Health services in Tunisia in the light of World Trade Organization agreements

Hédi Achouri[1] *and Noureddine Achour*[2]

Tunisia's health system

Tunisia's health system is dominated by the public sector, in terms of both the health services infrastructure, consisting essentially of hospitals, and financing. In this public health sector infrastructure, the bed:population ratio has held relatively constant at about 2 beds per 1,000 inhabitants; 90% of these beds are found in public health facilities throughout the territory (Table 1).

Beyond this hospital infrastructure, there is a number of primary health care centers developed under the Health for All policy to meet the primary health care needs of the population (Table 2). Their number has increased steadily from 1,294 centers in 1987 to 1,841 centers in 1997, and 1,922 centers in 1998. This has made it possible to guarantee coverage of approximately one primary health care center for every 4,886 inhabitants.

Table 1. Public hospital infrastructure in Tunisia, 1989-1998

Hospitals	1989	1992	1996	1998
University hospitals				
Number	22	21	20	22
Beds	7,723	7,659	7,752	7,987
Regional hospitals				
Number	24	24	29	31
Beds	5,020	5,360	5,578	5,379
District hospitals				
Number	98	109	111	105
Beds	2,664	2,793	2,640	2,647

[1] Director, *Tutelle des Hôpitaux,* Ministry of Health, 1030 Tunis, Tunisia.

[2] Director, National Institute of Public Health, Ministry of Health, Tunisia.

Other than this health services infrastructure, since its independence, Tunisia has developed facilities for training health professionals in all categories (see Table 2). Except for the professional schools of public health, all training facilities are under the combined supervision of the Ministry of Higher Education and the Ministry of Public Health.

Table 2. Public infrastructure for the training of health professionals in Tunisia, 1987 and 1998

Training centers	1987	1998
Schools of medicine	4	4
Schools of pharmacy	1	1
Schools of dentistry	1	1
State schools for health science and technology	0	3
Schools for training health professionals	21	19

Human resources in the public health sector are indicated in Table 3. In 1998, physicians in general practice represented 55% of all physicians practicing in Tunisia, and paramedical personnel, 98% of all other human health resources.

Table 3. Human resources in the health sector, Tunisia, 1997 and 1998

Human Resources	**1997**	**1998**
Physicians:		
General practitioners	1,826	2,022
Specialists	1,660	1,735
Total	**3,486**	**3,757**
Pharmacists	281	294
Dentists	399	342
Paramedical personnel	26,369	26,676

Health sector infrastructure in Tunisia (private sector)

The private sector has always existed alongside the public sector. Its infrastructure has developed relatively rapidly in the past decade, especially its hospital component. Nevertheless, it should be noted that private hospitals represent only one tenth of the country's total hospital capacity and that the number of paramedical personnel in private practice is relatively low, constituting barely 2% of the total paramedical personnel (Tables 4 and 5).

Financing of health expenditures

Health expenditures quintupled in current dinars (D) between 1985 and 1998, soaring from D249 million to 1,255 million (Table 6). In terms of financing, there has been a decrease in the share financed by the State and an increase in that financed by social security. However, the proportion of public expenditure declined, falling from around 66% in 1985 to 52% in 1998. Out-of-pocket household expenditure rose, increasing from 34% in 1985 to 47% in 1998. Here it should be noted that the private and mutual insurance systems contribute very little to the coverage of health expenditures, and its share is included in the household expenses data found in Table 6.

