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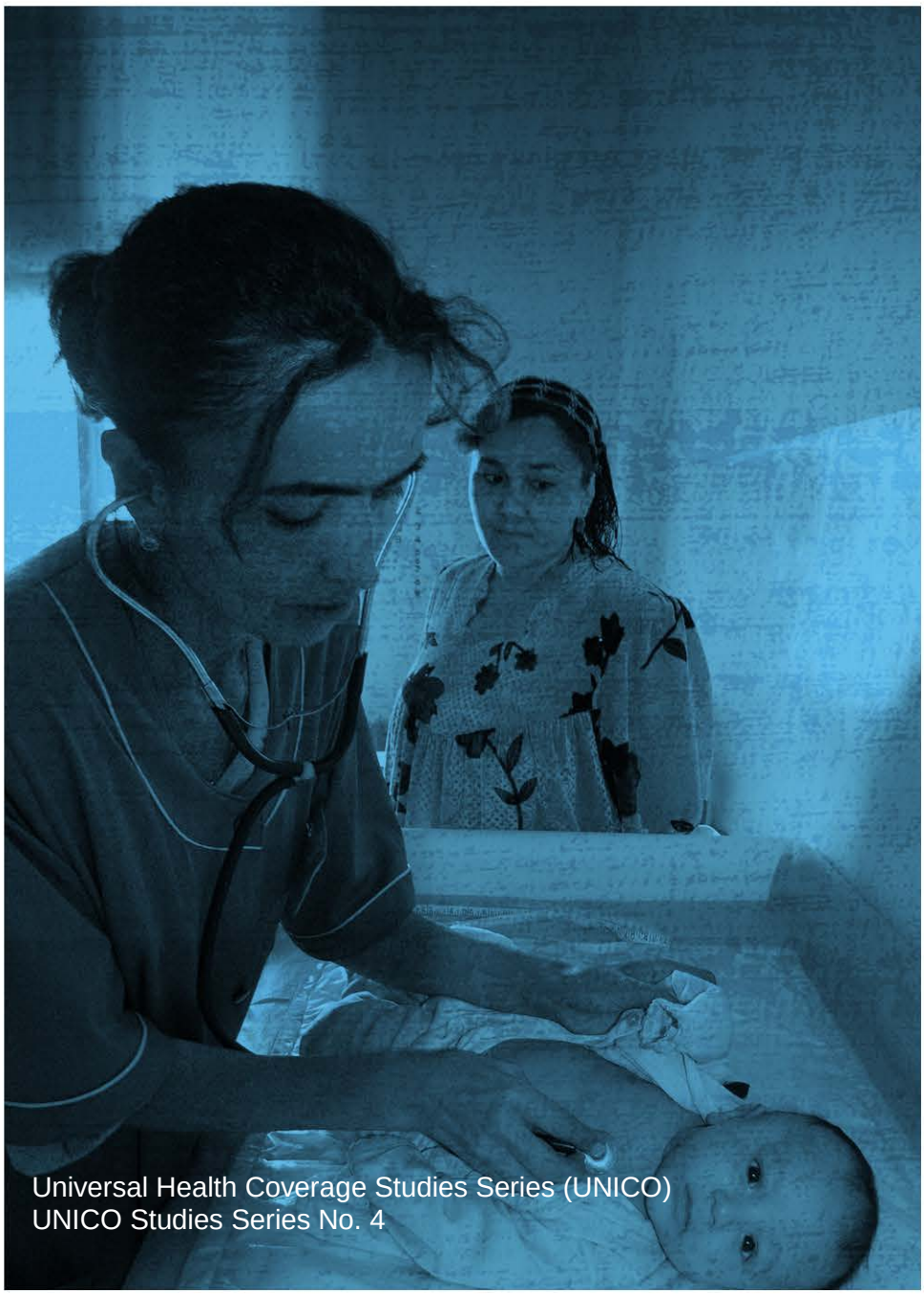
Consolidation and Transparency:

Transforming Tunisia's Health Care for the Poor

Chokri Arfa and
Heba Elgazzar



Universal Health Coverage Studies Series (UNICO)
UNICO Studies Series No. 4

Human Development *Network*

UNICO Studies Series 4
Consolidation and Transparency: Transforming Tunisia's Health Care for the Poor

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The World Bank, Washington DC, January 2013

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[2] This paper benefited from useful inputs and comments received from Ajay Tandon, Rekha Menon, Emiliana Gunawan, Enis Baris, and Eileen Murray, all of the World Bank; and from Alexander Preker of the International Finance Corporation. Excellent editorial support was provided by Diane Stamm (Consultant). The authors also benefited from the overall guidance of Daniel Cotlear and Charles Griffin, also of the World Bank. The authors thank the participants of the Authors' Workshop held in Washington, DC, in July 2012, and representatives of the Government of Tunisia, for their comments and input. The authors are grateful to them all.

The World Bank's Universal Health Coverage Studies Series (UNICO)

All people aspire to receive quality, affordable health care. In recent years, this aspiration has spurred calls for universal health coverage (UHC) and has given birth to a global UHC movement. In 2005, this movement led the World Health Assembly to call on governments to "develop their health systems, so that all people have access to services and do not suffer financial hardship paying for them." In December 2012, the movement prompted the United Nations General Assembly to call on governments to "urgently and significantly scale-up efforts to accelerate the transition towards universal access to affordable and quality healthcare services." Today, some 30 middle-income countries are implementing programs that aim to advance the transition to UHC, and many other low- and middle-income countries are considering launching similar programs.

The World Bank supports the efforts of countries to share prosperity by transitioning toward UHC with the objectives of improving health outcomes, reducing the financial risks associated with ill health, and increasing equity. The Bank recognizes that there are many paths toward UHC and does not endorse a particular path or set of organizational or financial arrangements to reach it. Regardless of the path chosen, successful implementation requires that many instruments and institutions be in place. While different paths can be taken to expand coverage, all paths involve implementation challenges. With that in mind, the World Bank launched the Universal Health Coverage Studies Series (UNICO Study Series) to develop knowledge and operational tools designed to help countries tackle these implementation challenges in ways that are fiscally sustainable and that enhance equity and efficiency. The UNICO Studies Series consists of technical papers and country case studies that analyze different issues related to the challenges of UHC policy implementation.

The case studies in the series are based on the use of a standardized protocol to analyze the *nuts and bolts* of programs that have expanded coverage from the bottom up—programs that have started with the poor and vulnerable rather than those initiated in a trickle-down fashion. The protocol consists of nine modules with over 300 questions that are designed to elicit a detailed understanding of how countries are implementing five sets of policies to accomplish the following: (a) manage the benefits package, (b) manage processes to include the poor and vulnerable, (c) nudge efficiency reforms to the provision of care, (d) address new challenges in primary care, and (e) tweak financing mechanisms to align the incentives of different stakeholders in the health sector. To date, the *nuts and bolts* protocol has been used for two purposes: to create a database comparing programs implemented in different countries, and to produce case studies of programs in 24 developing countries and one high-income "comparator," the state of Massachusetts in the United States. The protocol and case studies are being published as part of the UNICO Studies Series, and a comparative analysis will be available in 2013.

We trust that the protocol, case studies, and technical papers will provide UHC implementers with an expanded toolbox, make a contribution to discussions about UHC implementation, and that they will inform the UHC movement as it continues to expand worldwide.

