ERF Policy Brief

The Tunisian Social Protection System: Key Strengths and Challenges

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In a nutshell

- *Tunisia's social protection system is well designed and features contributory schemes for a large portion of the working population and their dependents as well as non-contributory schemes for the poor and vulnerable.*
- *The country's social protection system also faces a number of challenges, including improving effective coverage, reducing inequalities in parallel schemes, improving the effectiveness of targeted programs, and expanding support for the unemployed and other excluded categories.*
- *The contributory social insurance for pension and other kinds of benefits covers public and private sector workers against risks associated with old age, invalidity, survivorship, accidents at work, and occupational diseases. Public and private sector workers and their dependents are covered by the contributory health insurance system as well.*
- *Other than universal energy and food subsidy programs, Tunisia provides cash transfers and free or discounted medical assistance to needy and low-income families, people with disabilities, and children without family support.*
- *The existence of different contributory schemes by occupation has led to a series of inequities that give some groups more benefits than others. Moreover, the unequal distribution of medical services, the quasi-absence of specialized doctors, and the lack of medications in public hospitals seriously limit the effectiveness of healthcare in the interior regions.*
- *Social insurance in Tunisia does not cover informal workers or women workers who do not have permanent employers in rural areas, nor does it not protect workers from unemployment. Although nondiscriminatory in principle, Tunisian social security excludes temporary migrants and undocumented migrants.*
- *Many people who were entitled to receive benefits from social safety nets in Tunisia did not receive them, while others who were less in need received multiple benefits.*

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1. Introduction

Social protection is a fundamental human right that helps reduce and prevent poverty and the vulnerability of individuals throughout the life cycle. Despite the recognition of this right by article 22 of the Universal Declaration of Human Rights, social protection is not yet a reality for the majority of the world's population. Only 45 percent of the world's population is effectively covered by at least one social protection benefit, while the remaining 55 percent are unprotected (ILO, 2017). In this same vein, if the absolute number of people currently affected by human rights violations is taken as a benchmark, the gap between what is legally required and what is actually implemented in practice in regard to the right to health and social security is particularly wide (Kaltenborn, 2020). Further, only 30 to 40 percent of MENA populations are covered by formal social protection systems and large swathes of the population are excluded, such as agricultural workers, the self-employed, and informal sector workers (Jawad, 2015).

Based on a social contract between the state and society, Tunisia has offered free and universal services since its independence, such as healthcare and education, subsidized food and energy, and public sector job guarantees for graduates (Assaad, 2014; El Haddad, 2020). However, the economic and structural reforms of the 1980s and 90s led to the hollowing out of the middle class, the concentration of poverty and unemployment in interior regions, the emergence of the informal sector, and the exclusion of a large part of the population from any form of formal social protection. Ultimately, frustrations with the broken social contract fed into social tension and protests and gave rise to a popular revolution in 2010.

In the post-revolution period, despite the different social and economic entitlements anchored in the 2014 constitution, the implementation of a comprehensive and inclusive system of social protection (in the context of the growing population and limited resources) has remained a major challenge for Tunisia. Based on discussions with policymakers and civil society actors and a document review of academic literature and reports produced by the government, international organizations, and other stakeholders, this policy brief is devoted to identifying the key strengths in Tunisia's social protection system, as well as gaps in ensuring the delivery of social protection to all citizens and others living in the country.

2. Risks covered and benefits provided by contributory and non-contributory schemes

The Tunisian social security system

In Tunisia, the contributory social insurance for pension and other kinds of benefits differs in the public and private sectors and is implemented through two schemes managed by two distinct funds. The National Pension and Social Insurance fund (CNRPS) covers the public sector, while the National Social Security Fund (CNSS) serves the private sector. Both funds are run by the Ministry of Social Affairs (MAS) (World Bank, 2015).

The CNRPS covers public sector workers against risks associated with old age, invalidity, survivorship, sickness of civil servants, accidents at work, and occupational diseases. The contribution rate to the CNRPS under the general pension scheme is 23.7 percent of employee wages, of which 14.5 percent is paid by the employer and 9.2 percent by the employee. Family allowances, maternity, and work injuries are fully paid by the government and state-owned enterprises. In the public sector, pension benefits are calculated as a percentage of the employee's end-of-career salary, based on which they have paid contributions for at least two years. In no case must the pension exceed 90 percent of the reference salary on which contributions were paid or be less than two-thirds of the guaranteed minimum interprofessional wage (SMIG). The CNRPS provides survivorship benefits on the death of the insured individual. The spouse receives 75 percent of the retirement pension of the deceased on a monthly basis. Also, a temporary orphan's pension is granted to orphans. In addition to old age, invalidity, and survivors' pensions, the CNRPS also provides a death grant (one-off payment) to the dependents of the insured deceased individual, along with family benefits and other support benefits (social and university loans).

