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National Health Accounts in Tunisia: Results for Years 2004 and 2005

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Acronyms

- **NHA : National Health Accounts** (CNS : les comptes nationaux de la santé)
- NFSS : National Fund of Social Security
(CNSS: la caisse nationale de la sécurité sociale)
- NFSFR : National Funds of social foresight and retirement (CNRPS : Caisse nationale de retraite et de prévoyance sociale)
- SSF : Social Securities funds (CSS : Les caisses de sécurité sociale)
- NFHI : National Fund of Health Insurance / (CNAM : La caisse nationale d'assurance maladie)
- DEP : Direction of planning and Studies (Direction des études et de la planification)
- CIMSP : Centre Informatique du Ministère de la Santé Publique
- THE : Total Health Expenditures (DTS : les dépenses totales de la santé)
- MoPH : Ministry of Public Health (MSP : Ministère de la Santé Publique)
- FS : Financing Sources
- HF : Financing Agents
- HP : Health Providers
- HC: Functional Classification
- ICHA: International Classification of Health Accounts
- National Institute of Statistics (INS : Institut National de la Statistique)
- OCDE : Organisation de Coopération et de Développement Economique
- WHO : World Health Organization (OMS : Organisation Mondiale de la Santé)
- GDP : Gross Domestic Product (PIB : Produit Intérieur Brut)
- SCS : Systèmes des Comptes de la Santé

- SCN : Système de Comptabilité National
- MoPH Facilities (SSP : Structures du Secteur Public)
- SMIG: Minimum guarantee salary (salaire minimum interprofessionnel garanti)
- UHC : University hospitals and Centres
- RH : Regional Hospital
- CH : hospital de circonscription
- BHC: Basic Health centres
- DHPS : Direction of health planning and studies
- MASSTE : Ministry of social affairs, solidarity and Tunisian residents abroad
- PHF : Public Health Facilities
- NFHI : National Funds of health insurance
- HE: Health Expenditures
- THE : Total Health Expenditures
- GDP : Gross Domestic products
- PuHE : Public Health Expenditures
- PrHE: Private Health Expenditures

Introduction

National accounts of the health (NHA) are recognized as an important tool of steady systematic, coherent and exhaustive of financial flows of the system of health. It is an international tool known for its capacity to synthesize, describe, quantify and analyze all aspects of health system financing. NHA system provide obviousness database of health care expenditure and give with other indicators, like mortality, morbidity, hospital activities, a support to decision makers regarding improving performance of health system. NHA system is implemented in more than 60 country, including countries with lower or intermediate income.

NHA system is useful to identify better ways of health resources utilization and allocation. In Tunisia, many attempts to setting up NHA have been made at the National Institute of the Public Health (Arfa C. and Achour N., 2004). NHA exercises are applied for the years 1995, 1997 and 2000, regarding the availability of national data of household's surveys of budget, consumption and standard living (National Institute of Statistics). Although authors of these works mention always numerous difficulties regarding NHA exercises, they are nevertheless upstart to get results, no matter what partially. In fact, health care in Tunisia are provided and/or financed by complex combinations public, private and para-public sectors. The Tunisian health system is fragmented regarding financial and supply of health care, so we felt several insufficiencies, like data availability. For next exercise, we must get solutions for data problems and disparity of nomenclatures which characterizes all publications of health partners.

NHA results for the year 2000 are published by WHO headquarters (web site: www.who.int/@@nha) and are briefly reported on the present report in order to compare with others years. This report focused on obtained NHA results for 2004 and 2005 and it discuss results and clarify the structure of the health financing and expenditures for all health system entities as sources or financing intermediaries. Results are obtained applying WHO methodology (See WHO Guide, 2003). The research and data collection has begun in February 2007 and finished on October 2007.

The report is divided into four sections. The first one gives a brief description of Tunisian health system and health insurance. The second one reminds same elements of NHA methodology following WHO guide for the case of Tunisia. The main results obtained for the year 2000 as well as results for 2004 and 2005 are given at the third section. The last section synthesises and discuss the obtained results.

1. Tunisian health system and health insurance

This first section is devoted to a global analysis of Tunisian health system. We will provide a description of health care supply and health coverage. We also analyze trends of health care financing. The Tunisian health system is defined by the sanitary law 91-63 July 1991 who stipulates in its first article " All person has straight to health protection at possible and best available conditions". The device of health care benefit is mainly composed by a public and private sector. In addition, others para-public health facilities are owned by national funds of social securities (NFSS) and others ministries than MoPH, like ministry of national defense, ministry of interior and local development, ministry of sport...

1.1. Health care supply

1.1.1. Public sector

Organized as networks, it comprises three levels:

- The first level accounts for 2067 basic health care centers (2004) and 118 circumscription hospitals and peripheral maternities with 2613 beds. Basic centers provide preventive cares (vaccinations, infantile and maternal health, health education, chronic sickness prevention) as well as primary curatives cares, external consultations and paramedical acts. Circumscription hospitals provide general medicine, pediatrics and have technical basis tray and pharmacy.
- The second level accounts for 34 regional hospitals with 5479 beds (2004). They are endowed with external consultations of general and specialized care, and provide drugs. They have specialists and equipment to bring cares not provided at basic health centers.
- The third level accounts for 22 university hospitals with 8590 beds (2004). They should provide specialized health care, teaching and research. They have specialized teams and perfected technical, equipments and plant.

Table 1. Numbers of public facilities (1970-2005)

	1970	1980	1992	2000	2004	2005
UHC		8	21 (7659)	22	22 (8544)	22 (8553)
RH	12	20	24 (5360)	32	33 (5909)	33 (6253)
CH	54	54	109 (2793)	118	121 (2815)	121 (2881)
BHC	435	765		2008	2067	2074
Total			154 (15 812)	172 (16 659)	174 (17268)	17591

() : Number of beds

Source : MoPH/DHPS (2005)

1.1.2. Private sector

Private sector is developed since independency of the country, as complement and/or with concurrence with public sector regarding inpatient and outpatient care aspects.

- Private sector is organized as a network of physician practice, pharmacists and dentists. It employs the half of Tunisians physicians, 75% of pharmacists and 11 % of paramedical staff.
- Private inpatient accounts 2000 beds for health facilities that have for 40 to 100 beds and provide generalists medicines and high specialized activities (cardio-vascular diseases, genecology...). In addition, we observe renal dialysis activities that benefit from a particular financing.

Table 2. Private Facilities

Year	1999	2002	2004	2005
Clinics	67	70	81	88
Private physicians	3254	3293	4371	4695
Drug stories	1361	1392	1492	1612
Biological laboratory	149	159	201	214
Renal dialysis centers	99	99	99	99

Source: MoPH /DEP (2005)

1.1.3. Para-public sector

Para-public sector accounts for six policlinics managed by NFSS, since 1980. They provide ambulatory care, renal dialysis. This sector include three militaries hospitals (Tunis, Bizerte and Gabés), on hospital related to ministry of interior and many health care centers related to ministry sports. It includes also many autonomous health centers owned by firms.

1.2. Human resources

During the period 1981-2004, an important trend on medical staff is observed. For example, the number of physicians has growth from 1800 to 9805 accompanied by a growth of the ratio of physician per inhabitation from 3200 to 1013.

Table 3. Trend of Medical Staff in Tunisia (1981-2004)

Years	1981	1990	1998	2000	2004	2005
Physicians	1800	4424	6819	7444	9805	10259
Dentists	320	809	1276	1315	1889	1914
Pharmacists	700	1240	1623	1951	2069	2268
Paramedical (technicians, mid-wife, nurses and auxiliaries nurses)	13570	32743	26676	27392	36383	37078
Nb of inhabitation per 1 physician	3200	1825	1380	1284	1013	978
Nb of inhabitation per paramedical	483	340	343	340	336	272

Source: MoPH/ DHPS (2006)

1.3. Management and regulation of health system

Management and regulation of health system is a vocation of MoPH. For the public sector, MoPH treats all questions related to investment, human resources. Since reforms taken at the beginning of the decade 1990, it has been decided to progressively give autonomy for hospitals financing and management, specifically for universities ones:

- 50% of beds was implemented into university' hospitals, which are managed as public health establishments with financial autonomy: their services are invoiced on the base of prices (or tariffs) fixed by MoPH.
- The remained beds was implemented at regional and circumscription that have an administrative character meaning that are again subject to public accounting rules and depends on MoPH rules.
- Private sector was freely developed specially on for profit centers (it does not exist certificate of needs, except for pharmacies and renal dialysis centers).
- Most of health professionals are concentrated at big cities (urban area) and coast area that concerns ambulatory care (notably specialists' care), public hospital or clinics (outpatients). For example, among the 22 university hospitals, 15 are located on great Tunis (4 governorates including the capital city Tunis). This concentration entails an over-use of the third level hospitals (university hospitals) given also their localization on big cities that have only regional hospital, so observed insufficiencies on governorates imposes displacement for patients which could be avoided with a more strict organization, allocation of resources and regulation.

1.4. Health System Financing

- The health financing in Tunisia is usually realized by three economic agents (table 4) :
 - State financing (State subsidies) has decreases from 53.1% in 1980 to 24.5% in 2004.
 - Social Securities Funds (SSF) has increased from 10.1% in 1980 to 23.4% in 2004.
 - Households financing has increased 36.8% in 1980 to 52.1 % in 2004.

It's remarkable to see that since the beginning of 1990 decade, a progressive reduction of State contribution to health financing, but on the other hand an increase of households share and with a lesser degree the SSF Share.

A List of expenditure ratio estimated by DEP (MoPH) and published by WHO (2006), give a nice illustration to national efforts of health financing and major trends of health expenditure in Tunisia. Following, we comment the main results:

- Small increase on Health expenditure as share of GDP: It hasn't exceeded 1 point during the period 1995-2005.
- Public health expenditures share of total health expenditures has decreased from 49.5% on 1995 to 48.7% on 2004.
- Private health expenditures share of total health expenditures has increased from 50.5% on 1995 to 51.3% on 2004.
- Public health expenditures financed by tax has decreased from 70.8 % on 1995 to 70.6 % on 2004.
- Public health expenditures financed by external resources has decreased from 0.8% on 1995 to 0.4% on 2004.