COMMERCIAL PRESENCE IN THE COUNTRY

Foreign physicians practicing in Tunisia's public sector

Current regulations state that only Tunisian citizens can practice medicine

Table 4. Clinics, physicians, dentists, and pharmacists practicing in the private sector, Tunisia, by year

Private sector	1987	1992	1997	1998
Clinics				
Number	28	43	57	65
Beds	956	1,638	1,894	1,944
Hemodialysis centers				
Number	13	27	68	81
Machines	168	300	695	815
Physicians in private practice				
General practitioners	852	1,092	1,509	1,526
Specialists	522	1,016	1,469	1,507
Total	1,374	2,108	2,978	3,033
Radiology facilities		60	90	95
Dentists in private practice	495	684	801	808
Paramedical personnel	195	372	473	567
Pharmacy laboratory	947	1,087	1,292	1,329
Wholesale distributors of supplies	27		45	46
Diagnostic laboratories	53	120	154	156

Table 5. Paramedical personnel in private practice, Tunisia, 1998

Personnel	1998
Nurses	237
Opticians	132
Physical therapists	72
Midwives	28
Dental prosthetics technicians	12
Hearing aid technicians	8
Speech/language therapists	8
Orthoptists	6
Others	64
Total	567

in their country. There are, however, two exceptions to that rule: foreign physicians recruited by the Ministry of Public Health to meet needs in public health facilities that cannot be met by Tunisian nationals and private physicians married to Tunisians.

Public sector use of foreign physicians is currently limited to specialists, although general practitioners were also employed up to the mid-1980s. Foreign specialists practicing medicine in public health facilities represented 16% of all specialists in 1995 and 14% in 1998. These specialists, mainly from Eastern Europe, practice in the areas of surgery, gynecology, and anesthesiology and resuscitation, and accounted for 50% of foreign physicians in 1998.

Foreign specialists are concentrated in the western regions of the country, where needs cannot be met with Tunisian professionals due to lack of personnel or unwillingness to reside there. Table 7 indicates the number of foreign specialists practicing in Tunisia in 1995 and 1998, with a breakdown by specialty.

Table 6. Total health expenditure and financing, Tunisia, by year

	1985	1990	1995	1996	1997	1998
Total health expenditure (millions of dinars)	249.0	577.7	935.7	1,023.0	1,141.5	1,255.1
State	50.3%	38.4%	37.3%	37.2%	34.9%	34.4%
Social security	15.3%	14.7%	15.5%	15.0%	16.9%	17.2%
Households	34.4%	46.9%	47.2%	47.8%	48.2%	47.4%

Foreign physicians practicing in Tunisia's private sector

The number of foreign physicians in private practice is relatively low, according to the census taken in September1999. No more than 111, or 1.63% of the 6,790 physicians practicing in Tunisia, —or 3.66% of those in the private sector (3,033 at that time), —were foreign-born.

Among foreign physicians, 51 practice in the District of Tunis, capital of Tunisia (46%); 21 of them are specialists (55%), and 30 are general practitioners (41%). Of the specialists, 15 are obstetricians/gynecologists (75%).

Foreign paramedical personnel

According to the legislation and regulations in force, foreign paramedics can practice in Tunisia if their credentials are equivalent to a Tunisian diploma. In any case, authorization to practice is subject to the decision of the Minister of Public Health.[3]

To date, no request for authorization by foreign paramedical personnel has been filed with the services of the Ministry of Public Health. Paramedical personnel in the public sector are virtually one hundred percent Tunisian—with some rare exceptions

Table 7. Foreign medical specialists practicing in the public health services of Tunisia, 1995 and 1998

Medical specialty	1995		1998	
	No.	%	No.	%
General surgery	46	21	49	20
Obstetrics and gynecology	41	18	45	19
Anesthesiology/Resuscitation	…	…	27	11
Ophthalmology	21	9	23	9
Pediatrics	14	6	16	7
Otolaryngology	12	5	17	7
Orthopedics	10	4	18	7
Other	80	36	48	20
Total	224	100	243	100

[3] Law 92-74 of 3 August 1992, on the conditions of private practice in the liberal professions.

of individuals recruited on a contract basis owing to social considerations.

Tunisian health professionals practicing abroad

There is high demand for Tunisian health workers in certain countries, especially in the Persian Gulf, where they numbered 2,500 just prior to the Gulf War. At the end of 1998, personnel sent to different countries to provide technical cooperation numbered 1,725 in total and consisted almost entirely of paramedical personnel. Table 8 shows the distribution of Tunisians practicing abroad, by host country, at the end of 1998.