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Abbreviations

CNAM	Caisse Nationale de l'Assurance Maladie (social health insurance)
DEP	Direction des Etudes et de la Planification
FMAP	Free Medical Assistance Program
GDP	gross domestic product
FMAP	Health Care for the Poor
MENA	Middle East and North Africa region
MICS	Multiple Indicator Cluster Survey
MOH	Ministry of Public Health
MOSA	Ministry of Social Affairs
OECD	Organisation for Economic Co-operation and Development
OOP	out-of-pocket
PNAFN	National Program of Aide to Needy Families, Programme National d'Aide Aux Familles Nécessiteuses
SMIG	Guaranteed interprofessional minimum wage, salaire minimum interprofessionnel garanti
TND	Tunisian dinars

Executive Summary

Since the 2011 popular revolution in Tunisia, calls for a new social contract have been made to improve social inclusion, including addressing gaps in health care coverage for the vulnerable households. This paper evaluates Tunisia's Free Medical Assistance for the Poor (FMAP) and seeks to identify opportunities to improve universal coverage in Tunisia. The study focuses on the structural and institutional framework of health care coverage for the poor in Tunisia in terms of strengths, weaknesses, and recommendations for achieving universal coverage. The paper reviews Tunisia's health financing and delivery system with a special emphasis on FMAP, and analyzes the main structural and targeting challenges the program faces. The distinctive characteristic of this paper is the focus on institutional design and organizational practice of FMAP. The legal and regulatory framework is assessed in terms of management, beneficiary targeting methods, benefits package, and the information environment.

Poor households are covered by one of two subsidized medical assistance programs under FMAP, provided to heads of households and dependents. The poorest households are exempt from all user fees for health care services, while eligible vulnerable households are entitled to receive health care benefits for reduced fees. Following the revolution, FMAP was expanded to reach an estimated 27 percent of the population, and is funded through central government transfers. In 2010, FMAP accounted for 13.9 percent of total public health expenditures and 0.5 percent of gross domestic product. However, FMAP faces a number of challenges. Significant deficiencies in efficiency exist and targeting of the poor is relatively weak. The challenges preclude the effective implementation of universal coverage and the desired results of improvements in health outcomes and financial protection, unless fundamental changes are made.

Several key reforms are recommended to strengthen FMAP financial sustainability and targeting of the poor. A clear legal and institutional framework is needed to improve targeting mechanisms and institute a clear benefits package. Consolidation between FMAP and the national health insurance fund in Tunisia will help reduce fragmentation and improve administrative efficiency. The establishment of an information system that tracks beneficiary use of services, satisfaction and complaints, and a process to establish eligibility in a rigorous manner, will be crucial. By realizing gains in universal coverage, a more level playing field for inclusive growth in the new Tunisia can be realized.

1. Introduction

In January 2011, Tunisia witnessed the first of a series of cascading revolutions in the Middle East and North Africa (MENA) region. Calls for overhauling 30-year-old political regimes reflected long-standing public perceptions of exclusion from economic and political life. With the advent of the Tunisian revolution, social dialogue has acquired a renewed focus on voice and participation, particularly since poverty and unemployment have risen and regional disparities in health persist. This paper seeks to evaluate the Government of Tunisia's (GOT) objective of improving coverage and sustainability of health insurance in light of the postrevolution focus on equity.

Social exclusion in health care coverage has come under greater scrutiny since the revolution. Tunisia's poverty rate was estimated to be 15.5 percent as of 2010[3] and is nearly double in rural regions (using a national threshold equivalent to approximately US$2/day), where maternal mortality is also higher. Unemployment is 18 percent overall, but nearly 28.6 percent in interior regions (such as the central-west). Tunisia witnessed an improvement in infant health and the eradication of most communicable diseases between 1960 and 1990, due largely to investments in public health and education. However, public health investment has not kept up with increasing demands due to demographic and epidemiologic transitions, with a greater need now for more preventive services and expanding insurance coverage.

Since the revolution, the GOT has implemented an economic and social recovery program that has focused on improving targeting of social safety nets and the quality of services. The main social safety net program providing social and health care assistance for the poor is Tunisia's National Program of Aide to Needy Families (Programme National d'Aide Aux Familles Nécessiteuses, PNAFN). PNAFN reached approximately 9 percent of the population (235,000 households) as of June 2012. The program was created in 1986 in parallel with structural adjustment reforms and has received no direct donor financing. Due to the economic slowdown since January 2011, strengthening coverage and sustainability of PNAFN and its health care programs for the poor, the Free Medical Assistance Program (FMAP), will be key to ensuring coverage of the poor during economic recovery.

Against this backdrop, this paper evaluates FMAP and seeks to identify opportunities to improve universal coverage in Tunisia. Section 2 provides an overview of health financing and service delivery in Tunisia, including the relationship between the FMAP and the main financing schemes. Section 3 describes key supply-side issues in terms of primary health care provision for the poor. Section 4 assesses the institutional framework of the FMAP in greater detail and its linkages to the health care delivery system. Section 5 focuses on beneficiary selection and targeting methods under the FMAP. Section 6 examines public financial management under the FMAP, which is followed by a discussion in Section 7 of the benefits package. Sections 8 and 9 describe the information environment of the FMAP and how this links to the special focus of future financing reforms. The concluding section discusses the pending agenda and priorities for the FMAP moving forward.

[3] Tunisia Household Budget and Consumption Survey 2010, Institut National de la Statistique (INS).

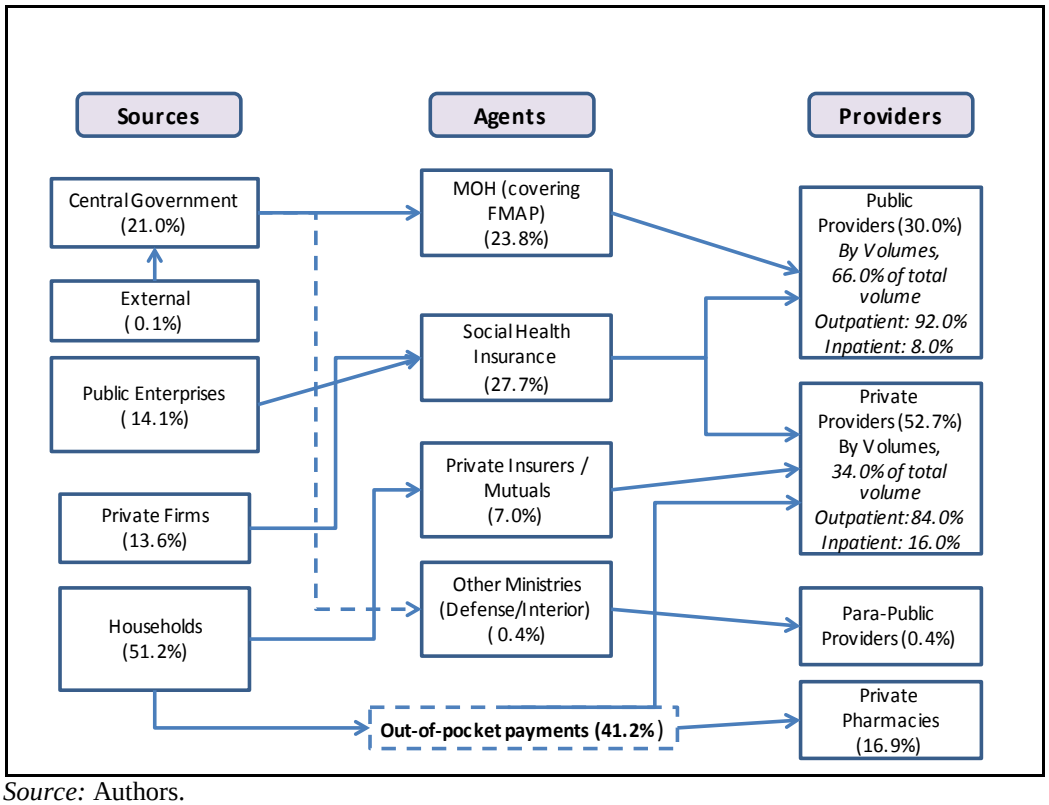
A key limitation in the analysis is the lack of detailed information on financing and delivery mechanisms for the FMAP. Therefore, most of the analysis relies on information collected from administrative resources, household surveys, and aggregate information from the Ministry of Finance (MOF), the Ministry of Social Affairs (MOSA), and the Ministry of Health (MOH).

