Understanding the private health sector
in Tunisia

World Health Organization
Eastern Mediterranean Region

unicef
for every child

USAID
FROM THE AMERICAN PEOPLE

UNFPA

UNAIDS

UNHCR
The UN Refugee Agency

Wonca
EAST MEDITERRANEAN

Understanding the private health sector
in Tunisia

World Health Organization
Eastern Mediterranean Region

unicef
for every child

USAID
FROM THE AMERICAN PEOPLE

UNFPA

UNAIDS

UNHCR
The UN Refugee Agency

Wonca
EAST MEDITERRANEAN

WHO Library Cataloguing in Publication Data

Names: World Health Organization. Eastern Mediterranean Region

Title: Understanding the private health sector: in Tunisia / World Health Organization. Eastern Mediterranean Region

Description: Cairo: World Health Organization. Eastern Mediterranean Region, 2024

Identifier: ISBN 978-92-9274-357-4 (pbk.) | ISBN 978-92-9274-358-1 (online)

Subjects: Private Sector | Health Status Indicators | Health Care Sector - organization & administration | Health Workforce | Healthcare Financing | Public-Private Sector Partnerships | Universal Health Insurance | Delivery of Health Care - organization & administration | Tunisia

Classification: NLM WA 540

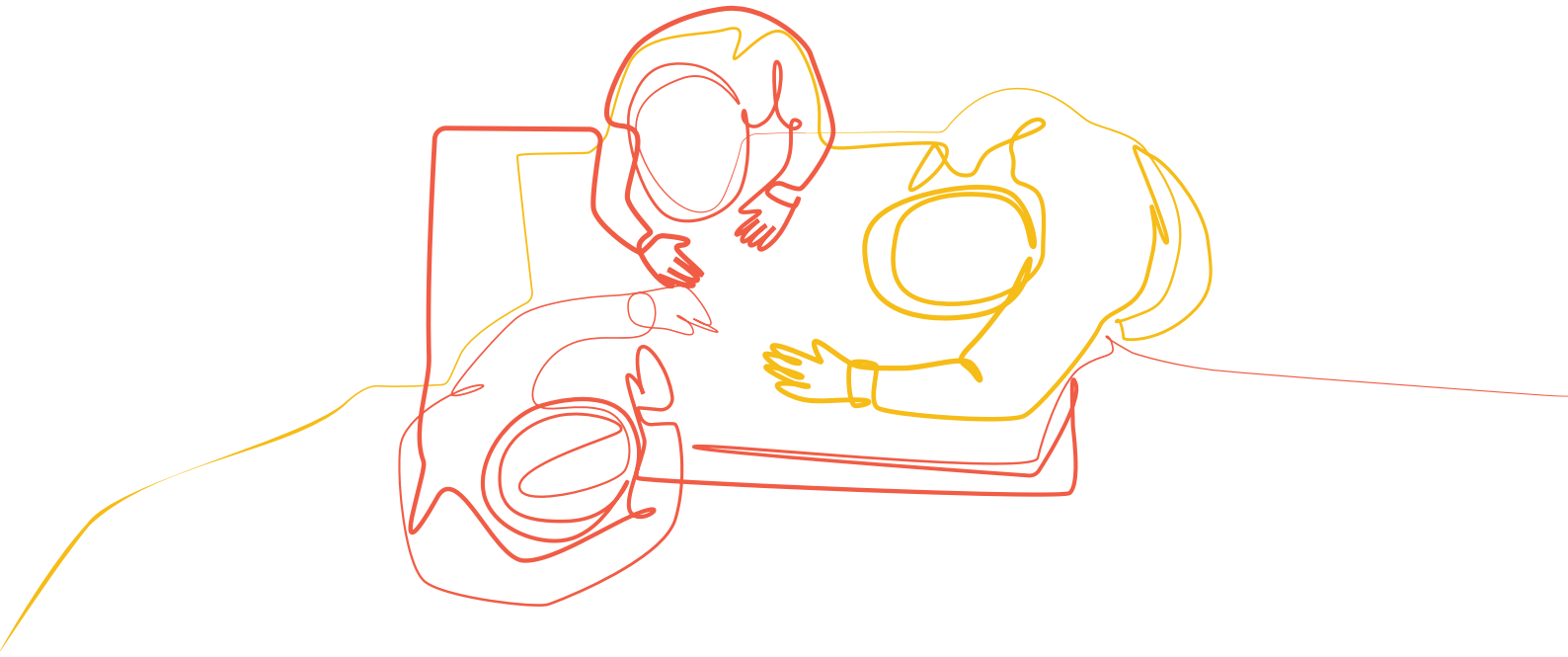
Contents

Acknowledgements

This report was developed by Dr Inés Ayadi, Professor of Health Economics at Sfax University in Tunisia and international consultant in health economics, in response to a request by the WHO Regional Office for the Eastern Mediterranean.

WHO would also like to acknowledge the support and technical input of Abdelwahed El Abassi, Hédi Achouri, Hichem Abdesselem and Riadh Ben Abbes, who provided invaluable comments during the development and finalization of this document, and Yassine Kelboussi for his contributions and support in carrying out interviews with various stakeholders.

The report, whose structure and methods follow the guidelines and assessment tools developed by the WHO Regional Office in 2018, was reviewed by Aya Thabet (WHO consultant), under the supervision of Hassan Salah, (Regional Adviser, Primary and Community Health Care, WHO Eastern Mediterranean Region).



1
Country context

Tunisia has a total area of

163 610 km^2

Using the 2019 population of

11.78

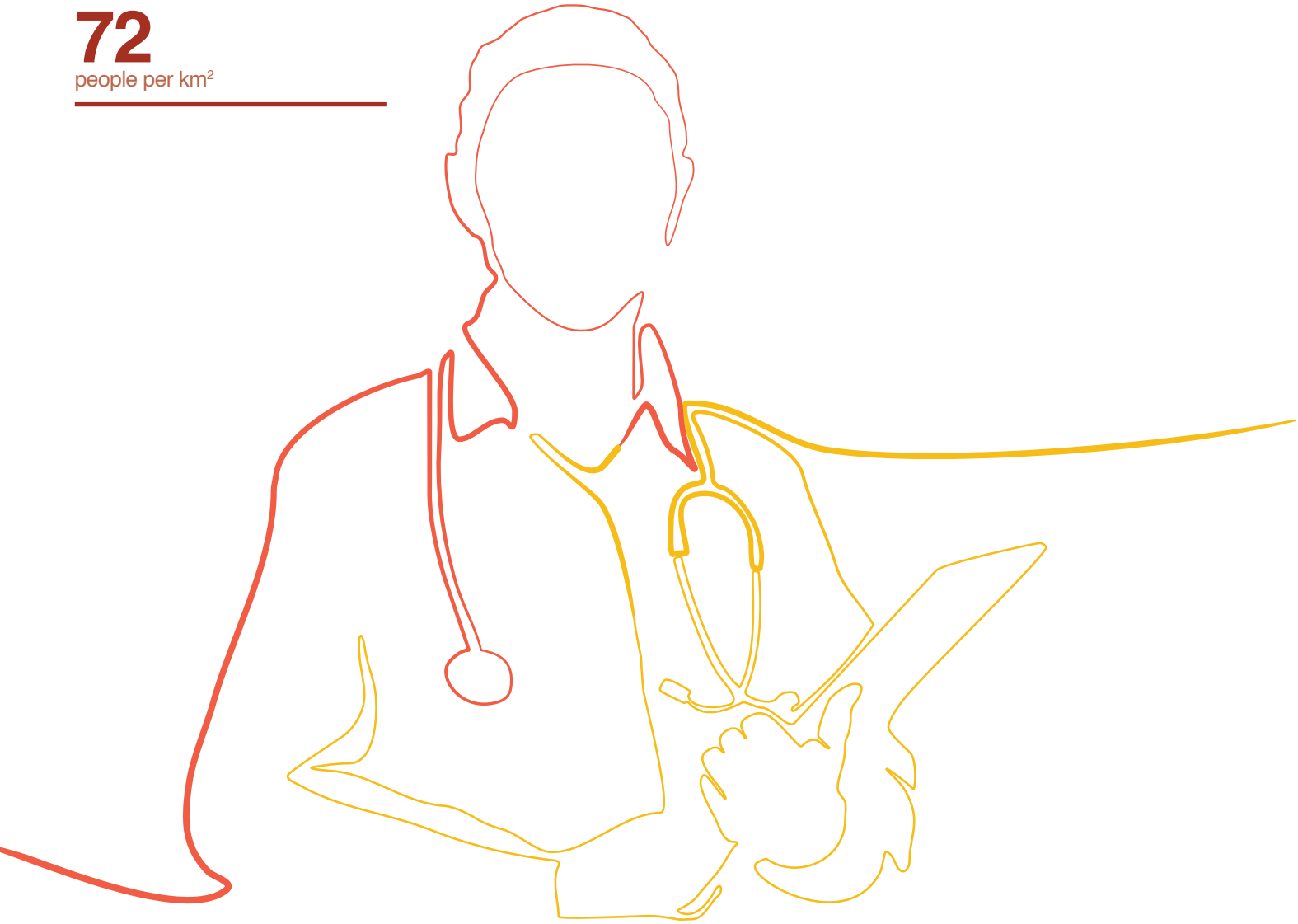
million people, the population density of Tunisia is

72

people per km^2

Tunisia, the northernmost country of Africa, is the smallest country in the Maghreb region, with a surface area of 163 610 km^2. It is bordered by the Mediterranean Sea, Libya to the south and Algeria to the west. Using the 2019 population of 11.78 million people, the population density of Tunisia is 72 people per km^2.

In the country's Constitution, adopted in 2022, Article 43 explicitly recognizes the right to health and urges the State to guarantee the right to health coverage and access to high-quality health care for all citizens.



2

Selected social, economic and health indicators

In 2017, Tunisia was ranked 95th in terms of human development, with a human development index[1] score of 0.735

Since the global financial crisis and the outbreak of the revolution in January 2011, economic indicators have been unfavourable. In 2018, economic growth in the country picked up to 2.6%, mainly due to an increase of added value in the agriculture and tourism sectors. Despite this renewed growth, the economy is still vulnerable, with its chronic budget deficit and sharp depreciation in the Tunisian dinar (abbreviated DT, for dinar tunisien), as well as a stubbornly high inflation rate of more than 7% and an unemployment rate of over 15%. This situation has resulted in Tunisia being unable to fulfil the social aspirations that were strongly expressed during the revolution.

In 2017, Tunisia was ranked 95th in terms of human development, with a human development index[1] score of 0.735. This indicates that significant progress has been made, particularly in the social sectors. When we look at the country's inequality-adjusted human development index score, the value drops by 22% to 0.573, demonstrating that development has not been inclusive *(1, 2)*. For example, while life expectancy at birth averages 75.9 years, coastal regions have a higher life expectancy than regions in the south and west of the country.

In 2014, 1.25 million of Tunisia's inhabitants were over 60 years of age, accounting for 11.4% of the population *(3)*. It is expected that this will reach to 19% by 2030, representing 2.5 million people *(4)*. Tunisia has seen an epidemiological transition, characterized by an increase in the incidence of noncommunicable diseases and a decline in the incidence of communicable diseases including the eradication or near-eradication of measles, polio and neonatal tetanus . This transition is associated with changes in lifestyle towards less physical activity and unhealthy diet and an ageing population and has affected the country's morbidity pattern and mortality rate. Cardiovascular disease, accidents and cancer are currently the most common causes of death *(5)*. In 2016, the prevalence of diabetes and hypertension in the Tunisian population aged 15 and over stood at 15.5% and 28.7%, respectively *(6)*.

In 2016, neonatal, infant and child mortality rates in Tunisia were lower than in the average of upper-middle income countries and Middle East/ North African countries with average incomes. That said, the maternal mortality ratio has remained relatively high and has not declined as much as that of the Islamic Republic of Iran or Türkiye; Tunisia did not reach its expected target for the 2015 Millennium Development Goals.

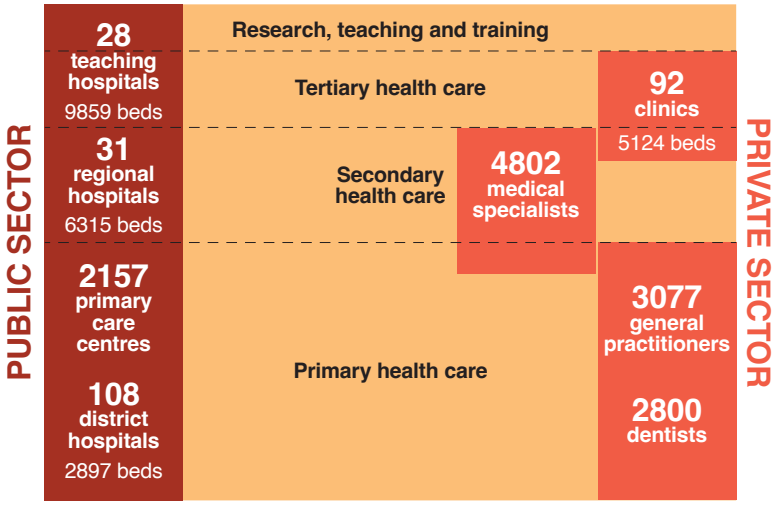
1 The Human Development Index measures the long-term progress of several countries in the world, taking into account three essential aspects: a long healthy life, access to education and a decent standard of living.

3

Organization of the health system and delivery of health care services

The health care system in Tunisia is composed of the public sector, the main service provider in the country (with more than 80% of hospital beds), a strong private sector and a relatively negligible semi-public sector (Fig. 1).

Fig. 1. Distribution of health care services in the public and private sectors



Source: Data from Ministry of Health and the Ordre des Médecins de Tunisie (Tunisian medical board)

3.1. Public health sector

Ministry of Health

The Ministry is the main public health service provider. Health care services are organized into three levels, based on the proximity of health care. The missions of each level are set out in Law No. 91-63 on health care organization (Articles 11 to 14) and Decree No. 2002-846, supplemented by Decree No. 2010-133. In reality, there are significant shortcomings in comparison with the respective missions set out, with gaps in operations in levels one and two, and a tendency to overburden the third, highly specialized level.

The first level: basic, small-scale facilities, fairly equally distributed across the country. These include primary health care (PHC) centres and district hospitals. This level absorbs 26% of the total spending for public health.

PHC centres are the population's first point of contact with the health care system and are considered the gateway into the system. They include PHC centres (types 1, 2, 3 and 4), maternal and child health centres, tuberculosis centres, outpatient consultations in district hospitals and intermediate centres. They are part of a multifaceted, geographically distributed network (64% of PHC centres are situated in rural areas and the remaining 36% are located in urban areas *(8)*) that should meet the most current needs of the population in terms of preventive care, curative care and health education. Services on offer include maternal and child health care, family planning, prevention of communicable and noncommunicable diseases, vaccination, and preschool, school and university health services. Standardized treatment protocols are practised in relation to national programmes.

However, in most facilities, consultations are only carried out in the morning. In rural areas, facilities may only be open for the time needed to conduct the number of consultations required. In urban areas, there is a discrepancy between the opening hours of facilities and the times when consultations are available *(2)*. In addition, the vast majority of PHC centres (80.4%) do not make consultations with doctors available every day; of the 2123 centres, only 416 offer consultations every day of the week (based on the 2015 health map of the first level *(9)*). There are significant disparities between regions. For example, 100% of PHC centres in Tunis (where there are 49 centres in total) carry out consultations six days a week, compared with 3% of PHC centres in Tozeur (where there are 34 centres in total). Furthermore, medicine shortages in PHC centres affect people's perception of how reliable these centres are, and make people less likely to use their services. In a national survey on public services carried out among households by the National Institute of Statistics in 2014, the main cause of dissatisfaction was the shortage of medicine supplies (79%) *(10)*.

Medicine shortages in PHC centres affect people's perception of how reliable these centres are, and make people less likely to use their services

A district hospital generally covers one or several districts. It usually comprises a general medical ward, a maternity ward for births without medical intervention, a ward for outpatient consultations and emergency services and a ward for outpatients and emergencies, and normally has basic technical facilities (for example, an X-ray machine, laboratory, dental chair and a stock of medicines).

Based on data from the Ministry of Health, in these district hospitals and maternity wards (both rural and urban), 10% of the total beds are owned by the public sector and host just 3% of vaginal births. District hospitals still seem to be influenced by the health care model of the 1970s and 1980s, which hamstrings their ability to meet new demands or keep up with the rapid developments in health technology and communications. As a result, they have been unable to fulfil the missions assigned to them by the aforementioned Law 91-63. There seems to be a lack of foresight in terms of strengthening complementarity between regional and district hospitals. This is particularly the case for district hospital management of patients who had prolonged hospital stays in second or third levels and need adherence to medication to be monitored at district hospitals; the follow-up of these patients at district hospital level is not well organized.

The hospital beds in district hospitals account for 14% of the total beds that are hypothetically available across all three levels; 19% of district hospitals have less than 10 beds, 43% have between 10 and 30 beds, and 38% have more than 30 beds. However, 6% of beds in district hospitals are reported not functional, without any reason for this being given. This is just one of the reasons why these hospitals do not carry out the volume of activities they should, given that for most of the population they are their nearest health care facility. With opportunities in terms of new demands not being met, these facilities often become reduced to a kind of triage centre.

These gaps reported in the first level of public health care have resulted in users calling on the emergency services of hospitals at different levels, which are open longer hours and through which access to specialist doctors is easier. Users have therefore had little choice but to rely on private facilities that are more expensive and give up on public health care.

The second level is fairly equally distributed across the country. There is typically one regional hospital for each governorate, though in some cases one covers several districts within a governorate (see Annex 2 for the districts in each governorate). There are two categories of regional hospitals: A and B. Their category is determined by their capacity, budget, staffing and the number of services offered (Decree No. 2003-2070 of 6 October 2003). In addition to general medical services for obstetrics and emergency care, regional hospitals provide specialized medical and surgical services. They therefore need to make sure they continue to provide access to specialized care within the core areas. For this reason, they fulfil two roles: 1) providing care to the local community and being the benchmark for all primary health care facilities, and 2) referring patients to university hospitals to reduce overcrowding. This second level accounts for 29% of total spending for public health facilities. Some health services at regional hospitals are considered teaching services.