Table 8. Tunisian health professionals practicing abroad in 1998, by host country

Host country	Number	%
Saudi Arabia	1,340	77.7%
Sultanate of Oman	18	1.0%
Qatar	105	6.1%
United Arab Emirates	109	6.3%
Kuwait	38	2.2%
Libya	18	1.0%
Bahrein	1	0.1%
France	1	0.1%
Austria	84	4.9%
Belgium	1	0.1%
Italy	2	0.1%
Sweden	1	0.1%
Germany	1	0.1%
Canada	6	0.3%
Total	1,725	100.0%

Clinics with mixed capital

All the capital in private health facilities is held by Tunisian nationals, with the exception of a clinic in Tunis with a very small share of foreign capital. However, a large off-shore clinic project financed completely with French capital will be carried out in Tunisia to offer state-of-the-art services in the fields of cardiology, pediatric and adult cardiovascular surgery, orthopedics, neurosurgery, reconstructive surgery, and oncology. Its potential clientele will come from the Maghreb and Egypt.

TELEMEDICINE

Telemedicine has been developed essentially in the public sector; to our knowledge, no such services are currently available in the private sector. In the public sector, it is expected to make up for the shortfall in specialized human resources in certain hospital facilities. The regional hospitals, in particular, can tap into university resources or distant exchanges between university hospitals for complex cases that require consultations with several specialists. Telemedicine and teleconferencing services between countries have also been developed, especially teleconferencing between Tunisian university hospitals and their counterparts abroad, notably France.

Completed projects

There have been teleradiology projects completed between the Children's Hospital in Tunis and the La Timone Hospital in Marseilles, and also between the Charles Nicolle Hospital in Tunis and the Regional Hospital in Kef.

Pathology projects have included the telepathology project between Farhat Hached Hospital in Sousse and French hospitals, with an exchange of microscopic images through a videoconferencing station, and the formation of a telestaff and teleconferencing network between three Tunisian cancer centers (the Salah

Azaïez Institute in Tunis, the Farhat Hached Hospital in Sousse, and the Habib Bourguiba Hospital in Sfax) and the Antoine Lacassagne Center in Nice. This Center in Nice is connected to the videoconferencing network and links 20 French cancer centers, a network set up by the French Cancer Federation (FNLCC).

Projects in progress

There were several teleradiology projects in progress in 1999:

- the project between the orthopedic institute in Ksar Saïd and the regional hospital in Gaïsa links the scanner of Gaïsa Hospital to the diagnostic imaging service of the orthopedic institute in Ksar Saïd;
- the project between the Mongi Slim Hospital in Marsa and the Neurology Institute in Tunis allows consultations on urgent neuro-surgical cases through teleradiology and teleconferencing; and
- the Project GALENOS, acronym for "general advanced low-cost trans-European over satellite", located in La Rabta Hospital in Tunis, aims to develop a trans-European communications satellite network capable of supporting various collaborative services and applications. Eight countries are involved in this project: France, Italy, Germany, Romania, Bulgaria, Austria, Greece, and Tunisia. In this project, it will be necessary to add a permanent national component and a teleradiology link between the hospital in La Rabta and a regional hospital in the country's interior, which would be the hospital in Jendouba.

Current telepathology projects were:

- the project between Farhat Hached Hospital in Sousse and the hospital in Mahdia, which involved the exchange of microscopic images through a videoconferencing station; and
- the telecytology project of the Aziza Othmana Hospital in Tunis, centered in the Hematology Services, which involved the transmission of slides between the Hematology Service of the Farhat Hached Hospital in Sousse and other hematology services in Tunisia and abroad.