2. General Health System Overview: Financing and Delivery

An analysis of the Tunisian health system reflects the vision of the Tunisian welfare state in which FMAP is situated. Based on the notion of broad social solidarity, in 1956 President Bourguiba established the basis of a universal system of health care provision as one of his primary reforms following independence from the French. Between 1956 and the late 1980s, service delivery was improved and social health insurance was established for the employed. Investment has not kept pace since the 1990s, however, resulting in a deteriorating quality of health services and an uptake of private services by citizens. Following the revolution, the interim Government of Tunisia began renewed investments in health infrastructure, with renewed interest in addressing sustainability and coverage of health insurance in parallel.

Health care in Tunisia is financed through a combination of social health insurance, general government revenues, and private spending, with health insurance accounting for an increasingly greater share. Between 1980 and 2010, total health expenditure increased from 3.2 percent to 7.0 percent of gross domestic product (GDP). The main financing agents include the central government (general governmental expenditure, 23.8 percent), social health insurance, known as the Caisse Nationale de l'Assurance Maladie (CNAM) (27.7 percent), private insurance (7.0 percent), and out-of-pocket payments (41.2 percent) (figure 1). As of 2010, government spending on health constituted approximately 7.0 percent of the total governmental expenditure and 2.3 percent of GDP. Public spending decreased between 1995 and 2011 from 2.7 percent to 2.3 percent of GDP, while private health spending by households rose rapidly at an average annual rate of growth of 19 percent. This growth has been attributed to increasing household costs of pharmaceutical care and the growing use of private care. Private expenditures accounted for 51 percent of total health expenditures as of 2010, approximately 80 percent of which are direct payments at the point of use and 20 percent of which represents health insurance premiums.

Figure 1 Main Actors and Fund Flows in the Tunisian Health System, 2010

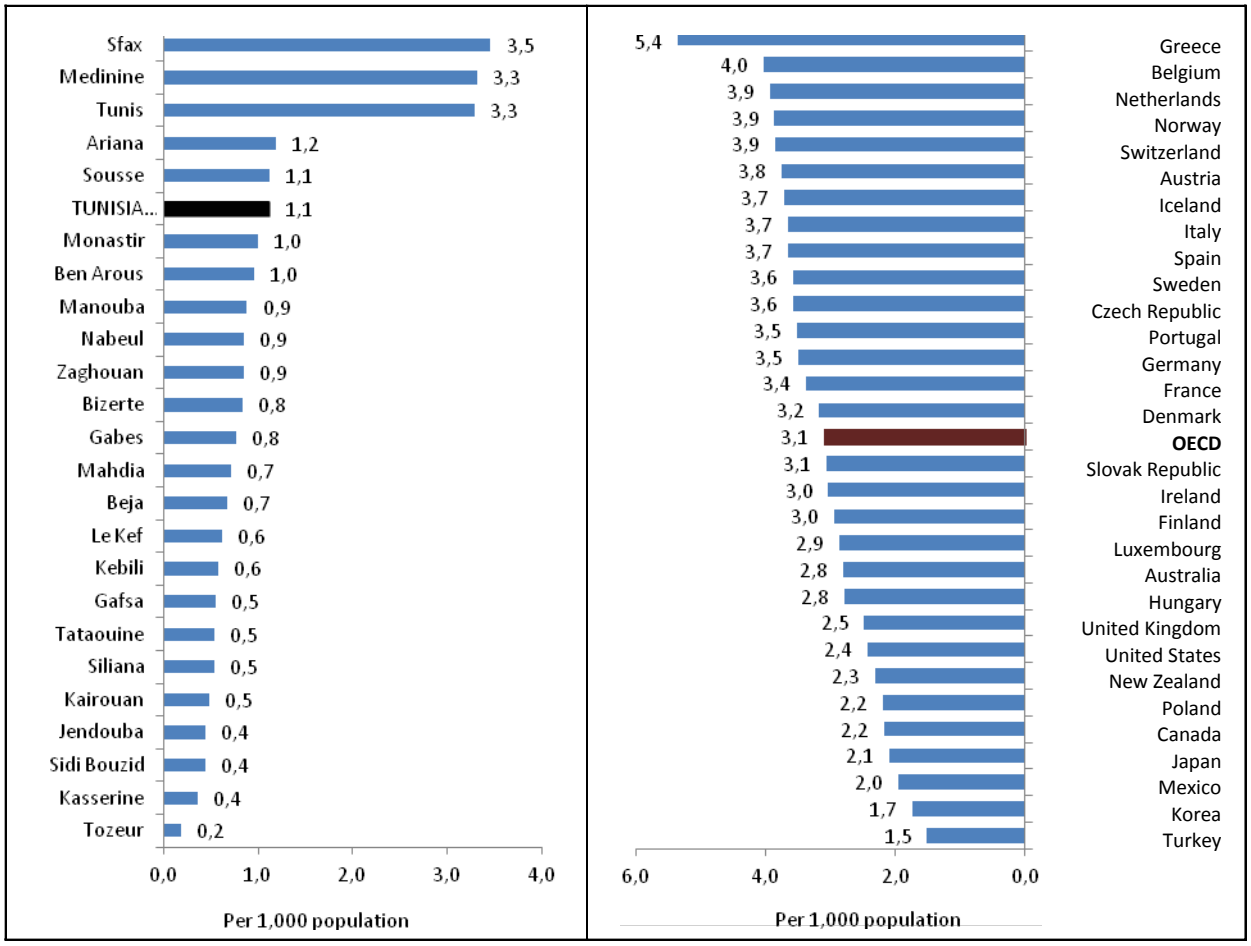


Source: Authors.

CNAM covers approximately 68 percent of the total population. It purchases health services from public and private providers in the country. Formal contracting systems exist with doctors, laboratories, dentists, and pharmacists, but criteria are unclear. Currently, retrospective reimbursement is the main scheme in place. FMAP is financed by transfers from the central government to the MOH to cover the estimated CNAM contributions of beneficiaries under the FMAP. However, it is unclear how the budget per beneficiary allocated to the MOH is estimated.

Tunisia's health system infrastructure is generally adequate but lacks sufficiently skilled personnel (particularly nonmedical), equipment, and information systems. The main steward is the MOH, although its oversight of the private sector is limited. The health care system is predominantly public; 87 percent of all beds are found in public hospitals and 13 percent in private clinics. On average, Tunisia has nearly as many doctors per capita as the Republic of Korea and Turkey, and in the capital, the figure is comparable to Germany (MOH 2010; OECD 2009). At the same time, the density of doctors is considerably lower in Tunisia's poorer regions, where most beneficiaries of the FMAP are located (figure 2).

Figure 2 Density of Doctors, Tunisia and OECD Countries, 2007/08



Sources: MOH 2011; OECD Indicators 2009, table 3.2.1.
Note: Rates shown represent the number of doctors per 1,000 inhabitants.

3. Brief Overview of Public Health, Primary Care, and Key Supply-side Efforts

In principle, access to services in Tunisia is based on a referral network along the above-mentioned three levels across its 24 regions—(a) primary health centers (centres de soins de base) and local hospitals (hôpitaux de circonscription), (b) regional hospitals (hôpitaux régionaux), (c) and university hospitals (centres hospitaliers universitaires), of which most are autonomous entities in terms of budget management (établissements de santé publiques). Patterns of utilization reveal the low efficiency of health service delivery. In 2008, the average bed occupancy rate of regional hospitals was 48 percent compared to an OECD average of 75 percent in 2009.[4] University hospitals account for the majority of days in hospital, up from 61 percent in 2002 to 65 percent in 2008. There is no formal referral system in place to coordinate access to services, nor gatekeeping to ensure an efficient use of different levels of services.

[4] MOH, Directorate for Evaluation and Planning 2011; OECD Indicators 2009.

While health facilities are relatively well distributed, the main challenges facing the system emanate from poor delivery of services and a lack of adequate financial protection. These challenges include (a) **regional disparities** in health status and the use of services, such as infant and maternal mortality, rates of assisted births, and access to sanitation; (b) **rising household out-of-pocket payments** on health care despite the existence of health insurance coverage, putting households at risk of economic shocks and poverty; and (c) **lagging quality of service delivery**, exacerbated by an increase in the prevalence of chronic health conditions that require long-term, sustainable health care coverage.