The five-year development plan for 2016–2020 plan was based on five strategic approaches established by the Ministry of Health: 1) Prioritize prevention and address the deciding factors; 2) Put in place a regional health service through health centres organized around a coherent health project; 3) Focus on innovation; 4) Establish a new governance for a more effective health policy; 5) Strengthen the public sector. One of the aims of the plan was to transform 13 district hospitals into regional hospitals, giving them an additional capacity of 1400 beds. Unfortunately, the long-term outcome of developing several district hospitals into regional hospitals tends to make conditions worse across the entire second level by spreading resources even more thinly and increasing the risk to patient safety. As part of the same plan, seven new regional hospitals will be transformed into multidisciplinary hospitals or hospitals with a particular specialty, such as oncology or maternal and child health. This will give an additional capacity of 1500 beds.

The third level is overcrowded and not as equally distributed across the country. The main mission of university hospitals is to provide highly specialized care. They also conduct scientific research and contribute to university and postgraduate teaching in the areas of medicine, pharmacy and dentistry, as well as training health professionals. However, due to the gaps at the first and second levels, the third public level is saturated with patients who suffer from conditions that could have already been treated at the first or second level, which obviously has an impact on the quality and continuity of care. Furthermore, the third level lacks facility maintenance services, and suffers the damaging effects of complementary private activity (CPA) on the availability of services, such as the mandatory transfer of patients to the private sector and corruption.

Decree No. 95-1634 of 4 September 1995 and its amendment, Decree No. 2207-120 of 25 January 2007, regulate CPA (a new name for the full-time organized exercise) which allows professors with at least five

years since their appointment the right to conduct CPA according to several conditions: (i) Medical consultations are done at the level of public structure; (ii) hospitalization and medical acts are done at the level of private structures; (iii) the beneficiary doctor is entitled to practise in only one private institution; (iv) the right of practise of the PCA is limited to two afternoons per week; home visits or call-in tables at the level of private structures; and (vi) 30% of PCA consultation revenues are paid to public structure.

Third level facilities are mainly concentrated in the large towns along the coast, further adding to regional disparities. They account for 45% of the total spending for public health facilities.

Other public sector and ministry facilities are composed of:

i. Six polyclinics of the National Health Insurance and Social Security Fund that provide general outpatient care, as well as diagnostic procedures for insured persons;[2,3]

ii. Three military hospitals under the Ministry of Defence;

iii. One internal security forces hospital under the Ministry of the Interior; and

iv. Occupational health services and medical services in some national companies[4] that provide outpatient care to employees and their families.

3.2. Private health sector

3.2.1. The for-profit private health sector

Health care services in the for-profit private health sector have developed very quickly. This sector has the majority of heavy equipment and advanced technologies, employs more than 50% of doctors, and accounts for 55% of current health expenditure. In recent years, there has been a sustained increase in private health facilities (Table 1). The number of private clinics has almost quadrupled in the last 30 years, with over eight times the capacity now available. In addition, 87 clinics are currently being built and/or extended, providing 6500 additional beds. The number of private clinics has increased in recent years, driven by financial and tax incentives and the influx of patients from neighbouring countries, particularly Libya (see Sections 6.1 and 6.3.1 for discussion of the export of health services). The for-profit private health sector has more availability but is less geographically accessible than the public sector. The number of medical and dental practices has multiplied more than fivefold in the last 30 years (Table 1).

2 Two in Tunis, one in Bizerte, one in Sousse, one in Sfax and one in Metlaoui.
3 The three polyclinics of the National Health Insurance and Social Security Fund (El Omrane in Tunis, Sousse and Sfax) dispense expensive, specific medicines such as those for treating cancer. These drugs are used to treat insured persons in the public and private sectors.
4 For example STEG, SONEDE, TUNISAIR.

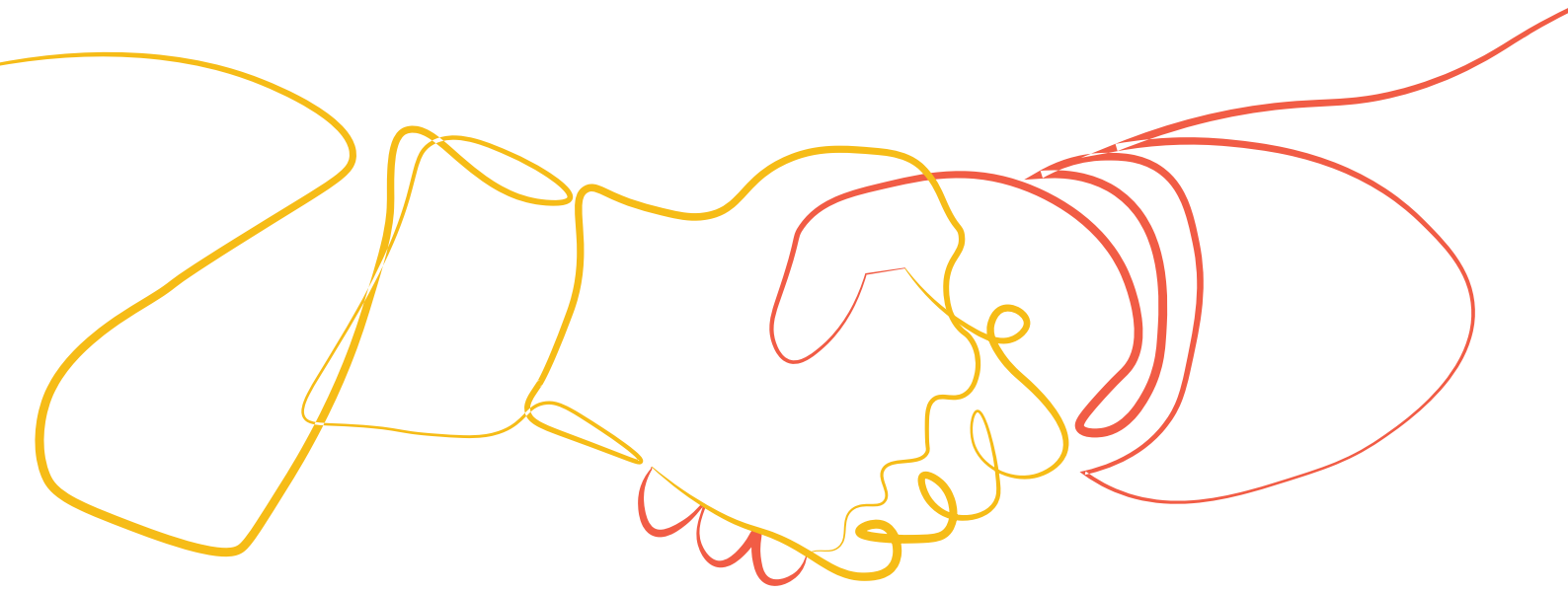
Table 1. Increasing number of private health facilities

Health facilities	1987	1990	2010	2015	2016	2018
Clinics	28	33	81	91	91	102
Medical practices	1374	1717	6273	7675	7727	N/A
Dental practices	561	625	2276	2800	2802	N/A
Haemodialysis centres	13	N/A	99	111	N/A	123
Pharmacies	N/A	1055	1882	2,006	2,038	2109
Medical laboratories	N/A	N/A	287	445	485	510
Hospital beds	796	1142	3029	5020	5020	6500

Source: Ministry of Health. N/A = not available

3.2.2. The not-for-profit private health sector

Tunisia has a limited private not-for-profit sector for specific fields. This is composed of: (i) the Tunisian Red Crescent, (ii) nongovernmental organizations[5] that contribute to the HIV/AIDS and hepatitis C response by providing screening and psychosocial support for patients and (iii) several national and international NGOs that offer services to migrants. Comprehensive data about these services is not available; however, an example is Médecins du Monde, an NGO providing medical services to migrants through three outpatient clinics in the regions of Tunis, Sfax and Mednine. They provide free medical services focusing on maternal and child health and mental health.



5 For example, ***L'Association Tunisienne de Prévention Positive*** (Tunisian association of positive prevention), ***L'Association Tunisienne de Lutte contre les Maladies Sexuellement Transmissibles et le SIDA Bureau National*** (Tunisian association for the fight against HIV/STDs), ***Association Tunisienne Information & Orientation Sur Le Sida & La Toxicomanie*** (Tunisian Association Information & Guidance On Aids & Drug Addiction), which are financed by the Global Fund.

4

Health sector capacity

Regional disparities affect the distribution of general practitioners, as well as specialist doctors. Public sector general practitioners are spread evenly across Tunis (Fig. 2). For specialist doctors, the disparity between the two sectors is considerably greater (Fig. 3).

Fig. 2. Number of general medicine doctors per 100 000 inhabitants, 2017

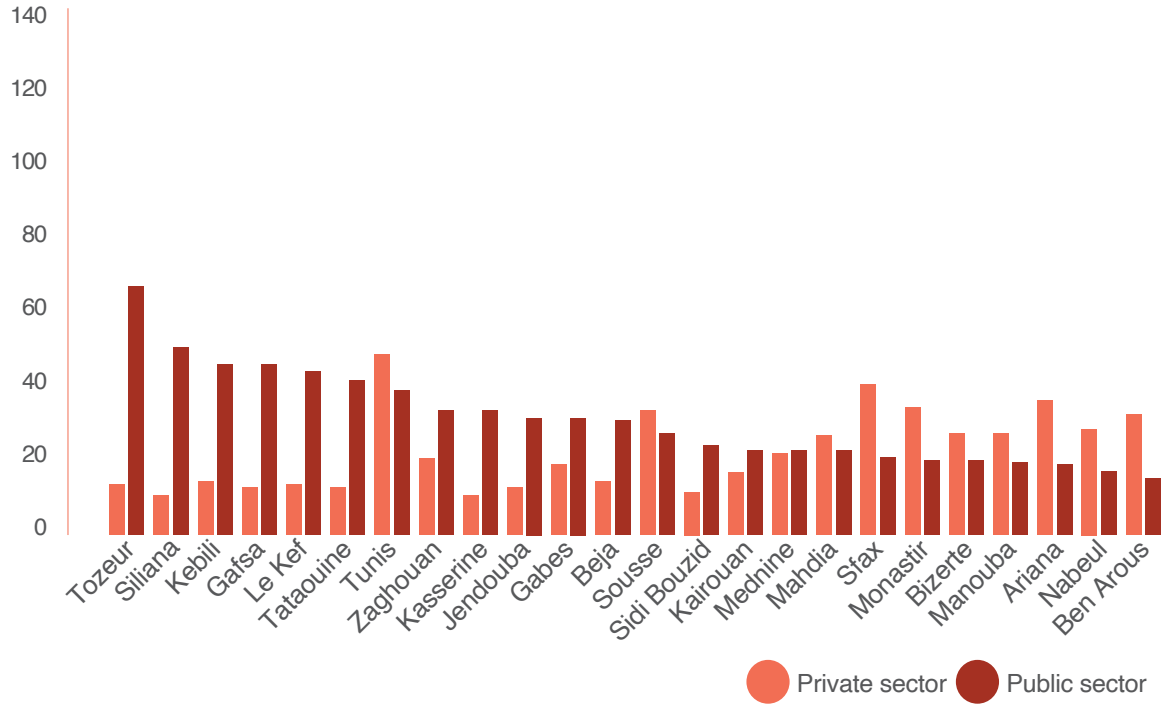
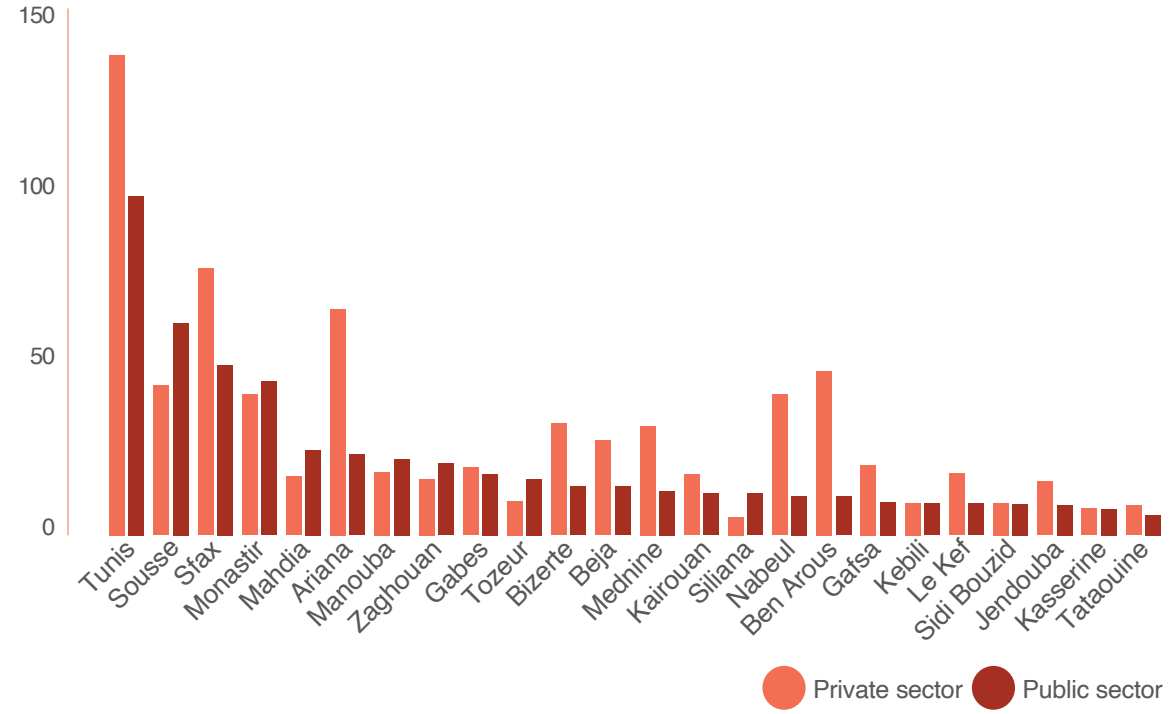


Fig. 3. Number of specialist medicine doctors per 100 000 inhabitants, 2017



Source: Ordre des Médecins de Tunisie, Tunisian medical board
Note: Calculation based on population figures as of 1 July 2017, according to the National Institute of Statistics.

A major challenge is dual practice between public and private sectors among professors and specialized physicians and, accordingly, the complexity of accurate reporting. Dual employment, colloquially known as moonlighting when it is ilicit, has negatively affected the health sector. Some of these public employees build time and collateral towards public pensions while referring patients to private clinics where they also work.

The private sector partially fills the gaps in the public sector (particularly its lack of availability and responsiveness). In certain regions, the private sector makes up for technology gaps in the public sector (Table 2). This complementarity is not established in the framework of a public—private partnership project or a health map considering the two sectors. For example, two governorates do not have a CT scanner (Tozeur and Kebili) and four (Zaghouan, Siliana, Tozeur and Kebili) lack an MRI scanner, meaning these devices are available neither in public nor in private health facilities.

Table 2. Distribution of MRI scanners by region and sector per 100 000 inhabitants, 2015

	Public sector	Private sector	Total
Greater Tunis	0.18	0.63	0.81
North-east	0.00	0.19	0.19
North-west	0.00	0.17	0.17
Central-east	0.11	0.30	0.42
Central-west	0.00	0.14	0.14
South-east	0.20	0.59	0.79
South-west	0.00	0.16	0.16
Total	0.09	0.35	0.44

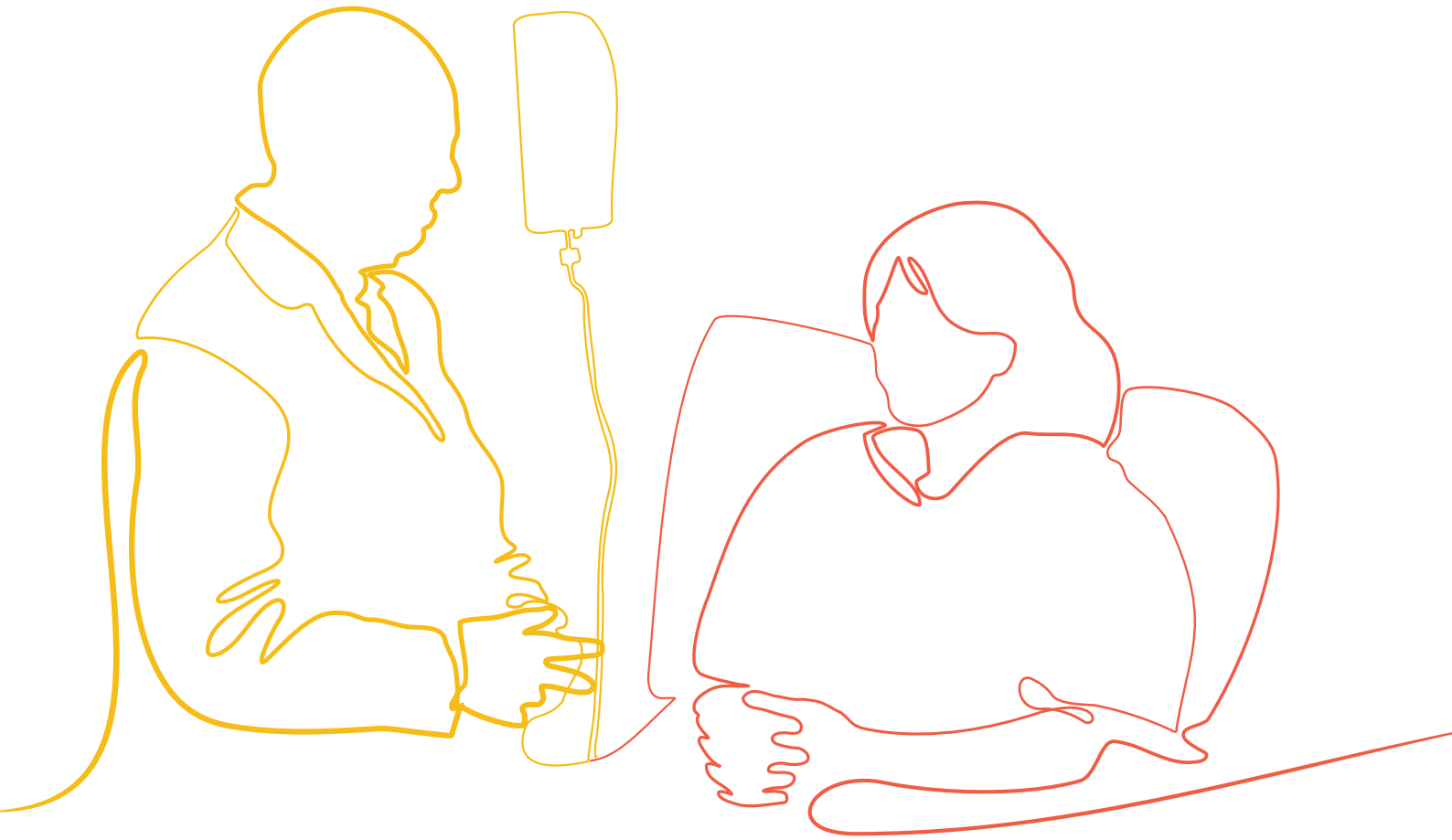
Source: Health map 2015 (published in 2016) *(9)*
Note: Figures based on the population as at 1 July 2015, according to Tunisia's National Institute of Statistics.

