Développement du système de santé

Quelques considérations internationales

Dr Denis Porignon
OMS, Genève

"La couverture universelle est la plus puissante idée que la santé publique ait à nous offrir."
Margaret Chan, Directrice Générale de l'OMS - Mai 2012

Les grandes orientations

- Depuis quelques années, un accent a été mis sur les valeurs d'équité, de solidarité, de participation
- Rapport de la Commission dur les Déterminants sociaux de la Santé (2008) qu'il subsiste des **inégalités** souvent importantes **entre les pays** et **au sein des pays** entre les plus riches et les plus pauvres,
  - en matière d'accès aux soins de santé de qualité,
  - en matière d'utilisation des services,
  - en matière de couverture et
  - en matière de bénéfices pour la santé.

Les grandes orientations

- Au niveau international des orientation ont été prises pour être appliquées dans différents contextes

WHA64.9

Sustainable health financing structures and universal coverage[1]

The Sixty-fourth World Health Assembly,

Having considered the reports on health system strengthening;[2]

Having also considered *The world health re...* International Ministerial Conference on ... (Berlin, November 2010);

A/67/L.36

Nations Unies

Assemblée générale

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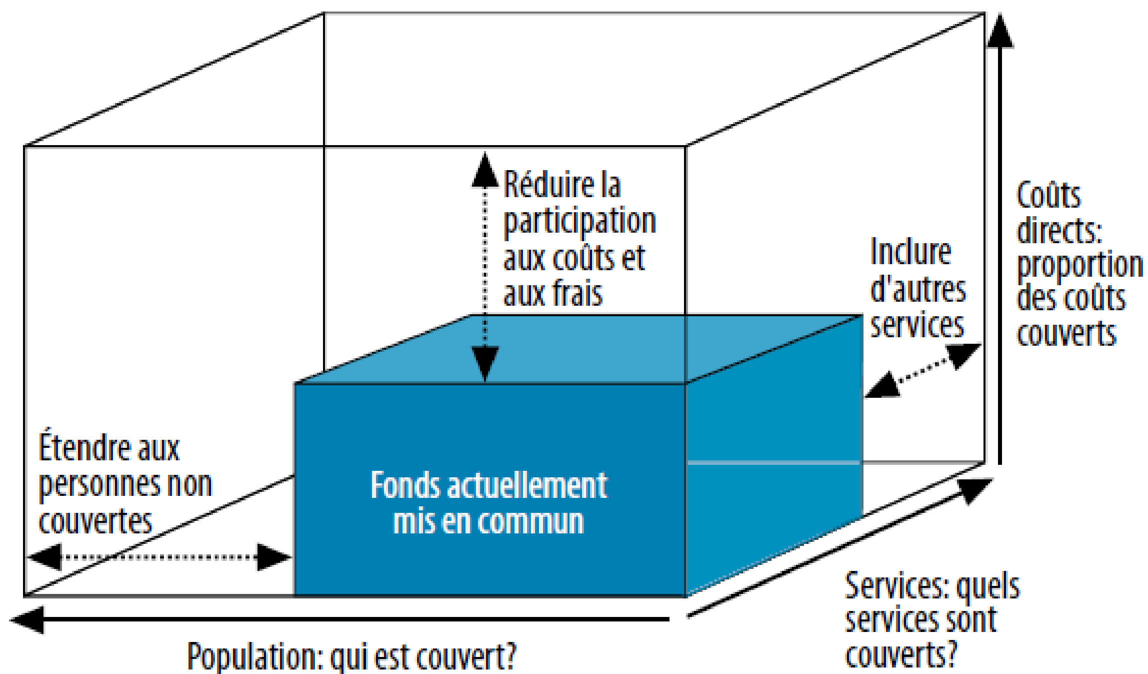
- La ***couverture universelle*** fait partie de ces orientations. Cette dernière a fait l'objet d'un consensus général :
  1. Résolutions AMS 2005 & 2011 et
  2. Résolution AG des NU 2012
  3. Agenda post-2015

Vous avez dit couverture universelle ?

- La couverture universelle renvoie à la notion d'accès pour **chaque individu** qui qu'il ou elle soit à des **soins de qualité** sans que cela le/la pousse dans des **difficultés financières**
- 3 dimensions



Vous avez dit couverture universelle ?