For example, the maternal mortality ratio is over three times higher in rural areas such as Kasserine than in urban areas such as Sousse (70 deaths compared to 20 deaths per 100,000 live births, respectively) as of 2006 (MOH 2008). Although only 6 percent of children are stunted, they are over twice as likely to be stunted in rural areas as in urban areas (10 percent compared to 4 percent, respectively). High-income groups are significantly more likely to use outpatient health services than low-income groups after controlling for age, gender, insurance coverage, and self-reported health status. In rural areas, 55 percent of women visit prenatal services at least four times compared to 75 percent in urban areas (MICS 2006). Approximately 75 percent of maternal mortality was due to avoidable causes, such as monitoring and postnatal follow-up in Tunisia as of 2008 compared to 46 percent in France as of 2006 (Dellagi et al. 2008; FIPHS 2011).

The quality of services is also perceived to be lower in underserved areas and in public facilities, in terms of proxy indicators and user perceptions of responsiveness. The rate of hospital-acquired infections (nosocomial infections) has been estimated to be 17.9 percent in Tunisia. This rate is relatively high compared to 6.8 percent in Lebanon, 6.5 percent in Thailand, and 4.4 percent in France (WHO 2011). Fifty percent of users were dissatisfied with public hospital services.[5] The responsiveness of public services lags behind private services notably in terms of staff treatment, waiting time, and basic amenities (WHO 2004). While these are self-reported perceptions by a sample of users, they indicate areas that tend to be closely associated with incentives and accountability mechanisms, as well as skills development and education.

4. FMAP Institutional Architecture and Interaction with Broader System

The PNAFN was established as the overarching safety net program for the poor, including cash transfers and FMAP, where the PFAFN is responsible for allocating FMAP health cards to poor beneficiaries. MOSA is responsible for the program and eligibility determination of potential beneficiaries. This ministry has established a national poverty database that includes socioeconomic information of families enrolled in the PNAFN. Under this program, the ministry selects the beneficiaries. The MOH is responsible for the delivery of services to all citizens, including FMAP beneficiaries, but does not manage the program itself. The MOH is supportive of the FMAP, but is concerned about financing the increasing demand for services by FMAP beneficiaries without associated budget increases. In addition, the FMAP is largely an implicit, poorly regulated and monitored system, so as such it does not explicitly contribute to improving the way the health system operates, either by example or design.

[5] Tunisia Hospital Performance Study 2008.

Households enrolled in PNAFN receive a cash transfer of 100 TND (Tunisian dinars) per month, equal to a value of 20 percent of the poverty line, and automatically receive a Free Health Card (as part of the FMAP). The poverty line used to determine eligibility is 585 TND (approximately US$1.25 per day). A child allowance is also given, which is 10 TND per child per month up to a limit of three children. Families that do not meet the criteria for PNAFN but are near-poor qualify for Subsidized Health Cards, which cover 20 percent of the population. PNAFN and FMAP do not have clear term limits after which beneficiaries reapply, and verification of need is rarely conducted by mobile social workers of the MOSA, who are mandated to do so at least once a year.

The institutional framework of the FMAP and mandate are specified under Health Care System Law No. 91-63 of July 29, 1991. The law relates to the organization and mission of the health sector and mandates that the state guarantee free access or reduced tariffs to low-income groups to public health care services under the FMAP: *"the benefit of free health care and hospitalization is granted to any needy people, his spouse and legally dependent children. The list of beneficiaries is fixed jointly by the Ministries of Public Health and Social Affairs. The free health card is issued for a period of five years…"*

In addition, Article 35 of the law stipulates that all preventive health services offered in public facilities devoted to individuals or the population are to be provided free of charge to all Tunisian citizens, regardless of income group. The law also states that *"the entitlement to free care and hospitalization is also given to all patients that are involved in the scientific studies, the preventive campaigns or epidemic diseases."*

Article 36 of the law stipulates that *"Reduced tariffs of outpatient and inpatient services are provided by the public health facilities to certain categories of the Tunisian people, their spouses and legally dependent children."* In addition, Decree No. 1998-409 of February 18, 1998, establishes the conditions and procedures for this scheme that include two types of family assistance: free access and reduced tariffs for the lowest-income groups.

The FMAP guarantees free access to public health facilities for PNAFN beneficiaries. The decree specifies that the free access concerns only families already enrolled or eligible for the permanent program of social assistance (under the poverty threshold). The free card is issued for a period of five years within national limit and regional quotas.

The decree for the FMAP also provides non-PFAFN vulnerable households the benefit of reduced tariffs as part of a Subsidized Health Card. The health card is given to families based on self-reported annual income and household size. Vulnerability is based on self-reported income that shall not exceed:

- An amount equal to the guaranteed interprofessional minimum wage (salaire minimum interprofessionnel garanti, SMIG) for families composed of two or fewer persons
- An amount equal to one-and-a-half times the SMIG for families composed of three to five persons
- An amount equal to twice the SMIG for families larger than five members.

The fee reduction card is issued in principle for five years according to regional quotas and must be validated annually with a deposit of 10 TND. Patients with a reduced tariffs card must pay a copayment (*ticket modérateur*) for hospital visits.

5. Targeting, Identification, and Enrolment of Beneficiaries

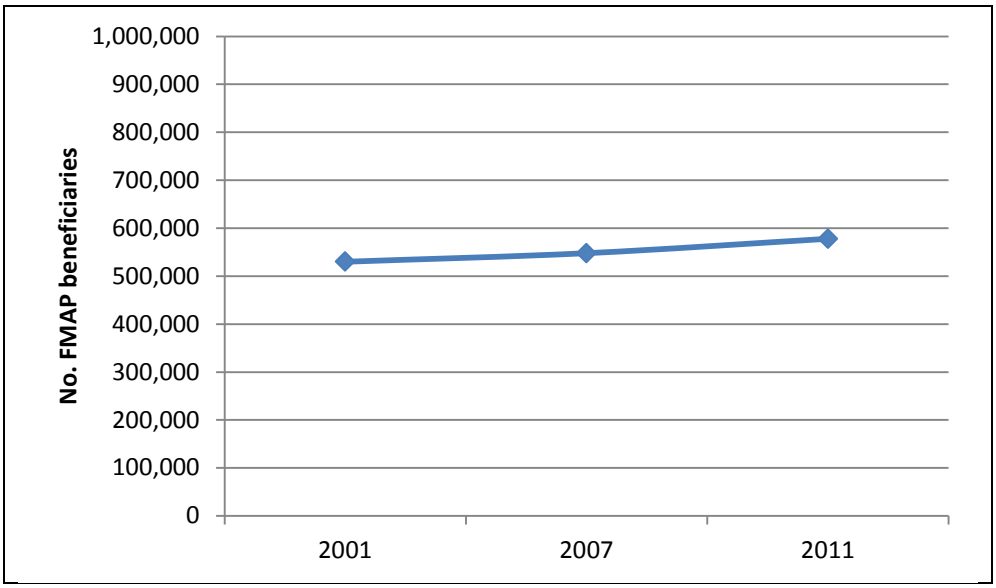
PNAFN uses categorical targeting to determine the eligibility of potential beneficiaries for the FMAP; however, eligibility determination and accountability mechanisms are not well documented. There is no poverty registry in Tunisia. PNAFN has a database of its beneficiaries, who are determined on the basis of categorical criteria by local commissions, but there is no precise verification process of household consumption, income, assets, and so forth.

Commissions of local authorities, who include representatives of Civil Society Organizations, determine eligibility on the basis of self-presentation and according to a list of categorical criteria. Eligibility criteria include (a) self-declared (unverified) household revenue falling below the poverty line, defined in PNAFN as 585 TND per year (US$1.25 per day), up from approximately 400 TND per year (US$0.75 per day) before the revolution; (b) household size; (c) number of household members with a disability and/or chronic health condition; (d) household living conditions, such as dwelling and assets; and (e) the inability for the head of household to work due to an impairment (physical or mental). The system has been prone to accusations of corruption and a lack of transparency and equity and, as of 2011, MOSA has been in the process of reforming the system.

