Health insurance for the Maghreb countries: challenges and planned reforms

Report of a WHO consultation
Hammamat, Tunisia, 14–16 November 2001
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1. INTRODUCTION

In Algeria, Morocco and Tunisia, as in many other countries, attempts are being made in health systems to balance health service budgets, and reforms are being introduced to achieve this goal. Health financing, one of the pillars of these systems, is receiving special attention, interest focusing on health insurance.

In order to take stock of health insurance reforms and foster an exchange of experiences, the WHO Regional Office for the Eastern Mediterranean organized a Consultation on Health Insurance for the Maghreb countries: Challenges and Planned Reforms, which was held in Hammamet, Tunisia, from 14 to 16 November 2001.

The participants were responsible officers from the health and social security sectors of the three countries, staff members of the Eastern Mediterranean Regional Office and a staff member from WHO Headquarters in Geneva.

The objectives of the meeting were:

- To foster an exchange of experience among the three countries regarding health insurance and planned reforms
- To identify the areas requiring technical assistance from WHO and/or RESSMA (Maghreb Network on Health Systems and Health Economics).

The consultation was opened by His Excellency Mr Habib M’barek, Minister of Public Health of Tunisia. In his address, the Minister welcomed the participants and recalled that the health systems of Algeria, Morocco and Tunisia were going through a period of transformation, marked by reforms affecting various aspects of those systems, such as hospital management, drug policy and, in particular, financing. In this connection, he recalled that the health insurance system played a central role in the modes of financing the sector in the three countries and that there was no alternative but to reorganize it if current challenges were to be met.

The Minister hoped that the exchange of experiences between the experts and specialists present would result in objective, practical recommendations which would help the authorities of the three countries to build their reforms on firmer foundations. He ended his address by wishing the participants a pleasant stay in Tunisia.

During the opening ceremony, Dr Belgacem Sabri, Director, Health Systems and Community Development, Eastern Mediterranean Regional Office, read out a message from Dr Hussein Al Gezairy, WHO Regional Director for the Eastern Mediterranean. Dr Gezairy said how pleased he was to see countries belonging to two WHO Regions, the Eastern Mediterranean and Africa, meeting to share experiences and move forward together in their project of reform, and went on to note the interest of the Region’s policy- and decision-makers in assessing their health insurance systems and developing appropriate policy reforms, an interest which had again been expressed at the last Maghreb Congress of Physicians held in
Casablanca in May 2001, the main theme of which had been “health sector reform and health insurance”.

Dr Gezairy welcomed the participation in the consultation of the main experts in health insurance, from service providers to the managers of social insurance funds in the three countries of the Maghreb, and hoped the discussions would help the countries of the Region and WHO to make a clear assessment of the main issues related health insurance and to improve technical cooperation with WHO in this respect.

He recalled that health insurance schemes were facing similar problems generated by the increase in demand for quality health services, the development of biomedical technology leading to escalating costs of health services, and the difficulties of extending coverage, particularly for informal sectors, the self-employed and workers in rural areas. Health professionals were pressuring for reimbursement through user fees, which were considered inflationary and which contribute to increasing burden on both employers and employees.

Dr Gezairy hoped that RESSMA (the Maghreb Network on Health Systems and Health Economics), whose dynamism and initiative he praised, would continue to play a decisive role in disseminating the results of countries’ experiences and identifying areas in which technical support was needed from WHO and other partners.

He believed particular interest should be paid to areas that need support in terms of expertise, such as actuarial studies, management information systems, decentralization, quality assurance and improvement, as well as incentives for service providers. WHO was endeavouring to promote technical cooperation among developing countries and efforts should be made to strengthen the role of the Maghreb network on health systems and health economics in this respect.

Dr Gezairy ended his message by wishing the participants a pleasant stay and success in their work.

The consultation was organized in the form of a succession of plenary sessions and round tables.

Professor Noureddine Achour (Tunisia) was elected Chairman and Dr-Chahed Mohamed Kouni (Tunisia) was appointed Rapporteur of the meeting. The agenda, programme and list of participants are given in Annexes 1, 2 and 3, respectively.

The first day was devoted to the presentation of country experiences, the Algerian report being presented and discussed in the morning, and the Moroccan and Tunisian reports in the afternoon.

The second day was devoted to the three round tables on the agenda: Payment of providers, health insurance financing, and health insurance coverage while, on the third day the final report was presented, discussed and adopted.
2. REVIEW OF COUNTRY EXPERIENCES

2.1 Algeria

The social security system in general and the health insurance scheme in particular are topical themes of concern to both authorities and social partners in Algeria. The scheme, which was set up some 20 years ago, is now anachronistic in relation to the reforms introduced, the political reforms establishing a multiparty system and the economic reforms that introduced market mechanisms to the previously planned economy.

The system is now facing numerous constraints, particularly economic constraints, which are placing a great strain on the budget. Furthermore, the poor management that burdens the system makes reform essential if bankruptcy is to be avoided.

The general debate on the social security system and one of its principal components, health insurance, began two years ago. Reforms are beginning to take shape and their formulation to become more precise.

History of health insurance in Algeria

The Algerian social security system and its principal component, health insurance, are derived from the French system. Health insurance dates back to the colonial period and was introduced in 1949 as an extension of the system in France to its overseas colonies. Its introduction was very selective since it concerned the very few Algerians (a few thousand) who worked in the colonial administration and services. The peasantry, who accounted for 90% of the population, were completely excluded.

After independence, the health insurance scheme was continued in its original form, until a few years later, when it was considerably developed. Originally restricted to limited sections of the population, the system underwent major transformations as a result of socialist policy and as part of socioeconomic development plans.

Before 1983, there were a number of health insurance schemes in Algeria: the social security system included ten occupational schemes (farmers, civil servants, railway workers, gas and electricity workers, miners, seamen, the unwaged, students, soldiers, temporary replacement staff), 71 social security bodies and 11 supplementary pension bodies, thus reflecting the variety of occupational sectors. Their funding and the related legislation differed from one scheme to another. This diversity made the running and management of the system complex.

With respect to health, the coverage of the systems was virtually identical and gave those with social insurance and their dependents access to health care, either in establishments belonging to the particular scheme or in public sector facilities (the private sector was little developed at that time).
In 1970, the first attempt was made to unify the schemes by grouping the existing ones into five independent funds. It was not until 1983 that unification was completed, replacing the principle of occupation by the risk covered. Two distinct funds are responsible for health insurance: one for employed persons and one for the unwaged. The fundamental principles on which the new system is based are: the principle of universal social security, the principle of unification of schemes, advantages and funding, the participation of workers’ representatives in the management of social security funds through strong representation on their governing boards, setting up a very generous social health protection system covering all sections of the population, including people with disabilities and the elderly.

In addition to the unification of systems, the major thrust of the 1983 legislation was to move towards the greatest possible extension of social protection. More than 25 million Algerians (more than 85% of the total population) benefit from all the advantages provided with respect to all the risks covered. This move is based on the principle of the Welfare State, which gives great social protection to almost the whole population. The generosity of the system was called into question following the serious socio-economic crisis the country has been suffering since the mid 80s.

Social security, (and therefore health insurance) thus shifted from the economic and “occupational, sectoral” field to the social field (all sections of the population).

One of the many results of this change (shift) looked at strictly from the health point of view was to give easier access to preventive and curative health services to great sections of the population.

*Health insurance now*

Health insurance and its extensions (coverage for maternity, invalidity, work injury and occupational illness), the most important branches of social security, are financed by two funds: the “employed” scheme by the National Social Insurance Fund (CNAS), and the Unwaged Social Insurance Fund (CASNOS).

The funds, which operate throughout the country and are headed by directors-general appointed by the minister responsible for social security, are public institutions with a specific type of management. This special status means that the funds are subject to public law in their relations with the state and private law in their relations with third parties. Their governing boards are dominated by trade union representatives.

As explained above, the Algerian system has several branches of social insurance for everything concerning health: health insurance itself, maternity, invalidity, occupational accident and illness insurance; life insurance to a lesser extent.

Health insurance is a guarantee against risks connected with illness and therefore helps beneficiaries meet the cost of treatment and temporary or total loss of earned income. Technically, payment for treatment (reimbursement) is called “benefit in kind” and replacement income “cash benefit”.

Health insurance was initially based essentially on an occupational system and covered categories of people actually working. Extension since the 1983 legislation to special categories (people with disabilities, military veterans, apprentices, trainees, students, poor households reached by the social safety-net, unemployed persons signing on at unemployment offices) has meant that it has gone from being an occupational system to a social system including special social categories. This extension, which virtually amounts to universal health insurance, since it now covers more than 85% of the population, is part of the social policy introduced since the reforms of the early 1980s which redirected a large proportion of available resources to social services.

Health insurance is by far the most important type of insurance in terms of the number of people covered and the financial resources allocated to it. Twenty-five million people benefit from it (85% of the total population), and 6.5 million employed persons pay contributions. The conditions of eligibility are very simple and favour ease of access to benefits, which cover all illness-related expenses.