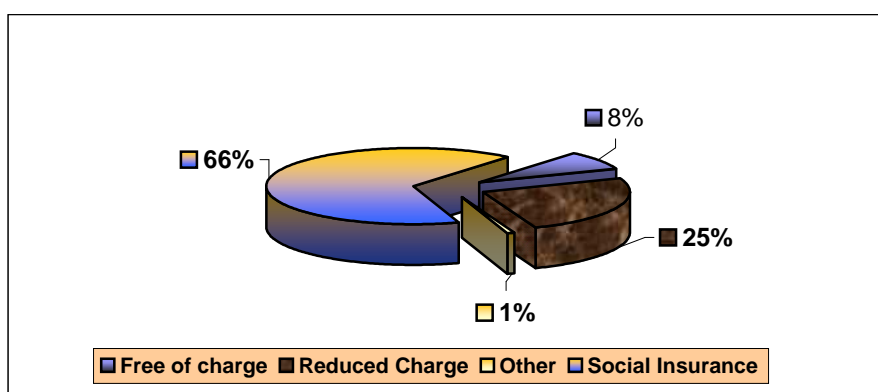
It's also notably important that health expenditures used on private sector has continually increased (Now it attempts 50% of total health expenditures) and directs household's payment becomes higher. We know that the increased out of pocket can induce many problems related health financing equity, accessibility and equity. In other terms, we will observe insufficiency of resources allocated to health insurance.

1.5. Health Insurance System

Tunisians population (99%) benefits from a health coverage schema which depends on socioeconomics elements, professional's status and as consequence persons or family income. Figure 1 reports distribution of health coverage per different categories of health insurance regimes. Three regimes dominated health risk coverage in Tunisia, but until the setting up of the National Funds of health insurance (NFHI)¹ but they are not conceived according a predefined health services package. Exception may be concerning the individual's choices regarding mandatory and facultative regimes of National Funds of social foresight and retirement (NFSFR) which allow coverage of long duration diseases and surgical interventions, according to prefixed list.

¹ NFHI is actively implemented on January 1, 2006.

Figure 1. Distribution of Tunisian's population per health coverage regimes



Health insurance Mechanisms

The health insurance mechanisms vary by social group and financing sources. Preventive and public health activities, individual or collective, are guaranteed at no cost for the entire population. The same model applies to individuals with illnesses that qualify them to take part in research studies. Individual costs for preventive services provided privately, however, are a household responsibility. Some professional groups (and their families) receive free health care in primary health care centers (*primary health care*) and other special schemes, in addition to their social security coverage. In some situations, mutual insurance membership gives some groups² access to services from private providers. The members of the resistance movement (participants in Tunisia's liberation movement) and their dependants also receive free health care services through the MoPH Facilities and military hospitals.

By law,³ the state guarantees free or subsidized health care services to low-income groups through two public medical aid schemes⁴: the free health care scheme and a reduced-fee plan.

Beneficiaries of the *free health care scheme*, defined according to the poverty line, are target families of a long-term government assistance program. Ruling No. 98-1812

² These groups are: the military; national security forces; customs agents; and health care professionals.

³ Article 35 of law No. 91-63 July 29, 1991, the public health organization law.

⁴ In 1998, there was a reform of this health assistance scheme. Eligibility for the health care card was revised, mainly to better target the needy families counted by the MASSTE, and service fees were reduced for persons with limited incomes, who cannot enroll in one of the social security funds.

describes the conditions and allocation and distribution mechanisms of the free health care card. The card is issued for five years within national limits and regional quotas. Beneficiaries of *reduced fees or charges* receive fee-reduction cards according to their annual household income relative to family size. Their income cannot exceed: the minimum wage (*salaire minimum interprofessionnel garanti*, SMIG) for families of two or fewer members; one-and-a-half times the SMIG for a three- to five-member family; and twice the SMIG for families larger than five members. In addition to those conditions, current social security affiliates are ineligible for fee reductions. Social agents from the Ministry of Social Affairs, Solidarity, and Tunisians Abroad (MASSTE) work in the field to make sure the eligibility conditions are met. The fee reduction card is issued for five years, within regional quotas, and must be validated annually through the deposit of TD10. Cardholders must pay the inclusive contribution for each medical visit.

To better target intervention and support to needy families, the MASSTE has set up a national poverty database. This database includes socioeconomic information on beneficiary families under the National Program of Aid to Poor Families (Programme National d'aide aux Familles Nécessiteuses, PNAFN). This program's tools for monitoring socioeconomic status are an important resource for various social partners that select beneficiaries for aid programs (long-term, temporary, free, or reduced charges for health care). They are also useful in the selection of beneficiaries for income generation activities under regional development programs and job creation assistance mechanisms. Within the framework of the two medical aid programs (free health care and reduced health care charge beneficiaries), access of the poor to health services is not subject to any restrictions or rationing. However, public hospitals' budget limitations and drug shortages can be considered an implicit form of service rationing.

In addition, the reform of, introduced in 1998, has helped expand coverage under formal insurance schemes, particularly by appealing to independent individuals, workers in the agricultural and informal sectors. Together with other measures, this program raised the real social coverage rate to 85.5 percent in 2004, and a further rise, to 90 percent, was forecast for 2006 (table7). These formal insurance schemes include social security, contracts with private insurance companies and mutual insurance companies, and associations of public and private employees.

Social security schemes are available for employees and employers, both mandated to participate. The funds are pooled within two principal funds: the CNSS and the

National Pension and Social Protection Fund (Caisse Nationale de Retraite et de Prévoyance Sociale (CNRPS). These national funds provide allowances for pensions, family services, and social protection and for industrial accidents and occupational diseases. The CNSS covers private sector workers, while CNRPS covers employees of the state, local public unions, and other public institutions.

Coverage rates vary by sector (table 7). All state employees are covered (CNRPS). Coverage of workers in the private sector (CNSS) is gradually increasing for several reasons. Legal allowances for the socially insured and their dependents have grown, reaching more than TD 1,943 million in 2003, equivalent to 30.8 percent of government-sponsored benefits and 6 percent of GDP. Coverage has also been extended to groups not previously covered by social security such as homemakers and construction workers, people unable to participate in their respective schemes such as small-scale fishermen, farmers, artisans, craftsmen, and artists.

Table 4. SSF Coverage Rates (percent of eligible population)

<i>Coverage</i>	<i>1987</i>	<i>1997</i>	<i>1998</i>	<i>2001</i>	<i>2004</i>	<i>2006</i>
Total, private sector (affiliated with CNSS)	41.6	74.6	77.0			
Nonagricultural workers	66.3	94.0	96.3	na	na	na
Agricultural workers	16.9	41.7	42.8			
Independents	9.2	48.5	50.22			
Total, public sector (affiliated with CNRPS)	100	100	100	100	100	100
Total, eligible beneficiaries	54.6	80.7	82.6	84.2	85.5	90.5

Source: MASSTE (2006)

The health care benefits covered vary by fund organizations. The NFSFR offers two schemes: a mandatory scheme and a facultative (complementary) scheme. The mandatory scheme has two mutually exclusive options:

- The first option offers a “health care card,” to beneficiaries. This card allows access to all MoPH facilities. Beneficiaries must pay a moderated ticket.
- The second option is reimbursement regime which concerns only beneficiaries with chronic illnesses and surgical interventions and allows access various public and private providers.

The facultative scheme is an extension of the cited second option on providing coverage to all common illnesses.

The NSSF offers its beneficiaries, regardless of which scheme the head of the

household belongs to, two means of illness coverage, based on in-kind benefits: (1) within the PHF, the same benefits for the ill as for reduced-fee beneficiaries and (2) within its polyclinics, only ambulatory care services with a co-payment at the point of service. Besides the health care services covered by these schemes, the two social security funds finance completely or partially: expenditures for special services, intensive care covered through special agreements with public and private providers, and international health services.

Private and public sector enterprises can contract with private insurance companies to cover their employees. Mutual insurance companies and private and public sector employee associations offer several social services including of health care coverage. In some mutual insurance companies, membership is mandatory. Membership in a mutual insurance company or in an insurance group is parallel to the mandatory affiliation of both the employee and the employer to the SSF. They usually use a fee-for-service reimbursement scheme and put a yearly ceiling on payments to a beneficiary.

Any uninsured patient pays the entire health care cost out of pocket, irrespective of whether care was obtained in the private or public sector.

2. Methodological aspects for setting up NHA

2.1. NHA Utilities

It was currently known that NHA system is an essential stape for developing strategy to improve economic and management performance of the health system. NHA system allows to:

- Estimate total health expenditures
- Describe flows of funds used on the health sector
- Asset health expenditures per providers and functions (economic or medical classification), socioeconomics factors, income, geographic ...
- Asset financial contribution of different socials partners of health sector whose participate on health regulation (providers, health insurance...)

Technical purpose, implementation of NHA will contribute:

- Estimate total health expenditures on its global forms and then per financing sources, financing agents, providers...;

- Estimate and separate public and private funds for health facilities, for health insurance...;
- Describe financial resources used for health per the two ways of functional classifications. Classification consisted here on matrix that permits to decompose health expenditures per providers, per item, per geographic area etc.

NHA Experiences of many countries show that health accounts is very useful to get solutions to questions like:

- How resources were mobilized and managed to health system?
- Who pays for health care and how much?
- Who provides health goods and services and with any resources?
- Who funds are allocated for different services, interventions and activities produced by health system?
- Who benefit of health expenditures?

2.2. Classification of health economics agents: Tunisian case

WHO guide (2003) adopts rules of health accounts system (HAS) of OCDE countries (OCDE 2000)⁵. The OCDE Manuel provides a details classification for health accounts (IHAC). The IHAC are evidently useful for OCED countries that have usually a major source of health financing. This is not the case for weak or intermediate revenue countries that have in general, a fragmented and pluralist's health systems. Health care activities or intervention can benefits from several sources of financing. Indeed, we use IHAC for our NHA implementation as recommended by WHO guide, but we should introduce some flexibility for classifications regarding country characteristics and needs. Classification must evidently obey to mutual and exclusive rules of accounts. Exclusivity means that each transaction should never be recorded into one and only one cells of the NHA Matrix. Together, the two mentions rules imply that all transactions are recorded within one category. NHA distinguish between four great financial entities for the health system (each entity has a code):

- **Financing sources (code FS):** For Tunisian case, it twill be the following entities: Ministry of finance (Public fund treasurer), public and private employers, households and rest of the world. In others terms, health financing is obtained from Stat subsidies, social contributions of employers and households, directs

⁵ OCDE (2000), "Système de Comptes de la Santé, Version 1.0 », Paris

payment of household and private insurance premiums.

Financing agents (code HF): It was entities that direct or indirect payments or purchasing for health care. Financing agents are entities that put common resources coming from financing sources. For Tunisian case, these agents are MoPH and others ministries (national defense, interior and local development, sport ...), SSF, private insurance companies, mutual, households. National accounts using OCDE Manual says that this set of agents are called “financing sources”.

- **Providers of health services and goods (code HP) :** It was entities that produce health services. For Tunisian case, we have the following providers :
 - Public Health Facilities owned by MoPH
 - Public Facilities owned by others ministries
 - NFSS Facilities
 - Private Facilities (clinics, private physician, laboratoires, pharmacies etc.).
- **Function of health systems (code HC):** NHA guide is base on IHAS of OCDE countries (ICHA-HC). ICHA distinguish among many types of produced health care per providers and actors. This distinguishes between provided services and entities are very important and it was same time sources of many confusions. Health services may be some times provided by mix facilities. In fact, service type does not always coincide with a specific provider.