Users were more satisfied with the health services provided by the private sector than those provided by the public sector. In the THES survey 2016 *(6)*, in which users aged 15 and over expressed how satisfied they were with public and private facilities, users were asked to express their satisfaction. 13.1% of users were dissatisfied with the amount of time spent in the waiting room. This level of dissatisfaction was greater in public facilities (20.1%) than in private facilities (8.3%). 6.4% of older patients reported that the health facility had hygiene issues. This percentage was much higher in public health facilities (12.2%) than private ones (2.4%). Interviews with patients conducted as part of this study confirmed that they thought the private sector was more responsive than the public sector. Private health care providers were seen to have cleaner facilities, more respect for confidentiality, more empathy and shorter waiting times.

The responses collected during this study confirm the differences between the public and the private sector regarding responsiveness. Forty-nine (49) patients were interviewed at the exit of various clinics about why they chose a private service provider rather than a public one. Of these, 46 stated that the quality of services was better in the private sector than the public sector; 41 considered that private facilities were

easier to get to; 40 thought there was more empathy shown in private facilities and 38 said that waiting times were shorter in the private sector (see Annex 8).

That said, there is currently very little evidence assessing the quality of care in the public sector and almost no evidence for the private sector. In addition, there are few if any approved good practice standards. The National Authority for Health Assessment and Accreditation (INEAS) is currently working to get these approved and make them available. The first reference document entitled The management of chronic heart failure in adults was published in December 2018. Four reference documents are currently being finalized on the following topics: diabetes and pregnancy, the prevention of sudden death in school and university-age athletes, breast cancer screening and the use of statins to treat dyslipidaemia and prevent cardiovascular disease. As part of implementing an accreditation process, public and private health care facilities will be required to produce and publish their data on the quality of health services provided.



5

Health sector financing and expenditure

5.1. Health insurance in Tunisia

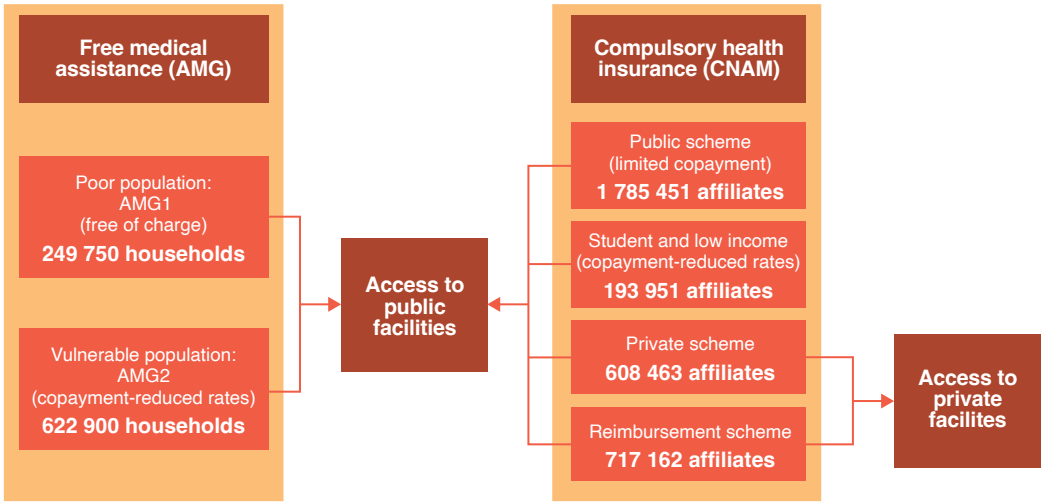
In Tunisia, more than four in five people are covered by an insurance scheme, leaving around two million people without coverage. According to Volume 3 of the 2015 national survey on household budget, consumption and standard of living, 16.7% of the population did not have any coverage, while 0.5% of the population did not respond *(11).*

There are two main schemes (Fig. 4). The first is compulsory health insurance through the *Caisse nationale d'assurance maladie* (CNAM — the national health insurance fund — the health insurance reform implemented in 2004 (Law 2004-71 of 2 August 2004) helped to unify the various schemes created in the last 50 years into one basic scheme), covering the formally employed (in both public and private sectors) and their dependents. There are three pathways for this scheme: the public pathway, which provides access to public providers; the private pathway, providing access to contracted private providers; and the reimbursement system, which provides access to various contracted public and private providers.

The second scheme is Free Medical Assistance that offers free health care to the poorest families (categorized as Free Medical Assistance 1 — poor) and reduced rates to vulnerable families with limited incomes (categorized as Free Medical Assistance 2 —vulnerable), giving them unique access to public health facilities and the possibility of being transferred to the private sector or abroad if they cannot be treated in a public facility. In practice, an order must be given by the hospital director to transfer a patient to a private facility, and prior approval must be granted by a committee within the Ministry of Health in order to transfer a patient abroad.

In addition, private insurers and *mutuelle* insurance companies offer health coverage that is complementary or supplementary to the compulsory scheme. The scheme is deemed to be complementary if it covers health care services or expenses that are not covered under the basic scheme. The scheme is deemed to be supplementary if it covers health care services that are covered by the basic scheme. Other services are provided free of charge to citizens under specific legal agreements, which gives them the right to access public health facilities. This category mainly includes the internal security services, military staff, customs officers, health workers and those who have been given amnesty and all their family members.

Fig. 4. Financial protection for health in Tunisia, 2017



CNAM affiliates pay a single contribution rate of 6.75%, which gives them access to a variety of different health services depending on the scheme[6] they choose for common illnesses:

- **Those insured through the public scheme (57.6% of all insured in 2017, down from 71% in 2008) have access to public health facilities, and the polyclinics of the National Health Insurance and Social Security Fund in public facilities contracted to CNAM (e.g. the military hospital) on settlement of a co-payment. Private providers can be called on for certain services (dialysis, interventional cardiology, heart surgery, lithotripsy, CT, MRI, etc.) if CNAM has given prior approval.**

- **Those insured through the private scheme (21.5% of all insured in 2017, up from 10% in 2008) need to visit a referring doctor (their family doctor) to be able to gain access to a specialist, except for obstetrics and gynaecology, ophthalmology, paediatrics and dental care. In doing so, the insured person pays a co-payment of 30% of the rate agreed between CNAM and the private provider (contractual relations are detailed in Annex 5). The fees covered by CNAM are capped.[7]**

- **Those insured within the reimbursement system (20.9% of all insured in 2017, up from 13% in 2008) have free access to specialists and enjoy the benefits of both sectors by paying the provider directly and in full and being subsequently reimbursed by CNAM at the approved rate and the agreed price as long as they do not exceed the capped amount.**

6 The chosen scheme remains valid for at least one year unless a pathway change request is made before the 30 September of that year. If the insured person does not choose a pathway, they are enrolled in the public one.

7 The Decree of 3 June 2008 by the Ministry of Social Affairs sets an annual cap of DT 200 per policyholder, with an additional DT 50 per dependent parent and DT 50 per dependent child for up to four children. An additional DT 100 is added to this cap for pregnant women. The annual cap can include coverage of outpatient care expenses (consultation with a doctor, midwife, medical and paramedical procedures, x-rays, lab tests, dental procedures and medicines).

However, the same services are offered to all insured, regardless of their scheme in terms of: (i) the management of hospitalization in the public and private sectors using the conventional arrangements, and (ii) services that require prior approval from CNAM. However, the lack of availability in the public sector has resulted in management being transferred to the private sector. Patients suffering from one of 24 fully covered chronic conditions such as diabetes or asthma (known as affections prises en charge intégralement) who are insured through the public scheme are reimbursed for medicines prescribed and dispensed by private pharmacies when these are not available at public health facilities.

5.2. Health financing in Tunisia

Between 2005 and 2010, the total amount of health care spending per inhabitant rose from DT 259 to DT 383, an increase of 48%. This increase was driven by the establishment of CNAM. However, spending did not continue to increase at the same rate as before, probably due to the economic situation of Tunisia, and currently stands at DT 439 per inhabitant (an increase of 14% between 2010 and 2014). The factors fuelling this increase in spending are still present: increasing supply, a more sedentary lifestyle and an ageing population on the one hand, and the absence of an effective health promotion policy and the health care system's poor overall efficiency on the other.

Table 3. Health spending

Indicator	2000	2005	2010	2014
Current health expenditure (CHE) per capita in US$, purchasing power parity	303	423	602	772
Domestic general government health expenditure as % of CHE	53	51	56	58
Domestic private health expenditure as % of CHE	47	49	43	42

Source: WHO Global Health Expenditure Database *(12)*.

Current health expenditure (CHE) includes expenditures of public and private sectors on medical products and services as well as spending on prevention and curative programmes and administration costs. Public spending includes general government tax revenues and the contribution of the CNAM, while private spending mainly involves household out-of-pocket expenditure and private insurance.

Despite the advent of CNAM, funding from public bodies (i.e. all spending by the Ministry of Health, other health-related ministries and spending by CNAM) in Tunisia only represents 58% of the current health care spending compared with the European Union, where public bodies cover 79% of current health care spending *(13)*. The level of public spending reflects the State's commitment to providing equal access to health care.

In fact, households are the main source of funding for health services and assume 38% of the current health care spending, followed by CNAM with 33.4%, tax resources 25.3% and a small contribution from private insurance of 3.3% *(7)*.

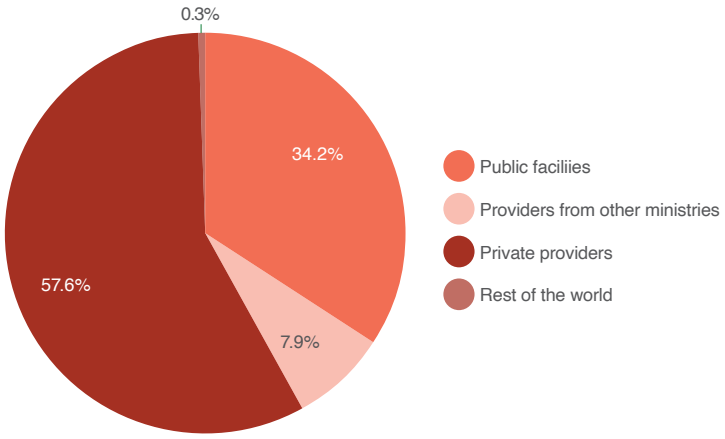
Given that households assume the largest share of health care spending, they are at higher risk of having to cover catastrophic health expenditure. This puts them at risk of being pushed into poverty. One study *(14)* showed that the incidence of catastrophic spending and impoverishment is highest in the south-eastern and central-western regions and lowest in Greater Tunis.

Health spending for private providers accounts for 58% of current health spending, excluding costs associated with governing the system, i.e. public administration expenditure (Ministry of Health, Ministry of Defence and CNAM).

In 2014, 57% of CNAM spending (excluding specific medicines) went to private providers although only 38% of all persons insured by CNAM could access these (namely those covered by the private scheme and reimbursement system); see Fig. 5.

A small part of the spending to public providers is from other ministries (Ministry of Defence, etc.), accounting for 7.9% of current health spending. A small proportion is going to spending on services provided outside the country (0.3%).

Fig. 5. Distribution of current health spending excluding system governance costs, 2014



Source: National health accounts, 2014 *(7)*

5.3 Financing of the private sector

With the 2004—2005 reforms of health insurance, the private sector was able to enter contractual arrangements[8] governing their relations with CNAM. Several sectoral agreements were signed between CNAM and private providers through their representatives.[9] Different terms and conditions govern these agreements, such as their duration[10] and agreed fees (Annex 5). Several amendments have since been introduced and in fact, negotiations are currently under way with CNAM to revise the various agreements.

8 Articles 11-13 of Law No. 2004-71 of 2 August 2004 stipulate that the relations between CNAM and various public/private providers are governed by agreements. The terms of these agreements are established by Decree No. 2005-3154 of 6 December 2005.

9 These are: the Tunisian Syndicate of Private Sector Doctors, the association of free practice doctors,, the National Union of Free Practice Biologists of Tunisia (SNBLPT), the National Trade Union Chamber of Private Clinics, the National Union Chamber of Tunisian Physiotherapists and the National Council of the Order of Pharmacists of Tunisia.

10 A duration of 6 years for doctors, biologists and pharmacists in free practice, 5 years for dentists and physiotherapists, and 3 years for clinics. These agreements are automatically renewed unless one of the stakeholders is reported by another within six months of the start date.

CNAM affiliates who have chosen the private scheme and the reimbursement system are able to access the private providers that have been agreed on. For outpatient services and diagnostic procedures relating to common illnesses, CNAM reimburses up to the amount of the price ceiling for patients based on agreed prices that have been negotiated with the providers' unions.

The difference between the agreed price and the price set by the facility is paid by the patient as an out-of-pocket expense. Payments for the fully covered conditions are not capped, but reimbursements are based on agreed prices. For hospital admissions, a list of 54 surgical procedures has been decreed by CNAM. These are covered based on a fixed price equivalent to the price paid to public health facilities. The difference in price is borne by the patient.

Medicines dispensed in pharmacies are reimbursed up to the price ceiling for patients, based on the reference price (the price of the cheapest generic medicine available) and using the following therapeutic categories: vital (100%), essential (85%) and intermediate (40%). Medicines to treat fully covered conditions are reimbursed 100% based on the reference price, without a price ceiling. (The table in Annex 6 provides a summary of the different coverage methods used by CNAM.)

In addition to their share of the co-payment, the insured patient has to pay the difference between the agreed price and the price that is actually charged (Table 3).[11] This could be the reason the interviewed patients stated that the high cost of services provided by the private health sector was their main cause for concern regarding the sector. Of the 49 patients interviewed, 37 thought the services provided by private clinics were expensive (see Annex 8).

Table 3. Examples of differences between agreed prices and actual prices charged (in Tunisian dinar)

	Agreed price	Price actually charged (set by the Board)
Consultation with a general practitioner	DT 18	DT 30 to DT 35
Consultation with a specialist doctor	DT 30	DT 40 to DT 50
Consultation with a neurologist or psychiatrist	DT 35	DT 45 to DT 55
Consultation with a dentist	DT 18	DT 30

For hospital admissions, the insured person has to add a substantial co-payment, as well as paying for additional costs such as accommodation, which only adds to their out-of-pocket payments (Table 4).

11 As an example, a CNAM member through the private pathway has to pay the following for a consultation with a general practitioner: (i) a co-payment of DT 5.40 (30% of the agreed price), and (ii) the difference between the agreed price and the actual price.

Table 4. Examples of hospital care coverage costs in private clinics (in Tunisian dinar)

	Total agreed fixed price		Amount covered by CNAM		Amount paid by the patient
	Medical team	Clinic	Medical team	Clinic	
Birth with epidural	DT 380	DT 320	DT 150	DT 200	DT 350
Dissection tonsillectomy in children	DT 280	DT 200	DT 125	DT 125	DT 230
Simple surgical treatment of hernias and incisional hernias	DT 350	DT 450	DT 100	DT 200	DT 500

Note: The amount paid by the insured person has been calculated during the drafting of this report based on the price difference. It does not take the prices that are actually charged into account.

Therefore, despite CNAM covering the health services offered by private providers, households bear 65% of the cost of health care in the private sector, followed by CNAM with 29% and private insurance companies and *mutuelles* (complementary health insurance, on top of national health insurance) with only 6% (Table 5). The significant share paid by households varies according to the type of provider and the illness being treated. These out-of-pocket payments need to be addressed in light of the private sector's contribution to universal health coverage. This high out-of-pocket spending could be rooted in both inadequate financial coverage and overmedicalization.

The fees of doctors working in private practice (general practitioners, specialist doctors and dentists) only account for 16% of spending by private providers, the lion's share of which goes on specialist doctors (64% of total fees). Pharmacy expenditure constitutes the largest area of spending followed by clinics, both for CNAM (36% and 15%, respectively) and households (30% and 29%, respectively).