Reimbursement rates are 80%, and for some illnesses and certain categories of persons 100%. The outstanding 20% is reimbursed by the supplementary health insurance company, if the individual has taken out a policy. In the case of maternity insurance, medical expenses and maternity leave are reimbursed in their entirety.

The pricing of medical and paramedical procedures is done according to the general nomenclature of professional procedures which sets out the nature of different kinds of treatment and their valuation in relation to key-letters which are given monetary values.

With respect to invalidity insurance, an invalid is defined as a worker who has lost 50% of his or her capacity for work and therefore income as a result of a medically determined and assessed physical or mental incapacity. Invalidity insurance compensates for the loss of income by granting a replacement income. There are three categories of invalidity. Invalidity benefit is granted on a temporary basis and subject to revision (upward or downward) according to the individual’s health status on the occasion of periodic medical visits. Receiving invalidity benefit automatically confers eligibility for health insurance benefit in kind for the individual and his or her dependents. The 20% usually retained by the fund is waived where the benefit is lower than, or equal to, the national guaranteed minimum wage (SNMG).

Category 1 invalidity benefit may be drawn concurrently with the beneficiary’s salary and any occupational accident or illness allowance, on condition that the total does not exceed the salary on the basis of which it has been calculated.

For employed persons, the invalidity benefit is adjusted according to the category of invalidity:

- Category 1: 60% of salary
- Category 2: 80% of salary
• Category 3: 80% of salary plus 40%.

For the non wage-earning persons, it is 80% of the declared, taxable income subject to contributions, up to an annual ceiling of eight (8) times the official minimum wage, plus 40% in the case of Category 3 invalidity.

Compensation for work injury and occupational illness are incorporated into social security which regards them as employment risks. Occupational accident and illness insurance only concerns salaried employees (CNAS). The non wage-earning persons (CASNOS) are excluded from such insurance as they are not regarded as subject to such risks. Employed persons are eligible from the hour following their recruitment. Algerian legislation provides for two types of risk: accident at work, and an accident during a journey (on a mission ordered by the employer, to or from home or the usual place where meals are taken, family visits).

There are two types of benefit: temporary incapacity benefit, which consists of benefit in kind and cash benefit (100% reimbursement of medical expenses, daily allowance during sick leave), and permanent incapacity benefit (allowance determined according to the degree of incapacity).

The allowance is granted from the day after consolidation. It is increased by 40% if the individual needs assistance to perform ordinary daily functions. It may be drawn concurrently with the retirement or invalidity pension and the daily health or maternity insurance benefit.

The purpose of life insurance is to give the dependents of a deceased insured person a lump sum. It concerns the employed (CNAS) and unwaged (CASNOS) schemes. The amount is 12 times the highest monthly salary or, for the unwaged, the annual declared income.

The contributions are, for salaried employees, 34.5% of the salary, of which 25% is the employer’s contribution, and, for the non wage-earning persons, 15% of declared income. Special categories contribute at reduced rates.

The bodies responsible for health insurance have large deficits, essentially as the result of the loss of jobs (400,000 jobs), the increase in the cost of drugs, the development of medical demography and the extension of the informal sector.

Direct health expenditure alone (hospital fees, treatment abroad, drugs and medical procedures) account for 64% (two-thirds) of total CNAS expenditure, which shows how important are the relations between CNAS and the health care system. Efforts to control expenditure necessarily involve controlling spending on health and introducing a contractual relationship in health care services funding.

Social security expenditure as a proportion of GDP was fairly stable throughout the 1990s. Per capita social security expenditure was on average 5% of per capita GDP and changed little throughout the decade. With respect to health expenditure, however, the level of spending increased about fourfold between 1990 and 1998. Health insurance spending per capita is rising, increasing by 231% between 1990 and 1998.
It should be pointed out that health resources and the supply of care have increased considerably in recent years and this has had a clear impact on health insurance. The public sector employs 188,000 people, 15% and 50% of whom are medical and paramedical staff, respectively.

Since the consolidation of the system under the 1983 legislation and the many profound structural socioeconomic changes, health insurance is now at a crossroads. It is facing challenges that, if bold, stringent measures are not taken to adapt it to those changes, may threaten the principles of solidarity and improving the population's health that have guided it since 1983.

Main challenges facing health insurance in Algeria

The major challenges facing health insurance in Algeria are:

- balancing the budgets of the funds;
- consolidating the system and improving services;
- management performance;
- developing new, supplementary forms to strengthen coverage.

Other future concerns include the ageing population (demographic transition), the heavy burden of chronic diseases (epidemiological transition), and the gradual disengagement of the state from the economic sphere (economic transition).

The current challenges essentially concern the continuing budgetary deficits that first appeared at the beginning of the 1990s and are becoming structural, putting a great strain on the system and threatening its very existence. The accumulated, increasing, deficits show that the system is structurally unsound and all the measures so far taken to deal with the problem have simply accentuated the deterioration in the level and quality of services (freezing the monetary value of key-letters, selective reimbursement of drugs, extreme pressure on quantitatively inadequate services). Two major problems have yet to be solved: the contractualization of the relationship between public health facilities and social security organizations, and drugs, a serious financial burden on health insurance, accounting for one quarter (25%) of all CNAS expenditure.

Furthermore, state health service contracts with the private sector and payment mechanisms other than fee-for-service (case payment, lump sum payment, subsidy, capitation) should speedily be introduced since they make it possible to keep costs under control.

In view of the financial and material resources involved, the great number of people it employs and the quantity and variety of services it provides, the health insurance system is characterized by clearly outmoded management at every level.
Deficient health insurance management makes it imperative to introduce instruments for the rational management of spending, backed up by a mechanism to combat contribution evasion (non-declaration and under-declaration). The computerization of all management procedures should also be developed as a matter of urgency.

With the multiparty system at political level, the development of the market economy at economic level and the limitations of a general basic system, the idea of putting an end to the monolithic structure of health insurance and extending it to other operators able to improve the level and quality of services would be one way out of the current crisis. Such operators could be cooperative (mutual funds) or private (private insurers).

The idea is not yet sufficiently developed and is opposed, not only by the General Union of Algerian Workers (UGTA), which defends the public nature of health insurance, but also by the Social Security Workers' Federation, whose members are afraid they will lose their jobs as a result of competition.

It is also important under this heading to deal with the question of extending social coverage to the unstructured (informal) sector which is believed to be of considerable size. Without exaggerating its repressive nature, it is essential to introduce a mechanism for bringing this economic potential (waged and unwaged) into the health insurance system. An in-depth study will certainly determine ways and means of doing so.

Future challenges are the demographic, epidemiological and economic transitions. With respect to the first, which by its nature exerts pressure on the social security system, it is on the basis of its features that social policy choices will be made. Decision-makers will also allocate resources to the social security system according to demographic changes and trends. Algeria entered a period of demographic transition in the 1990s. The change in age structure has profound implications for the social security system.

Like many developing countries, Algeria is experiencing a period of epidemiological transition characterized by a fall in communicable diseases associated with underdevelopment and the clear emergence of serious chronic diseases associated with development. The epidemiological profile has been changing for some time and various recent data confirm the ever-increasing incidence of serious chronic diseases that generate high expenditure, such as diabetes, cardiovascular diseases, cancer, mental illness, and pathological conditions of road accident victims.

Over the next few years, the epidemiological profile of the country will be characterized by chronic diseases among adults and the elderly, whose future weight in the age pyramid is confirmed by the demographic transition. The epidemiological transition is an important factor which should fully be taken into account in future health insurance policy.

The economic transition under way is from a managed to a market-regulated economy. With respect to funding the health insurance system, significant reforms have clearly already begun, characterized by gradual state disengagement from funding the social security system. It is clear from the spirit of the reforms that the aim is to rationalize public budgets.
Liberalism will be the panacea and the privatization of state-owned enterprises will be pushed to the limit. The adjustments will certainly include the contributions households make to health insurance schemes. Economic trends suggest that there will be no increase in employers' contributions, since this would increase their expenses, limit their investment capacity (and therefore job creation) and make them less competitive in a context of openness to, and integration in, the global market and free trade areas. This being the case, it will certainly be wage-earners (households) who will be asked to make a greater contribution to health insurance financing.

Planned reforms and the roles of partners and unions

Social regulation is the ability to adapt social systems to a country's capacities and available resources and is carried out by governments when they set social budgets and transfer money from sectors that are income-generating to those that are not. It is such sustainable regulation that can ensure the durability of the health insurance system. One line of reform would therefore be to revise the role of the state through draft laws to introduce new provisions corresponding to the terms of reference and concepts of a liberal economy with a significant dose of social economy.

The drafting of a new law on health insurance is a priority if the system is to be strengthened and adapted to the new economic and social context. As the state no longer has the resources to pay for the whole of the nation's social programme, the law should include the involvement of new public and private operators and supplementary forms of insurance.