However, the CNSS covers workers in the private sector against a range of risks, including old age, disability, accidents at work, and Occupational diseases (however, the latter two can be voluntary in some schemes). A number of schemes exist under the CNSS fund, and they vary in terms of contributions according to the individual's occupation. These regimes include the non-agricultural private sector scheme, employees in the agricultural sector, employees in the fishing sector, and the self-employed, including those in agriculture,

domestic and site workers and low-income earners, Tunisians living and working abroad, students and interns, and artists, intellectuals, and creators.

Insured private sector employees receive pension benefits after having paid at least 120 months of contributions. The pension amounts are calculated as a percentage of the average salary on the basis of which contributions were paid over the last 10 years of employment. For some workers' groups, the reference salary is linked to the SMIG/SMAG. The CNSS provides survivor pensions on the death of the insured individual and a death grant (one-off payment) to the dependents of the insured deceased individual. Family allowances are allocated to CNSS affiliates with dependent children (up to a maximum of three). Moreover, employees in the private sector are entitled to other family benefits for single wages, birth leave, and leave of young workers. In addition, under certain conditions, workers in the private sector are entitled to benefit from early retirement and become eligible for a disability benefit if their working capacity is reduced by at least two-thirds due to a disability. The CNSS can also provide certain categories of insured persons in the private sector with personal loans, home/construction loans, or loans to acquire land or a vehicle.

On the other hand, workers in both the public and private sectors and their dependents are covered by the contributory health insurance system administered by the National Health Insurance Fund (CNAM). According to official data, the CNAM covered more than eight million individuals (8,064,733) including workers and their dependents in 2018, which is equivalent to 70 percent of the total population. Indeed, in addition to the health insurance scheme, the CNAM manages legal schemes for compensation for damages resulting from workplace accidents and occupational diseases in the public and private sectors. The fund also grants sickness benefits for insured persons working in the private sector and diaper allowance for salaried women suspending their work due to childbirth.

Social safety nets in Tunisia

Contrary to contributory schemes, non-contributory schemes in Tunisia do not involve direct contributions from beneficiaries or their employers as a condition of eligibility. The main non-contributory programs are cash transfers, medical assistance programs, and energy and food subsidy programs.

The most important cash transfer program in Tunisia is the National Program of Aid to Needy Families (PNAFN). The PNAFN provides direct financial assistance to families that meet the eligibility criteria determined by the ministry. The monthly amount of financial assistance increased from TND 7.7 in 1987 and TND 36.3 in 2000 to TND 56.7 in 2010. In 2013, the monthly amount was TND 105, and the total budget of the PNAFN reached TND 292 million, equivalent to 0.47 percent of GDP. In 2020, the monthly amount reached TND 180, which is more than triple the amount in 2010.

Figure 1 shows that over the years, the value of the PNAFN benefit increased faster than the minimum wage (SMIG). The transfer (not including the supplement) is currently 45 percent of the minimum wage compared to seven percent in 1987.