Table 5. Spending by type of private provider and by source of funding, 2014 (in millions of Tunisian dinar)

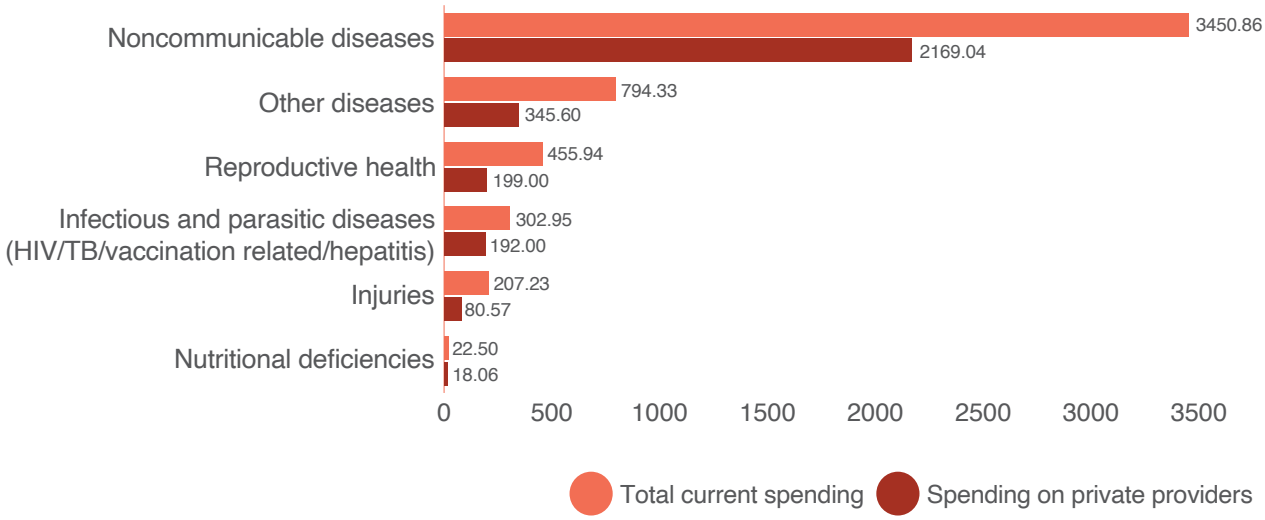
Type of private provider		CNAM	Insurance companies and *mutuelles*	Households	Total	
					In millions DT	%
Clinics		128.31	50.01	573.77	752.10	25
Medical practices		134.83	28.1941	331.00	494.03	16
Haemodialysis centres		88.74	0	0	88.74	3
Medical imaging[12] **centres**		48.87	4.11	47.11	101.62	4
Medical testing laboratories		53.29	7.72	88.60	149.61	5
Physiotherapy and rehabilitation facilities		34.82	0.16	7.69	42.67	1
Pharmacies		315.32	51.95	588.42	955.70	32
Retailers of medical supplies		60.71	28.79	330.30	419.80	14
Total	**Millions DT**	864.91	170.93	1966.89	3004.26	100
	%	29	6	65	100	

Source: National health accounts 2014 *(7)*

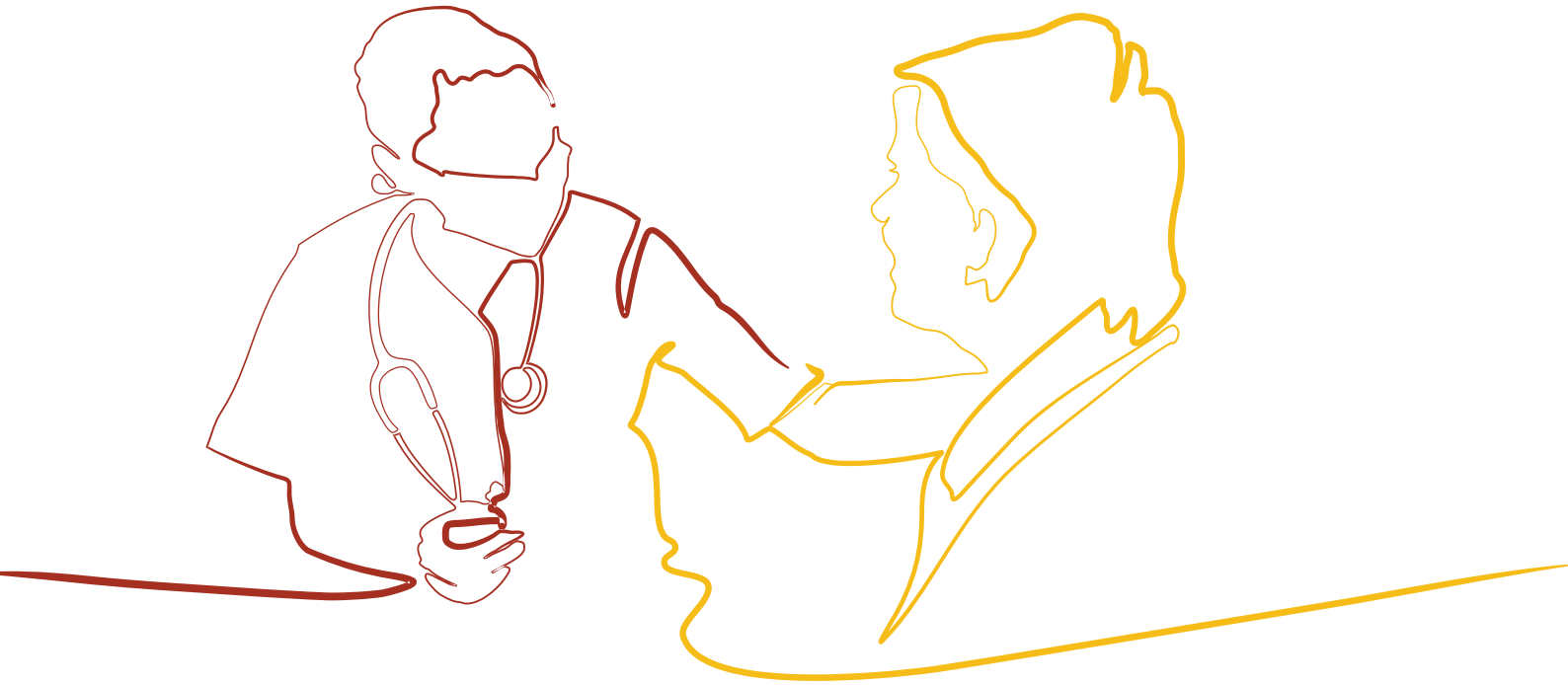
12 Public health facilities pay DT 1.53 million through transfers to private medical imaging centres.

In relation to the epidemiological and demographic transition, noncommunicable diseases rank first for health spending on illnesses for both public and private providers together (on a national level) and for private providers alone (Fig. 6).

Fig. 6. Distribution of health spending for private providers by group of illnesses, 2014 (in millions of Tunisian dinar)



Source: National health accounts 2014 *(7)*
Note: To obtain the total current health spending, the fees for managing the health care system must be added.



6

Private health sector analysis and stakeholder perspectives

6.1. Private health sector growth and expansion: determinants

Private sector medical practice has always existed, primarily in the form of individual practitioners in outpatient practices. Inpatient care, on the other hand, is a relatively new development, with the law on health system organization being enacted in 1991 and the investment incentive code coming into force in 1993, providing financial and tax benefits to the private sector.

Since the 1990s, the private health sector in Tunisia has experienced sustained and rapid growth and has simultaneously expanded due to:

- The creation of CNAM and its opening up to the private sector. With the health insurance reform, the private sector gained access to contractual arrangements[13] governing their relationship with the National Health Insurance Fund. CNAM affiliates who have chosen the private scheme and the reimbursement system are able to access the agreed private providers. Before the establishment of CNAM in 2007, services in the private sector were fully paid out-of-pocket.

- A framework of incentives for developing the health care sector: Article 49 of the Investment Incentive Code enacted in 1993 specified the investments by health establishments and hospitals[14] eligible for tax incentives. In addition, the Order of 16 December 1997 acts as a guide for private investors and developers in the health sector. An example of these incentives is the exemption for private clinics from customs duties and taxes with a similar effect, suspension of value added tax (VAT) and consumption duty for imported equipment with no locally manufactured equivalent that is necessary for the realization of those investments, as well as suspension of VAT on equipment manufactured locally. A guide to the Tunisia Investment Incentives Code *(15)* explains the tax benefits and financial benefits, some of which are specific to certain groups and some of which are applicable to all groups. In addition, tax benefits and other arrangements are granted (or taken away) as part of the various finance laws. (The table in Annex 4 provides a summary of the initiatives in place.)

- An emerging middle class: increased purchasing power and some budget restrictions on public spending have created an opportune environment for the growth of the private sector.

- Perceived better quality: the population considers the private health sector to be more responsive (in terms of availability, respect, quality of care, ease of making appointments, shorter waiting times, etc.).

13 Articles 11-13 of Law No. 2004-71 of 2 August 2004 stipulate that the relations between CNAM and various public/private providers are governed by agreements. The terms of these agreements are established by Decree No. 2005-3154 of 6 December 2005.

14 Decree No. 94-492 of 28 February 1994 set out the health facilities to benefit from these incentives: polyclinics, clinics, hospitals, health centres, rehabilitation centres, haemodialysis centres, medical and paramedical practices, medical laboratories, pharmacies and health transport services.

- The flexibility of the private sector and its ability to use resources effectively has been instrumental in making it appealing to health professionals. Working in both sectors, a common practice among certain categories of health professionals (particularly under the framework of CPA), seems to have boosted the development of the private sector. However, it has also had damaging effects on the public sector, with situations where there have been conflicts of interest that have either not been properly regulated or have been inadequately regulated.

- The export of health services is another major determinant in this growth. The contribution of medical tourism and the subsequent effects (e.g. foreign currency expenditure for the patient and anyone travelling with them) contributed 0.4% to the country's gross domestic product from in 2003, a figure which grew to 1.5% in 2013, according to the African Development Bank (AfDB) *(16)*. According to this study, 376 000 foreign patients of various nationalities visited Tunisia for private health care, accounting for 36% of the total revenue generated by private clinics. Figures for 2013 were: DT 190.6 million in export revenue from health services, DT 100.3 million from pharmacies and other inputs, DT 186 million from medical care and surgeries, DT 13.7 million from dental care. The top reasons for foreign patients coming to Tunisia were the proximity of facilities, doctors' expertise and the quality of care. Health facilities have strived for excellence and obtained accreditation in order to maintain this comparative advantage. The majority of clinics in Tunisia are working towards accreditation either from INEAS[15] or international organizations. The aforementioned AfDB study *(16)* showed that Libyan patients accounted for 84% of all foreign patients treated at one time, meaning that Tunisia was fairly dependent on the Libyan market. However, regime change in 2011 and the subsequent national security issues saw the number of Libyan patients drop, forcing private health facilities to find foreign patients elsewhere. Between 2003 and 2013, the number of patients from Algeria and sub-Saharan Africa increased by 28.9% and 29.4%, respectively. The same study showed that several niche services are being offered to foreign patients. As an example, European patients mainly use Tunisia's private facilities for dental care, cosmetic surgery and thalassotherapy. The services used by other foreign patients tend to be surgical, with orthopaedic surgery being the most popular. Exports of health services have developed through a combination of private investments and incentives. Initially, the idea of exporting health services was a result of the demand from Libyan patients. Some financial incentives are occasionally provided to private clinics. The export of health services is not well-integrated into the work of public bodies that are responsible for promoting exports and tourism. The AfDB study *(16)* developed a strategy for exporting health services. In the framework of this strategy, a unit for promoting investment and the export of health services was created under the Ministry of Health. This unit is currently working on two main projects: developing a website to promote health services in Tunisia in foreign countries, and creating an agency that will manage the export of health services in future.

15 As part of the EU-funded Programme to Support Competitiveness of Services, 31 health facilities are being assisted with the accreditation process. There are: 15 public health facilities under the Ministry of Health, a military hospital under the Ministry of Defence and 15 private clinics. The private clinics are spread across the country as follows: four in Tunis, three in Sousse, one in Mahdia, one in Monastir, three in Sfax, two in Ariana and one in Gafsa.

6.2 Private health sector resources and service provision

The private sector owns the bulk of heavy equipment and advanced technologies. In 2016, the private sector had the majority of heavy equipment and advanced technologies (75% of CT scanners, 81% of MRI scanners and 72% of cardiac catheterization rooms). The sector experienced even greater growth following the ruling to relax purchasing authorizations. This has particularly benefited large clinics in the country's three major cities, Tunis, Sousse and Sfax (Table 6 and 8).

Table 6. Distribution of heavy equipment and advanced technologies by sector

Type of equipment	1997		2006		2016	
	Public	Private	Public	Private	Public	Private
MRI scanner	2	0	4	8	10	43
CT scanner	8	29	30	72	41	124
Cardiac catheterization rooms	7	4	11	10	11	29
X-ray equipment	N/A	N/A	N/A	N/A	8	12
Lithotriptor	3	5	3	15	5	23
Extracorporeal circulation facility	4	6	7	10	6	19
Gamma camera	N/A	N/A	N/A	N/A	6	7

Source: Ministry of Health. N/A = not available

The private sector places technical facilities in convenient clinics, as well as having consultation polyclinics housing a wide variety of specialists, but patients do not have to exclusively use their nearest clinic.

The private sector has a particular model of organization of care that makes technical services available in clinics with a wide variety of medical specialties without making it mandatory for patients to use these services.

While the public sector employs very similar numbers of specialist doctors and general practitioners (51% and 49%, respectively), there is less of a balance in private sector liberal or free practice (in which doctors are paid per service rather than salaried): according to CNOM, 61% are specialists and 39% are general practitioners. In 2017, according to the medical board, of the 6277 doctors working in the public sector, 3066 were general practitioners and 3211 were specialist doctors. Of the 7879 doctors working as free practitioners in the private sector, 3077 were general practitioners and 4802 were specialist doctors. Interestingly, WHO advises a ratio of 30% specialists and 70% general practitioners. The growth of specialized health care could have had an impact on the continuity of care and the overall quality of care for patients *(2).*

The private sector employs 76% of the country's pharmacists, 82% of dentists, 56% of doctors and only 7% of paramedics. Dual practice between the public and private sectors is common among certain categories of health professional. This may be done legally (through formal employment) or illegally (through informal arrangement). These categories include specialist doctors in the public sector who exercise

CPA and some paramedics in the public sector. Inadequate regulations for working in both sectors has had damaging effects on the health system.

This huge increase in the provision of private health care is mainly concentrated in regions where the patient base has a high income, which strengthens the existing private sector and puts the western and southern regions of the country at a disadvantage. In figures from 2018, of the 102 private clinics in the country, 42 were located in Tunis compared with only 10 in all of the western regions combined. In fact, five governorates did not have any clinics at all (Table 8; Annex 7).

Table 8. Number of private clinics by governorate

Governorate	Number of private clinics	Governorate	Number of private clinics
Ariana	4	Manouba	0
Beja	1	Mednine	7
Ben Arous	5	Monastir	5
Bizerte	2	Nabeul	8
Gabes	3	Sfax	15
Gafsa	1	Sidi Bouzid	0
Jendouba	3	Siliana	0
Kairouan	2	Sousse	7
Kasserine	1	Tataouine	0
Kebili	1	Tozeur	0
Le kef	1	Tunis	33
Mahdia	2	Zaghouan	1

Source: Ministry of Health

There are also vast regional disparities in the distribution of heavy medical equipment and advanced technologies. The majority is concentrated in the major cities where there are medical faculties and university hospitals (Tunis and the central-eastern regions), while central-western and south-western regions have hardly any of this equipment (Table 9; also see Annex 7 for a breakdown by governorate).

Table 9. Distribution of heavy equipment and advanced technologies by region, 2018

	CT scanner	MRI scanner	Cardiac catheterization rooms	Lithotriptor	X-ray equipment	Gamma camera
Greater Tunis	45	22	14	7	4	7
North-east	18	6	3	1	1	0
North-west	8	2	1	0	0	0
Central-east	41	14	9	8	4	2
Central-west	10	3	1	1	0	0
South-east	12	6	2	3	2	0
South-west	4	1	1	1	0	0
Total	138	54	31	21	11	9

Source: Ministry of Health.

Doctors working in liberal practice are free to choose where they want to work. Study results show that there is a high concentration of work in large urban areas and regions where patients generally have more purchasing power and/or there is a better quality of life *(1)*. The number of doctors who live and work in governorates in the central part of the country is still low, as is the ratio of doctors to inhabitants. Disparities are wider for specialist doctors than for general practitioners. As an example, in 2017, the national average was 27 general practitioners in free practice per 100 000 inhabitants. The main exceptions were the governorates of Tunis, where there were 49 general practitioners in free practice per 100 000 inhabitants, and Siliana, where there were just 10. For specialist doctors the gap is wider, with a national average of 42 per 100 000 inhabitants. Tunis and Siliana had 136 and 4, respectively (see Annex 7).

These disparities are more pronounced for some specialties. Both public and private sectors have a lack of specialists in the western governorates (Table 10).