MOVEMENT OF PATIENTS DOMESTICALLY AND ABROAD

Foreign patients receiving care in Tunisia

This information is not collected systematically, either in the public or the private sector. However, citizens of bordering countries avail themselves of Tunisian services for social or economic reasons, or both. In 1997, according to a survey of eight large clinics in Tunis, Sousse, and Sfax, around 12,000 foreign patients were treated in Tunisia. This figure included people who came to Tunisia exclusively for medical care and others seen in health services during a visit to Tunisia for other purposes.

The bulk of the foreigners who come to Tunisia for medical care are from Algeria and Libya. Geographical proximity and, very likely, conside-rations internal to the health services of these two countries may account for this.

Care for Tunisians abroad

Services for Tunisians abroad, strictly speaking, are those supported by collective financing, whether by the social security systems or by direct State financing for social categories not covered under the social security health insurance. Certain humanitarian organizations, such as Terre des Hommes, cover the cost of care for certain Tunisians.

In addition, some of this care may be financed individually: precise information on such cases could not be obtained because it is not disaggregated in the authorizations for transfers of foreign exchange to the Central Bank of Tunisia.

The number of people treated abroad and financed by a public source has steadily declined over the years, thanks to several measures, principally the development of national capacity in the area of high technology, in terms of the necessary infrastructure and training for the different categories of health personnel. Moreover, thanks to bilateral cooperation with diverse foreign hospitals, foreign health personnel are welcomed in Tunisia to perform the necessary services for certain patients and avoid having to transfer them outside the country. In any case, the decision to seek care outside the country, whatever the public source of financing, is only made after it has been authorized by a national commission on care abroad, made up of physicians and adminis-trators who study each case presented. It should be noted that the proposals to transfer patients abroad come from the attending physicians, who are most often affiliated with university hospitals. Table 9 summarizes the number of cases treated abroad in which the cost of care was covered by collective financing, from 1993 to 1998, with a breakdown by sources of financing.

Table 9 reveals that during the 1993-1998 period the number of patients treated abroad diminished by half, dropping from 513 to 260 cases. This reduction largely affected patients whose care was covered by the State, with the number of cases dropping by 80%, from 50 to 10. The reduction also affected patients whose care was covered by the social security system; in this case, the number dropped by more than half, from 431 to 210 cases. The number of patients whose care was covered by humanitarian organizations rose from 32 to 40, that is, by a 25% increase.

Table 9. Tunisians treated abroad, by source of financing, 1993-1998

	Social security		Ministry of Public Health		Humanitarian organizations	Total	
Year	Number	Cost[a]	Number	Cost[a]	Number	Number	Cost[a]
1993	431	10,055	50	1,061	32	513	11,116
1994	418	8,857	21	0,418	36	475	9,275
1995	266	6,013	16	0,510	38	320	6,523
1996	196	4,575	17	0,422	31	244	4,997
1997	196	5,895	16	0,355	32	244	6,250
1998	210	5,875	10	0,195	40	260	6,060

[a]In thousand of dinars.

The average cost of care for a patient treated abroad (except those covered by humanitarian organizations), rose from D23,110 in 1993 to D27,545 in 1998. This is why, even though the number of patients had been divided by two, the costs covered with public financing were divided by only 1.8. The selection of cases for treatment abroad, based on national capacity, also led to a change in the morbidity for which the cost of care is higher. Table 10 provides a breakdown by specialty of patients treated abroad between 1993 and 1998 and shows the predominance of cardiology and cardiovascular surgical patients, with these overshadowed by the pathologies of newborns, infants, and premature low birth-weight babies.

Table 10. Number of patients treated abroad, by specialty, 1993 and 1998

Specialty	1993	1998
Cardiology and cardiovascular surgery	52.4%	61.5%
Neurology and neurosurgery	13.1%	10.8%
Ophthalmology	9.9%	5.0%
Hematology	7.4%	6.5%
Other	17.2%	16.2%

Health insurance

No foreign insurance company currently offers health insurance benefits in Tunisia. In addition to the afore-mentioned medical coverage for Tunisians receiving care abroad, agreements have been signed between Tunisia and several countries, providing coverage for the care of foreign citizens in Tunisia.

