



Health Insurance and Social Security in Algeria: Historical Trajectory and Current Challenges

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Received: 15/03/2024

Accepted: 08/05/2024

Published: 19/06/2024

Abstract:

Algeria has seen significant changes in the financing of its health system since its independence in 1962, with social security emerging as a key pillar. This article aims to examine the current challenges faced by social security as the largest financial contributor to the health sector. It is hypothesized that these challenges affect the economic viability of the sector and impact access to care. The methodology is based on an in-depth literature review of historical data, government reports and specialized studies. The findings highlight revenue losses due to informal work and late payments, highlighting the importance of in-depth audits at company level. This raises questions about participants' confidence and the need for a thorough reassessment of the health and social security system in Algeria.

Key Words: Social Security, Health Insurance, Health System, Social Contributions, Algeria.

JEL Classification: I18, I13, I15.

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Introduction:

Algeria's health system finance has seen substantial shifts over the country's history since gaining independence in 1962. The primary function of social security as a significant source of revenue for the health sector is at the center of this intricate tale. The financial dynamics of the Algerian health system have been impacted over the years by structural changes, socialization initiatives, and economic upheavals. The first phase of the health care reform, which lasted from 1962 to 1973, involved a number of stakeholders, including the State, social security, and patients. Nonetheless, issues with pricing strategies and available resources quickly surfaced, posing the vital subject of financial equilibrium.

The following decade (1974-1984) was marked by an ambitious policy of socialization of health spending, orchestrated by the State and social security. Free health care in the public sector was introduced, symbolizing a step towards the creation of a national health service. Despite these advances, tensions persisted, particularly related to debates on private installation and growing deficits in the social security coffers. After 1984, economic pressures led to rationing policies and



an opening up of the private sector. Social security, facing increasing financial difficulties, has nevertheless emerged as a central player in financing, although its role in controlling the provision of care has been attenuated.

This complex development highlights the limits of the financing system, prompting an in-depth reflection on the relationship between social security and care providers, introduced in 1993. Our analysis explores these dynamics, highlighting persistent challenges and opportunities for improvement in the financing of the health sector in Algeria, focusing on the crucial role played by social security. (Oufriha, 1992) (Kaddar, 1989) (Chougrani & Kaddar, 2010)

Diving into the heart of the historical evolution of the financing of the health system in Algeria, this article focuses on a particular aspect that has endured through the different phases. Over the decades, social security has emerged as an essential pillar, playing a major role in the financing of the health system. The following analysis explores this dynamic by highlighting contemporary issues related to social security as a fundamental source of financing.

Problematic: During this historical trajectory, the fundamental issue focuses on the challenges that social security faces in becoming the main contributor to the financing of the health system in Algeria. What are the challenges inherent in this development and what impact do they have on the financial viability of social security and, by extension, on the quality of care provided? How does social security aim to overcome the specific challenges related to its financing, thus consolidating its position as the financial pivot of the health sector?

Assumptions: We proposed the following Assumptions in response to the preceding research question:

- **H1:** Social security, a significant financial contributor to Algeria's health system, has encountered sustainability issues over the system's evolution.
- **H2:** Certain concerns regarding the social security system's financial viability may directly affect health care access, posing challenges with coverage fairness and the system's capacity to provide high-quality medical treatment.

Research Methodology and Tools: To address the issue posed, our methodological approach is based on a careful analysis of the evolution of social security as a source of financing for the health system in Algeria. This approach focuses mainly on the use of historical data, documents from government authorities, and specialized studies. The methodological orientation of this article is essentially descriptive, based on extensive literature research. The content of this article is based on a meticulous compilation of articles, journals, electronic publications, and analyses of national and international reports.