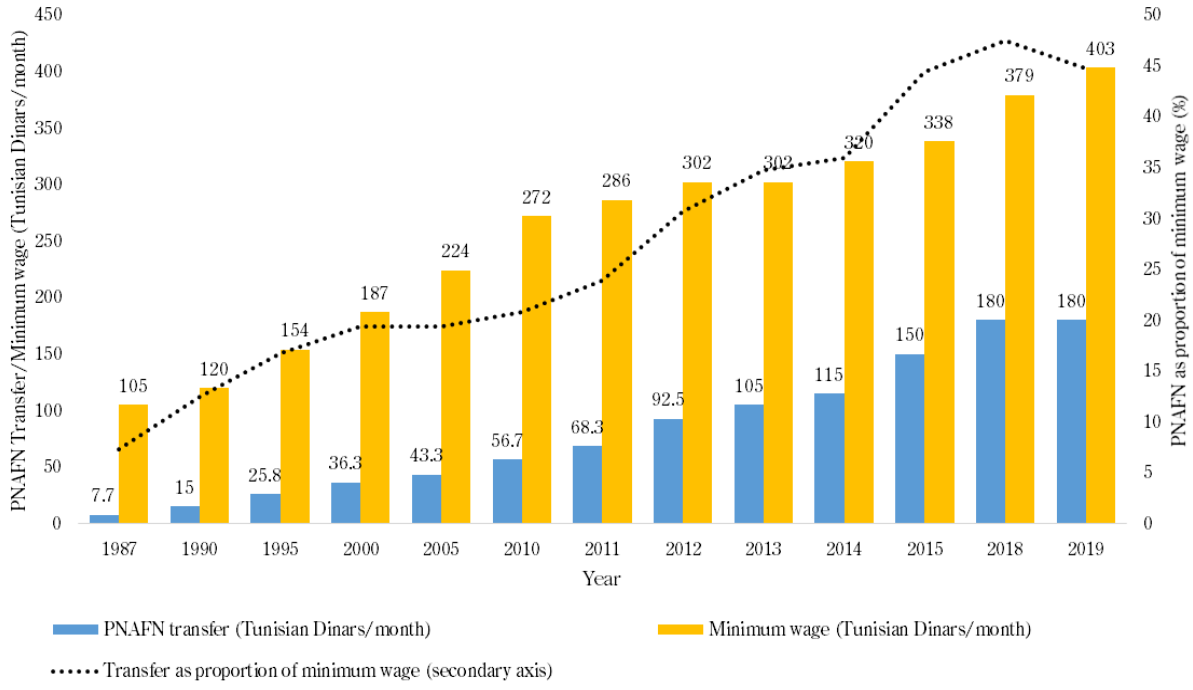
The coverage rate of the PNAFN program evolved from 6.7 percent of Tunisian households in 2010 to 8.4 percent in 2015. In the context of recognizing the rights of children from needy families to education and protection against failure and dropping out of school, Tunisia consolidated the PNAFN program by introducing an increase of TND 30 per child per quarter (with a maximum of three children) granted to needy families with children of school age. Moreover, Tunisia provides social medical assistance or free medical assistance (AMGI and AMGII) that allows access to healthcare in public hospitals for needy and low-income families, disabled people, and children without family support. The number of AMGII beneficiary families grew from 557,900 in 2010 to 607,697 in 2017, with an average annual growth rate of 1.2 percent (Table 1).

In 2015, AMGII beneficiaries accounted for 21.7 percent of all households compared to 8.4 percent for AMGI (PNAFN), which together represented 30.1 percent of households and 24.8 percent of the total population.

In addition to the monthly cash transfers to needy families (PNAFN), Tunisia provides a range of in-kind social assistance, usually planned as temporary interventions deployed in response to emergencies. The most important in-kind assistance is as follows: aid to school children and students, aid during cold waves, occasional and periodical aid, and aid in case of disasters (such as flooding and the COVID-19 crisis).

Other than the direct social transfer component (PNAFN/AMGI, AMGII), Tunisia provides an additional indirect and universal transfer component available to anyone who chooses to purchase subsidized commodities in any quantity desired. The compensation system aims to

Figure 1. Evolution of PNAFN transfer and minimum wage



Source: Economic and Social Commission for Western Asia (ESCWA, 2019).

Table 1. Evolution of the number of social assistance beneficiaries, 2010-2017

Year	2010	2011	2012	2013	2014	2015	2016	2017
AMGI	164,108	177,244	200,708	220,794	222,107	233,591	239,059	241,632
AMGII	557,900	576,700	577,900	602,900	592,763	602,900	598,624	607,697
Total	722,008	753,944	778,608	823,694	814,870	836,491	837,683	849,329

Source: Authors' calculations using MAS administrative data.

control the prices of basic products, particularly cereals, to mitigate price increases, which are highly dependent on the prices of primary products in world markets.

3. Inequality in access to social benefits and healthcare services

TUnder the contributory system, the existence of different schemes by occupation has led to a series of inequities that give some groups more benefits than others. For example, the public sector system uses the highest final salary to calculate benefits, while the private sector system uses an average of salaries over the last 10 years of employment. In addition, the minimum pension is equal to two-thirds of the minimum wage for those working in the public and non-agricultural wage sectors, while it is only 30 percent for the self-employed.