General social security agreements

Tunisia has signed general social security agreements with several countries. These agreements affirm the principle of equal treatment for nationals of the two countries under their respective social security laws and establish a reciprocity system for workers when they move to the other country to engage in professional activities governed by the social security laws or to establish residence.

The agreements cover health, maternity, and life insurance; old age, disability, and survivor's benefits; dependency allowances, and occupational accidents and illnesses. Under the terms of the agreements, salaried workers and their eligible dependents have a right to the same social security benefits as Tunisian workers, as well as the same obligations.

The countries with whom these agreements have been signed are: France: agreement of 17 December 1965, completed on 12 September 1975; Italy: agreement of 7 December 1984; Germany: agreement of 16 April 1984; Belgium: agreement of 29 January 1975; the Netherlands: agreements of 22 September 1978 and of 17 December 1965; and Algeria: agreement of 30 December 1973, conferring on Tunisian or Algerian government employees or comparable workers, as well as their dependents, the right to health insurance coverage under the same conditions as nationals of the two countries. For nonresident nationals of the two countries, under the principle of reciprocity, Tunisian and Algerian authorities have agreed to provide free

care in Tunisia for resident and nonresident Algerians.

Bilateral agreements

In the agreements on the hiring of foreign medical personnel to practice in Tunisia, these individuals and their families receive free care in the two countries. Agreements of this type have been signed essentially with the following countries: Bulgaria, Russia, Czechoslovakia, and Poland.

Several bilateral agreements have also been signed by Tunisia and other countries on both the transfer of benefits and premium payments: with Libya, agreement of 14 January 1957, whereby each State treats nationals of the other country in the same way as its own citizens; with Mauritania, agreement of 21 April 1999, granting health services to insured Mauritanian subscribers at the health facilities of the Ministry of Public Health of Tunisia; with Poland, cooperation agreement of 5 May 1996, which, under the principle of reciprocity, provides free health care in public hospitals to specialists exchanged under the agreement and their dependents and to the representatives of diplomatic missions and their dependents; with Morocco, health and labor agreement of 9 May 1966, granting full equality to nationals from the two countries in the following areas: free care for indigent patients from either country who reside in the territory of the other, and certain social security benefits and coverage for occupational accidents.

TRAINING OF HEALTH PROFESSIONALS

Training of foreigners in Tunisia

The number of foreign students receiving basic training in Tunisian institutions has held stable, representing about 10% of student enrollment. These students are essentially from the Maghreb and French-speaking African countries. The majority is enrolled under student exchange agreements between Tunisia and the countries in question. Table 11 traces the 1995-1998 evolution of the foreign student population in Tunisia, by health field.

Training of Tunisians abroad

There are no exhaustive statistics on the number of students enrolled in foreign universities. However, it is

Table 11. Foreign students enrolled in Tunisian training institutions, by health field, 1995-1998

	Academic year		
Health field	1995-1996	1996-1997	1997-1998
Medicine	499	491	511
Dentistry	152	143	123
Pharmacy	192	172	180
Health sciences and technology (Training of highly skilled technicians)	111	104	101
Total	954	910	915

worth stating that in the countries that traditionally attract Tunisian students, their numbers have steadily decreased because of the enrollment restrictions imposed by the countries for nationals as well as foreigners (numerus clausus). In contrast, new ties are being forged, especially with the countries of Eastern Europe (the former Soviet Union) and certain African nations.

According to the professional accreditation bodies, graduates trained abroad represent some 5% to 10% of the new professionals inscribed on the rolls, depending on the discipline. For medical specialists, training in Tunisia is often completed in sojourns abroad in state-of-the-art health services, particularly in certain specialties that are still in their infancy in Tunisia or where the aim is to master new technologies. Thus, 100 to 200 future specialists venture abroad each year, principally to France, to upgrade their skills for a 3 to12-month period.