Efficient organization of the health sector is essential if health insurance is to be regulated. Rationalization of health expenditure, efficient management of resources, controlling costs, optimal drug management (production, consumption, reimbursement, nomenclature, reference price, etc.), state health service contracts with the private sector, and development of prevention, are the focus of close cooperation between the health and health insurance sectors, whose ultimate objective is to make the best use of health insurance resources in order to improve the population's health status.

Strengthening relations between the health sector (public and private) and health insurance is an essential factor in the development and mass distribution of public health, the expected benefit of which is a general improvement in the population's health.

Common strategies based on extensive cooperation and backed by legislation and regulations are planned, focusing on the following:

- drugs (promotion of generic products; technical committee on reimbursement; reimbursement on the basis of a reference price by International Nonproprietary Names (INN); incentives to dispensing pharmacies; national nomenclature, etc.);
- updating the nomenclature of medical and paramedical procedures;
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- system for evaluating (real costs) and invoicing services (calculating costs, administrative invoicing mechanism, consensus treatment regimens, etc.);

- placing far greater emphasis on prevention, especially of occupational accidents and diseases;

- specialized local services to replace treatment abroad (oncology, cardiology, transplants, neurology, major burns, eyes, etc.);

- state health service contracts with the private sector;

- support for organizational measures (support for alternatives to hospitalization, medical emergencies, etc.);

Reform should focus on the conditions for overhauling the health insurance system in terms of improved performance, consolidation and modernizing the administration, management and governance of public and private organizations.

In future, health insurance development should be based on actuarial studies that take into account age, wage levels, contributory rates and economic trends.

As with any reform of this scale, consultation with social partners is a judicious means of pushing forward a reform programme.

A critical analysis of the social security system, including the 20-year-old health insurance system, shows that it is not appropriate for present socio-economic conditions. With respect to health insurance more particularly, it should be adapted to the requirements of financial solvency, its management instruments should be modernized and its services organized rationally. The general idea is to gain acceptance of the fact that the Algerian system is trapped in a view of the Welfare State (assistance) that needs to move forward to a stage where the community genuinely takes responsibility for itself, in other words, to move from social protection to social development. Structural reforms and the gradual opening to the market economy require different forms of insurance and modern management methods able to ensure that health expenditure can be controlled.

Fearing major liberalization of all branches of social security, including health insurance, the UGTA stresses the concern for social protection in all civilizations and recalls that the right to social protection is enshrined, at international level, in Article 25 of the Universal Declaration of Human Rights, and by the founding texts of the national liberation movement (Declaration of 1st November) and the various constitutions (1976, 1989 and 1996).

As for the employers, the main source of social funding whose contribution has increased rapidly in recent years, they constantly draw the government's attention to the negative effects of an excessive social burden. Indeed, they now pay 25% of the salary as the employer's contribution. This charge may accentuate their financial difficulties and
significantly reduce their investment intentions. Their main demand is for a reduction in social charges in order to give an incentive to invest, the only way of creating jobs and therefore increasing health insurance revenue. They are therefore hostile to any measure raising contributions.

Algeria's expectations from WHO

In view of the critical situation of health insurance and the scale of the anticipated reforms, the study and analysis required are enormous. In this context, a great deal of assistance is needed to supervise alterations to a system in crisis with the requisite technical and scientific rigour.

Algeria has very little experience or technical capability in conducting and exploiting actuarial studies. An actuarial study would enable Algerian experts to benefit from the experience of foreign experts, master the technique and then extend it to other bodies.

The introduction of a contractual relationship between social security organizations and public health facilities has encountered a number of obstacles, including the difficulty of completing a medical and economic evaluation of health interventions. Training a team of Algerian experts in medical and economic evaluation (PMSI\(^1\), DRG\(^2\)) would strengthen capacities for evaluation and conducting the necessary studies.

A technical study is needed to analyse, technically rather than politically, and evaluate the relevance and performance of the present health insurance system on the basis of appropriate criteria that have yet to be determined.

As with actuarial studies, Algeria lags behind seriously with respect to drafting standard medical references (références médicales opposables RMO). It would be extremely useful for the development of health insurance in the country if a few medical experts and economists could be trained to plan and organize consensus conferences to determine standard medical practices and draw up RMO. For this to be done, cooperation between the health and social security sectors is essential.

Direct payment by insurers facilitates access to health care, especially at a time when households' resources are falling. A study of technical ways and means would make it easier to plan an appropriate system for Algeria.

Apart from a little individual research, there is virtually no serious reference material on disease trends in Algeria and their financial impact on health insurance. Such a study would make it easier to forecast the financial resources that should be allocated to health care.

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1 PMSI: Programme de Médicalisation des Systèmes d'Information (Hospitals' Medical Information System).
2 Diagnosis Related Groups
There are enormous training needs with respect to health insurance. It is of prime importance to undertake specialized training to increase national analytical capacities. Training is needed in various fields: management techniques, quality of health insurance services, actuarial studies (analytical procedures and methods), techniques for medical and economic evaluation of health care provision, occupational risk prevention, and contribution collection procedures.

A great deal needs to be done to provide the Ecole Supérieure de la Sécurité Sociale with books on health insurance.

WHO could raise the awareness of the Ministry of Labour and Social Security and help it to establish an institution (Social Security Institute) responsible for carrying out all studies and analyses on social insurance. The findings of the studies and research would be an aid to political decision-making.

Conclusion

The social security system in Algeria needs more than ever to adapt to current socio-economic change. It needs to be consolidated through a set of measures to modernize it, adapt its funding to existing capacities and open it up to other operators.

The health/health insurance relationship includes the major features of the consolidation and preservation of health insurance. The measures that need to be taken concern organizing drug management, controlling health spending and improving and modernizing the management of the social security organizations responsible for health insurance.

Discussion

- It is a system providing high coverage (around 80%), but whose management is cumbersome.
- It provides many benefits, hence the risk of over-consumption and waste.
- For a significant portion of contributors (about one million), namely to CASNOS, the level of collection of contributions is low. The contribution rate is high for those who contribute to CNAS (34.5%), 25% being paid by the employer and 9.5% by the employee. In fact, 50% contribute at the full rate (employed persons), while 50% do not work (the disabled, students) and contribute at a very low rate (2-6%), but receive the same benefits.
- The price-setting system is out-dated and does not correspond to the prices users actually pay.

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3 Computerization of health care billing procedures
2. Only drugs are paid for directly by the insurer.

- Reimbursement is generous, especially for drugs, of 80% to 100% of real costs.
- The bodies responsible for health insurance are in deficit.
- The drug sector is being reorganized along the following lines:
  - the adoption of a list of reimbursable medicines;
  - fixing a reference price scale;
  - a national reimbursement committee to update the list of reimbursable medicines.

2.2 Morocco

Health financing is taking place in a comparatively unfavourable macroeconomic context. During the 1990s, average per capita economic growth was zero. Per capita GDP did not rise during the decade and was stable at less than US$ 1300. The economic situation made it impossible to reduce unemployment (22% in urban areas in 1999) or reduce the poverty rate, which actually rose from 13% in 1990/91 to 19% in 1998/99.

At the same time, health-related needs and costs, and people's demands and expectations have all been increasing steadily, in particular because of the demographic and epidemiological transitions the country is going through. It is therefore of prime importance constantly to rethink health financing in order to adapt it to people's needs, the society's economic capacities and the economic situation. For many years, much thought has been given in Morocco to how to reform health financing, but implementation is very slow in coming and this is undoubtedly causing the country further expense.

This summary seeks to outline the main ideas covered in the report on medical coverage (insurance) in Morocco. It focuses on problems of financing health services, the present situation with regard to medical coverage and planned reforms.

Main features of health financing

- Low level of spending on health and high treatment costs: total spending on health was a little more than 15 billion dirhams in 1997/98, i.e. almost 550 dirhams per capita (US$56 at 1997/98 exchange rates or US$135 in terms of purchasing power parity PPP). This represents barely 4.5% of GDP, which is significantly lower than in countries with a similar level of economic development, where the figure is between 5.6% and 12.2% in Islamic Republic of Iran, Jordan, Lebanon and Tunisia.

- The level of health services consumption during the same period was nearly 13.5 billion dirhams, i.e. less than 500 dirhams per capita per annum. Given that this is equal to the sum of the products between prices and corresponding quantities, it is low if prices and/or quantities are low. If prices are examined in relation to incomes and GDP, the ratios are very high. As an example, the average cost of a medical prescription is nearly
250 dirhams, which is the equivalent of four days’ work paid at the minimum wage or 2% of per capita GDP. A consultation with a specialist costs on average 150 dirhams, which is the equivalent of two-and-a-half days’ work at the minimum wage or 1.2% of per capita GDP. This means that it is quantities (i.e. volume, in other words the resort to treatment and access to medical supplies, which are low and underlie the low levels of health services consumption and total health spending.

- Collective health financing is insufficient: generally speaking, the funding of the national health system is very fragmented and its distribution inequitable. Out-of-pocket payment by households is the main source of funding, while collective funding (from taxation or national insurance contributions) is little over 41% of total funding (25% from taxation and 16% from the contributory system, i.e. health insurance). This situation is not appropriate for a sector in which individual spending is usually unforeseeable and sometimes ruinous. Thousands of families get heavily into debt or ruin themselves in order to pay for necessary treatment for one or more members of the family suffering from chronic condition(s). The situation is, of course, particularly serious among the poorest sections of the population.