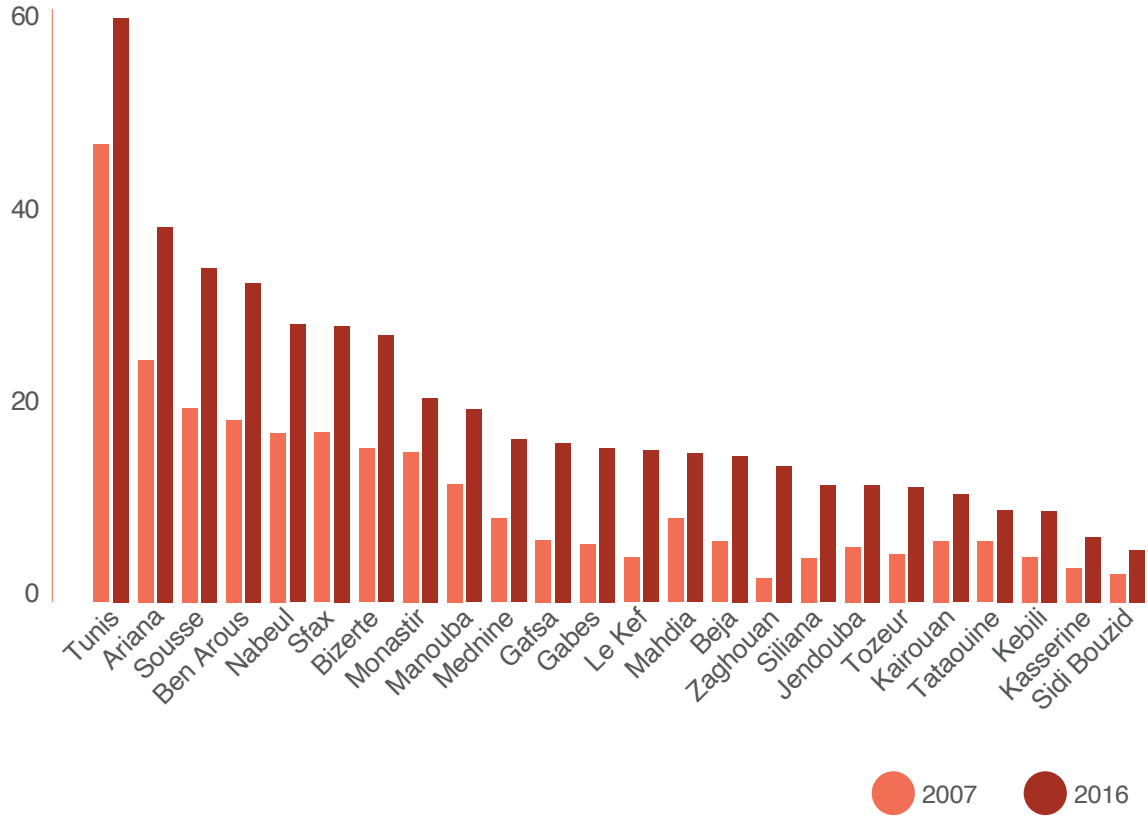
Table 10. Number of specialist doctors per 100 000 inhabitants, 2017

	Governorate with the least specialists	Governorate with the most specialists	National average
Obstetrics and gynaecology	Tataouine: 3.0	Tunis: 42.0	16.0
Paediatrics	Kebili: 3.0	Tunis: 37.0	13.0
Medical imaging	Siliana: 0.4	Tunis: 9.2	3.1

Source: Ordre des Médecins de Tunisie.
Note: Calculated based on population as at 1 July 2017, according to the National Institute of Statistics.

Dentists are also free to choose where they want to work. Regional disparities persist despite a relative improvement between 2007 and 2016 (during which time the coefficient of variation decreased from 0.9 to 0.6) due to an increase in the number of dentists on a national level (Fig. 7). The governorate with the highest rate of dentists (Tunis) has 59.7 per 100 000 inhabitants, 11 times more dentists than the governorate with the lowest rate (Kasserine), which has 5.4.

Fig. 7. Distribution of dentists in 2007 and 2016



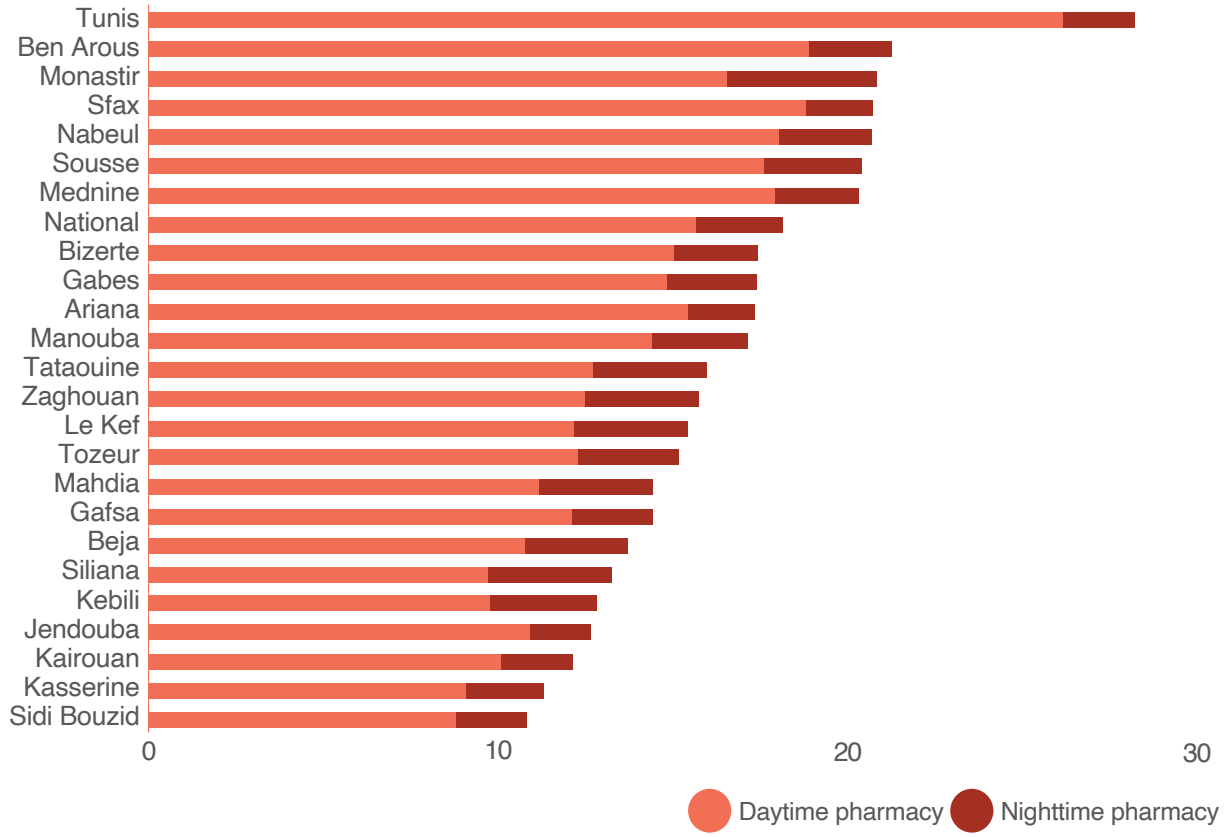
Source: Statistical Yearbook for 2007 and 2016 (National Institute of Statistics) (17, 18)
Note: Calculation based on population as at 1 July 2017, according to the National Institute of Statistics.

Biologists working in analysis laboratories are also free to choose where they want to work. Again, as a result, there are significant regional disparities, and the governorate with the highest density of medical testing laboratories (Tunis) has 21.2 times more per 100 000 inhabitants than the governorate with the lowest density (Siliana). The density of medical testing laboratories in Tunis and Siliana stands at 9.3 and 0.4 per 100 000 inhabitants, respectively. Disparities in anatomical pathology laboratories are even more pronounced, and their distribution seems to be associated with the number of clinics in each particular governorate. Tunisia has three cytogenetic laboratories in the private sector: two in Tunis and one in Sfax.

Pharmacies are the most equally distributed of all these structures. This is because of a regulation that caps the number of pharmacies based on the number of inhabitants in the region.[16] Between 2007 and 2017, the density of pharmacies across Tunisia increased from 366.2 per 100 000 inhabitants in 2007 to 398.9 in 2017, which meant that the number of pharmacies increased faster than the country's population over this period. This led to a significant improvement in the regional distribution of pharmacies, and they became more evenly spread across the country. However, the governorate with the most pharmacies per 100 000 inhabitants (Tunis) still has 2.62 times more pharmacies than the governorate with the fewest (Sidi Bouzid) (Fig. 8).

16. Decree No. 2007-4139 of 18 December 2007.

Fig. 8. Distribution of pharmacies per 100 000 inhabitants, by governorate, 2017



Source: Ministry of Health – Department of Pharmacy and Medicines
Note: Calculation based on population figures as at 1 July 2017, according to the National Institute of Statistics.

6.3 Legal, regulatory framework and governance in the private health sector

There are two forms of regulations: economic regulations that deal with monopoly, and competition and social regulation, which is concerned with the promotion of social objectives. Article 40 to Article 58 of Law No. 91-63 on the organization of health care sets out specific provisions for private health facilities: (i) regulatory classification of these facilities as private hospitals, multidisciplinary clinics (polyclinics), single-specialty clinics or non-profit health facilities, (ii) standardization of infrastructure (architecture and technical equipment) on premises intended for hospital care, (iii) standardization of human resources (number and qualifications) to be deployed based on the capacity of the facility, (iv) the requirement to produce periodic activity reports and to send these to the Ministry of Health, and (v) the organization and implementation of medical monitoring for health care activities.

Article 8 of Law No. 91-63 decrees the creation of seven advisory bodies, including two related to private health service providers, with limited roles.

- The Tunisian National Committee of Health Facilities, whose scope for interventions is established by Decree No. 2001-1080[17] of 14 May 2001, and includes the authorization of: (i) applications to

create or transfer a haemodialysis centre, (ii) applications to install heavy equipment and advanced technologies[18] at a private health facility, (iii) applications to permanently close a private health facility.

- The National Council of Technical Medical Equipment, in Article 1 of Decree No. 92-1208 of 22 June 1992, establishes the standards and indicators of needs by type of equipment and by facility, sets the health map and determines whether there is an opportunity to bring equipment into the country that applies new techniques, as well as setting the purchasing and distribution priorities for equipment, and establishing the maintenance policy. Some heavy equipment and advanced technologies require an agreement in principle and prior authorization.[19] However, the Order of 18 October 2018 authorized purchases outside of the set quota, removing the cap on heavy equipment in private health facilities in priority governorates[20] with a capacity of more than 60 beds, and private health facilities in other governorates with a capacity of more than 100 beds.

- Ad hoc committees may be set up for specific applications at the request of the Minister of Health.

While prices of medicines are set and approved by public authorities, the prices of health services are either set by the national boards (of doctors and dentists), Ministry of Commerce for hotel services or set in a less regulated way (by paramedics and clinics). Paramedics and clinics are setting the prices of services related to accommodation and more technical services even though the prices are theoretically set by the Ministry of Trade and they are obliged to make their applied prices publicly available. These price discrepancies occur because there is not enough done to enforce agreed prices.

The majority of private providers do not trust the State in terms of its regulatory role (see Annex 8). Bureaucracy and poor management (e.g. late payments from CNAM and a lack of public health facilities) are cited as some of the reasons for this. However, the various private providers recognize to varying degrees the importance of regulating the public and private sectors, both in terms of the State's distribution of services nationwide, and in terms of standards, guidelines and accreditations.

6.3.1 Registration, licensing and accreditation of private health facilities

Decree No. 93-1915 of 31 August 1993 and its 2010 amendment establish the characteristics and standards[21] of private haemodialysis facilities, though it should be stated that these standards are lacking in public health facilities. A set of specifications in the Order of 24 December 2007 contains the standards to be provided for running these private health facilities.

17 Article 2 of Decree 92-1208 sets out the requirement for the Committee to be consulted about any application for the operation and development of a private health facility.
18 Article 45 of Law No. 91-63 defines heavy equipment as being movable equipment that helps to diagnose, treat or rehabilitate patients and can only be used under particularly expensive installation and operating conditions. The list of this equipment is established by Order.
19 The joint order issued by the Ministry of Health and Commerce on 17 December 2013 provides a list of this equipment.
20 The Order of 17 December 2013 sets the priority governorates as (13): Beja, Jendouba, Siliana, Le kef, Kairouan, Sidi Bouzid, Kasserine, Gafsa, Tozeur, Kebili, Tataouine, Gabes and Mednine.
21 Decrees No. 2010-2200 of 6 September 2010 and No. 93-1915 of 31 August 1993 and the Orders of 24 December 2007 and 28 May 2001. For haemodialysis centres, the standards are set out in Decree No. 98-795 of 4 April 1998 and its amendments.

Beyond requirements for initial licensing to open private facilities, there are no periodic checks of health facilities to ensure continuing conformity for quality and safety of services. There is currently very little evidence of assessing the quality of care in the public sector and almost no evidence for doing so in the private sector. In addition, there are few or no approved good practice standards. INEAS is currently working to ensure that these are approved and made available.

A national accreditation system is being put in place for public and private health care facilities and as part of this system, public and private facilities will be required to produce and publish their data on the quality of health services provided.

Furthermore, Law No. 2001-94 develops the legal framework for health facilities exclusively geared towards the export of health services (for non-residents). These facilities may provide services to residents within the limit of an amount equivalent to below 20% of turnover generated by non-residents, except for in extremely urgent cases.[22] However, no health facility has yet been established based on this particular legal framework.

Decree No. 76-233 of 16 March 1976 and its amendments regulate pharmacies[23] and their operations by capping the number of pharmacies allowed per region and by specifying work schedules.[24] Law No. 2002-54 regulates the operations of medical testing laboratories.

6.3.2 Registration and licensing for health care professionals

Articles 86-98 of the code of medical ethics[25] govern the rules of free medical practice. There is a specific law for dentists.[26] The Ordre des Médecins de Tunisie (Tunisian medical board) and the National Council of Dentists (CNOMDT) are the regulatory bodies for single-doctor facilities and dentists, authorizing new practices and by holding the authority to de-license/close practices in case of infraction. No relicensing system is in place for medical professionals.

22 Decree No. 2002-545
23 There are two categories of private pharmacies: daytime (category A) and nighttime (category B)
24 For daytime pharmacies, the opening hours are 08:30–13:00 and 15:00–19:30 (between 1 September and 31 May), and 08:30–13:00 and 16:00–20:00 (between 1 June and 31 August). For nighttime pharmacies: 19:30–08:00 (between 1 September and 31 May), and 20:00–08:00 (between 1 June and 31 August). On-duty staff for daytime pharmacies for between the morning and afternoon hours (when pharmacies are closed) are taken from a list established by the regional boards under the supervision of the Tunisian national board of pharmacist)
25 Decree No. 93-1155
26 Law No. 91-21

7

Public–private partnership in health service delivery

7.1 The legal and institutional environment for public–private partnerships/private sector engagement

Law No. 2015-49 provides the general framework for public–private contracts. This law states that projects subject to partnership contracts must meet a predetermined need by the public entity and be fixed in accordance with national and local priorities and defined objectives in development plans.

The law defines the public–private partnership contracts as written fixed-term contracts by which a government entrusts a private partner with a mission relating totally or partially to the design and construction of works, equipment or tangible or intangible infrastructure necessary to provide a public service.

As for the institutional side, Law 2015-49 is a public–private partnership (PPP) law stipulating the creation within the Presidency of the Government of a strategic council responsible for establishing national PPP strategies and setting priorities in accordance with the guidelines of development plans. Article 38 of this law, on the other hand, allowed the creation of the Instance Générale des Partenariats Public-Privé, or general PPP body; see Annex 8) responsible for matters including providing technical support to public figures and assisting them in preparation, concluding and monitoring the execution of PPP contracts.

7.2 PPP examples in the health sector

For the Instance Générale des Partenariats Public-Privé (see Annex 8), no health-related projects are mentioned in the general activity report. Few reports mention the possibility of extending PPP to health and education.

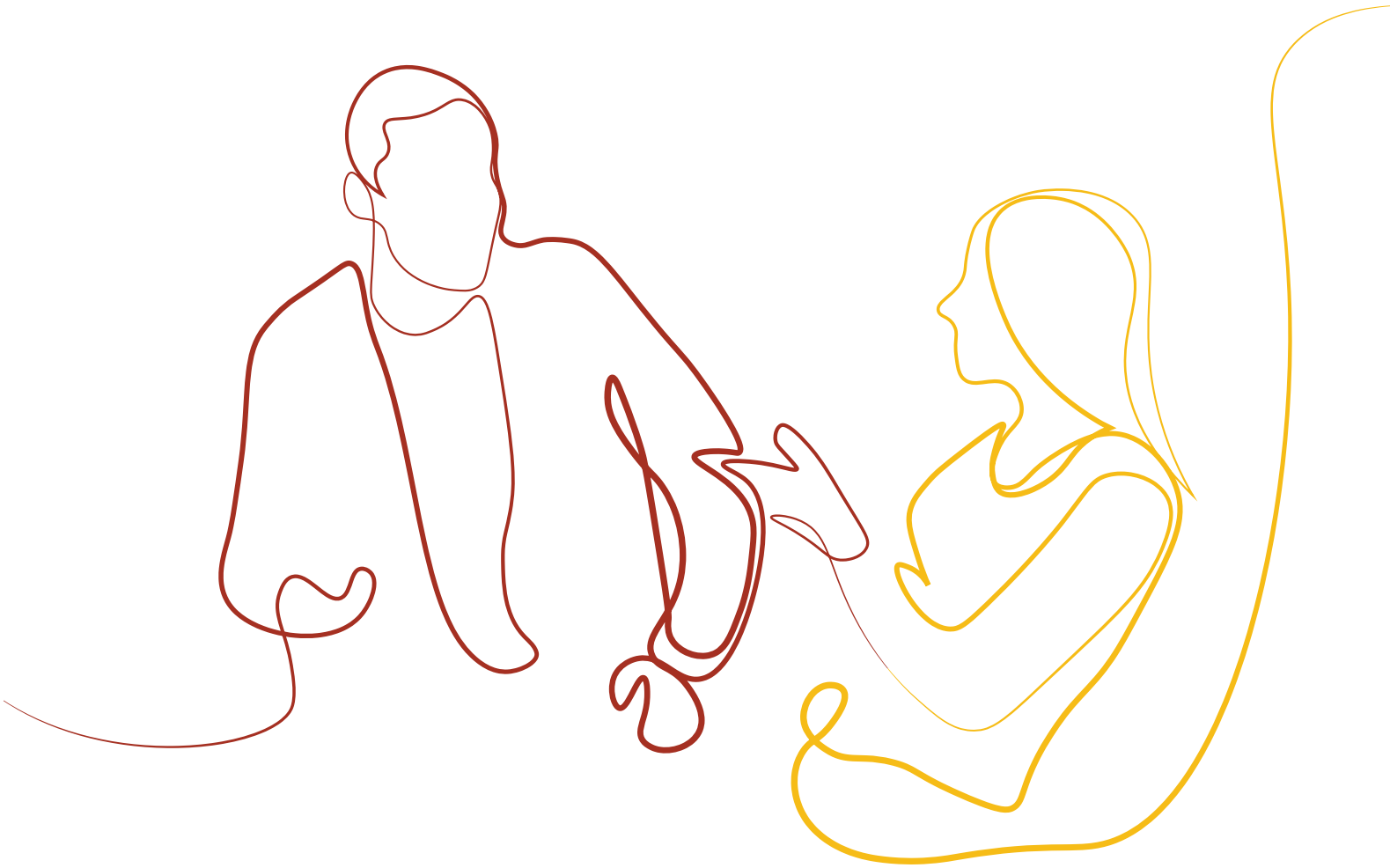
One initiative found is for health professionals working in free practice (doctors, pharmacists, dentists and senior technicians) to be contracted to work in public health facilities, and more specifically in priority areas. However, the pay scale does not seem to be very encouraging. This reflects an acknowledgement of the need for more effective use of resources, as a way of addressing the challenges of universal health coverage, particularly in disadvantaged areas.