2.3. NHA Matrix

Several countries have already regularly produce NHA tables, but never all required tables at least one time. Whatever country experience with NHA, it is recognized that is again a difficult task to produce simultaneously all NHA tables.

We should think to the opportunity for health accounts as a specific domain to be deeply subject to more research questions for data availability and national policy. Thus if it is difficult to get all expected NHA tables, it is nevertheless indicated to try to go more further in doing NHA. Each NHA table presents a facet of the expense of health care expenditures where are crossed two of the four dimensions of health expenditures. The four dimensions directly connected to the financial flow circulation are:

- Financing sources vs. financing agents
- Financing agents vs. Health care providers
- Distribution of financing agents expenditures per function
- Distribution of health providers expenditures per function

Into each table, one of these dimensions will be expressed as “origin” and a second one as “users” of financial resources. It is stipulate that the dimension origin should be presented on colons and the dimension users on lines. NHA tables try to model health system. This systematic approach shows that expenditures of actors are resources for others and an automatic relationship exist between different tables.

2.4. Health expenditures ratio

Synthetic health expenditures obtained from NHA tables, are used to evaluate contribution effort on health financing and for International comparison. Definition of main ratio is given by the following formula:

$$\mathbf{DTS} = \underbrace{\mathbf{DImp\hat{o}t} + \mathbf{DAMPub}}_{\mathbf{DPubS}} + \underbrace{\mathbf{DDM} + \mathbf{DAMPrv}}_{\mathbf{DPrvS}}$$

$$\frac{\mathbf{DImp\hat{o}t}}{\mathbf{DTS}} + \frac{\mathbf{DAMPub}}{\mathbf{DTS}} + \frac{\mathbf{DDM}}{\mathbf{DTS}} + \frac{\mathbf{DAMPrv}}{\mathbf{DTS}} = 1$$

3. Tunisian NHA: Results for Years 2000, 2004 and 2005

3.1. NHA Results for Year 2000

First matrix is an illustration of resources mobilized to health system that is obtained by tables showing flow of funds between financing sources and financing sources. (Table 4 and 5). This Matrix permits estimate funds designated to health per financing sources which is equal to 1581.186 million of TD.

Tunisian health system has a specific configuration on flow of funds for its financing actors. We observe that SSF (financing agent) provide a forfeit amounts to ministry of finance (financing sources) which would be then transmitted to MoPH (financing agent). This kind of transactions is not defined in terms of WHO guide where it not perceived to get health funds transmitted from financing agent to another one via financing sources. Using NHA, we think that it's required to get a coherent description and to respect paths of flow of funds, we conceive two matrixes. In other terms, the first stage is described using two stage NHA matrixes.

Matrix 1: Stage of resources mobilization

Table 5. Flow of funds between financing sources and financing agents

Financing Agents		Financing Sources					
		FS.1.1 State Budget	FS.1.2 Public Employers	FS.2.1 Private Employers	FS .2.2 Households	FS. 3 Rest of the World	Total
HF.1 NFSS	HF.1.1 Mandatory regime			187.006	60.848		247.854
HF.2 NFSFR	HF.2.1 Mandatory regime		36.138		36.138		72.276
	HF.2.2 Facultative Regime		6.677		13.354		20.031
HP.3 Mutual	HF.3.1 Public		nd				
	HF.3.2 Private			nd	48.397		48.397
HF.4 Private Insurance	HF.4.1 Insurance Group			56.560	28.280		84.84
HF.5 MoPH	HF.5.1 Functioning Budget	428.5					428.5
	HF.5.2 Investment Budget	87.600				1.5	89.1
HF.6 Others Ministries	HF.6.1 Others Ministries	16.195			19.126		35.321
HF.7 Household	HF.7.1 Public Facilities				87.900		87.9
	FA.7.2 NFSS Facilities				12.295		12.295
	FA.7.3 Private facilities				454.672		454.672
Total		532.295	42.815	243.566	761.01	1.5	1581.186
Share on %		33.70%	2.70%	15.40%	48.10%	0.10%	100%

Unit: Million of TD

nd: not available

Matrix 2: Resources mobilization

Table 6. Flow of funds between financing sources and financing agents

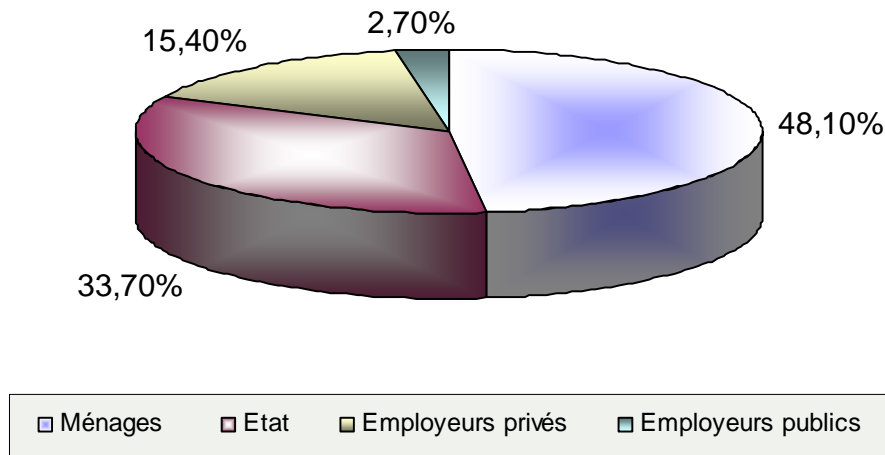
Financing Agents		Financing Sources					Total
		FS.1.1 State Budget	FS.1.2 Public Employers	FS.2.1 Private Employers	FS .2.2 Households	FS. 3 Rest of the World	
HF.1 NFSS	HF.1.1 Mandatory regime			110. 212	35. 250		145.462
HF.2 NFSFR	HF.2.1 Mandatory regime		22. 267		22. 267		44.534
	HF.2.2 Facultative Regime		6.677		13. 354		20.031
HP.3 Mutual	HF.3.1 Public		nd		48. 397		48.397
	HF.3.2 Private			nd			
HF.4 Private Insurance	HF.4.1 Insurance Group			56. 560	28. 280		84.840
HF.5 MoPH	HF.5.1 Functioning Budget	428.5	13. 871	76. 794	39. 469		558.634
	HF.5.2 Investment Budget	87. 600				1. 5	89.100
HF.6 Others Ministries	HF.6.1 Others Ministries	16. 195			19. 126		35.321
HF.7 Household	HF.7.1 Public Facilities				87. 900		87.900
	FA.7.2 NFSS Facilities				12. 295		12.295
	FA.7.3 Private facilities				454.672		454.672
Total			42.815	243.566	761.010	1.500	1581.186
Share on %			2.7%	15.4%	48.1%	0.1%	100%

Unit: Million of TD

nd: not available

A first result is share contribution to health financing per sources. Figure 2 show that health financing is essential given by households with 48.1% composed from direct payments (out of pocket) minus reimbursements received from complementary (facultative) insurance plan. On the other hand, social financing (obligatory levies (tax and contribution given by State and employers) represents 51.8%. Tax allocated to health is estimated at 33.7%.

Figure 2. Sources of health financing in Tunisian (2000)



NHA results show also that health financing is coming from several sources. This system is then complex because it's defined from many financing dimension of partners. In order to evaluate effort to mobilize and distribute resources (second NHA matrix), we order financing agents according to funds received (Table 6). Financing agents presented on table 6 plays a role on regulation rules of the health system according to their function of health financing intermediates which imply a function of distribution and allocation of health resources. It's so important to learn the above classification.

Table 7. Decreased classification of health financing agent according to received funds (2000)

Financing agents	Amount	Share on %
MoPH	647.734	41.0
Households	573.993	36.6
NFSS	145.462	9.2
Private insurance	84.840	5.4
NFSFR	64.565	4.1
Mutual	48.397	3.1
Others ministries	16.195	1.0
Total	1.581.186	100

At first level, we find MoPH with 41% of total of resources mobilized by financing sources. Next, direct payment of households presents 36.6% while all remaining financing agents receive only 22.8%. SSF comes on third rank, with 13.3% which highlights their restricted role on health financing in Tunisia. We think that the new implemented National Funds of health insurance (NFHI) obtained by the unification of the two SSF on their health insurance elements, will contribute to generate more resources given the increased rate of social contribution for households and employers. Facultative insurance schema receives only 8.5% of total health financing.

Regarding the same table, the households financing is given by direct payments (out of pocket) with 73%. These payments are allocated for health provided at private sector and their share for public sector remains very weak. Following, we give the distribution of households financing:

- 14.49 % is used for SSF contribution
- 10.07 % for health insurance premium
- 5.18% for MoPH (moderated ticket)

Tables 4 and 5, Social contribution of households for mandatory insurance is 14.49%. In fact, SSF have an intermediate role on health financing dealing with the 5.19% funds allocated to MoPH. Table 5 explains a detailed situation of health financing. SSF contribution is 9.13 while MoPH received only 5.18% of household's direct payments. The private insurance mechanisms remain very weak where very higher the out of pocket share on health financing.

3.1.1. Modalities of health providers financing

Table 7 hereafter, presents the second step of NHA that concerns the utilization of funds for providers financing. It's related to follow of funds from FA to providers. We observe that total amount of health expenditure as estimated by first NHA matrix (FS x FA) is different from that given on second matrix (FA x P)

It is clear, that funds allocated to agents by financing sources are not fully used for health. We attribute this difference to SSF whose have others social crenels (retirement, social foresight, capital death, social programs...) of which they must found money to these activities. Referring to the same table, total health expenditures are estimated at 1485.879 million TND from which 50.72 % are allocated to public health facilities. The private facilities share is as even important since it is 43.58%. NFSS and others ministries facilities receive a very weak share estimated to 2.7% and to 2.5% from total health expenditure.