Total health spending is low in a context, on the one hand, of high cost of medical treatment and supplies as compared to limited and stagnant purchasing power and, on the other, the inadequacy of health insurance, which covers only 16.4% of the population.

- Distribution of resources incompatible with health priorities and essential needs: a significant proportion of the resources of the national system is spent on drugs. The low level of ambulatory care is exacerbated by the poor level of collective health prevention, although expectations at this level are high.

Present state of medical coverage (insurance)

The level of institutionalized solidarity in the field of medical coverage (insurance) is very low. Firstly, health insurance is optional and covers only 16.4% of the total population, the vast majority of whom are urban dwellers. More than two-thirds of those covered are state employees or comparable categories and their dependents. Secondly, payment of the medical expenses of the poor is not institutionalized. The present system of certificates of indigence for “free” hospital treatment is inequitable and inefficient.

a) Health insurance

i) Population covered by health insurance

Medical coverage (insurance) is provided by a number of schemes managed by various institutions:
Nine mutual funds for civil servants and comparable categories (Royal Armed Forces\(^4\), Post Office, Education, Central Administration, Local Authorities, Auxiliary Forces, Police, Port Authority, Customs) are headed by the National Fund for Social Welfare Bodies (CNOPS). This system covers just over 3 million beneficiaries, i.e. 69% of those covered in Morocco.

Internal mutual funds (internal systems): health insurance provided and managed by publicly-owned enterprises (Sherifian Phosphates Office, National Railways, National Social Security Fund, Royal Air Maroc, State Tobacco Company, Bank Al Maghrib, Banque Populaire, etc.) for the benefit of their employees. The internal systems cover a little over 500,000 beneficiaries.

The Moroccan Inter-professional Mutual Fund (CMIN) essentially covers the employees of 256 enterprises in the banking and oil sectors. There are some 60,000 beneficiaries.

Private insurance companies cover the employees of a few private enterprises (a little over 3000 units). This cover takes the form of group health insurance contracted by the enterprises. The total number of individuals covered by such companies (more than 800,000 beneficiaries) represents 18% of the total of those covered by health insurance.

Altogether, these systems cover rather more than 4.5 million people, i.e. just over 16% of the population of Morocco.

ii) Levels of treatment covered by the various voluntary health insurance systems

Drugs and medical supplies account for almost 32% of total charges for medical cover (excluding administrative costs), followed by hospitalization, which accounts for 29%. Ambulatory treatment and care together account for 39%: 16% for consultations, 12% for analyses and examinations by radiology units and medical laboratories, 11% for dental care.

With the exception of pharmaceuticals and medical supplies, which account for no less than a quarter of the expenditure of all the schemes, the proportion spent on other services varies from one body to another. CNOPS (and public sector mutual funds) and the internal systems devote a large proportion of their spending to hospitalization (37.8% and 33.2%, respectively), while the largest proportion of insurance company spending (apart from pharmaceuticals and medical supplies) goes on dental care (29.6%). Furthermore, the exceptionally high spending on radiology and medical tests by the internal systems should be noted (25.6%).

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\(^4\) The Royal Armed Forces Mutual Fund recently withdrew from the Federation.
iii) Funding and coverage problems

Apart from the Moroccan Inter-professional Mutual Fund, whose resources per beneficiary are 1732 dirhams per year (as compared with 307 dirhams for CNOPS, 1102 dirhams for the internal systems and 670 dirhams for the insurance companies), all the other systems are in deficit. CNOPS, for example, is in chronic deficit essentially because the State pays only part of its employer’s contributions and because of poor management of the fund which prevents it honouring its commitments sufficiently quickly. It owes the public sector and private providers a great deal of money (several hundred million dirhams), while reimbursement takes several months or even a year or more. There is a slight gap between the resources and spending of the internal systems which is usually covered by a supplementary contribution by the employer. The insurance companies’ resources barely cover 71% of their expenditure. The losses on “health insurance” products are compensated for by the positive results of other products (work injury and occupational illness, property insurance) that are part of the package the companies offer their clients. Health insurance is the sector’s loss-leader.

iv) Institutional supervision problems

The voluntary health insurance systems are subject to the direct or indirect supervision of several departments. However, no ministry has complete authority to monitor all the institutions managing the systems, and particularly the “health insurance” aspect, separated from the other services they provide. Consequently, regulation is by the market, where there is ruthless selection, particularly by the private insurance companies, exploitation, adverse selection and no monitoring of developments in medical consumption or its structure (apart from the mechanism of excluding bad risks).

b) Payment of the medical expenses of the poor

The poor generally receive treatment free of charge in Ministry of Health hospitals. There is no law institutionalizing this; it takes place according to long-standing, but widely criticized, routine administrative decisions.

The mechanism is as follows. Any Moroccan citizen wishing to receive free health care in a public hospital may apply to the local authorities for a certificate of indigence. In theory, the certificate is issued only to those people able to contribute very little. Once the paper has been obtained, the individual in question presents it at the hospital so as not to have to pay for hospitalization. The certificate of indigence is the basis of the system for providing the poor with health care in public hospitals. This system is also the source of a number of evils affecting, not only the health of this section of the population, but also that of Ministry of Health hospitals.

The weaknesses of the system are as serious as they are numerous. Only the most important will be mentioned here.

- Eligibility criteria are not standardized and are subjective. The issuing of the certificate depends on the whim of one or two local officials. The vagueness surrounding the
granting of the certificate opens the way to abuse by corrupt officials who sometimes deprive the genuinely poor of certificates, and, in some instances, unjustly issue them to wealthy people.

- Cumbersome bureaucracy prevents the poor receiving their certificate of indigence speedily. Once they have obtained it, they can use it only once. If the beneficiary needs two different services in two separate establishments, he or she must on each occasion demonstrate eligibility for free care by providing an original certificate.

- Difficult access to care: people with a certificate of indigence have to wait a long time for appointments and are sometimes subject to discrimination in public hospitals, especially for services that are scarce and/or for which there is high demand.

- There is no separation between hospital budgets and the budget allocated to health care for the poor. This means hospitals have losses to make up and creates a degree of imprecision around their budgets which cannot be negotiated with the Ministry of Finance in good conditions. Consequently, hospitals that have to ensure care provision are also assistance bodies, but do not have the means to perform this function, which is, moreover, unacknowledged.

- The department that issues the certificates, which amount to authorizations for care, is not responsible for funding such care, but commits the funds of another department.

**Plans to reform health financing in Morocco**

In its statement of 17 April 1998, the new government (still in power) clearly announced its intention to reform health financing. In early 2000, the Prime Minister set up an Inter-Ministerial Committee (Health, Finance, Planning, General Affairs, Interior and Social Development) and a group of experts to consolidate the work done by the different departments concerned (particularly Health and Social Development) and speed up the progress of the two projects. The outcome of their work was a Draft Law on Compulsory Medical Coverage which sets out the basic principles of its two components: Compulsory Basic Health Insurance (CBHI) and the Medical Assistance System (MASED) in public health facilities.

a) Compulsory Basic Health Insurance (CBHI)

*Eligibility*: according to the general law on CBHI, the following categories are eligible for coverage:

- officials and civil servants of the state, public bodies and local authorities, and pensioners of the three;

- persons subject to the social security system (formal private sector, including pensioners);
self-employed persons, the professions, and unwaged persons of working age;

- students not eligible as dependents.

In the medium term (2003/2004), CBHI will concern all the categories listed above except the self-employed, the professions and unwaged persons of working age, i.e. only 30% of the population.

*Services covered:* compulsory health insurance cover reimburses, and may pay directly, the costs of curative, preventive and rehabilitative care medically necessary as a result of the beneficiary's state of health (hospital and ambulatory care, radiology, laboratory tests, dental care, drugs, etc.). Excluded from cover are plastic surgery, water cures, acupuncture, mesotherapy, thalassotherapy, homeopathy, so-called 'alternative' medical treatment and treatment which is advertised.

*Management:* the draft law suggests that CBHI should be jointly managed by the National Social Security Fund (CNSS), which would manage private sector health insurance, while a "Public Health Insurance Fund" would manage that of the public sector. Despite some disadvantages, the joint option is better than the multiple management option of the private sector. International experience and publications on health economics show this clearly. Because of the cost and recognized weakness of the private insurance market, stressed by many researchers, including the World Bank, this option is not reliable for the socialization of risk at national level in low and middle income countries. For INSEE and CREDES researchers (2000), competition open to private insurers, as there is in some countries (e.g. Chile and Singapore), is seriously open to abuse. In the case of Chile, the Inter-American Development Bank (1996) compares it to Colombia where cover is universal. It notes the "opportunistic behaviour" of private insurers (despite the existence of a supervisory body, the Superintendencia) who exclude bad risks (the people most liable to illness), so that responsibility for them falls to the public sector.