- Les pays de tous revenus se fixent des objectifs en matière de couverture universelle et de renforcement des systèmes de santé

- En Europe, environ 10 % du GDP va au secteur des soins de santé. En Tunisie, les montants disponibles sont inférieurs [6%], nécessité accrue d'une vision à long terme avec des engagements gouvernementaux structurés **[choix suffisamment forts pour induire un changement]**

Country (PIB/Hab)	Mexique (9.750 USD)	Rwanda (700 USD)	Thaïlande (5.500 USD)	Brésil (11.350 USD)	Ghana (1.600 USD)
Reforme	2003 - Un système d'assurance sur financement public et destiné aux pauvres et au secteur informel visant à réduire les disparités avec le secteur formel	2003 - Système d'assurance à base communautaire subsidié, intégré dans un réseau national	2001 – système couvrant ceux non assurés par les mécanismes formels	1990 - Systèmes et des services financés par le secteur public et opéré au niveau municipal	2004 - Combinaison d'un système à base communautaire et avec le système national de sécurité sociale
Bénéfices et financement	Couvre 95 % des hospitalisations Transferts du budget gouvernemental	Paquet d'activités couvertes défini au niveau national + variations locales. Centrés sur les soins primaires Transferts (taxes+ aide internationale)	Paquet large d'activités couvertes Différentes formes d'achat de soins	3 niveaux de soins couverts Pooling de différentes sources gouvern. au niveau des municipalités	Paquet d'activités couvertes (95% des problèmes de santé) Recettes TVA, primes limitées, ponction salaires

Qu'est-ce que cela implique ?

- Des outils indispensables: un document de politique sanitaire nationale qui donne la vision et un plan de développement sanitaire qui explique:
  - ce que l'on veut atteindre,
  - ce que l'on va faire pour cela et
  - en mobilisant quelles ressources

- La définition d'un paquet d'activités couvertes

- Un cadre organisationnel du ministère de la Santé qui soutient la réforme (Tchad, RDC, Moldavie, ...)

Qu'est-ce que cela implique ?

- Il faut laisser le temps au temps…

… mais 10 ou 15 ans peuvent être suffisants [**exemple du Rwanda, du Brésil, de la Turquie, de la France,…**]

- Obtenir une couverture universelle se fait de **manière progressive** selon les dimensions envisagées: on ne va pas couvrir tous les besoins dès le premier jour, pour tous,… il appartient aux participants au débat national de discuter les choix par rapport à cette progressivité

En Turquie, …

L'exemple turque...

The history...