Table 8. Follow of funds from financing agents to providers
 Second Step: Modalities of providers financing

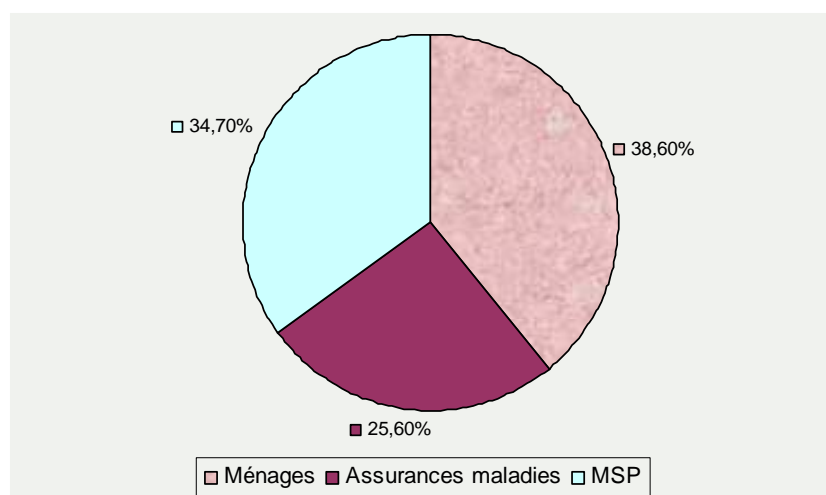
Unity: Million of TND

Providers	Financing agents							Total
	H.F.1 NFSS	H.F.2 NFSFR	H.F.3 Mutual	H.F.4 Private Insurances	H.F.5 MoPH	H.F.6 Others Ministries	H.F.7 Households	
H.P.1 MoPH Facilities	118.393	31.309			516.100		87.900	753.702
H.P.2 NFSS Facilities	28.892	0.000					12.295	41.187
H.P.3 Private facilities	41.607	26.240	51.337	76.448			451.967	647.599
H.P.4 Others ministries facilities	2.000	0.659				16.195	19.126	37.980
H.P.5 Health care abroad	1.556	1.149					2.705	5.410
Total	192.449	59.357	51.337	76.448	516.100	16.195	573.993	1485.879
Share on %	13.0 %	4.0%	3.5 %	5.1%	34.7%	1.1%	38.6%	100%

3.1.2. Providers financing

First result obtained concern the main financing agents of providers financing which is MoPH, Households, health insurance. This is an interesting result that shows the relatively important share of households' direct payments (out of pocket) equal to 38.6 % for the year 2000. The MoPH share is also important and equal to 34.7 % of total provider's resources. Health insurance system share is lower compared to MoPH and households direct payments. For instance, the complementary coverage given by private insurance and mutual is only 8.6%. They receive lower resources and as consequence they have a small contribution to providers insurance. The following figure gives a distribution of different modalities of providers financing.

Figure 3. Distribution of providers financing



Second important result is related to distribution of health financing for public and private providers. Public financing allocated by MoPH, SSF and others ministries is used to their owned facilities (public and para-public). The half of these resources is given to MoPH facilities (50.72%). On the other hand, private financing represents 47.2%. Private insurance and mutual contribute only to private facilities financing while households drains money to both types of facilities: it's respectively 20.78% for public facilities and 78.74% for private facilities of their total health expenditures. NHA results reveals a meadow equitable distribution of providers financing according to resources' origin (public and private funds). Households' Direct payments are important and have certainly, a negative influence of household's purchases.

3.1.3. Health indicators

Indicators are a synthetic ratio that illustrates a best meaning the health financing efforts of healthy actors. NHA results allow getting the following ratios (table 9):

- Total health expenditures as part of GDP is estimated to 5.6 % ;
- Public health expenditures are great than private expenditures. Public expenditures are estimated to 784.101 million of TND while private expenditures are equal to 701.776 million of TND.
- Public share is financed by fiscal represents 67.9 %, while social contribution is only 32.1%.
- Private Share is greatly financed by out of pocket of households (81.8 %) and secondly by private insurance (18.2 %). These indicators show that households made more efforts to health financing for the year 2000.

Others indicators obtained for this NHA exercise is reported on the following table.

Table 8. NHA Health indicators

Indicators	2000	
	Amounts	percent
Total health expenditures as part of GDP	1485.879/26651	5.6%
Public Health Expenditures as part of Total health expenditures	784.101/1485.879	52.8%
Public Health insurance as part Public Health Expenditures	251.801/784.101	32.1%
Health expenditures financed by fiscal as part of Public Health Expenditures	532.295/784.101	67.9%
Abroad resources as part of Public Health Expenditures	1.5/784.101	0.2%
Private health expenditures as part of total health expenditures	701.776/1485.879	47.2%
Private insurance as part of Private health expenditures	127.783/701.776	18.2%
Out of pocket as part of Private health expenditures	573.993/701.776	81.8%

3.1.4. Health insurance system financing

Tables 4 and 5 which reports second NHA step, provide also a nice description and clarify modalities of health insurance system financing. Obligatory health insurance is defined as regime related to NFSS and NFSFR. Table 9 below, gives total amounts and distribution per financing agents of funds allocated to health insurance. 30 % of total health expenditures are consumed by Health insurance system which is equal to 473.398 million of TND. Health insurance is financed by public and private employers (60.5%) and households (39.5%). We observe that SSF receive the majority of this funding (71.9%), where NFSFR share is only 20%. On the other hand, complementary insurance (private insurance and mutual) obtain 28.1% of total health insurance financing.

Table 9. Health insurance financing (Year 2000)

	FS. 1.2 Public Employers	FS.2.1 Private Employers	FS. 2.2 Households	Total	Part en %
HF.1 NFSS		187.006	60.848	247.854	52.4
HF.2 NFSFR	42.815		49.492	92.307	19.5
HF.3 Mutual	nd		48.397	48.397	10.2
		nd			
HF.4 Private insurance		56.560	28.280	84.840	17.9
Total	42.815	243.566	187.017	473.398	100
Share on %	9.0	51.5	39.5	100	

nd: data not available.

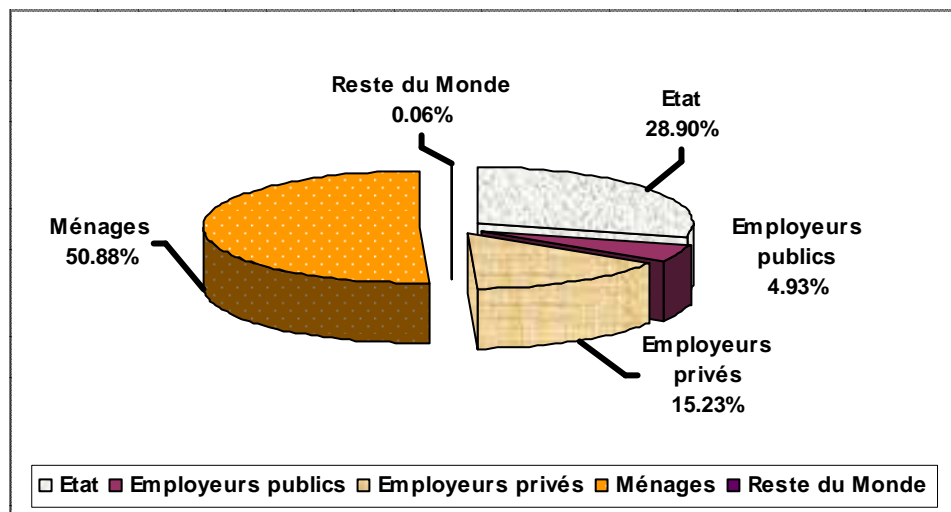
Private financing understands individual's expenditures that are reimbursed or not by private insurance or mutual and firms ambulatory care dealing with meager resources of these insurance companies (28.1 %). It should be noted that the share of households' health care expenditures was directly realized with a weakly amounts of reimbursements.

3.2. NHA results for the year 2004

3.2.1. Structure of Health financing

Table 10 given above, show that mobilized resources for health by financing sources. From the same table, total amounts of healthy financing is estimated to 2114.176 million of TND which is related to findings coming from State, public and private employers, households and accessory from rest of the world (international's agencies, like world bank, world health organization), while total health expenditures is closely equal to 2105.936 MD (with a share of GDP equal to 5.98) and 211.844 TND as per capita expenditures. Figure 1 show that households remain the main financing agents with a percent share of 50.9%. At second rank, State have a contribution share on health financing equal to 28.9 % while public and private employers comes on third rank with 20,15%.

Figure 4. Distribution of Health financing sources per types of agents (2004)



- Households allow 50.3 % of total health from which 62.1% are direct payments on private sector and 19.8% payments realized on MoPH facilities. Social contribution to SSF represents 12.5% of Households' health financing while insurance premiums is only 4.4%. Direct payments against received health care service on others ministries facilities are calculated to 1.1% (tableau 10).
- State allow 28.9 % of total health financing from which 97.7 % is a functioning and investment budget of MoPH, 1.5 % for facilities owned and 1% to some public mutual (tableau 10).

- Private and public employers contribute to health financing via social contribution for SSF and to complementary insurance. Their contributions are estimated to 428.103 million of TND where private employers have the great share (75.6%) (Table 10).
- The rest of world has a very small share estimated to less than 1% of total health financing (Table 10).

Furthermore, Health financing can be analyzed according to the origin of funds (social contributions and/or fiscal). With this respect, we get the following results for the year 20004:

- The share of health financing with fiscal as origin represents 28.9 %.
- The share of health financing with social contributions as origin represents 22.5%.
- The share of health financing with households' direct payments as origin represents 41.6 %.
- The share of health financing with insurance premium as origin represents 6.9 %.

Table 10. Follow of funds from financing sources to financing agents

Phase of resources mobilization						
Year 2004 (million of TND)						
Financing agents	Financing Sources					Total
	FS. 1.1 State Revenue	FS. 1.2 Funds of public employers	FS.2.1 Funds of private employers	FS.2.2 Funds of Households	FS.3 Funds of the rest of the world	
HF.1.1 MoPH	596.882	9.240	36.960	213.243		856.325
HF.1.2 MoND	7.041			10.810		17.851
HF.1.3 MoILD	1.492			0.286		1.778
HF.1.4 MoS	0.404			0.950		1.354
HF.2.1 NFSS			230.903	67.083	1.310	299.296
HF.2.2 NFSFR		50.420		67.897	0.049	118.366
HF.3.1 Private Insurance		39.252	53.948	17.214		110.414
HF.3.2 Mutual	5.171	5.250	0.130	30.373		40.924
HF.4 Health private Agents				667.868		667.868
Total	610.990	104.162	321.941	1075.724	1.359	2114.176
Share on en %	28.90	4.93	15.23	50.88	0.06	100.00

3.2.2. Financing structure of health insurance system

Health insurance is obligatory defined by SSF and by facultative (or complementary) insurance by private insurance and mutual. Health insurance system has received 629.000 million of TND. Table 11 give the structure of health insurance financing which is coming from private employers (51.0%), households (31.0%) and public employers⁶ (17.0 %). State attribute subsidies to mutual related to ministry department is only 0.01%.