SHARE OF NATIONAL HEALTH EXPENDITURE DEVOTED TO IMPORTS/ EXPORTS OF SERVICES

The only correctly documented data available are those of public expenditures for health care abroad, whose share of total health expenditure and of GDP is indicated in Table 12. Furthermore, however imprecise the data on private expenditure for health care abroad, which is poorly regulated, its share of total health expenditure and, of course, GDP, is tiny.

INSTITUTIONAL DIMENSIONS OF THE TRADE ON HEALTH SERVICES

International and bilateral agreements

Aside from the bilateral agreements mentioned above, between 2000 and 2003 Tunisia will begin negotiations within the context of the WTO

Table 12. Expenditure for care abroad vis-à-vis total health care expenditure and GDP, by source of financing, 1995 to 1998

	Year			
Expenditure	1995	1996	1997	1998
Total health expenditure	935,700	1 023,000	1 141,500	1 255,100
% GDP	5.5%	5.4%	5.3%	5.5%
Social security (care abroad)	6.013	4.575	5.895	5.875
% GDP	0,035%	0,024%	0,027%	0,026%
% Total health expenditure	0,64%	0,45%	0,52%	0,47%
State expenditure (care abroad)	0,510	0,422	0,355	0,195
% GDP	0,003%	0,002%	0,002%	0,001%
% Total health expenditure	0,05%	0,04%	0,03%	0,02%
Expenditure for care abroad	6,523	4,997	6,250	6,070
% GDP	0,038%	0,026%	0,029%	0,027%
% Total health expenditure	0,70%	0,49%	0,55%	0,48%

agreements, on the subject of the services trade, including health care (Annex A). A preliminary diagnostic report is available, which will be completed shortly in preparation for these negotiations. As for Tunisia's agreements with the European Union, at the present time they do not involve trade in services.

State regulation of the health services trade

Importing services

The barriers to procuring services abroad are financial in nature, since to do it with public financing requires, on the one hand, a well-documented medical dossier attesting to the fact that the services are not available in Tunisia, and on the other, funds from the Ministry of Public Health and the social security system. In contrast, for private financing of health care abroad there is no obstacle to transferring funds as long as a Tunisian practitioner requests that the patient seek care outside the country.

Furthermore, although investments in the health sector enjoy the same advantages as foreign investments in other sectors, health service providers can set up practice only if their credentials meet Tunisian requirements (equivalence, supplementary education, and others) and if they obtain special authorization in professional categories where the law requires Tunisian citizenship (physicians, dentists, and pharmacists).

Exporting services

There are no restrictions on foreigners who wish to receive care in Tunisia. As for Tunisians practicing abroad, Tunisian regulations offer major advantages to these expatriates by facilitating separation procedures, the transfer of social security premiums, and other details. Moreover, a specialized agency, the Tunisian Agency for Technical Cooperation, has been set up to facilitate the export of Tunisian know-how in all areas, including health services. The only obstacle to exporting services involves the immigration laws of the host country, especially in a developed country.

Risks and opportunities

The risks listed below should be addressed in the current discussions on social security and health insurance reform:

- the risk of inequities among the population, especially people without social security coverage;
- rising health expenditures and their effect on the financial equilibrium of the social security system;
- greater pressure on the market for health professionals, particularly in the private sector, with the potential influx of foreign practitioners;[4] and
- destabilization of the equilibrium between the public and private sectors, putting into question the

[4] It should be noted that the opportunities for public sector employment or private practice are diminishing, largely due to the number of professionals graduating annually and entering the job market.

future of public health facilities, confronted by poor private, national, and foreign coordination.

The trade in services situation provides the following opportunities:

- promotion of quality and efficiency in health care, thanks to coordination between national and foreign health care facilities;
- access to the new technology that will be available locally, reducing the need to seek care abroad; and
- improvement in the performance of national health care facilities, both public and private, thanks to the coordinated environment in which they will operate.