I. History and Organization of Social Security in Algeria:

Algeria's social security system, which was created in 1949 and is paid for by contributions from workers, has experienced a number of changes. Originally founded on the Bismarckian ideology, it was distinguished by a number of legislations meant to increase its reach. Following independence, there were 71 management bodies, 11 supplemental pension plans, and a severely fragmented structure. An administrative reform was started in 1970 with Decree No. 70-116 and continued progressively for the majority of projects until 1983. The agricultural plans, however, continue to be affiliated with the Ministry of Agriculture. All monies were transferred to the public treasury starting in 1978 and continued until 1983 as a result of this reorganization. Because of a strong employment rate associated with industrialization, social security has been able to preserve its financial stability. (MEKBEL, 2011)

After being reorganized and consolidated in 1983, Algeria's social security system came to be known as the National Social Insurance Fund for Salaried Workers (C.N.A.S.)¹, formerly known as the National Fund for Social Insurance, Occupational Accidents and Diseases (CNASAT)². Along with the National Pension Fund (CNR)³, this unification was executed in 1988, converting the funds into a Public Administrative Establishment, which in turn became a Specific Public Establishment, granting public companies' autonomy. (Merouani, Hammouda, & ElMoudden, 2014)

In the following years, new funds were created, including the Social Insurance Fund for the Self-Employed (C.A.S.N.O.S.)⁴ in 1992, the National Unemployment Insurance Fund (CNAC)⁵ in 1994, et the National Fund for Paid Leave and Unemployment-Bad Weather in the Construction, Public Works and Hydraulics Sectors in 1997. Previously, the CNAS itself collected contributions to finance the social security of salaried workers. The new fund has been placed under the supervision of the Ministry of Social Security. However, in 2015, after 8 years of operation, the CNRSS⁶ was dissolved, and its missions were reintegrated into the CNAS. (Graba & Koriche, 2010) (DELOIT, 2019)

The social security system in Algeria, based on Bismarckian doctrine, covers various risks such as illness, maternity, disability, death, industrial accidents, occupational diseases, retirement, unemployment, and family benefits. Beneficiaries include salaried workers, self-employed workers, various special categories, and beneficiaries of social security persons. People with a pension less than or equal to the National Guaranteed Minimum Wage, which is DZD 20,000 since Presidential Decree No. 21-137 of April 7, 2021, are exempt from contributions.

The funds under the supervision of the Ministry of Labor, Employment and Social Security now include the National Social Insurance Fund for Salaried Workers (CNAS), the Social Security Fund for the Self-Employed (CASNOS), the National Pension Fund (CNR), and the National Unemployment Insurance Fund (CNAC). These entities manage various functions related to contributions, social insurance, industrial accidents, pensions, and family benefits. (Le Cleiss, 2022)



II. The non-contributory and contributory system of social security financing

In the previous section, we noted that the system is primarily based on a premium-based insurance model (see Table 1). However, between 2006 and 2010, reforms were incorporated into the finance laws, introducing additional sources of funding to strengthen the system.

A presidential decision instituted in 2006 gave birth to the National Pension Reserve Fund, whose financing was strengthened in 2012 with an increase in the share of oil taxation, from 2% to 3%. (Ministère du travail de l'emploi et de la sécurité sociale, 2010)

Also, in 2010, the Finance Act established a National Social Security Fund, mainly funded by a share of the tax on tobacco products and by a 5% levy on the net profits generated by the import and wholesale distribution of imported medicines and resold as is. (Rédaction ALGERIE ECO, 2016)

Table 1: "Contribution Rate (as a Percentage of Salary Subject to Contribution)"

Branch	To be paid by the employer	At the employee's expense	At the expense of the Social Works Fund	Total
Social insurance: (sickness, maternity, disability and death)	11.5%	1.5%	-	13%
Accidents at work and occupational diseases	1.25%	-	-	1.25%
Retirement	11%	6.75%	0.50%	18.25%
Early retirement	0.25%	0.25%	-	0.5%
Unemployment insurance	1%	0.5%	-	1.5%
Total	25%	9%	0.50%	34.5 %

Source : (Le Cleiss, 2022).