Moreover, maternity leave has been set at one month for most female workers, with the exception of civil servants, who receive two months of maternity leave. Most women receive 67 percent of the average daily wage, while women working in agriculture receive 50 percent of their daily flat rate wage based on SMAG. Civil servants receive full pay during maternity leave. In addition, rural farming women are more likely than men to have precarious arrangements that are generally less covered by social protection than stable jobs. Furthermore, the persistence of gender pay gaps penalizes women's contributions, leading to lower benefit levels for work of equal value.

Under the non-contributory system, less than 13 percent of households with a reduced rate health card are headed by women, while beneficiaries whose heads of household are men constituted more than 87 percent of

Table 2. Number of doctors (general, specialized, and dentists) and paramedics per 100,000 inhabitants, 2018

Region	Total population	General doctors	Specialized doctors	Total doctors	Paramedics	Dentists
Great Tunis	2,815,102	35	47	82	356	204
North East	1,618,772	24	12	37	256	99
North West	1,184,709	38	10	48	405	77
Central East	2,755,887	33	38	71	353	164
Central West	1,493,701	28	8	36	298	62
South East	1,054,189	29	12	41	327	86
South West	629,088	49	10	59	560	86
Tunisia	11,551,448	33	26	59	347	131

Source: Authors' calculations using data from the Ministry of Health.

the total number of beneficiaries in 2010. Theoretically, each beneficiary of the AMG programs (AMGI and AMGII) has the right to access all medical services provided by the public health system (ambulatory care, hospitalization, radiology procedures…etc.). In practice, several failures of the health system highly limit access to this right. Indeed, the unequal distribution of medical services between regions, the quasi-absence of specialized doctors, and the lack of medications in public hospitals seriously limit the effectiveness of healthcare offered to AMGI and AMGII beneficiaries, especially in the interior regions.

The poorest regions, such as the North West and Central West (where most AMGI and AMGII beneficiaries are located), are the least served in terms of the number of doctors, specialized doctors, and dentists in the public sector per 100,000 inhabitants (Table 2). In 2018, 90 percent of public sector specialists were concentrated in the coastal area (North East region, Greater Tunis, Central East, South East). The consequences for people living in the interior regions are heavy. They are forced to travel long distances to access public healthcare services or to turn to the private sector and pay the associated costs, which remain too expensive compared to the public sector. The consequences can sometimes be drastic, with deaths that could have been avoided.

4. Exclusion of some categories and low targeting effectiveness

While the majority of the working population is legally covered by the Tunisian social protection system, social assistance programs are also available for those who cannot benefit from the insurance system in place for workers. Despite these strengths, the actual rate of insurance coverage is well below the legal rate, meaning that many citizens do not receive any benefits.

Social insurance in Tunisia does not protect workers from unemployment. In both the private and public sectors, there are no regular mechanisms to guarantee a minimum income for unemployed workers. In some cases, severance pay exists, although very limited, and income support is provided to first-time job seekers with high qualifications under the AMAL program. Even with the financial assistance, healthcare, and family allowances provided to the unemployed during periods of job loss or crisis, the conditions for receiving benefits are quite restrictive; only those who lose their jobs due to economic and technological reasons and who have worked for at least three years in the same company can benefit. In addition to the eligibility criteria, other procedural conditions make it difficult for the unemployed to obtain support (for example, in case of job loss, the employer is responsible for managing the support request of their former employees). Such conditions lead to a low coverage rate.

Although Tunisia has invented several schemes to integrate informal workers into the social protection system, a significant proportion of mobile workers have found themselves involuntarily absorbed by informal jobs (especially in the agricultural and fishing sectors, with seasonal or casual jobs) and excluded from the social security system, unless they benefit from programs for vulnerable families.

In 2014, the national informal employment rate in Tunisia was estimated at 25.8 percent, of which that of men was around 31.7 percent and that of women was around 10.7 percent. The informality rate of the self-employed reached 58.5 percent against only 18.6 percent

for employees. In Tunisia, informal employment is a phenomenon particularly concentrated among young people in the labor market since 60 percent of men and 86 percent of women in informal employment in 2014 were under 40 years of age (Ben Cheikh and Moisseron, 2021).