Panel 2: Towards universal health coverage: key developments in the HTP, 2002–12

- 2002: Justice and Development Party includes "improving access to health services" (urgent action plan) in its election platform.
- 2002: Justice and Development Party is elected with a strong parliamentary majority in the Grand National Assembly.
- 2002: Ministry of Health Decree (on the first day of the new government) to eliminate involuntary incarceration in hospitals of patients who cannot meet health-care expenses. The decree forbids hospitals from withholding the bodies of deceased patients when families are unable to meet hospital expenses.
- 2003: The Health Transformation Program (HTP) is designed, building on work done in the previous decade, including elements of the Basic Health Law. Implementation of the HTP begins.
- 2003: Introduction of higher salaries and performance incentives for hospital clinicians to encourage voluntary transition from dual practice to full-time working. Major expansion of the voluntary transition in 2005.
- 2003–04: Active and retired civil servants are allowed to use private hospitals. Ambulance services declared free.
- 2003–04: Green Card benefits expanded to include outpatient benefits and pharmaceuticals. Conditional cash transfers were introduced, covering 6% of the population (for pregnant women and children from the most disadvantaged households), to encourage use of maternal, neonatal, and child health services.
- 2004: Contract-based employment introduced for health-care personnel in rural and less developed regions. Performance-based payments piloted in ten Ministry of Health hospitals.
- 2004: Major changes in pharmaceutical policy, including changes to pricing and to value-added tax. International reference price system introduced, replacing the cost-plus model to reduce the price of drugs.
- 2004: Patient Rights Directive introduced in 2003 is implemented. Patient Rights Units established in hospitals. Electronic systems for patient complaints and suggestions introduced.
- 2004: User choice of health-care providers (hospitals, primary care centres, and physicians) introduced.
- 2005: Hospitals belonging to the Social Insurance Organisation (146 hospitals) integrated with Ministry of Health hospitals. The total number of hospitals managed by the Ministry of Health reached 840 in 2011.
- 2005: Contract-based family medicine with ...mance-based contracting piloted in Düzce province.
- 2006: Universal health insurance is legally adopted as a part of broader social security reforms. Health expenditures start to grow and global budgets (budget ceilings) are introduced for Ministry of Health facilities to moderate growth in services to address unmet need.
- 2006–10: Contract-based family medicine scaled up in all 81 provinces of Turkey.
- 2007: Cost-sharing for primary health-care services abolished. Primary health care available for all citizens free at the point of delivery.
- 2008: Social Security Institution established as a single organisation for financial pooling and purchasing. The Social Insurance Organisation, Bağ-Kur, and the General Employees Retirement Fund join the Social Security Institution.
- 2008: Free availability of emergency services and intensive care services (including neonatal intensive care) for the whole population extended from public hospitals to all hospitals, including private hospitals with and without Social Security Institution contracts.
- 2008: National air ambulance service introduced and is available to the whole population free of charge. Major expansion in 2010.
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- 2010: The Ministry of Health strategic plan for 2010–14 developed.
- 2010–11: Taxes for cigarettes and alcohol raised.
- 2010–12: Laws on Hospital Autonomy and Restructuring the Ministry of Health for a stronger stewardship function are adopted. Public Hospital Authority and Public Health Institution established; Law on Full-Time Practice of University and Health Personnel and Amendments is adopted, paving the way for full-time practice in legal terms.
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The fiscal space created by sustained economic growth in Turkey enabled the government to substantially increase health expenditures. From 2003, total health expenditures as a proportion of GDP increased from 5·3% to reach 6·1% in 2008, with almost three-quarters of this amount coming from the public sector. Private sector investment in the health sector also rose.