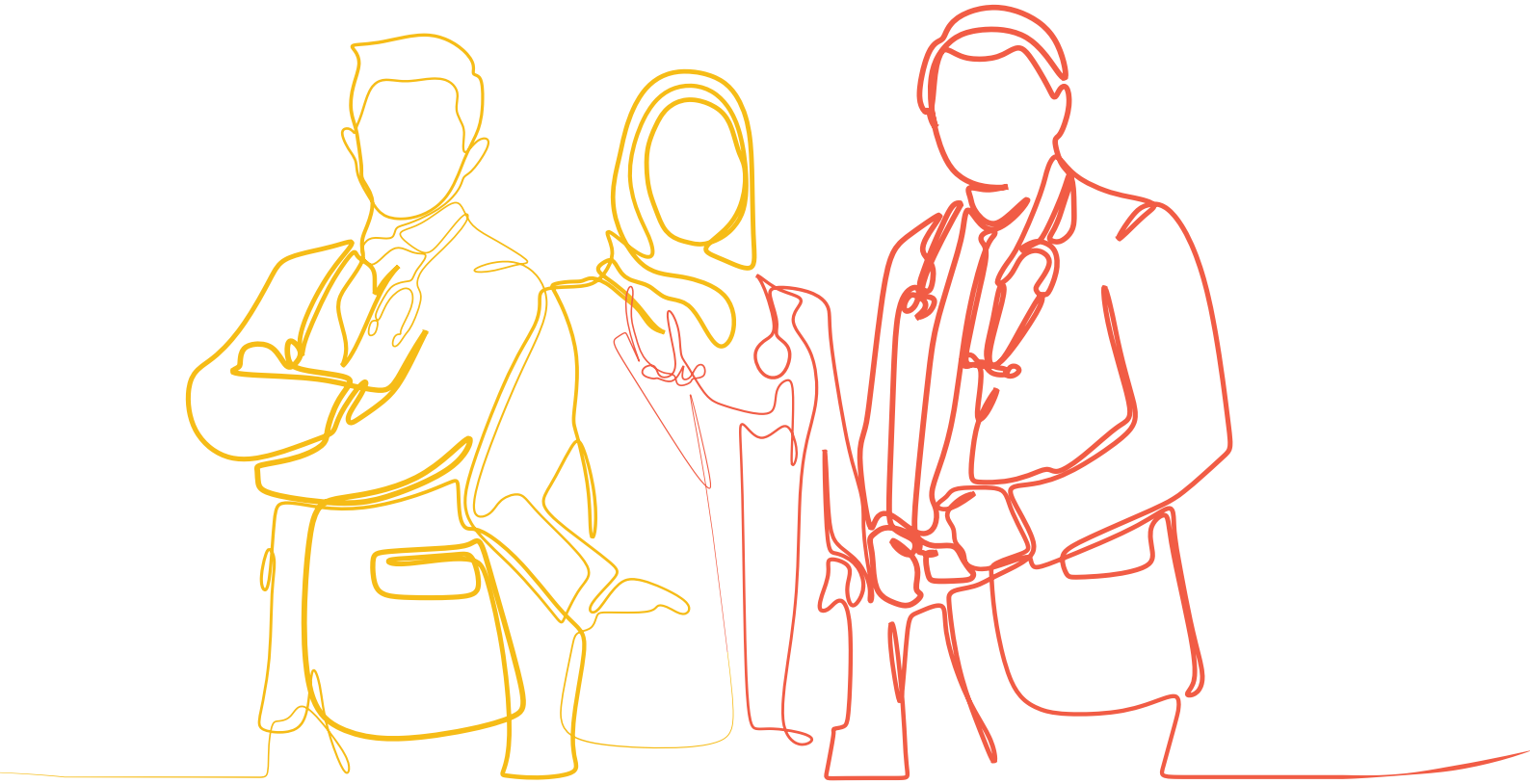
Private providers highlighted that a more encouraging and favourable legal and political framework is still needed (see Annex 8) and that the actual status of partnership is still insufficient.

Decision-makers and experts have emphasized the requirements for properly supervising and monitoring potential partnerships (see Annex 8). These include having a regulation and a coordination body in place and a clear understanding of the whole process of partnerships and their operating environment.

7.3 Scope and priority areas for PPP and private sector engagement in the future

Areas for collaboration and complementarity already exist and could be developed to better serve the population in terms of health services. Prevention, screening, chronic diseases, clinical support services and management of health facilities are just a few examples of potential areas for collaboration (see Annex 8). This would enable a more effective use of scarce resources (e.g. specialists, advanced technologies). Potential areas for partnership have been identified by private providers, in particular: national programmes, medical equipment and the management of health care facilities (see Annex 8).





8

Strength, weakness, opportunity and threat analysis for private health sector and PPP

The strength, weakness, opportunity and threat analysis shown in Table 11 was prepared using the information obtained through the desk review, as well as from the interviews with different stakeholders.

Table 11. Strength, weakness, opportunity and threat analysis for private health sector and PPP in Tunisia.

Table 11. Strength, weakness, opportunity and threat analysis for private health sector and PPP

9

Suggestions and recommendations on private sector, universal health coverage and policy directions

The private health sector in Tunisia has an important role to play in terms of meeting international commitments to sustainable development (including UHC) and Article 38 of the 2014 Constitution, which states:

Health is the right of every human being. The state guarantees prevention and health care for every citizen, and provides the necessary capabilities to ensure the safety and quality of health services. The state guarantees free treatment for the bondless and for those with limited income. It guarantees the right to social coverage according to what is regulated by law.

The private sector should be integrated into the national health policy. The Societal Dialogue on national health policies, strategies and plans was the process of finalizing Tunisia's new national health policy. The national conference on social dialogue culminated in a national health policy in June 2019.

The recommendations provided below are based on the data presented in this report as well as on the results of the strength, weakness, opportunity and threat analysis discussed in Section 8.

A. Policy recommendations

1. Sound, well-functioning and transparent legal and regulatory institutions, supportive and credible institutional processes, and the capacity and structures to move forward with collaboration are required for effective engagement of the private sector.

2. Policy dialogue platforms between the private sector and governmental bodies must be established, where both sides commit to achieve better health outcomes. These platforms should tackle issues related to capacity, prices, essential services packages, equity of access, quality, safety, affordability and overmedicalization issues.

   The public sector and the government should have first a leadership role in compliance with quality and safety regulations and standards and good practice guidelines. National regulatory measures must aim to ensure that both private and public health providers alike abide by the necessary quality requirements and that their personnel have the required training and certificates.

3. A standardized, regulated health sector that provides equal access to both public and private sector players in order to encourage both to work in a way that is as complementary as possible is vital, particularly in disadvantaged regions. Both sectors are also seen as essential for establishing standards and good practice guidelines, as well as for developing accreditations for public and private health care facilities. Adequate initiatives should be developed, and major efforts are needed to make these regulations effective, participatory, transparent and acceptable for all parties.

B. Operational recommendations

1. Tools and competencies need to be developed for using these regulations effectively in the public and private sectors in order to:

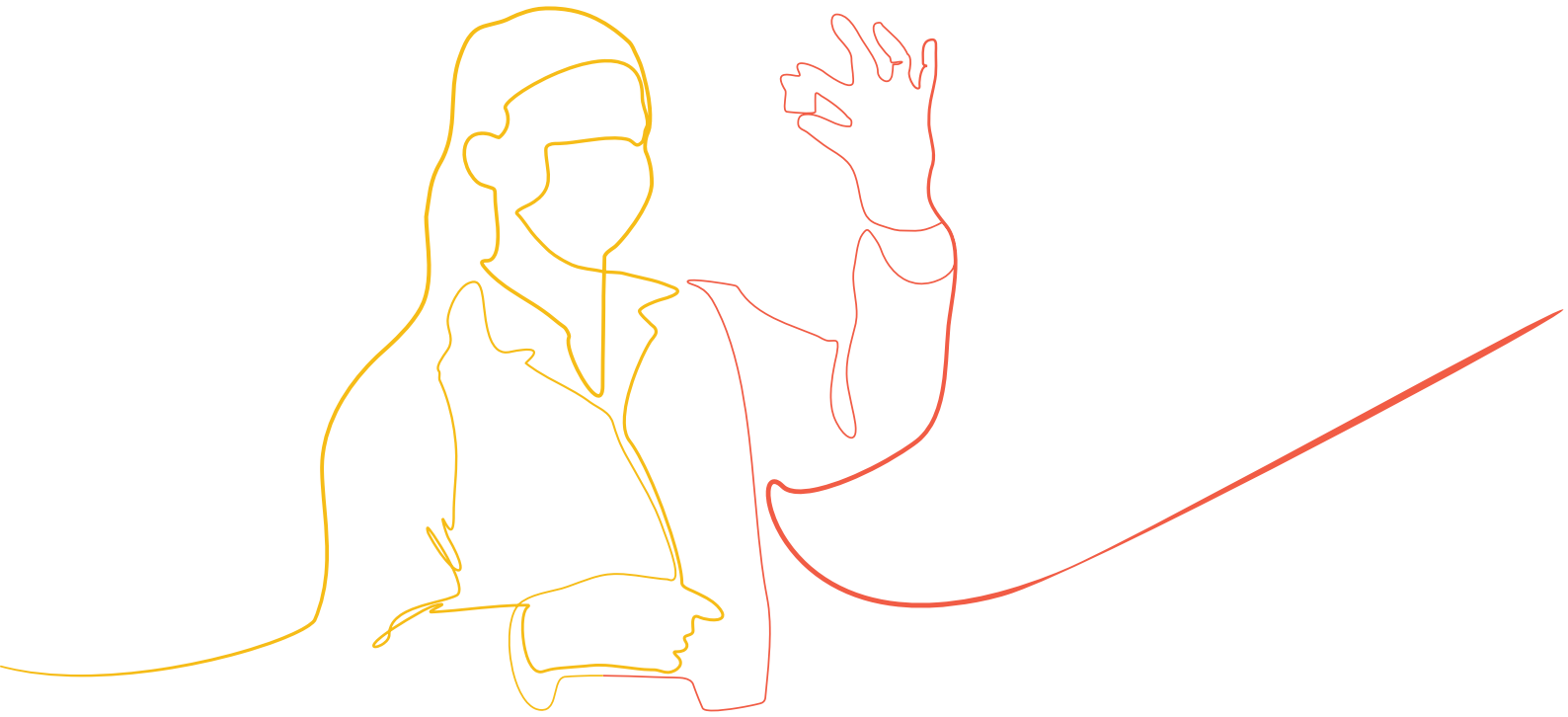
    - guide their respective steps towards high-quality health care for the entire Tunisian population and in order to ensure that the cost of this care remains affordable for patients and sustainable for the financial protection system in place.

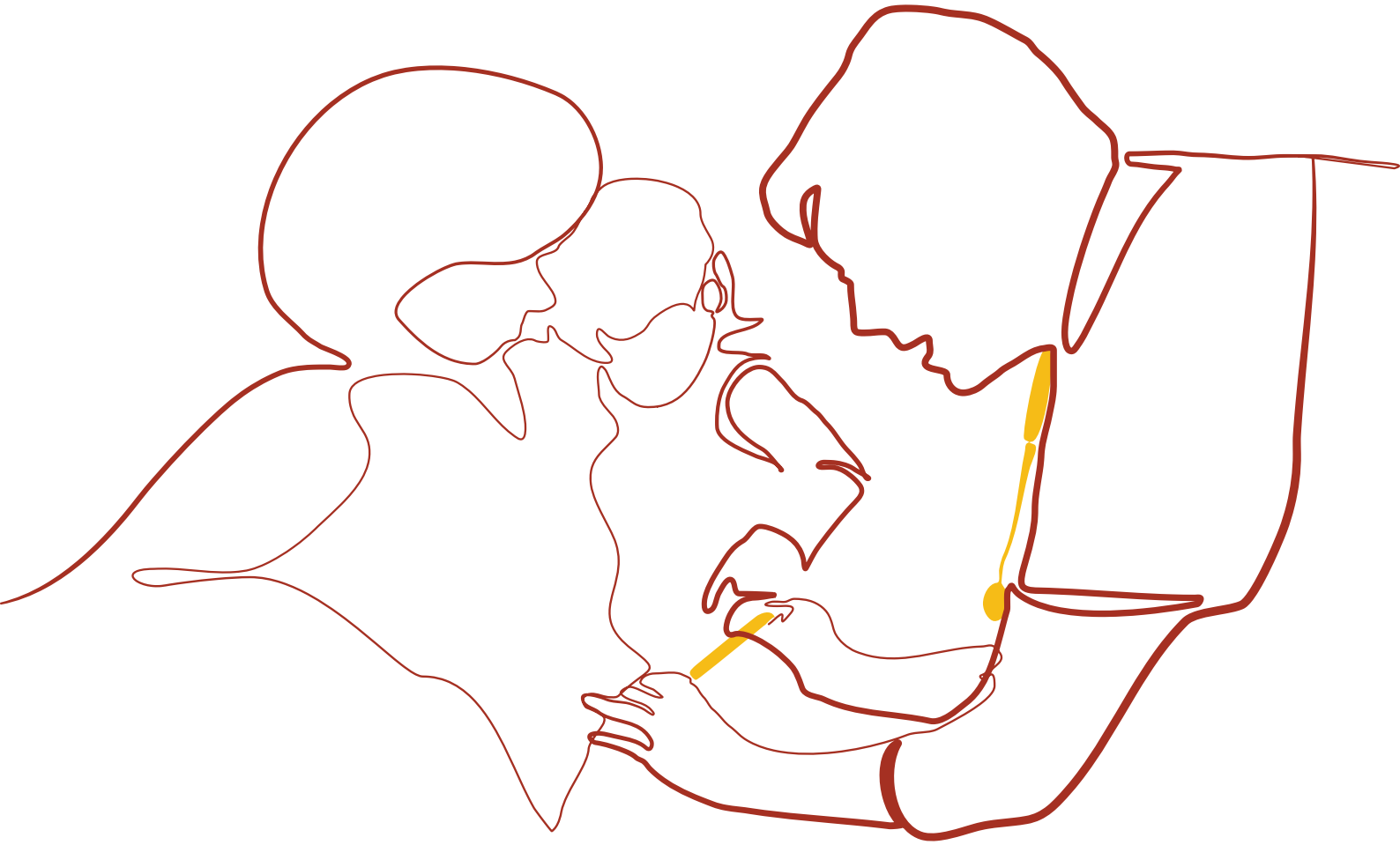
    - foster public–private collaboration by achieving public health goals that are set in line with strategies and approved national standards.

2. The public officials involved in PPP project teams need to have competencies to structure and evaluate the project considering its financial, legal and technical aspects. The concerned officials and governmental institutions need to have knowledge and skills in many related areas including public policy and planning, project economics, finance and relevant legal frameworks.

3. A dialogue and a consensus on the elements and indicators needed for this monitoring should be developed by private sector representatives, civil society and governmental bodies.