Table 11. Distribution of health insurance financing

Year 2004 (million of TND)						
Financing Agents	Financing Sources					
	State Revenue	Public Employers	Private Employers	Households	Rest of the world	Total
NFSS			267.863	78.123	1.31	350.056
NFRPS		59.66		70.657	0.049	127.606
Private insurance		39.252	53.948	17.214		110.414
Mutual	5.171	5.25	0.13	30.373		40.924
Total	5.171	104.162	321.941	196.367	1.359	629.000
Share on %	0.01	0.17	0.51	0.31	0.002	1.00

- NFSS receives the great share (52.6 %) which is evidently related to the important numbers of its beneficiaries. The financing of NFSS health insurance component is on majority given by private employers (76.5 %) while household's contribution is still 22.3 %.
- NFSFR receives 20.3 % of total health insurance financing. This financing is obtained from households (55.4 %) and public employers (46.8 %).
- Private health insurance receives 17.6 % of total financing. This financing is obtained from public employers (35.5%), private employers (48.9%) and households (15.6 %).
- Mutual receive only 7.19 % of total financing. This financing is obtained from households (74.2%), from State as subsidizes (12.6%) and from public employers (12.8 %). Private employers share is very lower and estimated to 0.3 %.

⁶ Including State as public employers.

3.2.3. Health expenditure by financing agents and by providers

Table 13 give modalities of providers financing according to the NHA second matrix: follow of funds financing agents to providers. The mention table shows firstly that total estimated amounts of national expenditures on health are 2105.936 million of TND. Expenditures of financing agents affected to health care providers represents 99.6 % of total health financing (see first matrix). A detailed data given on table 13 prove the following results:

Table 12. Follow of funds financing agents to health care providers

Year 2004 (million of TND)										
Health care Providers	Financing Agents									
	HF.1.1 MoPH	HF.1.2 MoND	HF.1.3 MoILD	HF.1.4 MoS	HF.2.1 NFSS	HF.2.2 NFSFR	HF.3.1 Private Insurance	HF.3.2 Mutual	HF.4 Health private Agents	Total
HP 1.1. Hospital with administrative character	286.658				36.623	13.241			98.923	435.445
HP. 1.2. RH and UHC	173.624				143.156	48.087			62.480	427.347
HP. 1.3. Hospitals owned by others ministries		6.389	1.492	0.404	6.177	3.089			2.780	20.331
HP.1.4. Clinics and private offices					51.207	72.487	25.038	10.771	244.374	403.877
HP.3. NFSS Facilities					37.777				10.517	48.294
HP. 4.1. Pharmacies					25.563		60.091	24.014	340.238	449.907
HP. 4.2 Others expenditures					3.907		5.008	2.046	118.038	128.999
HP. 4.3. Sellers and distributors of medical goods					7.978		10.0152	4.0924	2.007	24.092
HP.6. Administrative fees	61.828				5.224	4.97364	13.333			85.359
HP. 8. Rest of the world	0.273				4.418	2.443				7.134
HP. 9. Equipments expenditures	74.5	0.652								75.152
Total	596.883	7.041	1.492	0.404	322.030	144.321	113.485	40.924	879.357	2105.936
Share on %	28.34%	0.33%	0.07%	0.02%	15.29%	6.85%	5.39%	1.94%	41.76%	100.00%

3.2.4. Publics Expenditures and Privates Expenditures

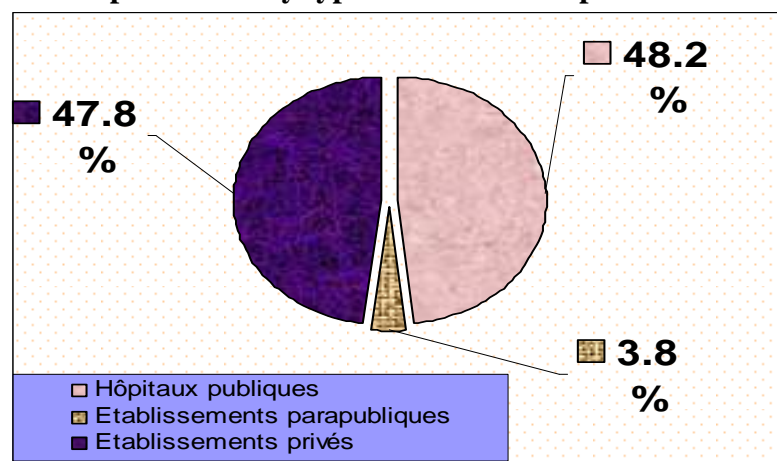
Public health expenditures (resources coming from fiscal and social contribution) are estimated to 50.91 % of total health expenditure while private health expenditures (out of pocket and private insurance premium) are estimated to 49.09%. Others results are:

- Fiscal resources represents 56.5% of total public health expenditures while social contribution resources represents 43.5 % ;
- Out of pocket represents 85.1% of total health expenditures;
- Health expenditures per capita are estimated to 211.844 DT. Public health expenditures per capita were 107.853 DT while private health expenditures per capita were 103.990 DT.

3.2.5. Financing modalities of health care providers

A lines lecture of table 13 allows learning about distribution of health expenditures by financing agents and it's more explicitly given by figure 4. Para-public facilities (NFSS and others ministries owned facilities) receive the lesser share 3.8 % while public facilities receive 48.2% and private one 47.8%.

Figure 5. Health expenditures by types of health care providers



3.2.6. Financing modalities of MoPH facilities

Public sector is financed by State budget (59.7 %), SSF (24.1 %) and Households 16.2 %. MoPH Budget is used on central level but also used to salary payment of its functionary and investment at various levels.

Table 13. Financing modalities of MoPH facilities

Public Providers	Financing agents				Total
	MoPH	NFSS	NFSFR	Households	
Hospital with administrative character	286.658	36.623	13.241	98.923	435.445
RH and UHC	173.624	143.156	48.087	62.48	427.347
Administrative Fees	61.828				61.828
Equipments expenditures	74.500				74.500
Total	596.61	179.779	61.328	161.403	999.12
Share on %	59.7%	18.0%	6.1%	16.2%	100%

3.2.7. Financing modalities of private health care

Private sector is financed by households 70.0% (Table 14). It concerns Households' direct payments from which is deduced complementary insurance refunds. According to NHA results, 48.3 % of total households expenditures on health are undertaken on pharmacies and on private facilities (34.7 %). 16 % of private facilities financing is coming from SSF and it's related to particular conventions that including long duration disease (for NFSFR) and labor accidents.

The share of complementary insurance on private facilities financing is equal to 14 %. This kind of health insurance has expenditures realized on private facilities (85%) and pharmacies. Mutual and private insurance use a meadow 60 % of pharmacies devices.

Table 14. Financing modalities of private facilities

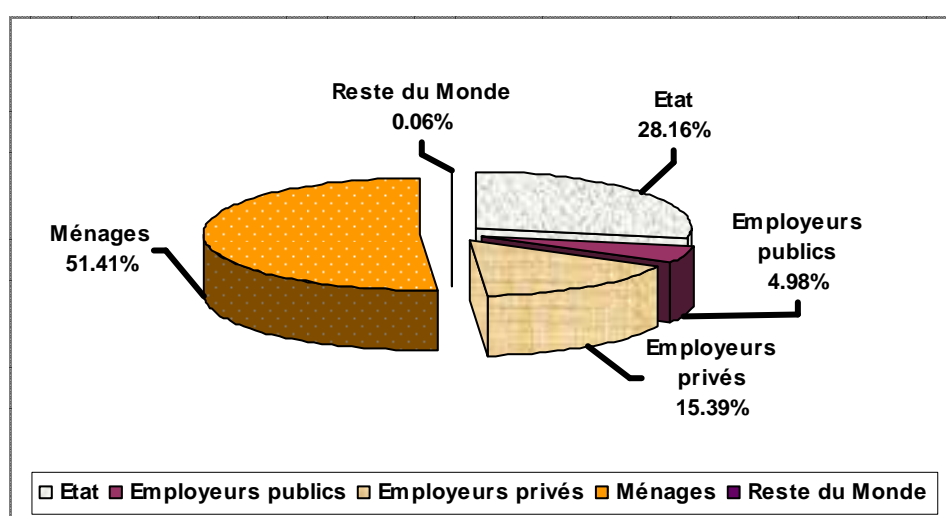
Private facilities	NFSS	NFSFR	Private Insurance	Mutual	Households	Total
Clinics and private offices	51.207	72.487	25.038	10.771	244.374	403.877
Pharmacies	25.563		60.091	24.014	340.238	449.907
Others expenditures	3.907		5.008	2.046	118.038	128.999
Sellers and distributors of medical goods	7.978		10.0152	4.0924	2.007	24.092
Total	88.655	72.487	100.152	40.924	704.657	1006.875
Share on %	8.8%	7.2%	9.9%	4.1%	70.0%	100.0%

3.3. NHA results for the year 2005

3.3.1. Structure of financing of the health

Table 15 given above, show that mobilized resources for health by financing sources. From the same table, total amounts of healthy financing is estimated to 2256.015 million of TND which is related to findings coming from State, public and private employers, households and accessory from rest of the world (international's agencies, like world bank, world health organization), while total health expenditures is closely equal to 2247.281 million of TND (with a share of GDP equal to 5.97) and 226.062 TND as per capita expenditures. Figure 6 show that households remain the main financing agents with a percent share of 51.4%. At second rank, State have a contribution share on health financing equal to 28.2 % while public and private employers comes on third rank with 20,37%.

Figure 6. Distribution of Health financing sources per types of agents (2005)



- Households allow 51.4 % of total health from which 62.7% are direct payments on private sector and 19.5% payments realized on MoPH facilities. Social contribution to SSF represents 12.5% of Households' health financing while Insurance premium is only 4.3%. Direct payments against received health care service on others ministries facilities are calculated to 1.1% (tableau 15).
- State allow 28.2 % of total health financing from which 97.7 % is a functioning and investment budget of MoPH, 1.5 % for facilities owned and 1% to some public mutual (tableau 15).
- Private and public employers contribute to health financing via social contribution for SSF and to complementary insurance. Their contributions are estimated to

459.572 million of TND where private employer gives the great share (75.6%) (Table 15).

- The rest of world has a very small share estimated to less than 1% of total health financing (Table 15).

Furthermore, Health financing can be analyzed according to the origin of funds (social contributions and/or fiscal). In this respect, we get the following results for the year 2005:

- The share of health financing with fiscal as origin represents 28.2 %.
- The share of health financing with social contributions as origin represents 22.1%.
- The share of health financing with households' direct payments as origin represents 42.8 %.
- The share of health financing with insurance premium as origin represents 6.9 %.