*Supervision:* The draft law provides for the establishment of a National Health Insurance Agency, which would be a financially independent public body with a legal personality under the authority of the Prime Minister. The Agency's role will be to provide the technical management of Compulsory Health Insurance and supervise the setting up of regulatory machinery for the system in accordance with the relevant legislative and regulatory provisions. The Agency may also put forward draft laws and regulations on health insurance. The administration will put before it all other related questions. It is also responsible for publishing a comprehensive annual report on the resources, expenditure and medical consumption data of the various Basic Compulsory Health Insurance schemes, and for the management of the financial resources of the medical assistance scheme (see below).

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6 Even in the advanced OECD countries, private insurance accounts for very little (generally less than 10%) of total health spending. The two great exceptions are the United States (34%) and the Netherlands (18%).
**Funding:** because of the nature of the medical cover offered, it will be funded primarily by para-fiscal means, i.e. compulsory contributions by employees and employers. For people who are working, the total contribution will be divided equally between employer and employee (50/50). Pensioners will pay a single proportion of their pension(s) through the body managing the pension.

b) The Medical Assistance Scheme for the Economically Disadvantaged (MASED)

**Beneficiaries:** several categories of the population are eligible for MASED, namely:

- persons who are not covered by any compulsory health Insurance scheme and have insufficient resources to pay for medical services;
- their spouse(s) and dependent children who are unwaged and not covered by any form of BCHI;
- their children with disabilities of whatever age who are completely and permanently unable to undertake paid employment as a result of physical or mental incapacity;
- their dependent parents or grandparents who are not covered by BCHI and live under the same roof.

MASED will also be granted to those who receive free care under specific legislation for all or a proportion of the services guaranteed by MASED (which is the case of military veterans).

The eligibility criteria are not set out in the draft law, so there are a number of possible scenarios:

- MASED will cover less than 20% of the population if it covers only those living below the poverty line;
- MASED will cover slightly more than 40% of the population if it covers only the economically vulnerable;
- Cover will be 55% of the population if a threshold is set according to households’ ability to pay for health care.

The combined coverage of CBHII and the MASED will be between 49% and 82% of the population in the medium term (depending on the MASED scenario) and between 67% and 100% in the long term.

**Treatment covered:** MASED will cover medically necessary care in public health facilities. Plastic surgery, except to repair damage and medically necessary maxilla-facial orthopaedics, will not be covered.
Because they are very costly, some forms of treatment (prostheses and orthodontic appliances, operations requiring the use of advanced technology) will require prior agreement before being paid for entirely or in part.

Sources of funding: mainly public or quasi public through national and local support (state and local authorities). The following sources may be added:

- contributions from the relatively economically disadvantaged (as opposed to the absolutely economically disadvantaged without a minimum income enabling them to make even a symbolic contribution);
- investments;
- donations and legacies.

Institutional organization: the Draft Law on Compulsory Medical Cover does not specify the institutional arrangements for MASED, but simply stipulates that its financial management be entrusted to the National Health Insurance Agency.

c) Remaining preparations for CBHI and MASED

At legislative level (apart from the approval process), an enormous amount of work awaits the various technical teams that will be working on the issue. A number of tasks need to be done, including:

- drafting the laws, decrees and orders necessary for implementation;
- reforming the hospital system and improving the system of governance;
- preparing managing bodies for their new role in the framework of compulsory medical insurance.

d) Immensity of the challenges ahead

i) In the short and medium term

Institutional problem of the managing bodies (National Social Security Fund and Public Fund/CNOPS): among the major challenges for the Funds, apart from improving their management, is decentralization (especially for CNOPS and the new Fund), the information system and putting in place effective supervisory mechanisms.

Setting up the National Health Insurance Agency: the Agency will have important responsibilities, but also new ones in the social security field since there will be a shift from an optional to a compulsory health insurance system. While it is relatively easy to draft laws on the institution, it is far more difficult actually to set it up.
Management of MASED: while financial management will be the responsibility of the National Health Insurance Agency, responsibility has yet to be allocated for assessing eligibility, issuing cards, etc.

Supportive and implementation measures: a whole host of supportive and implementation measures are required for the introduction of health financing reform, only a few of which will be reviewed here:

- Strengthening the negotiating capacities of the administration and public health facilities with the status of public establishment (university hospitals);

- How will providers be paid?

- What will be the policy with respect to controlling spending and the medical consumption of those covered?

- Compromise between the scarcity of financial resources (which has a significant impact on companies’ competitiveness and budget) and the wish to provide those eligible with good cover: what will be the rate of contributions to CBHI and the average rate of reimbursement guaranteed by the compromise?

- Reforming the hospital system, which involves, not only raising standards in public hospitals, but also other no less important measures, such as setting up a quality control process and drive; introducing a medico-economic information system, an accounting plan and cost accounting; developing planning; improving financial and human resources management; improving invoicing and collection; revising fee scales.

ii) In the long term

Gradual universalization of CBHI: the greatest obstacle to the universalization of compulsory health insurance and the shift from MASED towards CBHI is without any doubt the ability of the Moroccan economy to reduce poverty and include the informal sector; the main challenge here being to provide sustained and sustainable economic growth over a very long period.

Inclusion of occupational accident and illness

Creation of a single management structure for medical cover

Conclusion

Despite some weaknesses, the Draft Law on Compulsory Medical Cover in Morocco is definitely a step forward in the field of health financing. In addition to its strengths and weaknesses, it should be pointed out that it is a definite improvement on the present situation of collective health financing. Therefore, while it is useful to discuss it, it would be better still to pass it as speedily as possible.
The many challenges facing the Moroccan society in its quest for economic and social development necessarily require, among other things, that a social safety-net be put in place so that the country does not go over to uncontrolled capitalism and thus exacerbate the marginalization of a large proportion of the population. It should, however, be pointed out that the success of the project depends upon many conditions, notably:

- greater involvement by all those able to contribute to the ultimate implementation of the draft law, setting aside political, sectoral and corporate interests;
- the political will to take the initiative and bring the draft law to fruition without political calculation or budgetary justifications that reflect a short-term, purely financial outlook;
- the success of Ministry of Health reforms, namely, hospital reform and strengthening the department’s institutional capacities;
- that the National Health Insurance Agency be satisfactorily set up;
- not going for the easy option of making only the very poor eligible for MASED;
- guaranteeing minimum, stable funding for MASED;
- passing the law on the certificate of need (carte sanitaire) as soon as possible.

Setting up CBHI and MASED will undoubtedly have a positive social, as well as economic and institutional impact of considerable scope provided the above conditions, and a few others, are fulfilled. Generally speaking, the main positive effects of the project will be many:

- a rise in collective health expenditure;
- collective, community financing will be beneficial, not only for patients who do not now use the health services because of their standard of living or prohibitive market prices, but also the chronically ill who incur ruinous expenses;
- increased solvency of demand, combating poverty and higher indirect incomes for all sections of the population affected by the project;
- health financing reform, particularly MASED, will help to raise standards in public hospitals (81% of all beds) and improve the quality of the treatment they provide;
- positive macro-economic impact.

Discussion

- The main characteristic of the Moroccan system is that it is optional and covers 16% of the population.
• While this may be regarded as inadequate, it can also be seen as an advantage when seeking to set up a new compulsory system.

• The role of the National Health Insurance Agency, if it receives the contributions, could make it possible to balance the CBHI and MASED schemes through transfers.

• It is of prime importance to identify the economically disadvantaged in order to limit abuse and inequity.

• The importance of the state's effort to compensate for the present under-funding of the public sector, which finances health care for the economically disadvantaged, should be emphasized.

• Work accident and occupational illness are not covered by the planned reform. (They will be the subject of a separate law.)

• The public sector needs to be consolidated if it is to be the model sector undertaking training and research, and equitable with respect to the economically disadvantaged.

2.3 Tunisia

Health coverage in Tunisia

Individual and collective preventive and public health care, as well as the costs of certain illnesses that are the subject of research protocols, are funded by the state and provided free of charge to the whole population of Tunisia.

Coverage for curative care is provided by public health insurance schemes managed by two social security funds for the benefit of those affiliated to them (employees and employers) and by the state for the benefit of the poor, for whom care is entirely free of charge, and those on low incomes, who pay reduced, highly subsidized, charges in public health facilities. These public schemes cover almost the whole population: 8% receive health care entirely free of charge, 25% pay reduced charges and 66% are covered by social security health insurance.

There are also private schemes in the form of group insurance and occupational mutual funds, but they are limited to a few companies and occupational groups.

Furthermore, some occupational and/or social categories, the majority of whom pay social security contributions, receive free treatment in public health facilities and in health care facilities specific to them where these exist: the army, internal security forces, customs officials, health personnel, etc.
Present situation

Two social security funds supervised by the Ministry of Social Affairs manage compulsory health insurance schemes. In 1998, they covered some 2.1 million households with average coverage of the population estimated at 83%.