POLICY RECOMMENDATIONS

In the national interest

Liberalization of the health services trade entails risks that could have dire consequences for the current equilibrium of health systems, particularly in developing countries. To mitigate these risks, countries should take steps to guarantee that liberalization will not jeopardize equity, efficiency, global financial equilibrium, or the equilibrium of the national job market and the quality of services offered to the general population. Thus, the countries should:

- work toward harmonious development of the supply of health services at the different levels of care, ensuring complementarity between the public and private sectors;
- strengthen technical and managerial capacity and the maintenance of infrastructure to support decision-making regarding the introduction of truly innovative technologies;
- promote greater management autonomy for health facilities and greater results-orientation among operational teams to improve performance in the health sector;
- establish measures to improve management of the health care system—management that should be based increasingly on performance outcomes;
- promote real flexibility in employment, regulated by the State, and awaken interest among health workers in the results obtained by the facility;
- design and establish measures to promote quality care and cost control such as control of prescriptions and their orientation; arriving at a therapeutic consensus that combines efficacy with cost control and demurrable medical referrals; moderation of costs and the fees charged by health professionals through mechanisms such as the projected agreement under the health insurance reform; price controls on health supplies, especially drugs and medical devices; and the accreditation of health facilities, training institutions, and health professionals; and
- establish regulatory mechanisms for the system (particularly norms and standards for referral), an operational information system, and an incentive system to channel health care supply to the real needs of the population.

The role of international organizations

- International organizations should harmonize international legislation on educational qualifications, along

the lines of the European Union countries and earlier precedents in the countries of North America, and

- solve the problem of freedom of movement between countries. The developed countries have erected regulatory barriers that, in effect, prevent foreign citizens from establishing themselves in their territory. Eliminating these barriers is essential for promoting the two-way trade of services.

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ANNEX A. OPENING OF HEALTH SERVICES MARKETS

Services are defined under the GATS agreement in terms of the four existing modes of delivery:

- across national borders (telemedicine services, for example);
- through consumers abroad (treatment abroad);
- through a commercial presence, by setting up a foreign enterprise in a country (HMO); and
- through the presence of individuals who are health care providers (foreign health care professionals, for example).

These principles, however, are applied only to services for which a member of the WTO has agreed to open its domestic market. In other words, they apply to services that the countries themselves propose to foreign health-care providers. A national list indicates the service sectors and the activities to which a member will apply the obligations concerning access to the market and national treatment.

With regard to the movement of individual health care providers under the agreement, an annex stipulates that the terms of the agreement shall be applied only to people who are service providers or individuals employed by a service provider for a specific job. They are not applicable to persons seeking to penetrate the job market of a foreign country.

The article in the agreement that excludes services delivered “in the exercise of government authority” is of particular interest to the health sector, since that expression applies to services that are neither for-profit nor coordinated with other service providers. It should be noted that relatively few jobs have been taken in the health sector, where services are provided essentially by the government and where coordinated and for-profit service delivery is not widespread. About 27% of the Members (from both the industrialized and developing countries) have agreed to open hospital services to foreign providers, and 35% (a proportion in which the two groups of countries are equally represented) have done so for their medical and dental services. The lists of some 19%, largely industrialized countries, include the services of health personnel other than physicians.

Regarding the 21 developing countries concerned, the majority does not set limits on the use of hospital and medical services abroad. They make no commitment regarding services outside the country, and some of them sometimes set limits on the share of foreign capital.

Clearly, the most vulnerable category of services is that requiring the presence of health care professionals, to which the horizontal constraints on all sectors apply. Thus, only specialists and managerial personnel who already work for a health care enterprise are eligible to work, and these individuals must train local counterparts or belong to the national medical association.

The only commitment made by Tunisia concerns health insurance. Tunisia opens its borders in the area of health insurance.