Table 15. Follow of funds from financing sources to financing agents

Phase of resources mobilization						
Year 2005 (million of TND)						
Financing agents	Financing Sources					Total
	FS. 1.1 State Revenue	FS. 1.2 Funds of public employers	FS.2.1 Funds of private employers	FS.2.2 Funds of Households	FS.3 Funds of the rest of the world	
HF.1.1 MoPH	620.403	9.240	36.96	226.353		892.956
HF.1.2 MoND	7.393			11.351		18.744
HF.1.3 MoILD	1.567			0.300		1.867
HF.1.4 MoS	0.424			0.998		1.422
HF.2.1 NFSS			252.458	73.333	1.376	327.167
HF.2.2 NFSFR		55.487		71.22	0.054	126.761
HF.3.1 Private Insurance		42.000	57.724	17.41		117.134
HF.3.2 Mutual	5.481	5.565	0.138	32.195		43.379
HF.4 Health private Agents				726.585		726.585
Total	635.268	112.292	347.281	1159.745	1.430	2256.015
Share on en %	28.16%	4.98%	15.39%	51.41%	0.06%	100.00

3.2.2. Financing structure of health insurance system

Health insurance is obligatory defined by SSF and by facultative (or complementary) insurance by private insurance and mutual. Health insurance system has received 614,441 million of TND. Table 16 give the structure of health insurance financing which is coming from private employers (50.5%), households (31.6%) and public employers⁷ (16.8 %). State contributes with only 0.1% as subsidies for mutual owned by ministries department.

Table 16. Distribution of health insurance financing (Year 2005)

Financing Agents	Year 2005 (million of TND)					Total
	Financing Sources					
	State Revenue	Public Employers	Private Employers	Households	Rest of the world	
NFSS			289.418	84.373	1.376	375.167
NFRPS		64.727		73.98	0.054	138.761
Private insurance		42.000	57.724	17.41		117.134
Mutual	5.481	5.565	0.138	32.195		43.379
Total	5.481	112.292	347.281	207.959	1.430	674.441
Share on %	0.81%	16.65%	51.49%	30.83%	0.21%	100.00%

- NFSS receives the great share (55.6 %) which is evidently related to the important numbers of its beneficiaries. The financing of NFSS health insurance component is on majority given by private employers (77.1%) while households' contribution is still 22.5%.
- NFSFR receives 20.6 % of total health insurance financing. This financing is obtained from households (53.3 %) and public employers (46.6 %).
- Private health insurance receives 17.4 % of total financing. This financing is obtained from public employers (35.9%), private employers (49.3%) and households (14.9 %).
- Mutual receive only 6.4% of total financing. This financing is obtained from households (74.2%), from State as subsidizes (12.6%) and from public employer's (12.8 %). Private employers share is very lower and estimated to 0.3 %.

⁷ Including State as public employers.

3.3.3. Health expenditure by financing agents and by providers

Table 17 give modalities of providers financing according to the NHA second matrix: follow of funds financing agents to providers. The mention table shows firstly that total estimated amounts of national expenditures on health are 2247.281 million of TND. Expenditures of financing agents affected to health care providers represents 99.6 % of total health financing (see first matrix). A detailed data given on table 13 prove the following results:

3.3.4. Publics Expenditures and Privates Expenditures

Public health expenditures (resources coming from fiscal and social contribution) are estimated to 50.6 % of total health expenditure while private health expenditures (out of pocket and private insurance premium) are estimated to 49.4%. Others results are:

- Fiscal resources represents 55.4% of total public health expenditures while social contribution resources represents 44.6 % ;
- Out of pocket represents 85.7% of total health expenditures;
- Health expenditures per capita are estimated to 226.62 TND. Public health expenditures per capita were 114.405 TND and private health expenditures per capita were 111.657 TND

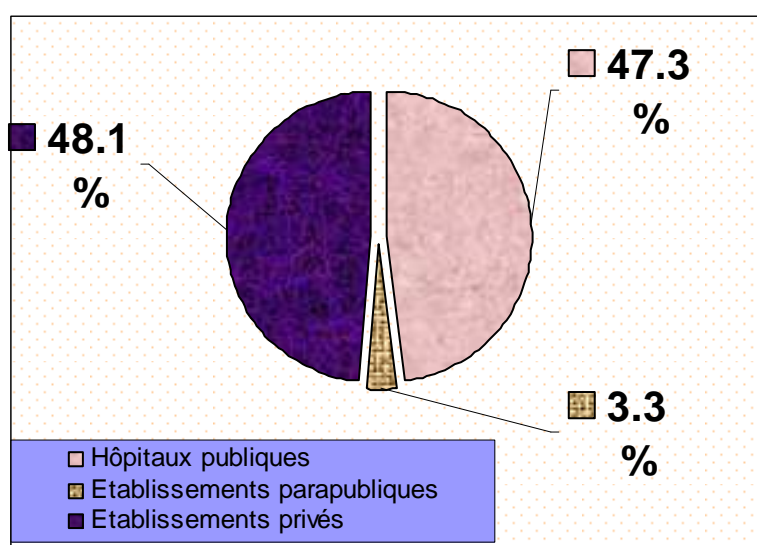
Table 17. Follow of funds financing agents to health care providers

Year 2005 (million of TND)										
Health care Providers	Financing Agents									
	HF.1.1 MoPH	HF.1.2 MoND	HF.1.3 MoILD	HF.1.4 MoS	HF.2.1 NFSS	HF.2.2 NFSFR	HF.3.1 Private Insurance	HF.3.2 Mutual	HF.4 Health private Agents	Total
HP 1.1. Hospital with administrative character	310.008				37.550	14.293			107.359	469.210
HP. 1.2. RH and UHC	173.605				160.568	56.035			66.854	457.061
HP.1.3. Hospitals owned by others ministries		6.708	1.567	0.424	6.486	3.243			2.919	21.348
HP.1.4. Clinics and private offices					53.767	78.232	25.513	10.845	267.581	435.938
HP.3. NFSS Facilities					40.421				11.253	51.675
HP. 4.1. Pharmacies					27.352		61.232	26.028	366.789	481.400
HP. 4..2 Others expenditures					4.102		5.103	2.169	126.094	137.468
HP. 4.3. Sellers and distributors of medical goods					8.536		10.205	4.338	2.937	26.017
HP.6. Administrative fees	67.208				5.746	5.348	12.765			91.067
HP. 8. Rest of the world	0.288				4.048	1.776				6.112
HP. 9. Equipments expenditures	69.300	0.685								69.985
Total	620.409	7.393	1.567	0.424	348.578	158.927	114.818	43.379	951.785	2247.281
Share on %	27.61%	0.33%	0.07%	0.02%	15.51%	7.07%	5.11%	1.93%	42.35%	100.00%

3.3.5. Financing modalities of health care providers

A line lecture of table 17 allows learning about distribution of health expenditures by financing agents and it's more explicitly given by figure 7. Para-public facilities (NFSS and others ministries owned facilities) receive the lesser share 3.3 % while public facilities receive 47.3% and private one 48.1%.

Figure 7. Health expenditures by types of health care providers



3.3.6. Financing modalities of MoPH facilities

Public sector is financed by State budget (58.3 %), SSF (25.3 %) and Households 16.4 %. MoPH Budget is used on central level but also used to salary payment of its functionary and investment at various levels.

Table 18. Financing modalities of MoPH facilities

Public Providers	Financing agents				Total
	MoPH	NFSS	NFSFR	Households	
Public Providers	310.008	37.550	14.293	107.359	469.210
Hospital with administrative character	173.605	160.568	56.035	66.854	457.061
RH and UHC	67.208				67.208
Administrative Fees	69.300				69.3
Equipments expenditures	620.121	198.118	70.328	174.213	1062.779
Total	58.3%	18.6%	6.6%	16.4%	100.0%

3.3.7. Financing modalities of private health care

Private sector is financed by households 70.6% (Table 20). It concerns Households' direct payments from which is deduced complementary insurance refunds. According to NHA results, 48.0 % of total households expenditures on health are undertaken on pharmacies and on private facilities (35.1 %). 15.9 % of private facilities financing is coming from SSF and it's related to particular conventions that including long duration disease (for NFSFR) and labor accidents. The share of complementary insurance on private facilities financing is equal to 13.5%. This kind of health insurance has expenditures realized on private facilities (85%) and pharmacies. Mutual and private insurance use a meadow 60 % of pharmacies devices.

Table 19. Financing modalities of private facilities

Private facilities	NFSS	NFSFR	Private Insurance	Mutual	Households	Total
Clinics and private officials	53.767	78.232	25.513	10.845	267.581	435.938
Pharmacies	27.352		61.232	26.028	366.789	481.400
Others expenditures	4.102		5.103	2.169	126.094	137.468
Sellers and distributors of medical goods	8.536		10.205	4.338	2.937	26.017
Total	93.759	78.232	102.053	43.379	763.401	1080.824
Share on %	8.7%	7.2%	9.4%	4.0%	70.6%	100.0%

Section 4. Synthesis of NHA results

First NHA Matrix (follow of funds from financing sources to financing agents) give a description of resources mobilized to health sector while the second one (follow of funds from financing agents to health care providers) describe the use of funding or distribution of health expenditures by providers. The existing difference between mobilized resources and expenditures of financing agents should be attributed to none used resources, particularly from health insurance entities. Table 20 gives a summary of these values and it also include the rate of annual growth of total health expenditures (2004-2005) and the share of health expenditures on GDP and health expenditures per capita.

Table 20. Health expenditures, share on GDP and health expenditure per capita

	2000	2004	2005
Total financing (Million of TND)	1581.186	2114.176	2256.015
Total health expenditures (Million of TND)	1485.879	2105.936	2247.281
Rate of annual growth of total health expenditures (%)			6.7
Share of total health expenditures on GDP (%)	5.60	5.98	5.97
health expenditures per capita (TND)	155.370	211.844	224.078
Rate of annual growth of health expenditures per capita (%)			5.8

4.1. Health indicators and ratios

According to table 25 that presents ratios of health expenditures, it's easy to find the following results:

- For years 2004 and 2005, total health expenditures is close to 6 % of GDP and to 7.6 % of total expenditures of final public and private consumption (market and no market consumption). Health expenditures share on GDP is on average 7% for OCDE countries in 1990 and 8.9 % in 2004. It's approximate to 10 % on Switzerland and Germany and 15 % in the United States of America which comes in head of OCDE. In countries with similar revenue as Tunisia (MENA region countries), the share of health expenditures on GDP is 5% in Morocco, 12.2 in Lebanon, 9.5 % in Jordan and 6.4 % Iran (Annex 2 give a brief and more detailed international comparison).

- Value added of health services is estimated to 3.3 % of GDP and to 6.2% of total value added obtained by market and no market services of Tunisia economy.
- The share of Public administration expenditures is weakly reduced from 50,9 % in 2004 to 50,6 % in 2005.
- Households' health expenditures have increased from 879.4 million of TND in 2004 to 951.8 million of TND in 2005 dealing with a growth rate equal to 8.2% and an increase of their share on total health expenditures from 41.8% to 42,4 %.
- Households' health expenditures represents 4% of their total expenditure of final consumption while the share of public administration on health represents meadow 20% of their total expenditures on final consumption. Nevertheless, the share of MoPH expenditures represents 9.3% of State operating expenditures in 2005 and 9.9 % in 2004.