The National Pension and Social Security Fund covers about 634 000 employed and retired people, public sector employees (state and public bodies) accounting for about 30% of those covered, with a coverage rate of 100% of those liable. It provides two categories of health insurance schemes:

- A compulsory scheme with a 2% contribution rate, half of which is paid by the employee, which provides two options:
  - reimbursement for long illnesses and surgical operations for which use can be made of different categories of provider;
  - a "personal health card" scheme providing care free of charge in Ministry of Health facilities;

- an optional scheme which is an extension of the ordinary reimbursement scheme, with a total contribution rate of 6.5% (4% paid by the employee).

The National Social Security Fund covers about 1 467 000 working and retired persons, employees of the private sector and some publicly-owned enterprises, accounting for about 70% of those insured by social security, with an average coverage rate of 77% of the working population liable. The rate varies according to the scheme, going from 94% for the non-agricultural workers’ scheme, the largest, to 43% for agricultural workers.

The rates of contribution to National Social Security Fund health insurance schemes vary; the highest is 4.75% for the non-agricultural workers’ scheme, divided between the employee (1.32%) and the employer (3.43%). The agricultural workers’ scheme has the lowest rate of contribution (a total of 0.91%). Whatever the scheme, two options are open to those covered based on benefits in kind in the public health facilities of the Ministry of Health and/or in National Social Security Fund clinics.

The private insurance system is of secondary importance in covering health risks and, in terms of services, is superimposed on the public system. Group insurance contracts entered into by publicly and privately owned enterprises and occupational mutual funds, particularly the one for public sector employees, fill gaps in the public system, in particular through access to private services. Information about the private health insurance system is scarce and fragmentary with respect to those covered, contributions and services provided.

Through the Ministry of Social Affairs, the state manages two schemes for providing health care directly in Ministry of Health facilities:
a scheme providing care entirely free of charge to people living beneath the poverty line, estimated at 170,000 households and consisting of families targeted by a state permanent aid programme, plus children with no family support;

a reduced charge scheme for those on low incomes unable to contribute to a National Social Security Fund scheme, defined according to the income of the head of the family compared to the guaranteed minimum wage and the number of family members. This section of the population is estimated at 530,000 households. The beneficiary makes an annual payment to public health care facilities set at 10 dinars and contributes with nominal changes to costs at each contact.

The mechanisms for targeting the population eligible for free health care and reduced charges are decided by inter-departmental committees and based on surveys carried out by the Ministry of Social Affairs. The major inadequacies of the targeting procedures adopted lie in the difficulty of strictly applying the various criteria and the impossibility of updating and effectively following up any changes in household eligibility.

In 1998, the general infrastructure of the health system provided approximately one basic health centre per 2724 inhabitants (including private sector general practitioners), one hospital bed per 500 inhabitants and one doctor per 1380 inhabitants. The Tunisian health system is predominantly public with respect to supply of care, particularly as regards hospital infrastructure, which accounted for 89% of the total supply in 1998, but also with respect to human resources, particularly paramedical staff (98%). It employs 55% of the doctors, 30% of dentists and 18% of pharmacists. It is structured into three levels of health care provision:

- the primary level, consisting of health centres and district hospitals, providing basic health care;

- the secondary level, consisting of regional hospitals, providing specialized care, with technical equipment and sufficient beds;

- the tertiary level, consisting of university hospitals providing highly specialized care, medical training and contributing to scientific research in health sciences.

The private medical and dentistry sector, which has always coexisted with the public sector, is composed of ambulatory care clinics. Patients are hospitalized in clinics that are mono- or multi-disciplinary, the number, capacities and technologies of which have developed quite rapidly in the last decade.

In addition to these two main sectors of health care provision, there are six National Social Security Fund clinics providing ambulatory care to those affiliated to the scheme and their dependents. Furthermore, some state-owned companies have health care centres for their employees.

The two social security funds have a net financial surplus. They devote about one-fifth of total spending to health insurance, including the management costs of the National Fund
clinics. This is the second largest budget item after pensions, which account for around two-thirds of total expenditure. Between 1990 and 1998, the ordinary volume of spending on health care rose from 84 to 234 million dinars, i.e. multiplied by 2.8, an annual average increase of 13.6%.

There are a great many different mechanisms by which the social security funds pay health care providers, for long dominated by direct lump sum payments to the Treasury for the public health facilities, the amounts of which are set by the government, and fee-for-service payment, in the case of private providers. In the last few years, mechanisms for payment by case or episode of care and invoicing on the basis of lump sums per episode of care have been put in place in order to link the financial contribution to the production of the health care facilities concerned.

The relationship between health care providers and institutional sources of funding is characterized by special treatment for public health facilities. As a rule, public sources of health care financing only fund public providers, especially those that come under the Ministry of Health. The private sector is funded essentially by household out-of-pocket spending and the private insurance system. A very few exceptions to this rule have enabled the private health care sector to receive some public funding.

Private funding of public providers comes essentially from direct contributions by patients to the cost of care, to which people covered by social security and those who pay reduced charges are liable. To a lesser extent, they also come from sums paid by patients who pay for their health care, either directly or through private health insurance.

Improved health insurance performance

The extension of health insurance coverage is closely linked to that of social security, which is still dependent on three essential factors:

- promoting employment and reducing unemployment, the rate of which was estimated in 1997 at 14% of those aged between 18 and 59;

- inadequacy of the cover of persons subject to the current schemes;

- the lack of schemes to cover certain sections of the population: casual workers, whoever their employers and of whatever sector, domestic staff and some categories of religious affairs workers cannot obtain social security cover as there is no scheme covering them.

A political decision was taken on 1 May 2001 to adapt rates of contribution to the ability of potential contributors to pay and to establish new schemes. This will result in the coverage of new categories of persons at reduced rates and the revision of rates for people on low incomes who are already covered, such as small farmers, fishermen and skilled workers. This decision, which will be implemented in the near future, will improve social security, and therefore, health insurance cover.
Improving the management performance of health insurance is strongly directed towards controlling health care spending by social security funds through implementing a range of cost-control procedures and provider payment mechanisms:

- freezing prices for those covered by the national pension and social security fund who have opted for reimbursement;
- reimbursement levels that leave between 10 and 20% at the patient’s expense;
- putting a ceiling on reimbursement according to the consumption of the insured person and his or her dependents;
- a patient’s direct contribution (co-payment), which has been regularly increased, paid by those affiliated to schemes giving direct health care in public facilities or National Social Security Fund clinics;
- the negotiation with public health facilities of preferential prices for payment per procedure and per case, adopted in some special circumstances;
- methods of payment in advance to enable social security fund spending to be set, either by the annual allocation of a certain sum of money to public health facilities or by making agreements for payment per case for the benefit of those paying contributions.

The social security funds have not developed management methods further, to a great extent because of the preferential channelling of health care funding to public facilities. However, with the development of new relations with public (invoicing of treatment on the basis of lump sums) and private providers (payment per case), management performance is gradually improving and moving towards integrated control of services and expenditure.

The development of managerial capabilities of the various actors in the health care system will make it possible to improve performance in the health system as a whole. New mechanisms and procedures need to be put in place in order to see that health care is equitably funded and that interventions are efficient within a new contractual framework with providers.

The technical expertise needed should be developed along the following lines:

- an information system containing epidemiological, economic and financial data that makes it possible to identify significant changes and forecast the impact of demographic, epidemiological and socio-economic transitions on the health care system;
- methods of paying health care providers and the ways they are implemented and managed and, in particular, advance payment, such as capitation and diagnosis related groups;
• developing a contractual system between insurers and providers, little developed at present and requiring more specialized expertise and experience;

• the implementation of hospital decentralization and autonomy, major options adopted for the management of the health care system, require the development of the governance capacities of the various bodies involved;

• the development of the regulatory capacities of the supervising departments and social security services in the fields of assessment and control and, more generally, planning processes. Continuing quality control of care and capacity-building with respect to actuarial studies are priorities here.

Medium-term strategic options: reform of social security health insurance schemes

The socioeconomic and health environments and the inadequacies of social security health insurance have necessitated the adoption of reform based on the following main policy orientations:

• adopting a single, compulsory basic scheme providing adequate cover for health risks that may be managed only by social security funds;

• introducing an optional supplementary scheme that may be provided by social security funds, private insurance companies or mutual funds;

• reorganizing National Social Security Fund clinics in such a way as to make them independent, thus separating funding agency and health care provider;

• strengthening care invoicing procedures in university and regional hospitals, in accordance with contracts between the different parties in order to move gradually towards full payment for actual cost of service;

• funding private sector services on a contractual basis, thus enabling the patient to use all health care providers, public and private, under the same administrative and financial conditions.

Working groups have been formed on the basis of the above to draw up the implementation strategy and programmes of the reform. The main points for examination have been entrusted to technical groups whose missions are:

• to define the content of the basic scheme for each illness and the related rates of cover;

• to estimate the potential cost of the scheme proposed and ways of funding it, according to different variables;

• to decide upon cost-control mechanisms, particularly medical prescription references and drug reimbursement rates;
• to identify the measures to be taken within the funds for the management of the new scheme, particularly upgrading health care management systems;

• to define the contractual relationships to be introduced between health care providers and social security funds, as well as the contractual arrangements and payment for services, including modes of payment;

• to define care quality indicators and criteria applicable to public and private health care providers;

• to identify the measures needed to upgrade health care facilities in order to ensure efficient management of the new procedures introduced by health insurance reform.