A large group of women in rural areas who do not have a permanent employer do not yet benefit from social security coverage. According to data from the National Social Security Fund, the number of women who have applied to join the social protection system "Ahmeni" (Protect Me) has reached around 15,000 workers out of an estimated 500,000 workers in the agricultural sector.

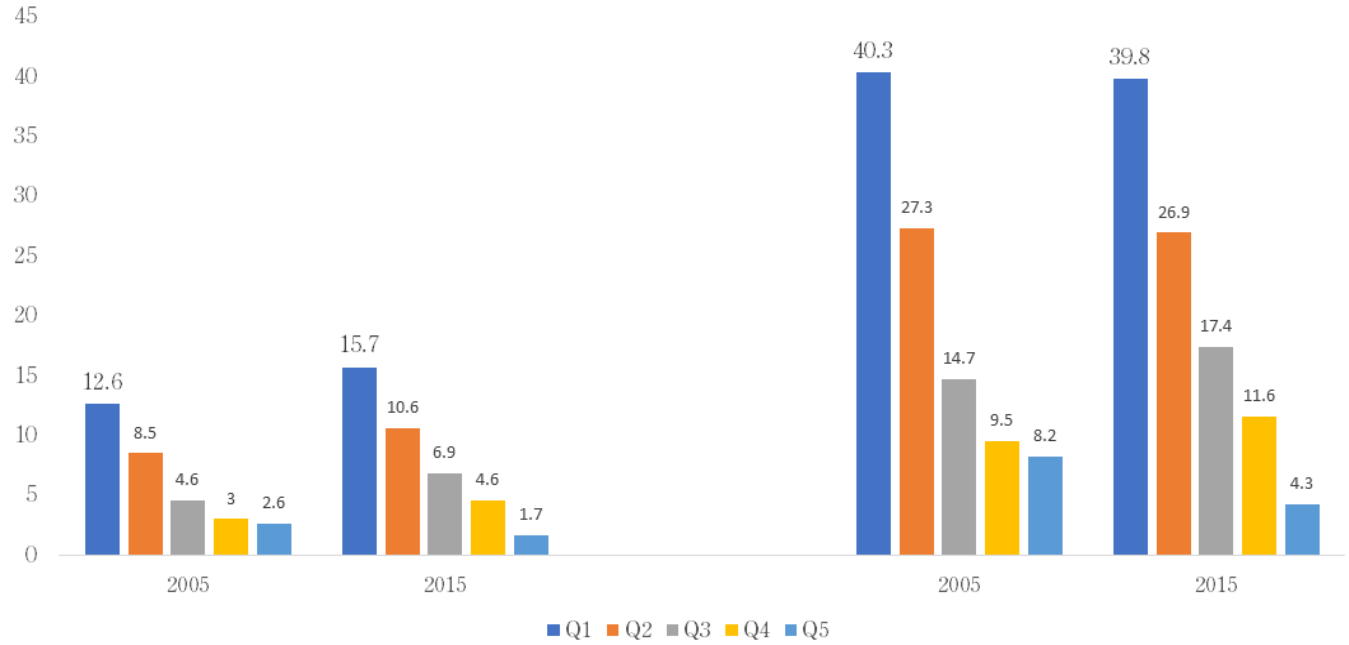
Although nondiscriminatory in principle, Tunisian social security excludes temporary migrants, undocumented migrants, and those without a formal employment contract. Given that foreigners' access to labor contracts is difficult, this means that access to the social security system is also difficult. Looking at health more specifically, access is not easy for irregular migrants, although some solutions are found through NGOs or international organizations. As for the assistance components (such as the cash transfer program PNAFN), without formally excluding foreigners, they seem de facto dedicated to resident nationals (Gelb and Marouani, 2020).

The social assistance system in Tunisia suffers from several weaknesses. Its benefits have not been sufficiently targeted. Many people who were entitled to receive benefits did not receive them, while others who were less in need received multiple benefits. For example, the exclusion errors for access to the AMGII program are worrying; around 61.9 percent of poor families and 53.3 percent of families live below the extreme poverty line. In addition, only 37.2 percent of the total direct cash transfer program (PNAFN) was allocated to the poorest 20 percent and 60.7 percent of the poorest 40 percent in Tunisia.