Table 21. Indicators and ratios of health expenditures for years 2004 and 2005

	2004	2005	Varying variables (%) for 2005 / 2004
GDP	35193.0	37663.6	7.02
Share of total health expenditures on GDP (%)	5,98	5,97	
Health value added (including pharmaceuticals products)	1154.2	1232.2	6.76
<i>Public Health Value added</i>	562.1	595.8	5.99
<i>Private Health Value added</i>	592.1	636.4	7.49
Total expenditures on final consumption	27600.0	29608.0	7.28
Households expenditures on final consumption	22256.0	23913.0	7.45
Public expenditures on final consumption	5344.0	5695.0	6.57
Total Health Expenditures	2105.9	2247.3	6.71
Public Health Expenditures	1072.2	1137.3	6.07
Private Health Expenditures	1033.8	1110.0	7.37
Including Households' health expenditures	879.4	951.8	8.24
Share of MoPH expenditures on total operating expenditures of State (%)	9.9	9.3	

Health Value added (including pharmaceutical products) as a share of GDP (%)	3.28	3.27	
Share of total health expenditures on total final consumption (%)	7.63	7.59	
Share of Public health expenditures on Total Public consumption of final goods (%)	20.06	19.97	
Total Households' expenditures on Total households' final consumption (%)	3.95	3.98	

4.2. Health financing

Health financing is mainly realized by households, State and employers. Since the year 2000, health financing structure has not changed, however; the share of contributory entities as financing sources has sudden a small changes, like the increased share of public employer and households and the reduced share of State. For instance, the decreased share of State is evaluated to 4.8 points for the period 2000-2004 and 5.5 points for the period 2000-2005 (see table 22).

Table 22. Trends of health financing by sources

Year	State	Public Employers	Private Employers	Households	Rest of the World
2000	33.70	2.70	15.40	48.10	0.10
2004	28.90	4.93	15.23	50.88	0.06
2005	28.16	4.98	15.39	51.41	0.06

Tunisian health system is financed by various entities, so it can be qualified as complex and fragmented which have as consequence many difficult to get a global regulation of health sector and to define a clear health policy. The new implemented reform of health insurance can reduce health financing complexity and contribute to regulate health sector.

- Health insurance financing made by Households is decomposed as follows :
 - Households' social contributions as share of households' health expenditures is respectively estimated to 14.5% in 2000, 12.5 % in 2004 and 2005.
 - Households payments of private insurance and mutual premium as share of their total health expenditures is respectively estimated to

10.1% in 2000, 4.3 % in 2004 and 4.4 % en 2005.

- An Employers social contribution is estimated to 286.381 million of TND in 2000, 428.103 million of TND In 2004 and 459.572 million of TND in 2005. The share of private employers has decreased from 85.5% in 2000 to 75.6 % in 2004 and 2005.
- State financing share have decreased from 33.7% in 2000 to 28.9% in 2004 and to 28.2% in 2005. For these three years, from 97% to 98% of State budget allocated to health was given to MoPH and the remaining is attributed to others ministries.
- The financing share of the rest of the world is usually weak. In 2000, the rest of world is estimated to 1.5% of total health financing while it's less than 1% for 2004 and 2005.
- According to the origin of findings, health financing is described as follows:
 - Public funds:
 - Fiscal Origin : 33.7 % in 2000, 28.9% in 2004 and 28.2 % in 2005
 - Social contributions origin: 21.5% in 2000, 22.5 in 2004 and 22.8 % in 2005.
 - Private funds:
 - Households direct payments (out of pocket): 36.3 % in 2000, 41.6 % in 2004 and 42.3 % in 2005.
 - Facultative health insurance premium (private insurance and mutual): 8.5 % in 2000, 6.9 % in 2004 and 2005.

4.3. Public expenditures and Private expenditures

Health expenditures can be decomposed into public expenditures and private expenditures. The first type is obtained by the sum of State budget and mandatory health insurance. It allows a measure to collectivity efforts to health financing. The second type is obtained by the sum of households' direct payments and facultative insurance premium. Total health expenditures in Tunisia can equally divided into public and private health expenditures. For this purpose, we have a 2% increase on private expenditures for the period 2000 and 2005 (table 23).

Table 23. Trends on public and private expenditures (value on %)

Type of Expenditures		2000	2004	2005
Public Expenditures	State Budget	35,8	28,76	28,03
	Mandatory Health Insurance	17,0	22,14	22,58
	Sub/Total	52,8	50,90	50,61
Private Expenditures	Facultative Health Insurance	8,6	7,33	7,04
	Households' direct payments	38,6	41,76	42,35
	Sub/Total	47,2	49,09	49,39
Total	100,0	100,0	100,0	

4.4. Health Insurance financing

In Tunisia, health insurance is financed by public and private employers and households. The amount of funds dedicated to health insurance system is estimated to 473.398 million of TND in 2000, 629.000 million of TND in 2004 and 674.441 million of TND in 2005. The health insurance financing represents 30% of total health expenditures for the three years. Social contributions of public and private employers is the most important share of health insurance financing, it is evaluated to 60.5 % in 2000, 68.1% i 2004 and 68.0% in 2005 (table 24). Households' contribution is estimated to 39.5% in 2000, 31.0 % in 2004 and 30.8 in 2005).

Table 24. Trends on health insurance financing by sources (value on %)

Year	Public Employers	Private Employers	Households
2000	9.0	51.5	39.5
2004	17.0	51.0	31.0
2005	16,5	51.5	30.8

4.5. Financing Modalities of health care providers

Considering table 25, public providers receive 50.7 % of total health expenditures in 2000. This value has decreased by 3 % for years 2004 and 2005. On the other hand, the share of private provider's expenditures on health expenditures has increased by 5% (from 43.6 % to 48.6 %) between 2000 and 2005. The share of para-public providers has also decreased by 2 %, from 5.3 % in 2000 to 3.3 % in 2004 and 2005. The share of abroad treatment on total health expenditures has been decreased by 0.1 % between 2000 and 2005.

Table 25. Trends of Facilities types share on total health expenditures

Type of providers	2000	2004	2005
Public facilities	753.702	999.120	1062.779
Para-public facilities	79.167	68.625	73.022
Private facilities	647.599	1006.875	1080.824
Abroad treatment	5.410	6.861	5.824
Total	1485.878	2081.481	2222.449

MoPH owned facilities are financed by State, SSF and Households:

- The share of State is equal to 68. % in 2000, 59.1% in 2004 and 58.3 % in 2005 ;
- The share of SSF is equal to 19.9 % in 2000, 24.9 % in 2004 and 25.3 % in 2005 ;
- The share of households is equal to 11.7 % in 2000, 16.0 % in 2004 and 16.4 % in 2005.

Private facilities are financed by households and health insurance entities. Households provide as usually, the great share evaluated to 69.8 % in 2000, 70.0 % in 2004 and 70.6 % in 2005. SSF contribute to finance private facilities: 10.5 % in 2000, 16.0 % in 2004 and 15.9 % in 2005. The share of facultative insurance (private and mutual) is equal to 19.7 % in 2000, 14.0 % in 2004 and 13.5 % in 2005.

Conclusion

NHA results presented in this report give a clear description of Tunisian case on health financing and utilization of resources within the health sector. The first two sections of the report have focused on the conceptual and methodological framework of NHA implementation dealing with the case of the Tunisian health system aspects of NHA for purposes to be applied for Tunisia while the sections three and four present NHA results respectively for the years 2000, 2004 and 2005. NHA framework is done following a strict application of WHO methodology (WHO 2003).

It is necessary to remind that NHA results for the year 2000 have been undertaken from a previous report (see Arfa and Achour 2004) and it was used here for the purpose of making trends of health financing and expenditures. NHA 2000 provides also a referring dataset for NHA results for the years 2004 and 2005. For the years 2004 and 2005, the efforts of data gathering and estimation are therefore undertaken at the beginning of the year 2007 for an approximate period of six months.

The main results obtained are the estimation of total health expenditures using WHO guide: 1581.186 million of TND in 2000, 2105.936 million of TND in 2004 and 2247.281 million of TND in 2005. Very useful other results extracted from NHA matrices are:

- Health financing in Tunisia is initially obtained from obligatory levies (taxes and social contributions) and direct payments of households (out of pocket and health insurance premiums). The share of the first component is evaluated to be 55.2 % in 2000, to 51.5% in 2004 and to 50.3 % in 2005.
- The health expenditure per capita has increased during five years (2000-2005) by 68.780 TND, while for the same period, the health expenditures for medical per person and per year (data from household surveys) has increased only by 41.2 TND (see table 27 reported on annex 3.4).
- The private sector receives the great share (80.9% in 2005) of households' expenditures which is on the majority used to purchasing drugs and ambulatory care.

NHA implementation has allowed estimating health insurance financing and value added of health services for the first time. These results and others are summarized here after:

- Health insurance entities are financed by public and private employers and households. All its funds represent 30 % of total health insurance in 2000 and

27% for years 2004 and 2005.

- Private and public employer's have the great share of health insurance financing. Varying from 60 to 67 %) while household's share have decreased by 7 % for the period 2000-2005. This insurance system is financially fragmented where SSF receive the great share of allocated resources against complementary insurance (mutual and private insurances).
- For the years 2004 and 2005, the health services value added is equal to 3.3 % of Tunisian GDP.

Finally, we should mention that the use of WHO guide to setting up t NHA, we get completed the two first matrix and due to disparities on data published by health entities we didn't obtain the others NHA matrix as required. Nevertheless, the presented results provide certainly some continuity and periodicity on NHA implantation. However, the NHA establishment continues to depend on the recognition of its importance as its importance and its indispensable tools for decision maker. Many efforts should be made from different health actors to collaborate as well as their ability to produce useful and reliable information.

Annexes

Annex 1. Trends of health expenditures indicators (1995-2005)

Indicators	1995	2000	2002	2003	2004	2005
THE / GDP (%)	5.5	5.6	5.8	5.6	5.98	5.97
PuHE / THE (%)	47.20%	52.8%	50	47.5	50.9%	50.6
PrHE / THE (%)	52.8 %	47.2%	50	52.5	49.1%	49.4%
PuHE/ Total public operating expenditures (%)	7.1	6.9	7.6	7.7	9.9%	9.3%
PuHE financed from external sources /THE (%)	0.8%	1.5%	0.2%	0.4%	0.1%	0.06%
Household's Health expenditures / PrHE (%)	85.8%	80.2%	83	82.9	85.1%	85.7%
SSF expenditures on health / PuHE (%)	29.5%	32.1%	22.9	23.5	43.5%	44.6%
PuHE financed from fiscal resources /THE (%)	37,2 %	35.8%	-----	-----	28.8%	28.0%
HE per capita (TND)	119.732	155.370	-----	-----	211.844	226,062
HE per capita on exchange rate (\$ USA)	104.11	114.67	126.00	141.00	172.23	183.79

Annex 2 : International comparison

This second annex is dedicated to international comparison in order to get answers to the following questions, like what is the share of total health expenditures on GDP? What is the share of public and private funds on health system financing? What is the share of tax resources and social contributions used on health financing as part of public resources? Etc. Tunisia is compared firstly to OCDE countries and then to some similar revenue countries (MENA region countries).

