice	No geographic or population restriction for implementation	
Private Clinics	<ul style="list-style-type: none"> - No geographic or population restriction for implementation - Obligation to satisfy norms of building, equipment and human resources 	
Renal Dialysis Center	<ul style="list-style-type: none"> - Certificate of needs and authorization - Obligation to satisfy norms of building, equipment and human resources 	
Heavy Equipments	Certificate of needs and authorization	
Laboratories for Medical and analysis acts	Authorization for fitting	Book of duties
Retail pharmacy	<i>Numerus Clausus</i>	
Medicines Distributor wholesaler	<i>Numerus Clausus</i>	Book of duties
Paramedical	Authorization for fitting	Book of duties

Source: MoPH

Modern, not-for-profit

It doesn't exist a not for profit private sector in the Tunisian health sector

Traditional

Health professions practice, outside the controlled modern setting, is forbidden by the law and is liable of heavy judicial pains. However, some isolated and few cases are described under shape of practice of healers or trade of medicinal plants or practice to the limit of the sorcery (witchcraft).

Key changes in private sector organization

- In 1991, many legal rules were implemented to regulate private hospitalization and to eliminate the old rules, used since the end of the 19th century. A series of lawful acts was promulgated in order to regulate private professions, as ancillary practice.
- Private sector receives increasingly foreign customers, coming from bordering countries. Many attempts have been made to satisfy this health care demand, using various contractual forms.
- Private sector develops new crenels dealing with, by investing on thalassotherapy and renal dialysis centers into or near tourist hotels.
- Main organizational changes are related to State disengagement from investment approval or authorization for the private sector fitting. Installation for some professions is no more submitted to MoPH previous authorization, but it is due to rules defined on the book of duties.

Public/private interactions (Institutional)

There's no official interaction policy or system that provide a link between the public and private health institutions. However, interactions between NGOs and the MoPH exist and it's especially devoted to patients. NGOs provide assistance to patients having diseases treated at the university hospitals, like housing.

Public/private interactions (Individual)

Private practice physicians are sometimes authorized to exert in the public facilities on:

- a purely voluntary basis, without remuneration,
- An individual convention basis with the consequent remuneration, when it's really needed.

University teaching physicians can have a private activity (CPA), as mentioned earlier

Planned changes to private sector organization

The main reform that will fundamentally transform the private sector will be the health insurance reform, defined following law n°2004-71 of August 2, 2004, which create the National Fund of Health Insurance (CNAM) and its application rules.

According to this law, relations between the CNAM and the private providers will be governed exclusively by conventions (contracts): a general chart and most of the sector conventions (physicians, dentists and medical laboratories) have been signed. Other conventions are again under negotiation (pharmacists and private clinics).

These conventions will introduce:

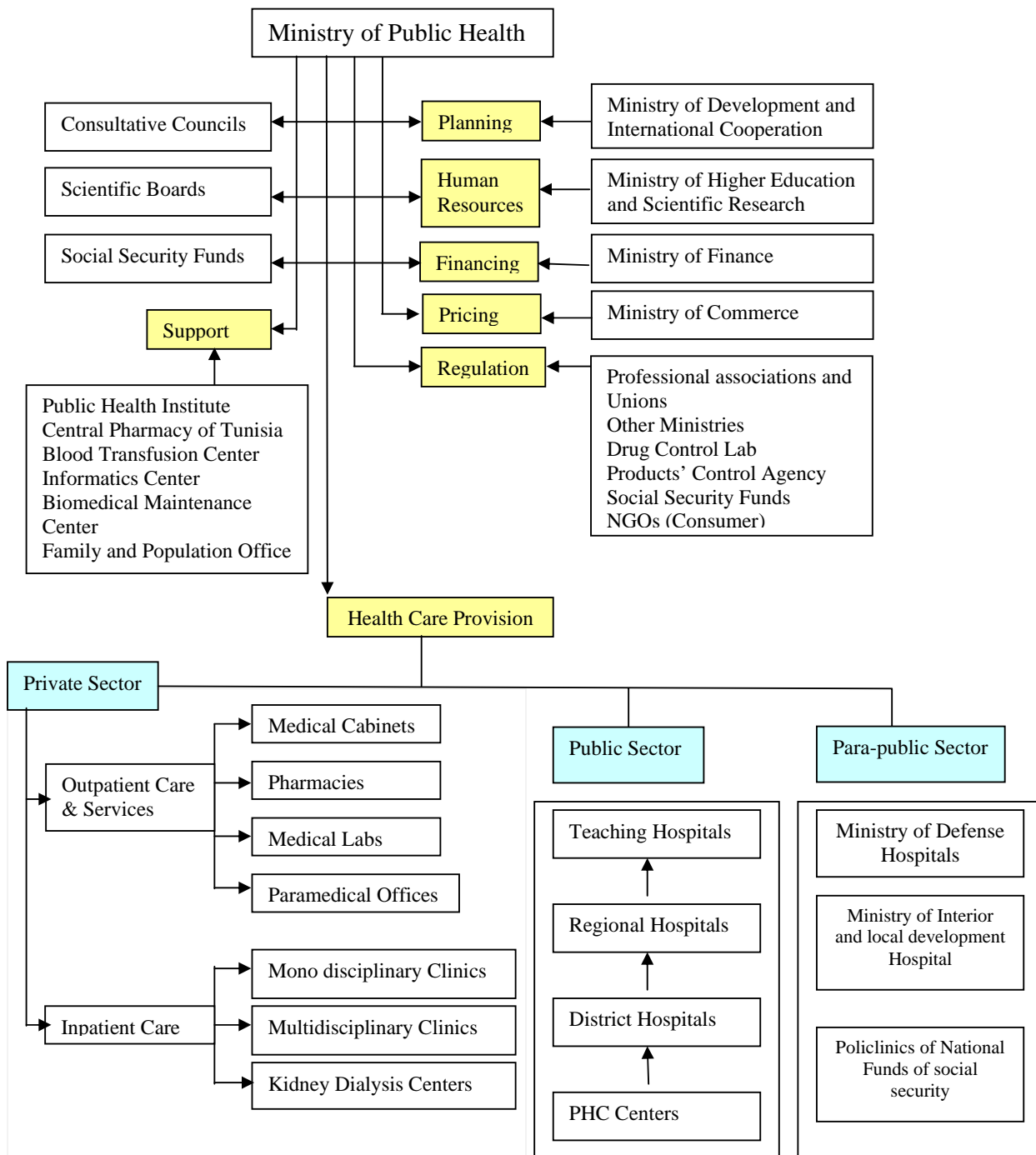
- conventional tariffs which will be fixed and can only evolve after negotiation with the CNAM;
- The medical control will permit to ascertain the quality of benefits and the expenses containment.

Implementation conditions and management procedures of the new system are under development and negotiation with the social partners, in particular the central employees' union and the employers' organization, and private providers of care and services.

4.4 Overall Health Care System

Organization of health care structures

4.4.1 Organization of health care structures



Brief description of current overall structure

The health care system in Tunisia is made of three sub sectors: Public, para-public and Private.

1. The Ministry of Public Health (MoPH) is responsible for formulating policies, strategies, plans, programs and technical and administrative standards on health matters in order to guarantee the people's constitutional right to health.
2. Health policy is based on primary health care and has been endorsed at the highest official level.
3. In order to reach the entire population, the services of the MoPH are decentralized and located in the 24 regions into which the country is divided for administrative and political purposes.

In order to improve health care insurance, new national funds (CNAM) has been implemented. This new regime is an obligatory and unified basic mode and look to ensure sufficient covering of financial risk disease. In the near future, the CNAM will provide a health care coverage for both public and private providers and on real cost basis. Then it will have a great importance in the overall health system, in terms of organization, financing and regulation.