There is a formal enrolment process for the FMAP and a waiting list. The government sets quotas for the FMAP based on historical data and expected numbers, but the precise mechanism for establishing quotas and annual increases has not been disclosed. There are no fees to enroll. Beneficiaries do not need to reapply. There are no formal, documented mechanisms of redress or accountability for responding to grievances, aside from informal complaints to the Bureaus of Citizen Relations (largely dysfunctional). There is an incentive for the enroller (MOSA) to maximize enrolment because there is a lump sum budget allocated to MOSA to distribute to this program, which is not routinely monitored or evaluated. There is no direct incentive to cream-skim since the FMAP is not monitored or based on health conditions.

Twenty-seven percent of the population receives FMAP health care cards, either for free or subsidized services, although current eligibility determination mechanisms leave ample room for corruption, lack of transparency, and inequity. Free health care cards (*carte de soins gratuits*) are automatically provided to PNAFN cash transfer beneficiaries and an additional 10,000 beneficiaries on the waiting list, totaling 195,000 needy households (7.4 percent of the population). A total of 557,900 “vulnerable” households receive subsidized health care cards (*carte de soins à tarif réduits*) (20 percent of the population), a number that has been growing steadily but slowly (figure 3).

Figure 3 Evolution of Enrolment for FMAP Subsidized Health Cards, 2001–11

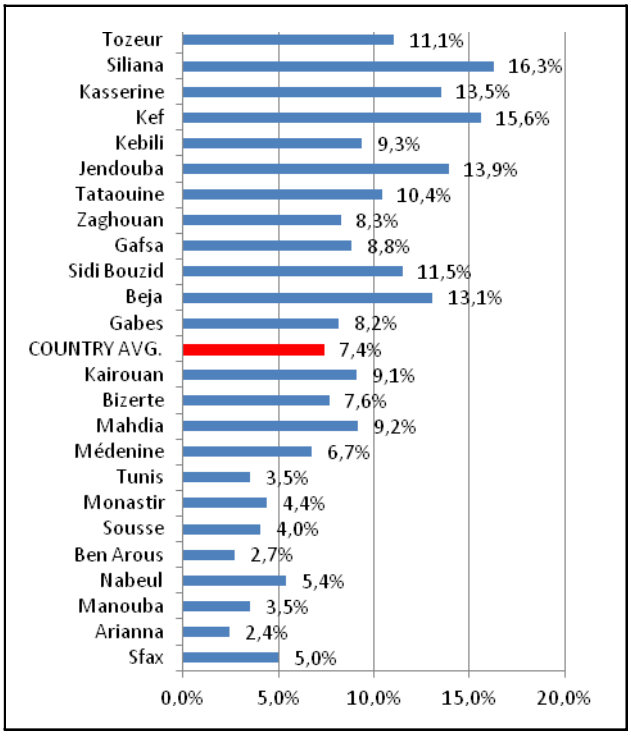


Source: MOSA 2011.

Evaluations of the FMAP in terms of public expenditure reviews, access to services, and governance in targeting beneficiaries are not routinely conducted. The Tunisia Household Consumption and Budget Survey suggests that 40 percent of the poor were enrolled in the FMAP as of 2005 (most recent data).[6] A key administrative database is the PNAFN beneficiary database, managed by MOSA, which contains basic demographic data on 185,000 families currently receiving cash transfers and health cards, but there is no information on household socioeconomic status. Based on 2011 data from the PNAFN database, 51 percent of beneficiaries are female (heads of households); 57 percent are over age 60, and 65 percent live in lagging regions (14 governorates to the west) (see figure 4). These results suggest that PNAFN may be acting as a form of social pension, due to insufficient pensions under the National Social Security Fund (Caisse Nationale de Sécurité Sociale)/National Fund of Retirement and Social Security (Caisse Nationale de Retraite et de Provoyance Sociale). Following the revolution, MOSA initiated a reform process meant to design an improved targeting system and a consolidated registry of poverty and social protection programs to improve coverage and reduce leakages.

[6] A World Bank study was initiated in July 2012 and is ongoing. Source: Authors' calculations using Tunisian Household Budget and Consumption Survey, National Institute of Statistics, 2005.

Figure 4 Percent of Individuals Receiving Free Health Cards (*carte de soins gratuits*) by Governorate, 2011



Source: MOSA, April 2011.

6. Management of Public Funds in the FMAP

The MOH is both a financing agent and a provider to the vast majority of public facilities in Tunisia and covers the FMAP directly. Based on utilization data, the FMAP accounted for 267 million TND in 2010, or 13.9 percent of total public health expenditures (tables 1 and 2). The FMAP financing scheme is not well documented and there is little information available on how the cost per beneficiary compares to the cost per beneficiary under CNAM to date (that is, no proof of execution; one of the challenges of the financing gap for this scheme is that public hospitals claim deficits, particularly in drug items). There is no earmarked budget to cover health care consumption of FMAP beneficiaries.

Hospital budgets are fixed but can be revised during the fiscal year. Hospitals attempt to adjust their activities in response to demand. In the subsequent year, hospital budgets can be adjusted to cover their arrears in principle, but deficits persist. Indirectly, CNAM financing is likely cross-subsidizing the FMAP, but the extent to which it does is unclear. There has so far been no strong push for moving from supply to demand subsidies. Much of the dialogue will remain muted until a permanent government is in place in the latter part of 2013.

Table 1 FMAP Expenditures, 2005–2010

Year	Total FMAP Expenditures in Local Currency (Millions of TND)	As % of Public health Expenditures	As % of Total Expenditures	As % of GDP
2010	267	13.9	1.48	0.47
2009	252	13.6	1.45	0.47
2008	286	17.0	1.78	0.57
2007	286	19.4	1.89	0.63
2006	266	19.7	1.92	0.64
2005	307	25.6	2.36	0.81

Source: Authors' compilation based on data from MOF and MOH.
Note: FMAP expenditures include those related to services received at university and regional hospitals.
FMAP = Health Care for the Poor.

Table 2 Financing of FMAP Expenditures, 2010

	Local Currency (Millions of TND)	Percent of Total
Total Expenditures of FMAP in 2010	267	100
Government Funding	238	—
Of which		
- Central government	187	69.5
- Social security contributions	51	20.2
- Subnational government	—	—
- Arrears	—	—
Beneficiaries	29	
Of which		
- Point of service payments (includes copayments. user fees, etc.)	29	10.2
- Registration fees	—	—
- Premium contributions	—	—
- Others (describe)	—	—
External Donor Contributions	0	0
Others (describe)	—	—

Source: Authors' compilation based on data from Ministry of Finance and MOH.
Note: — = not available.
FMAP = Health Care for the Poor.

Beneficiaries of free health care are entitled to use public services without having to make copayments, and providers in some cases have been seemingly reluctant to prioritize FMAP beneficiaries due to pending hospital deficits. Beneficiaries of reduced tariffs must pay copayments at the point of service (see table 3). A fixed amount is paid for outpatient services and another for inpatient services. Patients pay 20 percent of the amount of procedures, X-rays, and lab tests with a ceiling of 30 TND (US$20) per episode.