4. Partnership and regulation should cover all the aspects of service delivery and finance.

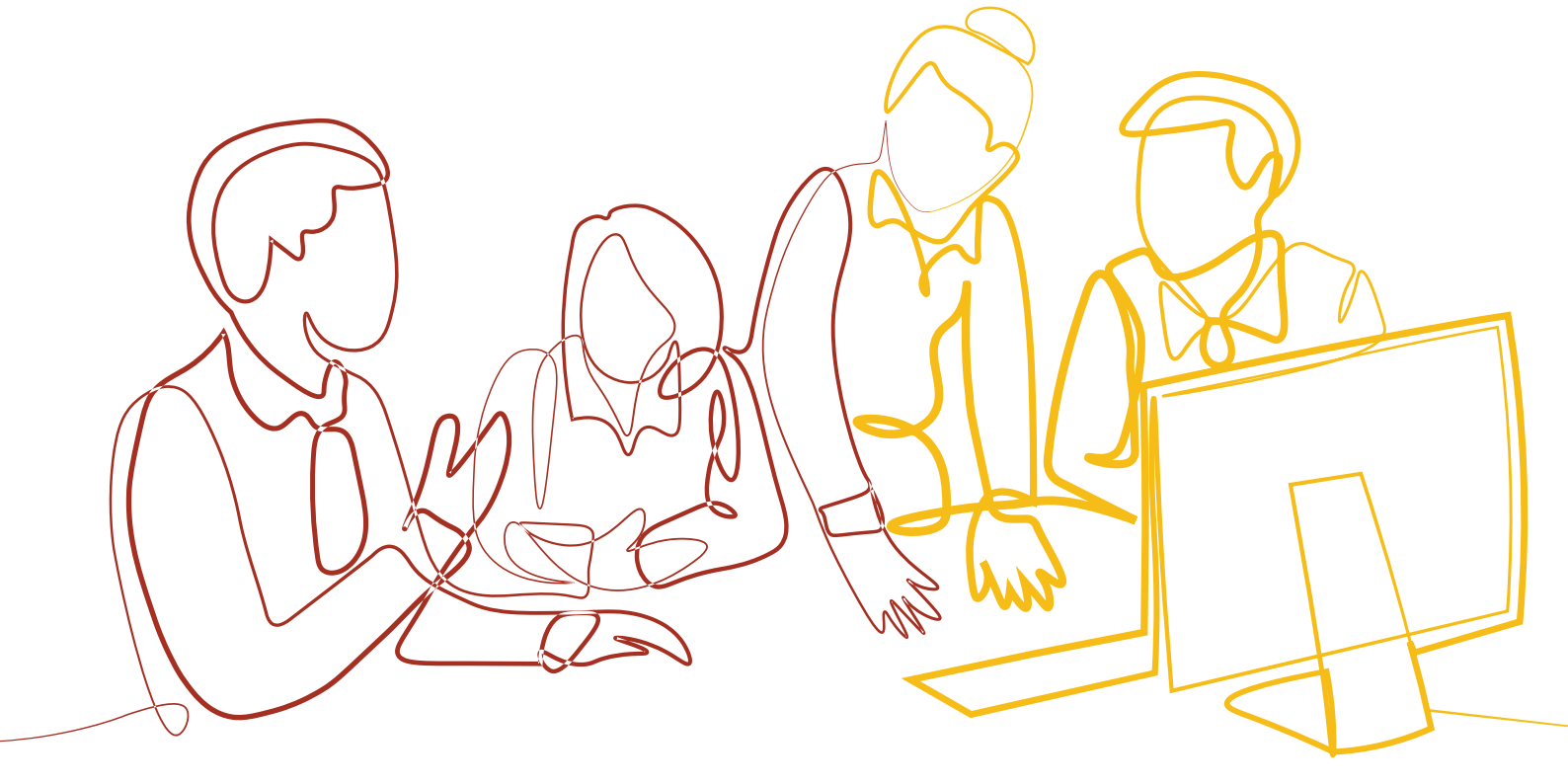




References

References

1. What policies should be implemented to address inequalities in health care in Tunisia? Abidjan: African Development Bank Group; 2014 (https://www.afdb.org/en/documents/document/economic-brief-what-policies-should-be-implemented-to-address-inequalities-in-health-care-in-tunisia-47689).
2. Santé en Tunisie: Etat de lieux [A general review of healthcare in Tunisia]. Tunis: Ministère de la Santé de la Tunisie; 2014 (in French).
3. Recensement Général de la Population et de l'Habitat 2014: Volume 8 [General population and housing census of 2014: Volume 8]. Tunis: Institut National de la Statistique; 2014 (https://www.ins.tn/publication/recensement-general-de-la-population-et-de-lhabitat-2014-volume-8) (in French).
4. Les projections de la population 2014–2044 [Population projections 2014–2044]. Tunis: Institut National de la Statistique; 2016 (https://www.ins.tn/publication/les-projections-de-la-population-2014-2044) (in French).
5. Global Burden of Disease Study 2016. Seattle, WA: Institute for Health Metrics and Evaluation; 2016 (https://www.healthdata.org/research-analysis/gbd).
6. Saidi O. Résultats de l'enquête «Tunisian Health Examination Survey 2016» [Tunisian Health Examination Survey]. Tunis: Ministry of Health; 2018.
7. National health accounts. Tunis: Ministry of Health; 2014.
8. Hamani W. Application of Operations Research to Healthcare Industry in Developing Countries: Optimization of the Location of Primary Health Care Centers in Tunisia [master's thesis]. Pompeu Fabra University; 2019(https://repositori.upf.edu/bitstream/handle/10230/42565/Hamani_HealthcareIndustry_MScMGEN02.pdf?sequence=1&isAllowed=y).
9. Health card. Tunis: Ministère de la Santé de la Tunisie; 2016.
10. Households Consumption Survey 2010: Volume C. Tunis: Institut National de la Statistique; 2014 (in Arabic).
11. Households Consumption Survey 2015: Volume C. Tunis: Institut National de la Statistique; 2018 (in Arabic).
12. WHO global health expenditure database [online database]. Geneva: World Health Organization (https://apps.who.int/nha/database).
13. OECD/European Union. Health at a glance: Europe 2016: State of health in the EU cycle. Paris: OECD Publishing (https://doi.org/10.1787/9789264265592-en).
14. Ayadi I, Guisset AL. Réduire la contribution directe des ménages pour leurs soins, un impératif pour la réalisation progriessive du droit à la santé [Reducing the direct contribution of households for their care, an imperative for the progressive realization of the right to health]. Tunis; 2014 (in French).
15. http://www.profiscal.com/anglais/Anglais/Digest_ENG/cii.htm
16. Étude sur le développement de la stratégie d'exportation des services de santé et de son plan de mise en œuvre [Study on the development of the health services export strategy and the plan for implementation]. Abidjan: African Development Bank Group; 2014 (in French).
17. Statistical Yearbook Tunisia 2007–2016. Tunis: Institut National de la Statistique; 2012.
18. Statistical Yearbook Tunisia 2016–2020. Tunis: Institut National de la Statistique; 2022.



Annexes

Annex 1. List of interviewees

Interview questions for senior policy-makers, national health authorities and health sector experts	Hédi Achouri	Health system expert, doctor, former Director-General in the Ministry of Health
	Riadistrict hospital Ben Abbes	CNAM (Tunisian National Health Insurance Fund), Central Director of Governance
	Slim Ben Salah	Chairman of the Tunisian National Board of Doctors
	Abdelwahed El Abassi	Health system expert, doctor, former WHO and UNICEF Representative
	Hédi Guelmami	Treasurer of Tunis Regional Board of Doctors
	Sonia Khayat	Ministry of Health, Director-General of Public Health Care Facilities
	Bechira Rhaiem	Ministry of Health, Director of the Directorate for Regulating and Monitoring Health Professions
	Khaled Zeghal	Ministry of Health, Director-General of the National Authority for Assessment and Accreditation in Healthcare
Questionnaire for private health sector representatives (clinics)	Pasteur	Tunis
	Alyssa	Tunis
	Errachid	Sfax
	Ibn Nafiss	Sfax
	Ibn Khaldoun	Sfax
	Médina	Sfax
	Chams	Sfax
Interview questions for private sector laboratories, pharmacies and diagnostic centres	7 pharmacies	3 in Tunis, 1 in Sidi Bouzid, 1 in Gabes, 2 in Sfax
	3 laboratories	2 in Sfax, 1 in Sidi Bouzid
	2 imaging centres	Sfax
Interview questions for nongovernmental, non-profit organizations	Médecins du Monde	
Interview questions for private professional associations, unions and business councils	SPOT	Syndicat des pharmaciens d'officine de Tunisie (national union of pharmacists)
	STML	Syndicat Tunisien des médecins liberaux (national union of doctors working in free practice)
	SNBLPT	Syndicat national des biologistes de libre pratique de Tunisie (national union of biologists)
Interview questions for donors (development partners)	Global Fund	
Exit interview questionnaire for patients at private health facilities	49 patients	

Annex 2. Governorates by region

Governorates	Region
Ariana	Greater Tunis
Ben Arous	
Manouba	
Tunis	
Bizerte	North-east
Nabeul	
Zaghouan	
Beja	North-west
Jendouba	
Le kef	
Siliana	
Mahdia	Central-east
Monastir	
Sfax	
Sousse	
Kairouan	Central-west
Kasserine	
Sidi Bouzid	
Gabes	South-east
Mednine	
Tataouine	
Gafsa	South-west
Kebili	
Tozeur	

Annex 3. Legal frameworks

Topics	Legal frameworks
Health organization	▪ Law No. 91-63 of 6 August 1991
Private health facilities ▪ general provisions ▪ national committee of private health facilities ▪ standards ▪ requirements ▪ list of equipment that benefits from tax incentives	▪ Section 3: Article 40 to Article 58 of Law 91-63 of 6 August 1991 ▪ Decrees No. 2001-1080 of 14 May 2001 and No. 92-1208 of 22 June 1992 ▪ Decrees No. 2010-2200 of 6 September 2010 and No. 93-1915 of 31 August 1993 ▪ Orders of 24 December 2007 and 28 May 2001 ▪ Decrees No. 2006-382 of 6 February 2006, No. 98-967 of 27 April 1998 and No. 94-1056 of 9 May 1994
Health facilities that offer all their services to non-residents and the conditions for providing these services	▪ Law No. 2001-94 of 7 August 2001 ▪ Decree No. 2002-545 of 5 March 2002
Heavy/technical medical equipment	▪ Articles 8 and 45 of Law No. 91-63 of 6 August 1991 ▪ Decree No. 92-1207 of 22 June 1992 ▪ Orders of 18 October 2016, 17 December 2013, 7 March 2003, 22 June 2000 and June 1996 stipulating the standards and indicators of needs for heavy equipment. ▪ Orders of 18 October 2016, 17 December 2013, 16 May 2000, 30 November 1995 and 5 November 1991 stipulating the list of heavy equipment for which purchasing, installation and usage are subject to a principal agreement and prior authorization from the Ministry of Health.
Haemodialysis centres	▪ Decrees No. 2009-1926 and 1927 of 15 June 2009, No. 2006-404 of 3 February 2006 and ▪ No. 98-795 of 4 April 1998 ▪ Orders of 28 February 2007 and 27 April 1998
Pharmacies	▪ Laws No. 2010-30 of 7 June 2010, No. 92-75 of 3 August 1992 and No. 73-55 of 3 August 1973 ▪ Decrees No. 2007-4139 of 18 December 2007, No. 92-1206 of 22 June 1992 and No. 76-233 of 16 March 1976 ▪ Order of 28 April 2009
Thalassotherapy centres	▪ Decree No. 2006-3174 of 30 November 2006
Telemedicine	▪ Law No. 2018-43 of 11 July 2018
Medical testing laboratories	▪ Law No. 2002-54 of 11 June 2002
Guide to tax and financial investments and incentives	▪ Article 49 of Law No. 93-120 of 27 December 1993, promulgating the investment incentives code ▪ Decrees No. 2006-382 of 6 February 2006, No. 98-967 of 27 April 1998 and No. 94-1056 of 9 May 1994 ▪ Order of 16 December 1997 ▪ The finance laws No. 2009-71 (Article 21), No. 2010-58 (Article 24.3)
Medical ethics	▪ Decree No. 93-1155 of 17 May 1993- Chapter 6 of Section 5: Articles 86-98
Dentists	▪ Law No. 91-21 of 13 March 1991
Health professionals working as free practitioners in public health facilities	▪ Orders of 31 December 2015, 24 December 2009 and 14 March 1992

Annex 4. Financial and tax incentives

Providers	References	Financial and tax incentives
Hospitals and health facilities: Hospitals, single-specialty clinics and multidisciplinary clinics	Investment law No. 2016-71 of 30 September 2016 Law on tax benefits No. 2017-08 of 14 February 2017	1. Reduction of taxes on profits from operations (Article 70, Personal Income Tax Code and Corporation Tax Code) ▪ For natural persons: deduction of two thirds of income from business notwithstanding the provisions of Article 12a) of Law No. 89-114 of 30 December 1989 ▪ For legal persons: payment of corporation tax at a rate of 10% Possibility for newly created companies to receive an income tax exemption or corporation tax exemption if investments are declared before 31/12/2020. If not, deduction of revenue or profits from operations during the first 4 years of business, as follows: ▪ 100% in the first year ▪ 75% in the second year ▪ 50% in the third year ▪ 25% in the fourth year 2. VAT at a rate of 7% on medical services 3. A tax of 1% on turnover (excluding taxes) from private health care providers, with the exception of dialysis centres. 4. Possibility of receiving benefits for regional development (excludes liberal professions) 5. Preferential regime for purchasing equipment (Article 13 of the VAT code and Government Decree No. 2017-419): (i) exemption from customs duties for all equipment where there is nothing similar manufactured locally and VAT suspended for equipment mentioned in the list stipulated by decree, (ii) suspension of VAT on equipment manufactured locally that is mentioned on a list stipulated by decree.
Health facilities that offer all their services to non-residents	Article 4 of Law No. 2001-94 of 7/8/2001	These facilities are only subject to payment of the following taxes, fees, duties, levies and contributions: 1. duties and taxes relating to cars 2. single compensati on tax on road transport 3. tax on existing buildings 4. duties and taxes collected for the direct provision of services pursuant to the legislation in force 5. contributions to the legal social security system. 6. income tax from natural persons after deduction of 50% of revenue from business activities with the tax due being at least 30% of the tax calculated on overall earnings, not taking the deduction into account. However, revenue from the activity will be deducted in full from this tax base for the first 10 years after business operations begin, notwithstanding the provisions of Article 12 a) of Law No. 89-114 of 30 December 1989, promulgating the Personal Income Tax Code and the Corporation Tax Code. 7. corporation tax after deduction of 50% of profits from business activities with the tax due being at least 10% of overall profits subject to tax, not taking the deduction into account. However, profits from activities will be deducted in full of this tax base for the first 10 years after business operations begin, notwithstanding the provisions of Article 12 of Law No. 89-114 of 30 December 1989 promulgating the Personal Income Tax Code and the Corporation Tax Code. Profits from the deduction stipulated in paragraphs 6 and 7 of this Article are subject to account-keeping in accordance with the Tunisian accounting legislation for companies.

Annex 5.

Contractual relations between private providers and the Tunisian National Health Insurance Fund (CNAM)

- **Law No. 2004-71 of 2 August 2004**
- **Decree No. 2005-321 of 16 February 2005**
- **Decree 2005-3154 of 6 December 2005**
- **Orders of 22 February 2006, 1 August 2006, 6 February 2007, 4 May 2007**
  - General framework of agreements
  - Sectoral agreement with doctors in free practice
- **Sectoral agreement with dentists in free practice**
  - Sectoral agreement with medical testing laboratories
- **Sectoral agreement with pharmacists**
  - Sectoral agreement with private clinics
  - Sectoral agreement with physiotherapists

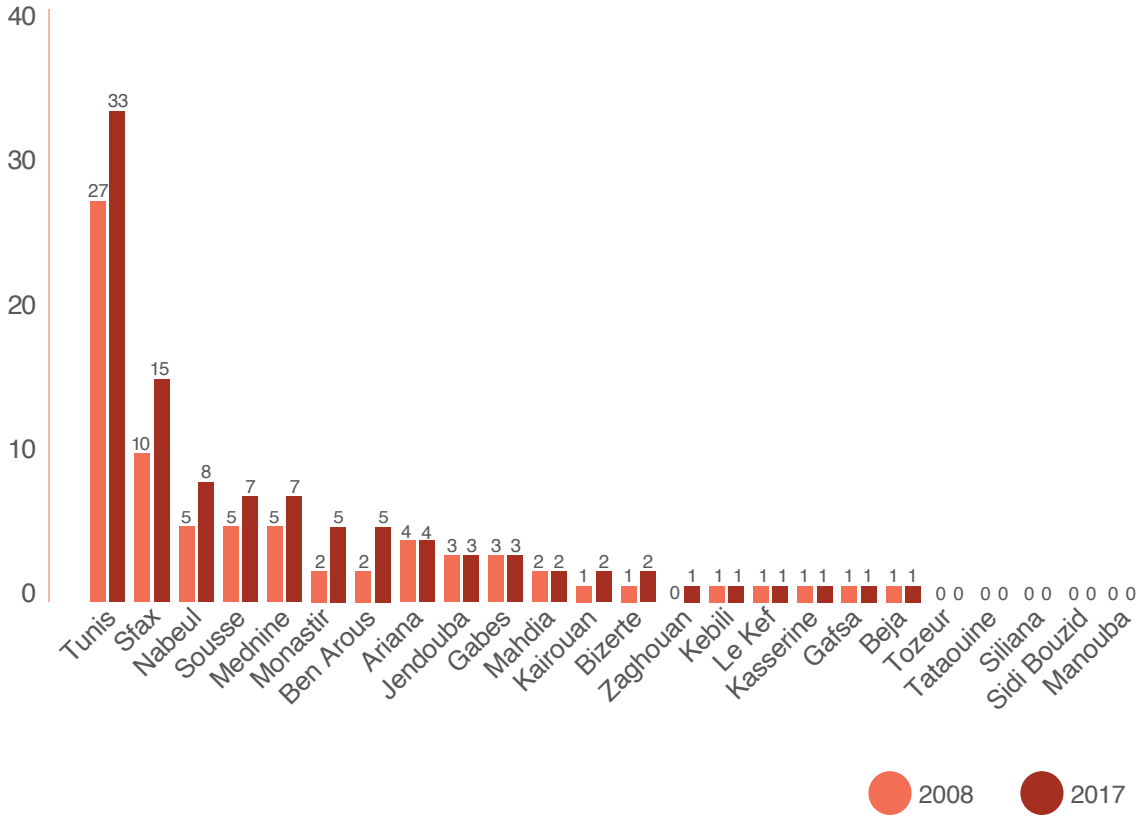
Annex 6. CNAM coverage methods for private sector health services

