

**Exploring challenges, their causes, and options for
health financing policy in Tunisia on its way
towards Universal Health Coverage**

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**UHC: providing all citizens with the health service they
need, of satisfactory quality, while ensuring that they
don't face financial hardship to access them.**

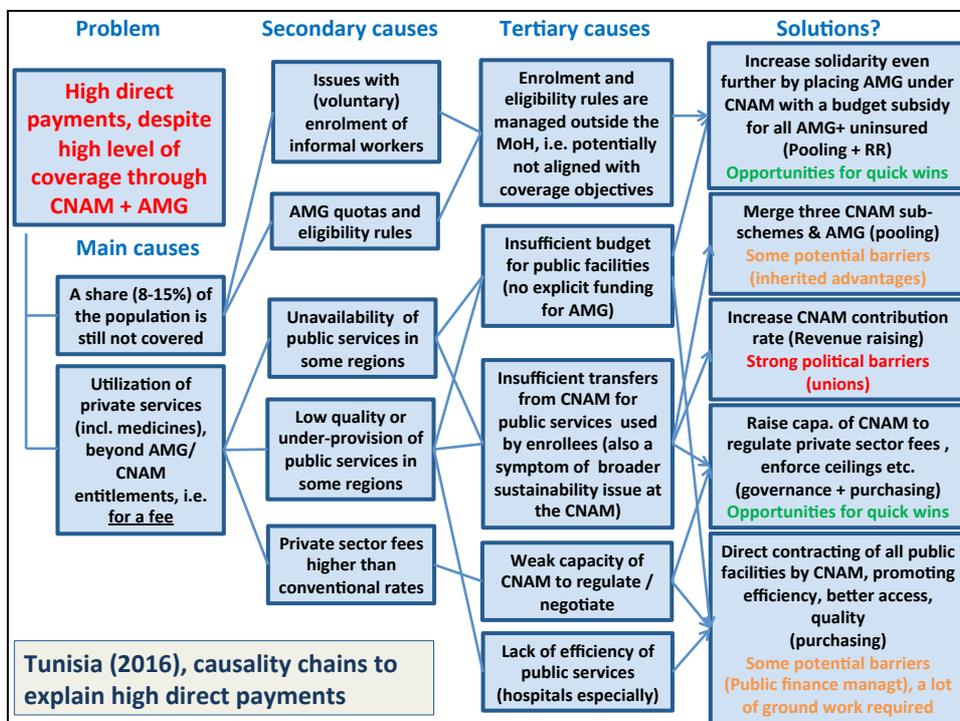
Where are we at in Tunisia?

- A clear commitment to health as a right and UHC, as expressed in the 2014 Constitution (art. 38) and in the 2014 White Book (priority 7).
- A system based on solidarity, with a high level of coverage of the population, through the combination of CNAM and AMG (85-92% of total population covered).
- A relatively dense network of health facilities., meant to ensure physical access (with regional disparities however).

But: paradoxically, direct payments from patients still represent a large proportion of total health expenditure (37.5% according to NHA 2013), and 1.8% of Tunisian households face catastrophic health expenditure according to a 2014 study, which reflects a perfectible level of financial risk protection of Tunisian citizens.

This presentation, aims at:

- Exploring the deep causes of the persistence of this high proportion of direct payment.
- Proposing potential solutions.
- Ranking these solutions in terms of priority / immediate feasibility relatively to the socio-economic, political and institutional situation in Tunisia.



In addition: the solutions proposed need to be designed on the basis of **reliable, up-to-date evidence**, which in turns implies to work on the capacity of national institutions to **generate quality data, interpret it and translate it in health policy recommendations** for decisions makers.

Thank you for your attention

commentaire de la diapo animé à lire à mesure que l'on développe l'arbre

The policy issue: high share of direct payments for health

The high share of direct payments in total health expenditure can look like a paradox as Tunisia achieved a relatively high level of coverage of 85-92% through CNAM (payroll-based, for the workers) and AMG (budget based, to cover vulnerables).

The two main causes we isolated for the persistence of OoP are :

- The fact that **8 to 15% of the population is not covered** and hence **fully rely on direct payments** to get treated.
- The fact that a number of citizens covered through CNAM and AMG **seek treatment in the private sector** (and medicines in private pharmacies), **beyond their entitlements** in both schemes.

First causality branch: how to enroll those currently left behind?

Secondary causes for the first branch:

- Two secondary causes may explain that we still have a significant share of uncovered population: the voluntary nature of enrolment, and some issues in the enforcement of eligibility rules.

Potential solution:

- The solution we propose is to defragment: merge AMG under CNAM and make it explicit that all citizens are covered, without voluntary enrolment or conditions of eligibility

Feasibility:

- some existing CNAM schemes can easily be applied to and perceived as attractive to the informal sector, if well promoted.
- Managing AMG through the CNAM, although a longer term reform, could bring significant gains in equity, allow CNAM to play a greater role as a purchaser of health services, and allow lower administrative costs.

Second causality branch: why do people go and seek care in the private sector?

Secondary causes for the second branch:

We think that the underlying reasons for AMG or CNAM enrollees to go and seek care in the private sector are:

- the **unavailability of public proximity services** (especially specialized),
- and the **poor quality of these services and shortages** of such inputs as medicines.

In addition, the private sector applies fees higher than those agreed and covered by CNAM, for those enrollees having access to private facilities as part of their entitlements.

Second causality branch (continued)

Deeper causes include :

- **Insufficient budget resources**, and especially the fact that there is no explicit funding to back the promise of free health care as part of AMG.
- **Insufficient transfers from CNAM to the state budget to cover for public services utilization of its enrollees** (which highlights deeper sustainability issues within the CNAM)
- Lack of efficiency of public providers.

Second causality branch (cont.)

Solutions we propose to tackle these issues :

- **In complement to a AMG/CNAM merge aimed at increasing solidarity: introduce an explicit budget subsidy to cover for all those not contributing.** The merge should be relatively straightforward, both technically and politically more difficult.
- As a more medium term measure, as a matter of **equity**, we could establish a **single coverage modality** (same package, same modalities of access to the private sector) **for all CNAM enrollees**. There may be reluctances due to the advantages inherited from the merge of past schemes into the CNAM, but in addition to being unfair, the current system, with three separate schemes jeopardizes the long term sustainability of the CNAM (as highlighted by a 2014 study).
- We could try to negotiate an **increase of the contribution rate**, maybe also modulate it to make it more progressive (but this is not politically feasible right now, in a challenging socio-economic situation).
- We could also, and this is doable within the existing rules, **tighten the contractual terms of service** with the private sector to make savings, starting with enforcing existing ceilings.
- Finally, we could **allow direct contracting between the CNAM and all public facilities** in order to introduce a set of purchasing mechanisms which would incentivize availability, efficiency and quality of care. This requires a lot of ground work on: choice and mix of purchasing mechanisms, information system, capacity building of managers, legislation (public finance management, status of providers).