Table 3 Payment Systems and Cost-containment Instruments for FMAPa

Payment Systems and Cost Containment Instruments for FMAP	Payment System[b] (Use codes below)	Utilization Controls[c] (Use codes below)	Comments
Inpatient Services			
Birth delivery	CP	COPAY	COPAY for beneficiaries of reduced tariffs only
Emergency Services	FFS	COPAY	
Other Inpatient hospital services		COPAY	
- Hospital component (hotel services, nursing care, disposables, tests)	CP	COPAY	
- Physician service components	SAL	COPAY	
- Pharmaceuticals	FFS	COPAY	
- Diagnostic imaging	FFS	COPAY	
- Adjustments (e.g., teaching, disproportionate share of poor, capital)	CP	COPAY	
Outpatient Services			
Public health services, such as immunizations	SAL	COPAY for ambulatory care	Any copayment
Outpatient primary care contacts	SAL	COPAY	
Outpatient specialist contacts	SAL	COPAY	
Pharmaceuticals for outpatient services	FFS	COPAY	
Clinical laboratory tests for outpatient services	FFS	COPAY	
Diagnostic imaging for outpatient services—basic (X-rays and ultrasound)	FFS	COPAY	
Diagnostic imaging for outpatient services—beyond X-rays and ultrasound (e.g., MRI, CAT Scan)	FFS	COPAY	
Other services			
Eyeglasses			
Dental care	SAL	COPAY	
Prosthetics and orthotics			
Dialysis or transplants	FFS	COPAY	Any copayment
Home care services			

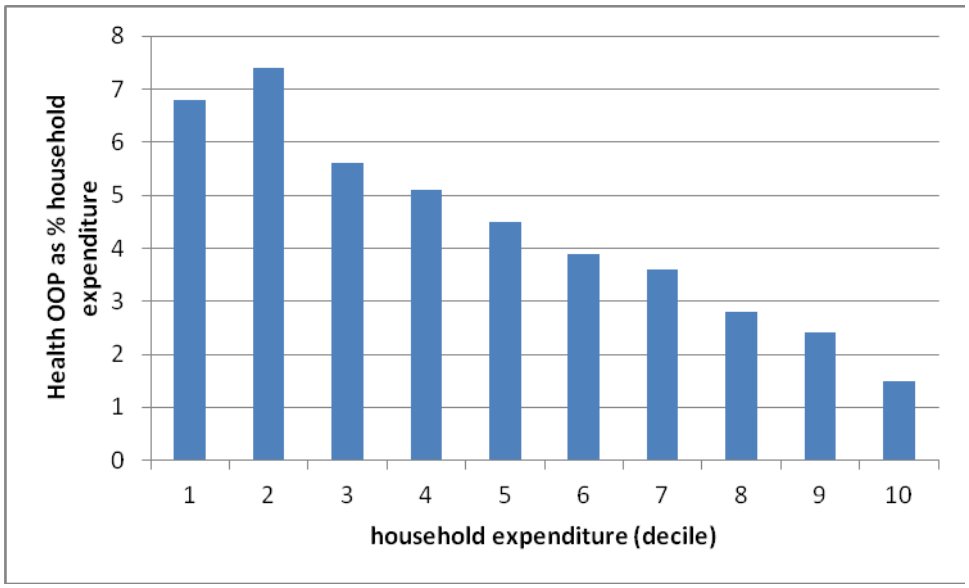
Source: Authors' compilations.
Note: a. Codes for Payment Systems and Utilization Controls.
b. More than one may be used.
c. More than one may be used.
COPAY = copayments paid by patient, CP = case payment (for example, DRG), FFS = fee-for-service, SAL = all services by a provider for a fixed period of time (that is, salary or global/line-item budget).

FMAP beneficiaries account for a sizable proportion of outpatient visits to regional hospitals, but a lower proportion to university hospitals, which are mainly located in coastal, wealthier cities. FMAP beneficiaries accounted for 25 percent of all outpatient visits to regional hospitals and 12 percent of all outpatient visits to university hospitals. FMAP beneficiaries accounted for 23 percent of all inpatient visits to regional hospitals and 16 percent of all inpatient visits to university hospitals.

There has been routine monitoring of informal payments in Tunisia, but household survey data show that low-income groups spend out-of-pocket for health services despite the FMAP. On average, households spend 10 percent of their total out-of-

pocket expenditure on health services, but the figure climbs to 68 percent among the poorest 10 percent of the populations (figure 5). Low-income groups, despite FMAP coverage, use fee-based care and purchase medicines in the private sector. Public hospital pharmacies often face shortages of medications.

Figure 5 Health Out-of-Pocket (OOP) Spending as a Percent of Total Household Expenditure, Tunisia, 2004



Sources: Staff calculations. WHO 2004. Reflects most recent available data. Data from the 2010 National Household Consumption and Budget Survey are forthcoming.

7. Management of FMAP Benefits Package

The FMAP does not include a specific benefits package for beneficiaries. All public providers are automatically required to participate in the FMAP. There is no accreditation system or formal approval/opting-out option in place and no outspoken clear champion of improved health outcomes in relation to the FMAP. Following the revolution, there have been calls by the Ministry of Regional Development and Planning (a relatively new ministry) and the MOH to improve access to services in lagging regions in the west of the country. However, these calls for improved service have not reached high political visibility, and the ministries have not achieved much clout in this area, given that this is still a relatively newly, *publicly* recognized phenomenon in Tunisia (that is, poverty and its implications were not publicly discussed during the previous regime).

8. Information Environment of the FMAP

MOSA has a very basic database on beneficiaries of Health Care for the Poor (FMAP), but the system is not a comprehensive information system and it is not accessible to other agencies (MOH and MOF). There is a need to institute routine monitoring and evaluation of beneficiaries,

eligibility, utilization, and costs associated with the FMAP. The FMAP information system in Tunisia faces infrastructure, technical capacity, and coordination challenges.
First, data collection and dissemination currently rely on manual and unsystematic processes that vary from health facility to health facility and are not included in or linked to the PNAFN database. There is no systematically collected information on quality or costs of health care. Second, there is limited capacity at the central and regional levels to collect data, and little information exists for the public to promote social accountability, in light of perceived inequities associated with the FMAP. Third, at least 10 public agencies are involved in the collection of health-system-relevant information, yet there is no centralized coordination or identification of FMAP beneficiaries.[7] A strong and well-documented information system will need to be put in place to enable greater information sharing between MOSA and MOH to improve targeting and coverage of essential services.

9. Special Focus: Toward a Strategic Vision for Financing FMAP

The overall fiscal burden associated with the economic transition puts pressure on public health spending, and the FMAP is already suffering from weaker and weaker public service delivery. Rates of maternal mortality and infant mortality remain high in lagging regions of Tunisia. Access to prenatal and postnatal care and deliveries assisted by skilled health professionals remain low among poorer groups. Ten percent of the population remains uninsured, and out-of-pocket payments are on the rise among FMAP beneficiaries even as the quality of health services deteriorates. Against this backdrop, there is a need to devise a clearer and more transparent funding mechanism for the FMAP that allows greater access to better-quality services.

The MOF, as of 2006, embarked on a program of performance-based budgeting with the MOH. The scheme serves as a prototype for a strategic vision for financing for the FMAP program, demarcating clear incentives for beneficiaries to ensure appropriate human capital investments and use of key services. Currently, however, the deteriorating quality of public services means that contracting with the private sector may help improve access to health services for the poor enrolled under the FMAP for selected services. Medications coverage needs to be reviewed in general in Tunisia, particularly financing of pharmaceuticals for lower-income groups who, despite the FMAP, continue paying high out-of-pocket payments for medications.

10. Pending Agenda

The period following the Tunisian revolution, like other democratic transitions in Eastern Europe, Latin America, and Southeast Asia, represents a window of opportunity for Tunisia to set a new trajectory for the social contract. Rather than a legacy of protecting a few, the reform of safety nets such as the FMAP can demonstrate a commitment to ensuring accountability,

[7] In principle, the MOH (Direction des Etudes et de la Planification [DEP]) is responsible for analysis of health system performance using data collected from the National Institute of Public Health, various departments of the MOH, and the National Institute of Statistics. The national health information system and the role of the DEP were evaluated between April 2008 and November 2009 as part of the Health Metrics Network, which provided input to the development of the DEP Strategic Plan to address gaps in technical capacity.

transparency, and a level playing field for the rich and poor. The governance of the FMAP system warrants careful review and is likely the most important agenda facing the FMAP in terms of how well targeted the system is for reaching the poor. Public expenditure tracking and purchasing of health services fall within a reform of the FMAP to ensure sustainability during the economic slowdown. Since management of the FMAP is not clearly demarcated between the MOSA and MOH, there is an opportunity for the CNAM to play a more active role in managing the FMAP through consolidation of benefits and information systems. While the MOSA is responsible for determining eligibility, the monitoring of services and access by beneficiaries falls under the MOH but is not routinely done. There is no information system that tracks each beneficiary's use and satisfaction with or complaints about the system, and no process to verify eligibility in a rigorous manner.