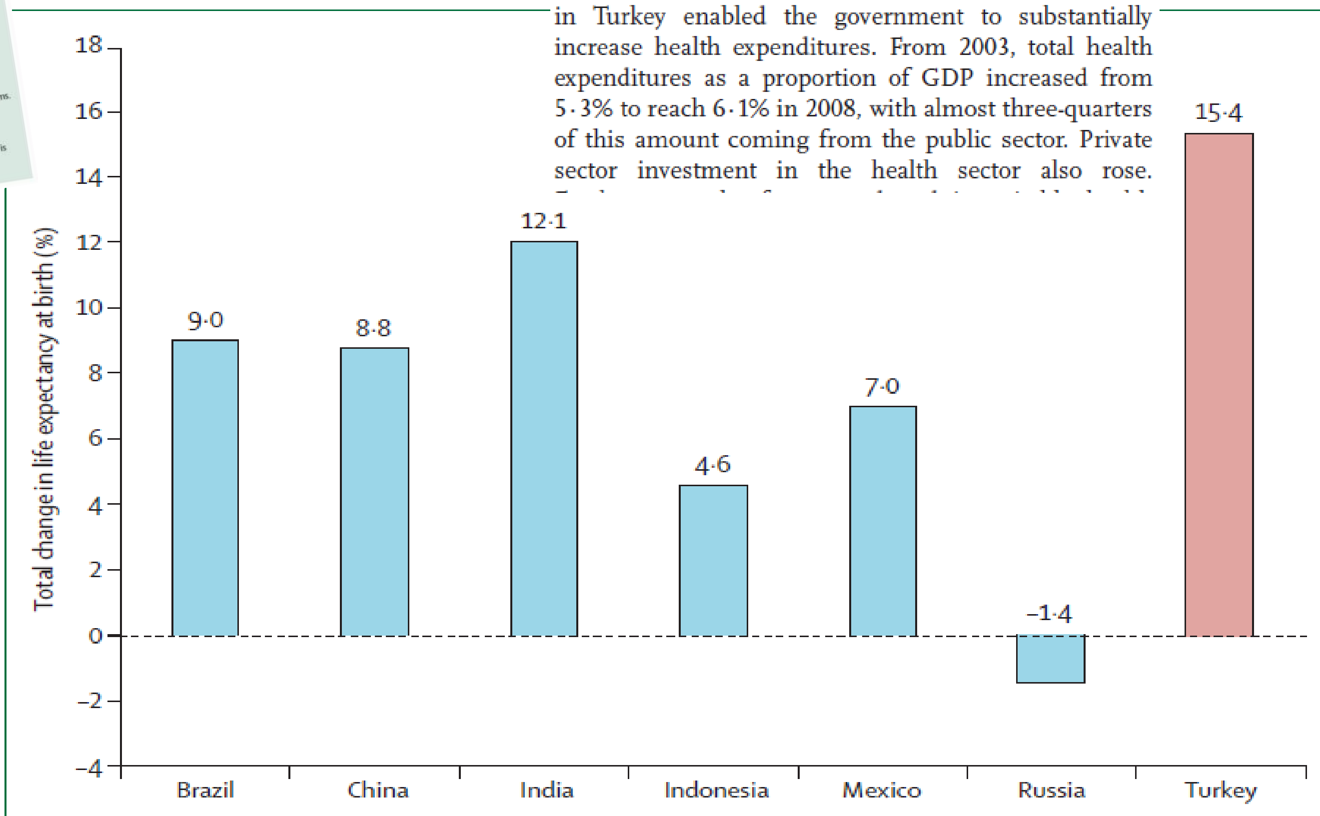


Figure 3: Percentage change in life expectancy at birth (years) in Brazil, China, India, Indonesia, Mexico, Russia, and Turkey, 1990–2009
Data are from reference 14.

The findings from the controlled before and after study undertaken as part of this study (appendix pp 2–13), which explored services provided by primary health-care physicians before (phase 1) and after (phase 2) the introduction of the new family medicine model, showed substantial improvements in the availability of key maternal and child health services after the introduction of the model. The immunisation services provided on a daily basis by the primary care physicians surveyed increased from 60·6% in phase 1 to 91·4% in phase 2.

Source: Atun R *et al*, The Lancet (2013) 382 65-99

Vision

A TURKEY where healthy lifestyles are embraced and everyone can easily exercise their right to health

Mission

To maximise the protection of individual and community health with a human-centred approach and to offer timely, appropriate and effective solutions to health problems

Ultimate Goal:

To protect and improve the health of our people in an equitable manner

Strategic Goal 1

To protect the individual and the community from health risks and foster healthy life styles

Strategic Goal 2

To provide accessible, appropriate, effective, and efficient health services to individuals and the community

Strategic Goal 3

To respond to the health needs and expectations of individuals based on a human-centred and holistic approach

Strategic Goal 4

To continue to develop the health system as a means to contributing to the economic and social development of Turkey and to global health

L'exemple turque...

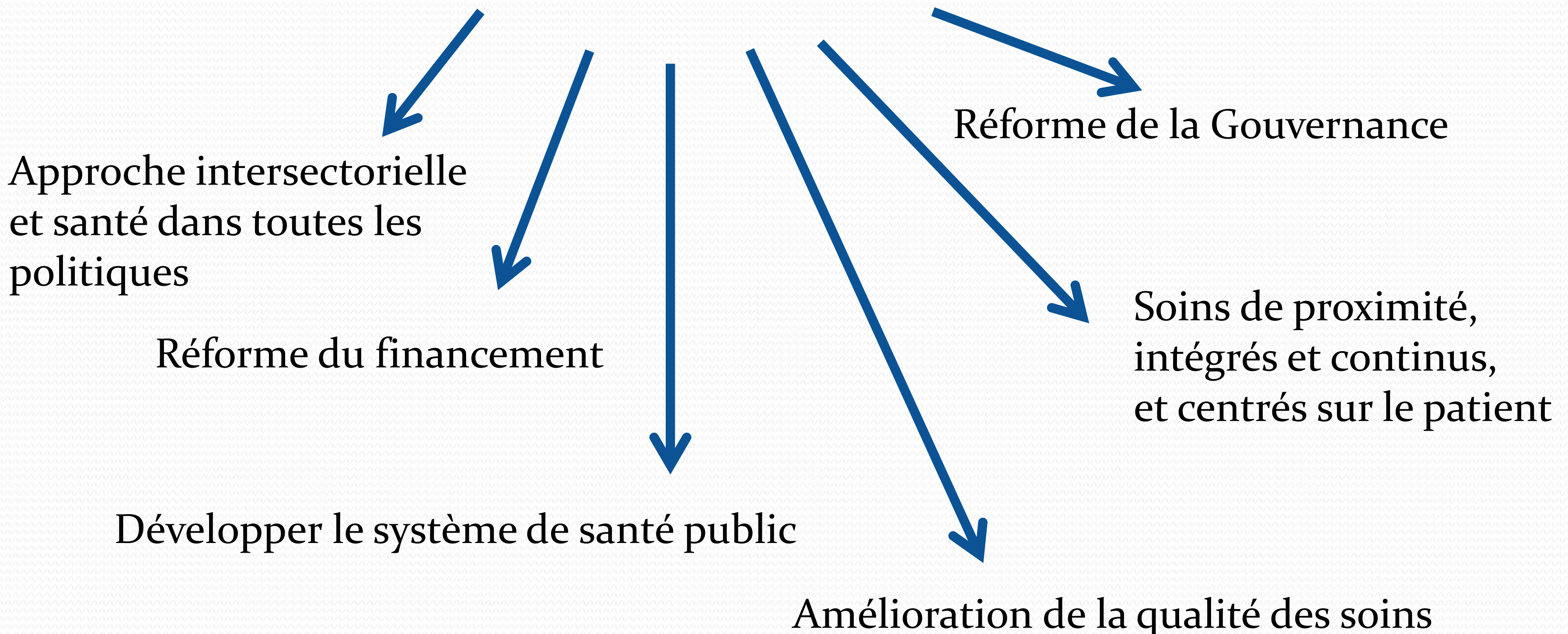
Qu'est-ce que cela implique ?