The main results of the work have been submitted for broad consultation with the various partners, including representatives of providers, trades union and employers’ organizations. At the present stage of the consultation process, it can be said that there is a consensus as to the need for reform and its general objectives. Differences of opinion remain as to the strategy and means of implementation, particularly on the following main points:

• with respect to the basic scheme providing a proportion of the health care costs, some partners believe that the proportion remaining at the patient’s expense is too high; they are afraid it will have a negative impact on access to health care, particularly in the absence of a culture and tradition of optional individual private insurance;

• since an increase in the rate of contributions is necessary for the solvency of the new scheme, its funding will be shared between employees and employers, but some partners believe the state should contribute, thus alleviating the burden on employers and employees;

• as the reform will have to be implemented in stages, the technical groups proposed postponing its entry into force for private hospitalization, but this is disputed by the managers of the establishments concerned;

• the proposed channelling of health care is structured around the general practitioner, who is identified as the single, compulsory entry point to the system; this approach is strongly disputed and there is an ever-increasing number of proposed exceptions, variously justified;

• the proposed methods of payment are primary capitation (general practitioners), fee-for-service (specialists) and diagnosis related groups (hospitalization); the proposed methods are contested by providers who see in them a transfer of financial risk at their expense;

• the settlement mechanism selected is direct payment by insurers; providers, especially pharmacists, have reservations about this based on concerns as to the managerial capabilities of the funds and their impact on times of payment.
In addition to the unresolved questions mentioned above, some areas have yet to be explored and should be the subject of in-depth study:

- the impact of health insurance reform on national health expenditure;
- the consequences of reform for the public sector, as regards numbers of people using it, its organization and resources;
- the reform's effects on the infrastructure, resources, organization and running of the private health care sector;
- means of regulating the health care system, especially the incentive measures and sanctions to be adopted;
- continuing education and retraining of health professionals;
- the bases of the optional supplementary scheme, its implementation and regulation and potential impact on access to health care;
- the future of health insurance in private insurance and mutual funds.

The scope of the reform requires ongoing work and uninterrupted availability as it introduces profound cultural changes for citizens, health care providers and the social security funds themselves. The management of the change will require a high degree of sustained political support.

Long-term strategic options: towards universal health insurance

Following the implementation of health insurance reform and possibly social security fund pension scheme reform, on a unified basis, maintaining two independent funds managing social security may be called into question and replaced by the establishment of funds specific to the risks insured, possibly including a health insurance fund. The health system would then distinguish between, on the one hand, those covered by social insurance able to benefit from public and private health care services and, on the other, low income households whose state funded health care would take place exclusively in public facilities. With a view to improving the efficiency of the health system and a fundamental revision of its modes of funding, a central health insurance fund financed by the social security and the state budget could be established to play the role of purchaser of health care from all providers on the basis of the best cost-effectiveness ratios on behalf of the whole population.

Such changes would require the development of strong regulatory capacities to manage the competition among care providers and insurers. This option could be envisaged in the long term because the planned reform maintains the social security funds' quasi-monopoly on health insurance management and this will put providers in competition with each other. Similarly, performance assessment mechanisms for the system could lead to the
implementation of accreditation procedures affecting health care facilities, health professionals and training and teaching institutions.

Lastly, in view of the direct relationship between the increase in health spending and the number of doctors practising, it would be reasonable to consider reducing the number of doctors and other health professionals to be trained and examine whether the training provided is suited to the new environment in which they will be practising.

Conclusion

The implementation of social security health insurance schemes is a complicated, sensitive process. It requires the appointment of a multidisciplinary team to work on it full time, backed by experts in specialized areas in which there is little or no national expertise.

The reform requires health insurance management capacity-building at both providers and social security fund levels. Furthermore, the key health system function of regulation and stewardship should be promoted on the basis of public-private partnership with respect to both services and funding.

The weaknesses of the health insurance market and the imperfect competition that characterizes it mean that consumers need to be protected both in terms of quality of care and financial risk. Since, where health is concerned, equity is at least as important as economic efficiency, effective mechanisms are needed to enable the authorities to guarantee and monitor equity and correct deviations from it.

Discussion

- The Tunisian system seems to be a complicated one in which there are several forms of contribution, service provision, methods of payment and schemes.

- The reform plan being implemented gives great weight to the accounting issues and seems less interested in matters that are easier to resolve.

- While the basic principles and foundations of reform are still under discussion, technical aspects are already being tackled, before the necessary consensus has been obtained about basic choices.

- The present discussions and negotiations among the various partners are coming up against conflicts of interest and ending in impasse, either through fear or because of insufficient clarification of planned actions.

- There is much that could be done to facilitate the reform's success: combating the waste resulting from multiple schemes, the personal health card booklet, medical records, public-private partnership.
• Existing practices need to be rationalized at the same time as current negotiations continue.

• Health insurance reform is only one element in a reform policy for the health system generally; other aspects should not be ignored, such as reorganizing the public sector to enable it to play its role as reference sector in a context of opening up to the private sector.

• The will to give the public system the support it needs should be accompanied by practical measures.

• The principle of direct payment by insurers is a guarantee of the accessibility of health care for the economically disadvantaged.

3. ROUND TABLES

3.1 Payment of providers

Controlling costs

• Issue of controlling costs, spending as a proportion of GDP: is it enough or how high should it go? How can spending be both increased and controlled?

The most recent ideas of the OECD countries: methods of controlling costs:

- methods of payment
- methods that influence supply
- methods that influence demand

Methods of payment (BUDGET)

- Fixed rates and prices
- Payment by case, DRG
- Payment per day
- Capitation (adjustments)
- Salaries
- Budget (overall allocation): cost price

Control by regulating supply

- Health service infrastructure
- Medical facilities (access, training, restriction, installation)
- Supply of medical staff
- Drugs and treatments: lists, protocols
Regulation through demand

- Direct payment by insurer: shared costs, but accessibility!!
- Opting to leave medical assistance (opting out)
- Bonus when the patient does not consume care during the year (no claim bonus)

Lessons of international experience

- Fixed budgets and target budgets: problem of substitution effects between budget items
- Advance budgets
- Basket of payment methods
  - Payment per case
  - Certification: it is adjustable so can help control costs
  - Direct payment by insurer
  - Capitation: minorities of systems
  - Salaries: combinations (Finland): salary + capitation + rates

Conclusion

Mixed payment system
Non-monetary methods of reviewing use
  - Peer review
  - Selective contracts
  - Gatekeeping
  - Hospitals
Highly regulated infrastructure
  - Hospital closures and mergers

Medical technology
  - NICE: cost-effectiveness of facilities (NHS)

Drugs
  - Lists
  - Reference prices +++ (generic)

Treatment
  - Treatment protocols (RMO) + incentives needed for their implementation
  - Sanctions
  - Strict monitoring of all prescriptions
  - Peer review

Conclusion

Difficulty of evaluating the impact of measures because they are often combined.

- Wide-scale application of a system of passing on costs creates problems of accessibility.
- The budget method is fairly efficient but responsiveness problems. Taking into account substitution among items.
Country situations

1. Algeria

The limitations of the overall budget method are demonstrated with a clear loss of interest on the part of professionals who move to the private sector or supplement their income through part-time private sector work:

- no committee of experts
- no RMOs
- all payment methods present

2. Morocco

- Low level of spending on health care: the goal is not to reduce spending, but to achieve better distribution of expenditure.
- The optional system has reached its limits.
- The new rationalization instruments, RMOs/DRGs/capitation, are not yet used.
- Current practice:
  - budget method: only valid for hospitals;
  - payment for services provided: pricing per procedure + advance of costs;
  - in the public sector, direct payment by insurer, the "public mutual funds", but the price scale is obsolete and the invoices the funds have to pay low.
- The rates for university hospitals have recently been updated but do not reflect real costs.
- Payment methods are either fee-for-service or daily lump sum. For costly interventions, it is a lump sum of 1000 dirhams.
- The mutual funds only cover minor risks.
- For the private sector, state health service contracts are not compulsory but increasingly common.
- All forms of payment are included in the planned health reform: capitation, gatekeeping.