Key issues in terms of overall architecture include:

- Lack of a clear benefits package and tariffs scale for copayments
- Mechanisms of accountability regarding MOSA and/or MOH for ensuring appropriate targeting, access to services, and grievance mechanisms
- Quality assurance and follow-up of services rendered to FMAP beneficiaries
- Lack of coordination with CNAM and private medical services
- Lack of clear funding/earmarking mechanisms that are clearly tied to volume and usage.

Management of the FMAP benefits package faces challenges in terms of:

- Lack of a clear benefits package and coordination with the private sector
- Lack of a rigorous Management Information System on benefits, utilization, costs, and grievances
- Lack of monitoring health status of beneficiaries and unmet needs
- Follow-up and monitoring of dependents.

In line with the spirit of the revolution, three key steps can be taken to strengthen voice and transparency in the health care program for the poor. These are:

- **Targeting criteria and processes will need to be strengthened substantially for the FMAP.** In the past, eligibility criteria mechanisms relied on local commissions that are not routinely audited in a rigorous way (that is, Cours des Comptes or other controllers' bodies). With nearly 24 percent of the population receiving health cards, and given an economic slowdown, the demand for health care is expected to grow. In September 2012, the MOSA launched the development of a new poverty registry and a means-based targeting system to improve the identification and reverification of beneficiaries.

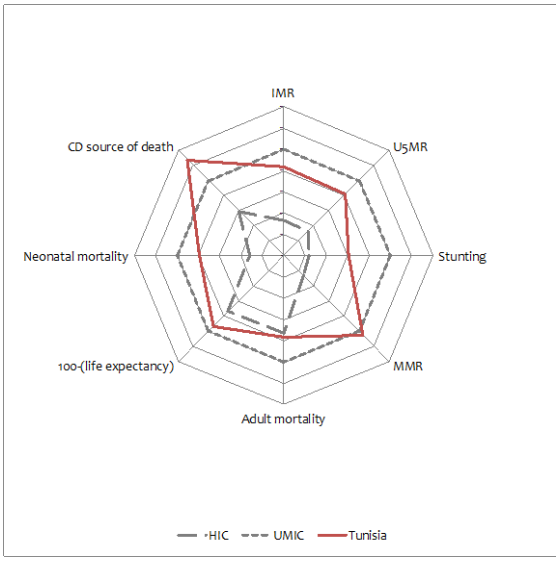
- **In line with the need to strengthen financing arrangements for the FMAP, reforming the central management structure and monitoring of the FMAP should be considered through a possible merger with CNAM toward a single-payer system.** This would include consolidation with the CNAM and coverage of private services where public services are unavailable. The benefits package should be more clearly defined, with specific incentives for accessing

primary care and, in particular, prenatal services. Waiting times, a lack of adequately skilled personnel, and a lack of public provision of medications are challenges faced by poorer beneficiaries who do not have access to alternative options (such as the private sector or travel abroad). Therefore, better purchasing of services, goods, and personnel can be established through contracting arrangements and incentives for improving performance in poorer regions. While decentralization and greater autonomy of health care providers is a medium-term agenda, innovative service delivery such as through mobile services should be strengthened significantly.

- **In parallel, building effective grievance and redress mechanisms and disclosing information about how well the program reaches the vulnerable are necessary to building social accountability.** Signals such as these can help promote a new legacy of social inclusion in Tunisia and make a break with the past under the former regime.

Annex 1 Spider Web

I. Outcomes comparisons: Tunisia and Upper Middle Income Countries



Note on interpretation:
In this plot 'higher' is 'worse' – since these indicators are positive measures of mortality / morbidity. Life expectancy is converted to be an inverse measure.

The values on the radar plot have been standardized with respect to the average upper middle income country value.

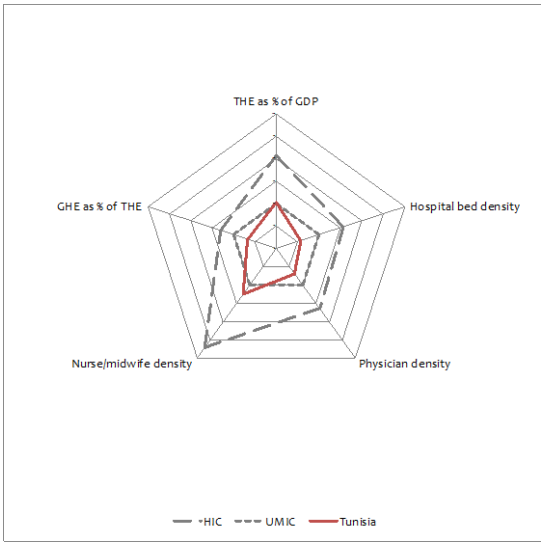
The table below summarizes outcome comparisons with the average upper middle income country (UMIC).

< -50%
[-25% ; -50%]
[-25% ; +25%]
[+25% ; +50%]
> 50%

Country Data	Tunisia	UMIC	% Diff.
GNI pc (2000 USD)	2146.2	1899.0	13.0%
IMR	13.8	16.5	-16.4%
U5MR	16.1	19.6	-18.0%
Stunting	9.0	14.8	-39.0%
MMR	56.0	53.2	5.2%
Adult Mortality	123.0	160.6	-23.4%
100-Life Expectancy	25.4	27.2	-6.5%
Neonatal Mortality	9.0	11.4	-21.1%
CD mortality	28.0	22.0	27.3%

IMR: Infant mortality rate (2010). U5MR: Under-5 mortality rate (2010). Stunting: prevalence of low height-for-age among children under 5 (2010). MMR: Maternal mortality rate (2010) per 100 000 live births. Adult mortality: Adult mortality rate per 1000 male adults (2010). [100-(life expectancy)]: Life expectancy at birth (2010) subtracted from maximum of 100. Neonatal mortality: Neonatal mortality per 1000 living births. CD as cause of death: Communicable diseases as cause of death (% total). All data from World Bank's World Development Indicators. Income averages for stunting calculated by Bank staff and are unweighted.

II. Inputs comparisons Tunisia and Upper Middle Income Countries



Note on interpretation:
This plot shows indicators which measure spending on health or the number of health workers per population.

The values on the radar plot have been standardized with respect to the average upper middle income country value.

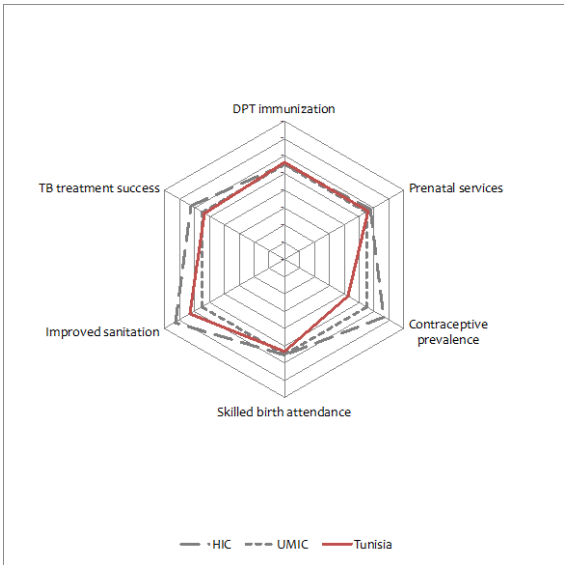
The table below summarizes inputs comparisons with the average upper middle income country (UMIC).