- Un dénominateur commun : la volonté politique -> leadership [**inclusion dans le programmes des partis politiques, choix sur les orientations politiques, allocation des ressources conséquentes, capacité d'implication des parties prenantes…**]

- Des principes pour renforcer la rationalisation de l'utilisation des ressources: équité, approche intégrée centrée sur le patient, accent sur les soins primaires, gouvernance,… **de l'idée au changement réel**

Vos 1ères grandes orientations…

Beaucoup de ces notions sont déjà présentes dans le Livre blanc : les chantiers



Conclusions

- La réforme est faisable, les premières bases en sont jetées…
- Des progrès rapides sont à portée de main… car la Tunisie a des atouts (histoire, expertise, ressources), et est engagée dans un **processus** de dialogue fructueux

Merci !

Country-Specific Pathways to UHC

There is no one-size-fits-all approach. Countries are taking different pathways:

Country (GDP/capita)	MEXICO ($9,741)	RWANDA ($619)	THAILAND ($5,473)	BRAZIL ($11,339)	GHANA ($1,604)
Reform	**2003: Seguro Popular.** Publicly funded "insurance" system for poor and informal sector, to reduce disparities with social security in formal sector.	**2003: Mutuelle de Santé.** Heavily subsidized community-based health insurance system integrated into a national network combining local accountability with national pooling and cross-subsidization.	**2001: Universal Coverage Scheme.** Newest and largest scheme covering everyone not included in the two schemes for formal sector workers.	**1988: Unified Health System (SUS).** Publicly-funded services run at the municipal level.	**2004: National Health Insurance Scheme.** National network of community-based insurance schemes combined with national social-security (formal sector) insurance scheme.
Financing & Benefits Covered	Government budget transfers. Original idea of enrollee premium tied to income largely dropped. Package covers 95% of causes for hospital admission.	Budget transfers (from tax revenues and donor aid) combined with sliding scale member contributions. National benefits plan with some scope for variation by each Mutuelle branch; must at least cover all services/drugs at health centers.	Solely general government revenues. Strong incentives for efficiency through various forms of active purchasing, global budgets and provider payment. Comprehensive benefits, includes both curative and preventive care; recently added HIV treatment.	General federal government revenues pooled at municipal level. Comprehensive benefits, divided into three tiers: basic, specialized and high complexity.	General tax revenue, mainly 2.5% levy on VAT, combined with payroll tax of social security beneficiaries (formal sector) and limited premium contributions from beneficiaries (except most vulnerable). National pool with fee-for-service payment to fund a benefits package that covers 95% of reported health problems.

Detailed profiles at jointlearningnetwork.org

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- La participation pas seulement pour contribuer au financement mais également pour définir ce qui sera couvert