Despite improvements in monthly allowance (especially after 2011) as well as coverage rates by region and by household standard of living, the PNAFN covered only 15.7 percent of the poorest (the first quintile) in 2015, compared to only 12.6 percent in 2005. The distribution of PNAFN beneficiaries by standard of living shows that 40 percent of these beneficiaries belong to the first quintile, i.e., the poorest households, and 27 percent belong to the second quintile (the left-hand side of Figure 2).

In addition to targeting problems, the PNAFN program is based on a quota policy (by governorate) that necessarily excludes people in need. It is not based on the universal right to a decent living, which is one of the objectives of a

Figure 2. Coverage rate of the PNAFN program (%) (left panel) and the distribution of PNAFN beneficiaries (%) (right panel) by quintile of per-capita expenditure



Source: Authors' calculations using EBCNV 2015. Statistics for 2005 are from the World Bank report (Banque Mondiale, 2013).

human rights-based approach. The declarative approach guiding the PNAFN program may reduce access for some groups of the population in need, especially for the elderly and those in disadvantaged areas who do not have easy access to information (Nasri, 2022).

School feeding programs have a limited coverage rate that does not exceed 16 percent of the total number of school-age children (for the school year 2017-2018). The School Allowance Program is limited to three children per household, and the zero to five age group is excluded. Moreover, children from families receiving AMGII, which are low-income families, are not eligible for this program despite the relatively high presence of children in these households.

Although the subsidy system is universal and does not exclude anyone, it makes sense for the poor to benefit from it more than the rich. However, the distribution of food subsidies among the different classes of the population is quite egalitarian.

5. Conclusion and policy recommendations

In this policy brief, we identify the key strengths of Tunisia's social protection system, as well as gaps in ensuring the delivery of social protection to all citizens and others living in the country. Compared to other countries in the MENA region, Tunisia's social protection system is well designed and features contributory schemes for a large part of the working population and their dependents as well as non-contributory schemes in the form of universal subsidies, targeted cash transfers, and social health insurance for the poor and vulnerable populations. Despite its diversification and achievements, this system has many shortcomings and excludes a large part of the population that does not have health and social coverage and no decent income.

Based on discussions with policymakers and civil society actors and a document review of academic literature, several policies and suggestions are recommended. Other than reforms aimed at getting social security funds out of financial deficit, there is an urgent need to encourage informal workers to participate in the social security system. This transition can be made by increasing the benefits and decreasing the cost of formality while minimizing the cost of the transition to more productive formal, stable, and decent jobs, and supporting workers during this transition. This approach would generate the intended consequences without the unintended negative ones. On the other hand, the optimization of the targeting of social programs (PNAFN and AMGII) can contain and limit the disincentive effects of social assistance on insurance programs.

Furthermore, there is an urgent need to establish a job loss insurance system managed by an independent fund bringing together employees made redundant for economic or technical reasons as well as graduates who completed their higher education and have been unemployed for some time by supporting and accompanying them in the implementation of projects. Even though these unemployment benefits may seem costly for the time being, their positive effects on social and economic conditions are highly important in the long run; they keep the unemployed linked to the labor market while avoiding more costly economic and social consequences in the future.

From a human rights-based approach, civil society organizations propose that gender and undocumented migrants be considered in social protection laws. They advocate for an overall social development strategy in order to ensure a social protection system resilient to unforeseen crises and to overcome disparities in access to healthcare services between regions and between public and private sectors within the same region. In order to ensure universal access to education and health, the government must implement the necessary means (financial, human…etc.). Timely access to quality healthcare services can avoid the costs of travel to coastal areas borne by households in interior areas.

For the non-contributory system, it is essential to adopt a new targeting approach to select new beneficiaries of social assistance programs based on scientific criteria that will reduce inclusion and exclusion errors. Tunisia is called to expand the coverage of its programs to reach more vulnerable groups such as the less poor but fragile population, women in rural areas without support, and formerly non-poor groups that have lost their sources of income due to the COVID-19 crisis. Moreover, it is highly important to improve the coverage and quality of school lunch programs as they play an important role in the education of students. It is important to coordinate with civil society, which works on this issue in elementary schools in disadvantaged regions. Finally, it is recommended to review the list of subsidized products and target subsidies to the most vulnerable groups. The transition from a universal subsidy system to a direct transfer system must be gradual and well-studied to minimize the negative effects that may accompany this transition.

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