> 50%
[+25% ; +50%]
[+25% ; -25%]
[-25% ; -50%]
< -50%

Country Data	Tunisia	UMIC	% Diff.
GNI pc (2000 USD)	2146.2	1899.0	13.0%
THE %GDP	6.2	6.1	1.6%
Hosp. bed density	2.1	3.7	-42.7%
Phys. density	1.2	1.7	-29.6%
Nur./midwife dens.	3.3	2.6	25.8%
GHE %THE	36.3	54.3	-33.1%

THE as % of GDP: Health expenditure, total (% of GDP) (2010). Hospital bed density: Hospital beds per 1,000 people (latest available year). Physician density: Physicians per 1,000 people (latest available year). Nurse/midwife density: Nurses and midwives per 1,000 people (latest available year). GHE as % of THE/10: Public health expenditure (% of total expenditure on health) (2010). All data from World Bank's World Development Indicators.

III. Coverage comparisons
Tunisia and Upper Middle Income Countries



Note on interpretation:
In this plot 'higher' is 'better' – since these indicators are positive measures. In this case, all are percent of the population receiving or having access to a certain health related service.

The values on the radar plot have been standardized with respect to the average upper income country value.

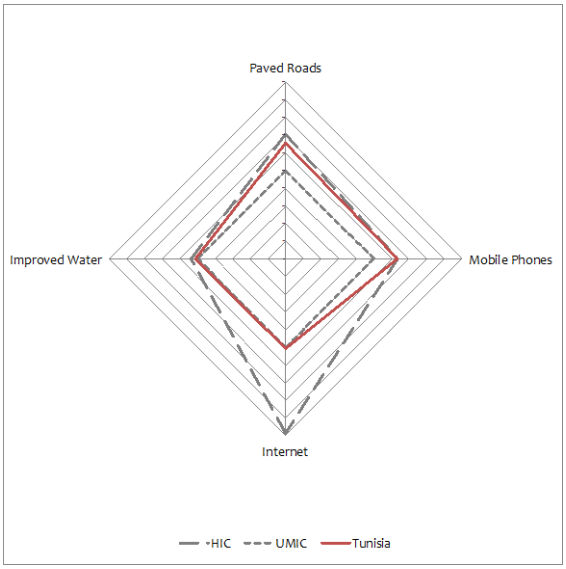
The table below summarizes coverage comparisons with the average upper middle income country (UMIC).

> 50%
[+25% ; +50%]
[+25% ; -25%]
[-25% ; -50%]
< -50%

Country Data	Tunisia	UMIC	% Diff.
GNI pc (2000 USD)	2146.2	1899.0	13.0%
DPT	98.0	95.8	2.3%
Prenatal	96.0	93.8	2.4%
Contraceptive	60.2	80.5	-25.3%
Skilled birth	94.6	98.0	-3.5%
Sanitation	85.0	73.0	16.4%
TB success	83.0	86.0	-3.5%

DPT immunization: % of children aged 12-23 months with DPT immunization (2010). Prenatal services: % of pregnant women receiving prenatal care (latest available year). Contraceptive prevalence: % of women ages 15-49 using contraception (latest available year). Skilled birth attendance: % of all births attended by skilled health staff (latest available year). Improved sanitation: % of population with access to improved sanitation facilities (2010). TB treatment success: Tuberculosis treatment success rate (% of registered cases). All data from World Bank's World Development Indicators.

IV. Infrastructure comparisons
Tunisia and Upper Middle Income Countries



Note on interpretation:
In this plot 'higher' is 'better' – since these indicators are positive measures of provision of certain good / service, and a measure of urban development.

The values on the radar plot have been standardized with respect to the average upper middle income country value.

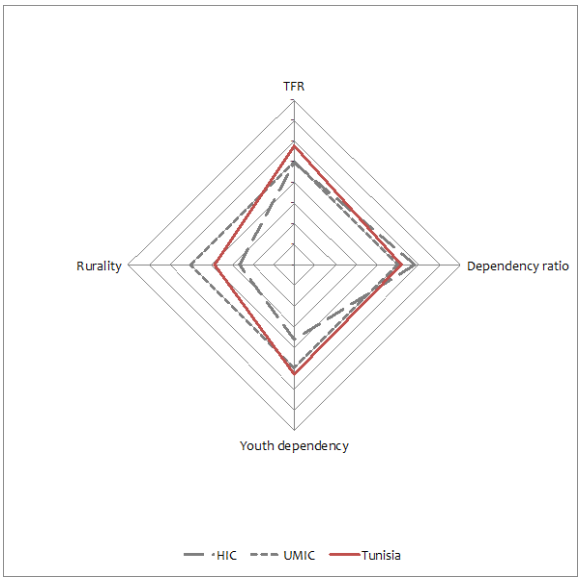
The table below summarizes infrastructure comparisons with the average upper middle income country (UMIC).

> 50%
[+25% ; +50%]
[+25% ; -25%]
[-25% ; -50%]
< -50%

Country Data	Tunisia	UMIC	% Diff.
GNI pc (2000 USD)	2146.2	1899.0	13.0%
Paved roads	75.2	57.6	30.6%
Mobile phones	116.9	92.3	26.6%
Internet	38.8	38.3	1.3%
Water	94.0	92.6	1.5%

Paved roads: % of total roads paved (most recent). Internet users: users per 100 people (2010, with some estimates from prior years). Mobile phone users: mobile cellular subscriptions per 100 people (2010). Access to improved water: % of population with access to improved water source (2010). All data from World Bank's World Development Indicators.

V. Demography comparisons
Tunisia and Upper Middle Income Countries



Note on interpretation:

Indicators here measure births per woman, the extent of rurality, and the number of dependents.

The values on the radar plot have been standardized with respect to the average upper middle income country value.

The table below summarizes demographic indicators comparisons with the average upper middle income country (UMIC).

	> 50%
	[+25% ; +50%]
	[+25% ; -25%]
	[-25% ; -50%]
	< -50%

Country Data	Tunisia	UMIC	% Diff.
GNI pc (2000 USD)	2146.2	1899.0	13.0%
TFR	2.0	1.8	15.3%
Dependency (Total)	43.7	42.2	3.5%
Youth share	77.1	73.0	5.7%
Rural pop.	32.7	42.6	-23.2%

TFR: total fertility rate (births per woman), 2009. Dependency ratio: % of working-age population (2010) aged less than 15 or more than 64. Youth dependency: % of working-age population (2010) aged less than 15. Rurality: % of total population in rural areas (2010). All data from World Bank's World Development Indicators.

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The World Bank supports the efforts of countries to share prosperity by transitioning toward universal health coverage (UHC) with the objectives of improving health outcomes, reducing the financial risks associated with ill health, and increasing equity. The Bank recognizes that there are many paths toward UHC and does not endorse a particular path or set of organizational or financial arrangements to reach it. Regardless of the path chosen, the quality of the instruments and institutions countries establish to implement UHC are essential to its success. Countries will face a variety of challenges during the implementation phase as they strive to expand health coverage. With that in mind, the World Bank launched the Universal Health Coverage Studies Series (UNICO Studies Series) to develop knowledge and operational tools designed to help countries tackle these implementation challenges in ways that are fiscally sustainable and that enhance equity and efficiency. The UNICO Studies Series consists of technical papers and country case studies that analyze different issues related to the challenges of UHC policy implementation.

The case studies in the series are based on the use of a standardized protocol to analyze the nuts and bolts of 27 programs in 25 countries that have expanded coverage from the bottom up, starting with the poor and vulnerable. The protocol consists of 300 questions designed to elicit a detailed understanding of how countries are implementing five sets of policies to accomplish the following:

- Manage the benefits package
- Manage processes to include the poor and vulnerable
- Nudge efficiency reforms to the provision of care
- Address new challenges in primary care
- Tweak financing mechanisms to align the incentives of different stakeholders in the health sector

The UNICO Studies Series aims to provide UHC implementers with an expanded toolbox. The protocol, case studies and technical papers are being published as part of the Series. A comparative analysis of the case studies will be available in 2013.

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