For OCDE countries, the growth of health expenditures has increased more than the growth rate of GDP for the period 1990-2004 (**Éco-Santé OCDE 2006**), except Finland. At these countries, health expenditures as part of GDP is on average estimated to 5% in 1970, 7% in 1990 and 8.9 % in 2004. For instance, the share of health expenditure on GDP is 10 % on Switzerland and Germany while United-states of America comes en first dealing with the height percent of health expenditures 14 % on 2004. Today, its value is very restricted for some countries like republic of Slovak (5.7%) and Mexico (6.1%) which similar to Tunisian case (6 % in 2004 and 2005).

On the most of OCDE countries, the essential share of health financing is obtained for fiscal levies sources and in 2004, public financing represent an average of 73 % of

health expenditures. 75% of health expenditures are financed by the State and even on U.S where private sector dominates the health sector public health expenditures is 6% of GDP. Health financing is therefore largely guarantee by public funds on mandatory framework health insurance (universal health insurance) including State intervention on regulation or according a regulation made by State and health insurance entities. Even though the decreased share of public health funds in some countries like, Poland, Hungary and Czech Republic where it was relatively important in 1990, it has increased in others countries like, Korea, Mexico, Switzerland and United States. In Korea, for example, the share of public financing has growth from 38 % in 1990 to 50 % in 2004. In United States, it has increased 40 % to 45 % for the period 1990- 2004, although the private funds continue to have a preponderant role on health financing but public health expenditures per capita health remain more important than the most other OCDE countries because total health expenditures is more important. Household's direct payments on health were an important source of financing for some OCDE countries, especially where private health insurance is less developed. In 2004, the share of household's direct payment was higher for countries like, (51 %), Greece (45 %) and Korea (37 %). Expenditures of private health insurances is on average only 6 % of total health expenses for OCDE countries, but these insurances entities have an important role for some population groups in Germany, Netherlands, and not aged population in US where it cover 37 % in 2004 of total health expenditures. In France and Canada, the private insurances cover a meadows 10 to 15 % of total health expenditures, bringing a complementary schema of the available universal health insurance system.

Health care expenditures have strongly increased since 50 years on OCDE countries. This phenomenon of constant and generalized expenditures rising for all OCDE countries has generated with acuteness the problem of health system financing. Despite the health care expenditures rising, the share of public funds on health financing remains always important. If current trends will continue, governments should increase fiscal or social contributions levies and as consequence others expenditures for others sectors will decreased or it will necessary to increase patient payments for health consumption.

Table 26. Health expenditures for OCDE countries and others countries with low revenue (2001)

Countries	Public Health expenditures / Total health expenditures (%)	Private Health expenditures / Total health expenditures (%)
Germany	74.9	25.2
France	76	24
South Korea	44.4	55.6
Unite States	44.4	55.6
Mexico	44.3	55.7
Tunisia	51.0	49.0
Lebanon	28.1	71.9

Source: WHO (2004)

Compared to similar revenue level, the total health expenditures as share of GDP in Tunisia is weak, except for Morocco which have a ratio equal to 5%. The same ratio is very high on Lebanon (12.2%) and 9.5 % in Jordan and 6.4 % in Iran. In addition, in country with average revenue⁸, private expenditures as part of total health expenditures is equal to 58% (varying from 38 to 70 %). The high rate of household's direct expenditures is due to great value of co-payment (moderated ticket) used by private and public insurances.

Annex 3. Sub-accounts analysis of NHA

A.3. 1. NFSS

Receipts		NFSS 2004		Expenditures	
Social Contributions				Health services	
Private employers	230.903			Public Health facilities	179.779
Households	67.083			Private Health facilities	6.177
Funds to public treasure	48.000			Para-public Health facilities	88.655
Transfer from exterior	1.31			Policlinic of the NFSS	37.777
				Management fees	5.224
				Transfer to exterior	4.418
				Surplus	25.266
		347.296			347.296

⁸ According to the regional cutting realized by WHO / MENA region countries with average revenue are: Djibouti, Egypt, Iran, Iraq, Jordan, Morocco, Arabic Republic of Syrian and Tunisia.

NFSS 2005			
Receipts		Expenditures	
Social Contributions		Health services	
Private employers	252.458	Public Health facilities	198.118
Households	73.333	Private Health facilities	93.759
Funds to public treasure	48.000	Para-public Health facilities	6.486
Transfer from exterior	1.376	Policlinic of the NFSS	40.421
		Management fees	5.746
		Transfer to exterior	4.048
		Surplus	26.589
375.167		375.167	

A.3. 2. NFSFR

NFSFR 2004			
Receipts		Expenditures	
Social Contributions		Health services	
Public employers	50.42	Public Health facilities	61.328
Households	67.897	Private Health facilities	72.487
Funds to public treasure	12.000	Para-public Health facilities	3.089
Transfer from exterior	0.049	Management fees	4.974
		Transfer to exterior	2.443
		Deficit	-13.955
130.366		130.366	

NFSFR 2005			
Receipts		Expenditures	
Social Contributions		Health services	
Public employers	55.487	Public Health facilities	70.328
Households	71.220	Private Health facilities	78.232
Funds to public treasure	12.000	Para-public Health facilities	3.243
Transfer from exterior	0.054	Management fees	5.348
		Transfer to exterior	1.776
		Deficit	-20.166
138.761		138.761	

Expenditures of NFSPS by health functions

	Expenditures categories	Year 2005	Year 2005
Mandatory regime	MoPH Facilities Billing	64.034	73.1994
	Long duration sicknesses	25.108	29.1853
	Devices of functional Rehabilitation	3.779	4.6466
	Surgical Operations	2.501	2.4575
	Particular conventions with private facilities	12.931	13.0017
	Abroad cares	2.443	1.7765
	Thermal cures	0.383	0.3718
	Renal Dialyses	19.041	20.1226
	Others health services	1.657	1.7918
Facultative regime		9.127	8.8169
	Total	141.004	155.370

A.3. 3. Ministry of Public Health

Year 2004			
Receipts		Expenditures	
State Subsidy	597.200	Personal Remuneration	482.200
Contributions of SSF	219.500	Central Administration	6.000
Households (Receipts of MoPH Facilities)	137.200	Equipment	73.800
		A.N.C.S.E.P	0.865
		C.I.M.S.P	2.300
		O.N.F.P	19.700
		E.P.S	191.700
		E.P.A	175.500
		Others expenditures	1.800
	953.900		953.865

Year 2005			
Receipts		Expenditures	
State Subsidy	621.000	Personal Remuneration	506.600
Contributions of SSF	246.500	Central Administration	6.100
Households (Receipts of MoPH Facilities)	138.500	Equipment	81.000
		A.N.C.S.E.P	0.930
		C.I.M.S.P	2.500
		O.N.F.P	20.000
		E.P.S	202.500
		E.P.A	184.500
		Others expenditures	1.800
	1006.00		1005.930

A.3. 4. Households' Health expenditures

According to national surveys of household's consumption, budget and standard of living (National Institute of Statistics), health expenditures have the most rapidly progressed then others categories of household's expenditures. Its share has doubled for the period 1975-2005 going from 5.4% to 10.3% of total expenditures. An illustrative data is available for the survey year 2000. For instance according to income, it is 4% for the most modest households that have an income inferior to 600 TND per month and approximate equal to 6% for households that have revenue varying from 1200 to 2400 TND per month.

Table 27. Structure of Household's (1975-2005)

Functions	1975	1980	1985	1990	1995	2000	2005
Feeding	41,7	41,7	39,0	40,0	37,7	38,0	34.8
Habitation	27,9	29	27,7	22	22,2	21,5	22.8
Clothing	8,8	8,5	6,0	10,2	11,9	11,1	8.8
Hygiene and cares	5,4	5,7	7,0	8,7	9,6	10,0	10.3
Transportation and telecommunication	4,7	4,9	9,0	8,2	8,7	9,7	14.4
Teaching, culture & leisure	8,0	7,7	8,9	8,5	8,9	8,7	8.4
Other expenses	3,5	2,5	2,4	2,4	1,0	1,0	0.5
Total	100	100	100	100	100	100	100

Source: Series of National Household's Surveys (NIS)

Table 29 gives trends of annual health expenditure per person for health care according to all households' surveys. This health expenditure (current dinars) have been multiplied by 25 for the period 1975-2005 : from 4.4 TND to 112.1 TND.

Table 28. Annual health expenditures per person (current TND)

Year of the survey	1975	1980	1985	1990	1995	2000	2005
Annual expenditures per person	4.4	8.2	14.4	33.5	49.5	70.9	112.1

Source: Series of National Household's Surveys (INS)

- Household's expenditures according to the type of health facilities ownership
- According to household's survey data, (table 30), private sector generate the most important share of household's expenditures which is equal to 87.3% in 2000 and

82.5 in 2005. It can be explained by subsidies allowed to health care supplied on public and para-public facilities.

Table 29. Distribution of household's expenditures according to the ownership type of the health facilities (%)

Type of ownership	2 000	2 004	2 005
Public	18.60%	18.80%	17.30%
Private	78.80%	79.30%	80.90%
Para-public	2.60%	1.90%	1.80%
Total	100.00%	100.00%	100.00%

- Household's expenditures categories

Household's health expenditures represents for the year 2005, 60 % of total hygiene and cares category where 56 % of these expenditures is used on purchasing medical cares and 44 % to pharmaceuticals products and medical devices.

Table 30. Modalities of Household's health expenditures (2000 and 2005, current TND)

Year	2000		2005	
	Amount	Share (%)	Amount	Share (%)
Running Medical cares	15.5	21.9%	30.3	27.0%
Exceptional medical cares	21.0	29.6%	32.1	28.6%
Pharmaceuticals products	33,3	47.0%	48.0	42.8%
Medical devices	1.1	1.6%	1.7	1.5%
Total	70,9	100.0%	112.1	100.0%

Source: National Institute of Statistics (2005)

Direct payments on private facilities are equal to 80.9% in 2005 of total health expenditures (800 million of TND) which approximately four times more than expenditures realized on others facilities. For the private sector, expenditures on drugs are the most important category of expenditures with 47% in 2000 and 42.8% in 2005. On the other hand, inpatient (hospitalization) and outpatient (ambulatory care) are respectively 7.9 % and 13.9% for the year 2000 which different from modalities of expenditures on others facilities.

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