3. Tunisia

- A mosaic: all payment methods
- Overall budget: has proved inadequate
- In the absence of DRG, speciality groups applied on hospitalization
- Fees-for-service: fees scale, health service contracts
- Fee scale with a far from realistic patient contribution
- The reform of payment methods plans:
  - General practitioners: capitation + gatekeeping
  - Specialists, supplementary examinations: fee-for-service payment
  - Hospitalization: DRG
Discussion

- Control by capitation is not the only possibility. It is only a technical aspect.
- The Maghreb countries have no experience of capitation. It has been successful in developed countries because there are structures and a pre-existing environment that make it possible.
- Control may also be achieved by other equally important factors:
  - training: to prepare general practitioners for gatekeeping;
  - encouraging specialized centres for the new technologies before making them universal;
  - favouring consensus conferences.
- Would gatekeeping work only with capitation? Perhaps we should opt for a Tunisian form of capitation.
- Transfer from general practitioner to specialist in the context of gatekeeping should be accompanied by monitoring mechanisms.
- There are forms of capitation that have worked in countries similar to Algeria, Morocco and Tunisia, such as Thailand.
- For spending in the private sector, the percentage of expenditure must be carefully monitored: a high percentage of spending in private insurance has created problems of equity (the rich also use private insurance).
- In addition to training, to think of incentives to encourage providers to apply gatekeeping.

3.2 Health insurance financing and health insurance coverage

Brief country presentations

1. Algeria

a) Characteristics

- compulsory public system
- unified system (benefits and funding)
- two schemes: employed and unwaged
- no reform planned
b) Financing: national health spending

- State: 30 billion (25%)
- Health insurance: 70 billion (50%)
- Households: 30 billion (25%)

c) Source of financing

- State: taxation
- Health insurance: social security deductions (contributions): 34.5%, 16.75% (CNAF), 7.5% (CASNOS)
- Households: income

d) Coverage: 85% of the population

e) Problems

- Low reimbursement (rates frozen)
- List of drugs not reimbursed is lengthening
- Hospital entries reduced by households
- No scale of fees with public health service
- No contracts with the private sector
- General dissatisfaction
- Chronic deficits of bodies responsible for health insurance

2. Morocco

Present situation

- Optional cover provided by several schemes managed by various institutions: only 16% of the population
- Malfunctioning of the system for identifying the poor
- Inefficiency and inequity

3. Tunisia

- Multiple social security health insurance schemes
- Rate of contribution varies from 1 to 6.5%, according to scheme
- The schemes cover 82% of the population
- The state provides free health care for the economically disadvantaged
- Health insurance funds reserve 25% of spending to cover health risks

Discussion

- Health insurance schemes provide a “health care package” and other services; things should be unified as much as possible.
The number of schemes should be limited and there should be a gradual shift to a single body in order to facilitate efficiency and effectiveness.

The rate of contributions is the eternal problem: what rate should there be to ensure the sustainability of health insurance?

Should decisions as to what services to provide be taken according to a macroeconomic or a needs analysis approach?

Attention should be paid to public sector funding which may generate a burden, and hence use. Secondary or private, hence excess cost.

There is now a two-tier health service in the three countries: public and private. The public sector is already disadvantaged. This imbalance should speedily be rectified.

4. GENERAL DISCUSSION

Dr Sabri recalled the role of RESSMA through the consultation objectives.

- Improving knowledge and taking stock of the situation, challenges, problems and planned reforms.

- Defining the main problems and identifying expectations from WHO and RESSMA, and technical support in terms of training, research, evaluation and monitoring tools.

Suggestions

WHO can play a role by:

- assisting in implementing the reform
- assisting with the assessment and gradual introduction of Tunisian experience
- facilitating exchange of expertise among the countries
- exploiting RESSMA's capabilities
- training human resources
- developing awareness of the importance of sustained quality.

5. RECOMMENDATIONS

For Algeria, Morocco and Tunisia

1. Develop health insurance system reforms within a comprehensive integrated framework, taking into account all the functions of the health system. The state should play a central role in devising and implementing the reforms in order to ensure the continuity and safeguarding of societal values concerning access to health care, equitable health financing, quality services and efficiency. For these countries, which have since independence invested
in a public sector providing broad cover, it is important to consolidate what has been achieved and ensure that it is developed satisfactorily in order to continue to be the reference, ultimate recourse and guarantor of high quality training and national research programmes.

2. Implement capacity-building in the departments involved in health policy formulation. Organizational measures would be desirable in order to individualize the units concerned within ministries of health.

3. Develop and expand study of health insurance reforms through:
   - expanding documentation on reforms undertaken in various countries;
   - organizing study visits to particular countries to interview health insurance managers about ways and means of implementing reforms;
   - undertaking pilot studies to test new instruments for implementing planned reforms (gatekeeping, capitation, DRG).

4. Encourage consultation with partners (including by nongovernmental organizations) by:
   - developing a communication and social marketing strategy devised and implemented by professionals who will approach the various partners, in particular people covered by social insurance; the media should be the object of priority targeting in this connection;
   - closely involving health professionals in devising, implementing and evaluating health insurance reforms.

5. Develop and implement a change management strategy which will help to reduce or even neutralize resistance to the reforms.

6. Develop the supportive measures necessary for the success of health insurance reform. The measures will concern all functions of the health system, including those concerning health care services (preventive and curative), funding the health care system and social security funds. In this connection, professionals’ basic training needs to be adapted to the new requirements, in particular by rehabilitating the role of general practitioners and developing the “family practitioner” approach and strengthening continuing education for health professionals.

7. Implement capacity-building of human resources in order to create a critical mass of expertise in health insurance and social security. This could be done through short, targeted continuing education courses and, above all, specialized higher education courses.

8. Develop and implement means of calculating and analysing costs and improving the management of the health system:
• cost analysis, diagnosis related groups (DRG)
• actuarial studies
• health information and computerization
• on-going quality control
• promoting the medical review capacities of health insurance funds, in particular by developing human resource capabilities and adapting procedures.

9. Develop cost-control mechanisms

9.1 Controlling supply

• Certificate of needs: carte sanitaire
• New technologies
• Human resources
• Ways of paying providers
• Supply, availability and price of drugs
• Gatekeeping
• Consensus statements for patient care that may develop into references for all three countries

9.2 Controlling demand

• Patient’s contribution to expenses (direct payment by insurer and joint payment)
• Incentive to moderation in consuming services (bonus)
• Promoting the use of follow-up systems (e.g. personal health booklet) for patient care and avoiding duplication.
• Conducting the studies needed to evaluate user’s behaviour and attitudes, and implementing corrective measures.

10. Revise the organization, procedures and supervision of public health facilities so as to foster decentralization and autonomy in order to help improve the management performance of the public health care sector.

For RESSMA

11. In cooperation with governmental authorities, training and research institutions and professional associations, contribute to human resources training in the areas within its remit.

12. Contribute to information about health systems, in particular through its web site: www.ressma.net.

13. Conduct research focused on a comparative analysis of approaches to health system reform in the three countries. The following are the priority areas:

• health system stewardship and regulation
• health mapping (certificate of needs) and controlled development of supply
• human resources: training to match quantitative and qualitative needs
• place of private financing in supply.

For WHO

14. Support reforms in the three countries through a set of coordinated, integrated actions, involving the various partners:

14.1 Assist the countries in acquiring the framework for health system performance analysis and in adapting it to their needs.

14.2 Encourage the development and dissemination of the work of expert conferences, in particular medical consensus statements and references on patient treatment and management, but also other references on the management of medical and paramedical care.

14.3 Disseminate existing analytical tools and methods relating to planning and human resources management.

14.4 Disseminate regional and international health insurance experience.

14.5 Assist in the development of national observatories and a regional observatory for health system reforms, including health insurance.

14.6 Develop and disseminate norms and standards for assessing the performance of health facilities and deploying health system resources.

14.7 Assist in developing the necessary tools for ensuring effective monitoring of health system responsiveness and user behaviour.

15. Support RESSMA

15.1 Support RESSMA’s technical work by putting at its disposal available databases.

15.2 Conclude partnership contracts with RESSMA for the production of finished products according to previously agreed themes and terms of reference.
Annex 1

AGENDA

1. Opening session
2. Objectives and working methods
3. Algerian report
4. Moroccan report
5. Tunisian report
6. Funding health insurance
7. Payment of providers
8. Health insurance coverage
9. Technical support for reforms
10. Presentation and discussion of the final report
11. Adoption of final recommendations and plan of action
12. Closing session


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Annex 2

PROGRAMME

Wednesday, 14 November 2001

08:00–08:30 Registration of participants
08:30–9:30 Opening session
  – Address by Professor Noureddine Achour, Director of the INSP
  – Address by His Excellency the Minister of Public Health
  – Address by His Excellency the Minister of Social Affairs
  – Address by the President of RESSMA
  – Address by the WHO Representative in Morocco

10:00–13:00 Presentation and discussion of the Algerian report
15:00–17:00 Presentation and discussion of the Moroccan report
17:30–19:30 Presentation and discussion of the Tunisian report
20:00–22:00 Working dinner of the extended Bureau of RESSMA

Thursday, 15 November 2001

08:30–10:00 Round table (Funding health insurance)
10:30–13:00 Round table (Payment of providers)
15:00–17:00 Round table (Health insurance coverage)
17:30–20:00 Summing up (Technical support for reforms)
20:00–22:00 Working dinner of the extended Bureau of RESSMA

Friday, 16 November 2001

08:30–10:00 Presentation and discussion of the final report
10:30–11:00 Closing session
Annex 3

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