Services and health services	Private pathway	Reimbursement system
Consultations for common illnesses	70% of the agreed price paid directly to the doctor within the annual price ceiling of DT 200 per policyholder with DT 50 for each dependent	70% of the agreed price reimbursed to the patient within the annual price ceiling of DT 200 per policyholder with DT 50 for each dependent
Consultations for fully covered conditions	100% of the agreed price paid directly to the doctor	100% of the agreed price reimbursed to the patient
Hospital admissions	Total agreed flat fee[28] for the list of 54 agreed procedures	Total agreed flat fee reimbursed
Medical procedures	Not exceeding the price ceiling (except for fully covered conditions), the provider is paid: ▪ 80% of the agreed price for medical procedures ▪ 70% of the price for paramedical procedure	Not exceeding the price ceiling (except for fully covered conditions), the patient is reimbursed: ▪ 75% for radiology procedures, based on agreed prices ▪ 75% for laboratory tests, based on agreed prices
Diagnostic procedures	Not exceeding the price ceiling (except for fully covered conditions), the provider is paid: ▪ 75% for radiology procedures, based on agreed prices ▪ 75% for lab tests, based on agreed prices	Not exceeding the price ceiling (except for fully covered conditions), the patient is reimbursed: ▪ 75% for radiology procedures, based on agreed prices ▪ 75% for lab tests, based on agreed prices
Dental procedures	50% of the agreed price paid directly to the dentist within the price ceiling	50% of the agreed price reimbursed to the patient within the price ceiling
Medicines (excludes medicines for fully covered conditions)	The pharmacist is paid the reference price (the price of the cheapest generic medicine available) based on the coverage rate and not exceeding the price ceiling: ▪ 100% for vital medicines, 85% for essential medicines and 40% for intermediary medicines	The patient is reimbursed the reference price (the price of the cheapest generic medicine available) based on the coverage rate and not exceeding the price ceiling: ▪ 100% for vital medicines, 85% for essential medicines and 40% for intermediary medicines
Medicines for fully covered conditions	The pharmacist is paid 100% of the reference price (the price of the cheapest generic medicine available)	The patient is reimbursed 100% of the reference price (the price of the cheapest generic medicine available)

28 This fee includes an amount for the medical team and for the clinic.

Annex 7. Data on private providers

Fig. A7.1. Distribution of clinics in 2008 and 2017



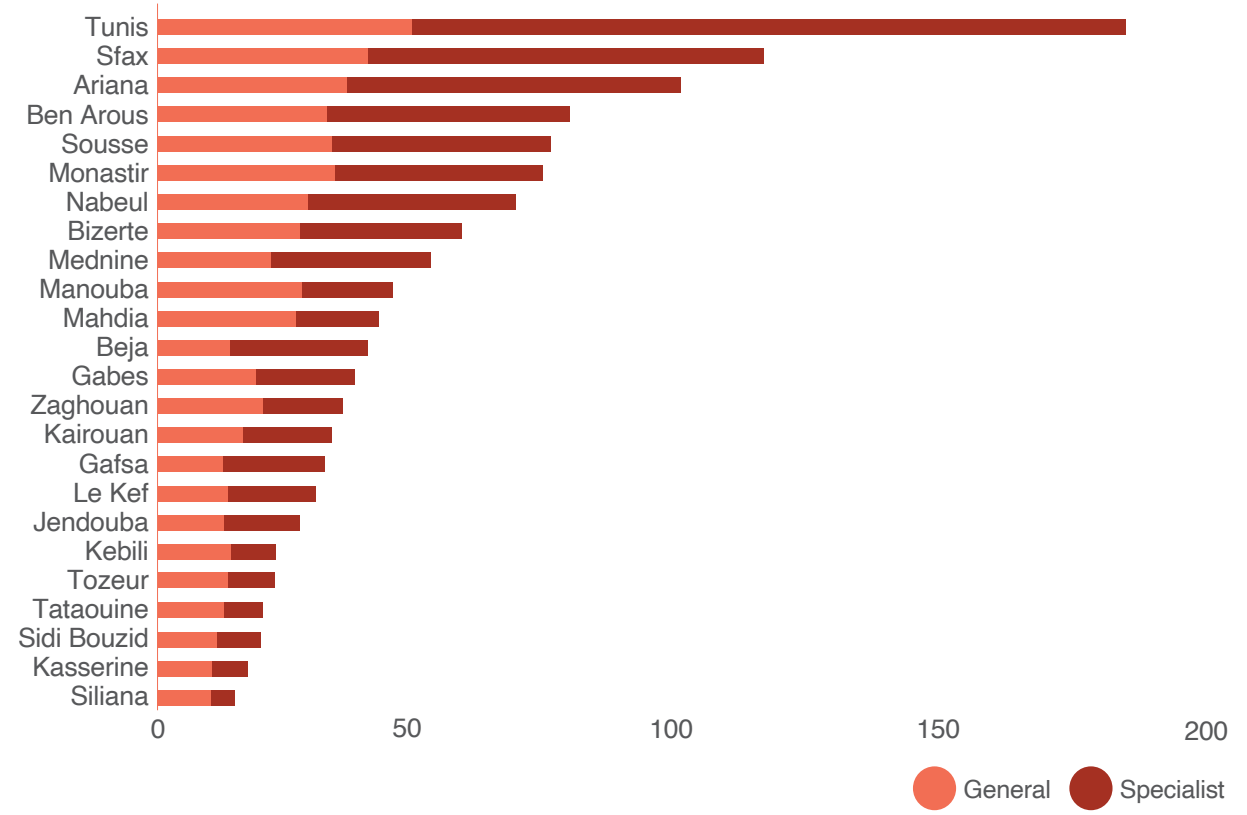
Source: Ministry of Health and Statistical Yearbook for 2008 (National Institute of Statistics).

Table A7.1. Distribution of heavy equipment and advanced technologies by governorate, 2018

Region	Governorate	CT scanner	MRI scanner	Cardiac catheterization rooms	Lithotriptor	X-ray equipment	Gamma camera
Grand Tunis	Tunis	27	14	13	5	3	7
	Ariana	8	3	0	1	1	0
	Ben Arous	8	4	1	1	0	0
	Manouba	2	1	0	0	0	0
North-east	Nabeul	12	2	2	1	1	0
	Zaghouan	1	1	0	0	0	0
	Bizerte	5	3	1	0	0	0
North-west	Beja	3	1	1	0	0	0
	Jendouba	2	1	0	0	0	0
	Kef	2	0	0	0	0	0
	Siliana	1	0	0	0	0	0
Central-east	Sousse	10	3	3	2	2	1
	Monastir	8	3	1	1	0	0
	Mahdia	5	1	1	0	0	0
	Sfax	18	7	4	5	2	1
Central-west	Kairouan	5	1	1	1	0	0
	Kasserine	2	1	0	0	0	0
	Sidi Bouzid	3	1	0	0	0	0
South-east	Gabes	3	1	0	0	0	0
	Mednine	9	5	2	3	2	0
	Tataouine	0	0	0	0	0	0
South-west	Gafsa	3	1	1	1	0	0
	Tozeur	0	0	0	0	0	0
	Kebili	1	0	0	0	0	0
Total		138	54	31	21	11	9

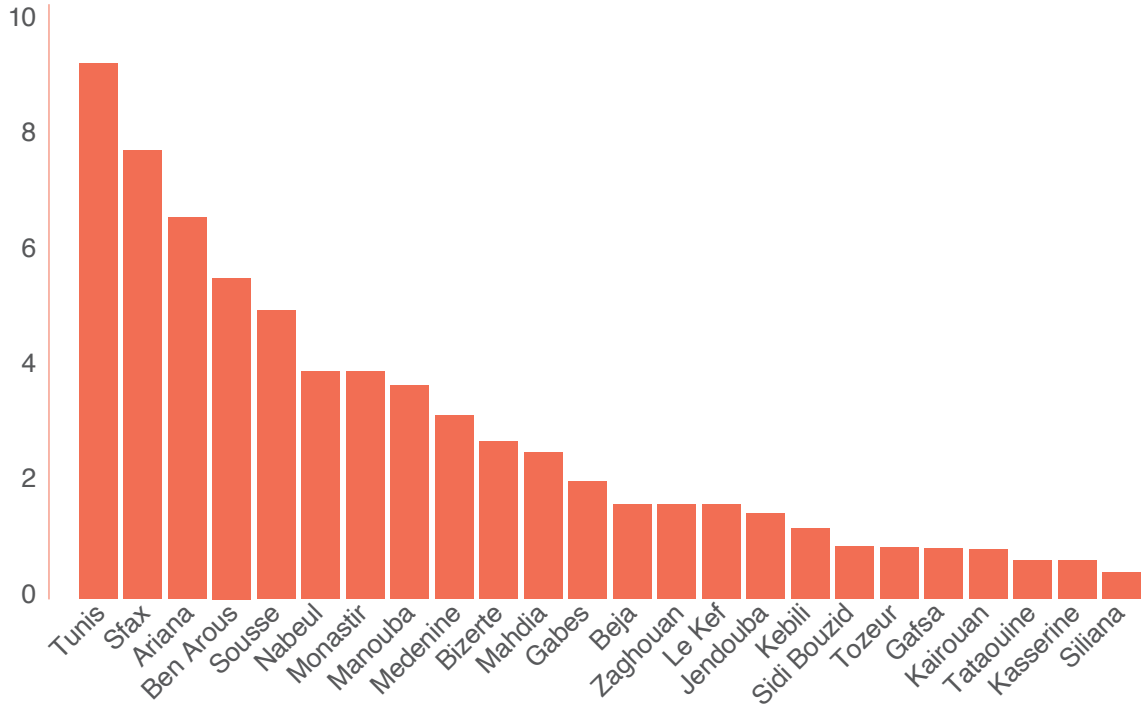
Source: Ministry of Health.

Fig. A7.2. Density of doctors working in free practice in each governorate per 100 000 inhabitants, 2017



Source: Tunisian Medical Board
Note: Calculation based on population as at 1 July 2017, according to the National Institute of Statistics.

Fig. A7.3. Density of medical testing laboratories in each governorate per 100 000 inhabitants, 2017



Source: Ministry of Health
Note: Calculation based on population as at 1 July 2017, according to the National Institute of Statistics.

Annex 8. Replies to questionnaires

Table A8.1. Respective roles of the State and the private sector

Categories	People interviewed	Role of the State (and particularly the aim of regulations)	Contribution/role of the private sector
Providers	Pharmacists	Red tape (bureaucracy) Payment delays by CNAM (compared with the deadlines stated in the agreement)	More available
	Biologists (at testing laboratories)	Lacking Payment delays by CNAM Bureaucracy	More available
	Radiologists (medical imaging centres)	Payment delays by CNAM and public facilities for transfers	More available Equipment maintenance
	Clinics	Mistrust and bureaucracy Provides free primary health care	Developed to fill the gaps in the public sector Provides better quality services Lower cost than the public facilities
Unions	STML (doctors)	Reimbursement rate	This sector covers 25 to 30% of the population It has the capacity to cover up to 50% of the population, especially first line illnesses
	SPOT (pharmacists)	Reimbursement rate Regulation that caps the number of pharmacies per region Approved prices	Geographical accessibility (well distributed) > proximity Availability of medicines > quality and safety
	SNBLPT (biologists)	Nomenclature of medical tests Reimbursement rate Development of a guide for conducting tests properly and correctly, enforceable in all laboratories Unequally distributed across the country (mainly concentrated in coastal areas)	Significant increase in the services provided, compared to public sector

Table A8.2. Perceptions of providers from PPPs

Categories	People interviewed	PPP priority areas	PPP aims	PPP concerns
Providers	**Pharmacists**	1. Prevention/screening programmes for certain diseases (breast cancer, leishmaniasis, HIV, etc.) and monitoring programmes for chronic diseases (diabetes, high blood pressure, etc.) 2. Governance of the system (conflict of interests, etc.)	1. Active involvement in national programmes with sharing of information. Example 1: malaria treatment provided to pharmacies free of charge Example 2: vaccines from the national immunization schedule provided free of charge 2. Involved in drafting legal texts	Lack of trust between the two sectors
	Radiologists (medical imaging centres)	Imaging and diagnostics	Facilitate purchasing for heavy equipment	1. Lack of flexibility from administrative bodies 2. Government's financial problems
	Clinics	1. Clinical support services (diagnostics, lab tests) 2. Primary care services 3. Management of health facilities	1. More accessible for all 2. Improvement in quality 3. Best possible use of resources	1. Poor contract management from the public sector 2. Complicated cases transferred (more difficult and more expensive) to the public sector 3. Less interest in public health objectives (promotion and prevention

Table A8.3. Answers from health experts and decision-makers

Topics	Main insights
The private sector as the main provider of health services	Rapid growth of private sector but public sector is predominant
	Private sector has more heavy equipment and advanced technologies than the public sector
	Training falls within the responsibility of the State (with a gateway to the private sector for paramedical training)
	Almost no statistical data on the volume and type of outpatient procedures within the private sector
	The data available relate to spending, and administrative data
Reasons for development and appeal of the private sector	Gaps in the public sector (responsiveness, quality, budget allocation, governance problems)
	Health insurance is a gateway to the private sector
	Opportunity for export of health services
	Financial and tax incentives
	Reducing regulations (particularly for heavy equipment)
	Setting of tariffs and fees entrusted to professional boards and unions
	Coexistence of several itineraries used by patients: depending on the illness, the region and town they live in, financial risk/protection
	The itinerary can change within a family depending on the person who is ill or the season (agricultural resources/work)
	Advantages for employees: more compensation (including for CPA), better working conditions and more flexibility
Advantages regarding development of private sector	Personalized care and good level of responsiveness: perception of high quality, appointments easier to get
	Possibility for referrals and coverage
	Flexibility and better use of resources
Negative effects/ concerns regarding development of private sector	Overmedicalization and subsequently greater demand
	Rise of two-tier medicine
	Regional disparities: the majority of private providers are in the large coastal cities (mainly clinics and facilities with heavy equipment)
	High cost paid by households which could constitute a barrier to access
	Little interest in public health programmes (solvable demand for care)
	Risk of health professionals who work in the public sector leaving
	Conflicts of interest that are detrimental to the public in terms of working in both sectors and CPA □ decrease in quality of management and risk to doctors' training
	Problem of transparency (particularly invoicing to foreigners)
Quality of the private sector	Accreditation process underway for 15 private clinics
	INEAS has started to produce good practice guidelines... but how will they be enforced?
	No factual data on the quality of the private and public sector

Topics	Main insights
Public–private partnership	No PPP policy or dedicated unit for the case within the Ministry, and no corresponding budget allocation Priority areas: Developing contracts (for doctors, heavy equipment) to ensure better distribution across the country Level of primary care Contracting and subcontracting non-clinical support services Developing a political framework and an institutional system for managing PPPs, including monitoring and evaluation Creating a financing mechanism dedicated to PPP, that does not have a negative impact on the other funding targets or the remuneration for professionals in the public sector
Regulation of the private sector	Legislation: ethics, health law, etc. Specifications and standards (buildings, facilities and human resources) for clinics that are free to choose where they are located Contractual relations between CNAM and private providers through unions Care pathways and good practice guidelines (INAESanté) are not binding or enforceable Heavy equipment and advanced technologies are capped (in accordance with the health map). Capping requirements have been relaxed since 2016, which has benefited the large metropolitan cities. For doctors, dentists and testing laboratories, there are no regulations that determine their location (they are free to choose) The cap on pharmacies is a good example of a successful regulation, as it ensures that pharmacies are more equally distributed across the country The Ministry of Health directorates carry out inspections to ensure compliance with the specifications and in the event of a complaint
Universal health coverage (recommendation)	Package of essential services for all, available, accessible, offered by both sectors – CNAM strategic buyer and harmonization of sectors Covering needs versus equity Involvement in promotion and prevention More financially accessible

Fig. A8.1. Patients' responses - Reasons for using private providers

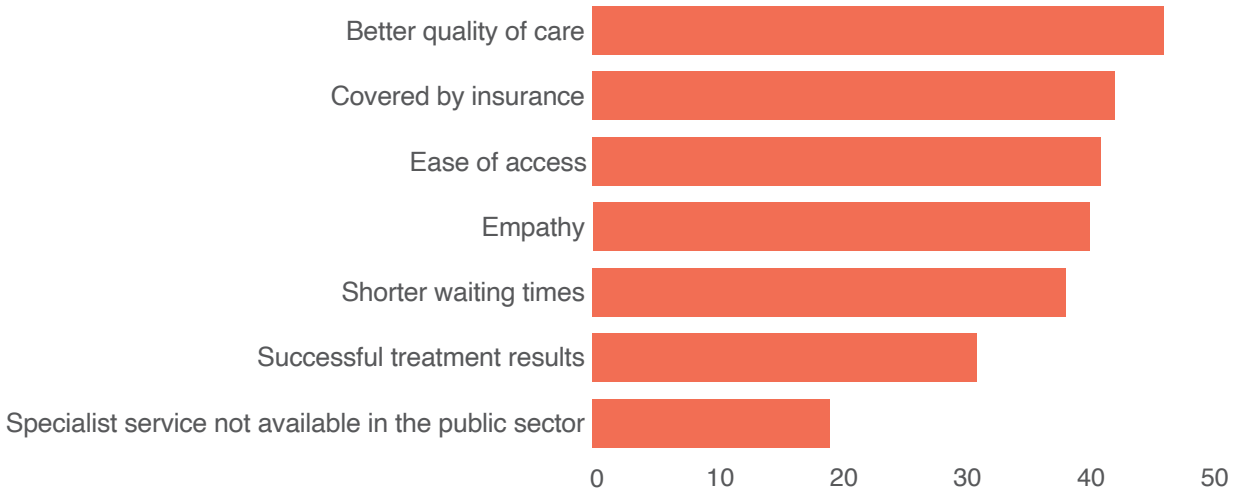
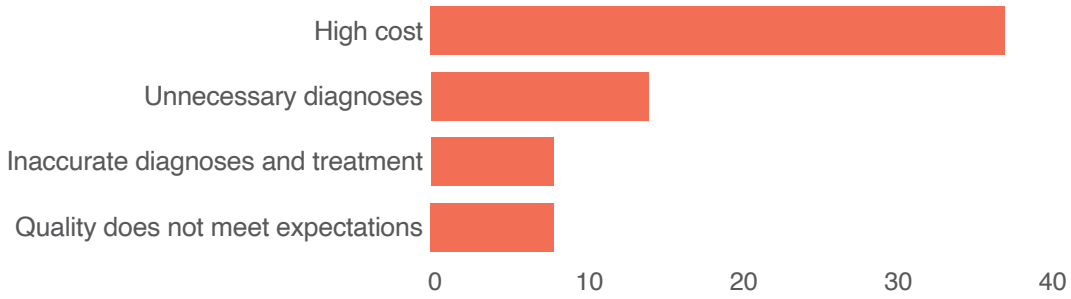


Fig. A8.2. Patients' responses - Reasons for concern when using private providers



9 789292 743581