After independence, the State did not initially participate in the financing of social security. Faced with significant salaries and modest benefits, the system had a surplus. However, with the unification of the system and the deterioration of the economic situation in the second half of the 1980s, marked by an increase in informal work, the state had to intervene to compensate for the deficits in the coffers. Thus, from 1995 onwards, the State began to finance family allowances. Ordinance No. 96-17 on social insurance also granted disadvantaged groups the right to receive benefits financed by the State, both in cash and in kind.

Currently, informal employment remains a major concern, especially with the increasing integration of the private sector into the wage bill. This development has led to an increasingly substantial intervention by the State, thus explaining the growth of social transfers in recent years.



Budgeted social transfers increased steadily from 2000 to 2017. Between 2000 and 2004, their rate represented 22.8% of the state budget and 7.4% of GDP. From 2005 to 2009, this rate increased to 24% of the budget and 8.6% of GDP. For the period 2010-2015, social transfers reached 25% of the state budget and 11% of GDP, before decreasing to 23% of the budget and 9% of GDP between 2016 and 2017 (APS, 2018)

In monetary terms, these social transfers increased by 8% in 2018 compared to 2017, highlighting the importance given to social policy by the Algerian government. These funds aim to support the population by subsidizing essential sectors such as basic food, access to health, education, water, energy, housing, pensions, while supporting disadvantaged and disabled people (Algérie Press Service, 2018). The bulk of these transfers are directed towards support for families, housing and health, accounting for 64% of all transfers. (Nesrine M, 2018)

More recent figures indicate that the total direct and indirect subsidies fluctuated, during the period from 2018 to 2021, between 3,900 and 5,130 billion dinars, of which 56% were generalized subsidies (2,800 billion dinars). (L'Algérie Aujourd'hui, 2022)

III. The current place of social security within the health system: The health insurance branch/

The health insurance branch, currently managed by two entities, CNAS and CASNOS, covers virtually the entire Algerian population by offering benefits in cash and in kind. This section focuses only on benefits in kind.

In theory, the health insurance branch should cover the reimbursement of preventive and curative care performed by health professionals, including doctors, as well as medicines, appliances, and hospitalization costs in private institutions under agreement. However, this ideal definition does not correspond to reality. With the exception of drug reimbursement, tariffs have been frozen since the 1980s.

Clinics and private doctors manage to profit from the system to the detriment of the so-called insured, especially affecting the disadvantaged. In this context, the application and extension of the agreement appears to be a crucial necessity. (La presse médicale, 2017)

1. The third-party payer:

Initially, patients paid in full for medicines, which was later reimbursed by the social security fund at 80%. Currently, the third-party payment system is in force, where the patient pays only 20% thanks to the electronic card "CHIFA Card", introduced in 2007. Although initially limited to pensioners and people with chronic diseases, this procedure has been extended to the entire population, with more than 11,350,000 cards issued, benefiting more than 37 million people (ALGERIE ECO, 2016)

However, the generalization of the system is still in progress, currently accessible only to retirees during consultations with general practitioners under agreement with the social security (Executive Decree No. 09-116 of 7 April 2009).



2. Contractualization and Agreements:

Contractualization, introduced in the Finance Act in 1993 to remedy the inefficiency of the financing of health structures through the hospital lump sum, was intended to enable each financing entity to take charge of the categories for which it was responsible, promoting transparency and evaluation of hospital activities (GH M O, 2004). Although planned for 1997, its implementation was postponed and subsequently abandoned due to unmet conditions, including fluctuating oil prices (La presse médicale, 2017). Today, the contractualization is still under discussion, remaining a project on paper.

At the same time, agreements with the private sector are gaining ground, established by executive decrees setting out model agreements. These agreements aim to reduce expenses for treatment abroad. (Zerzouri, 2015) In 2017, the agreement system included 11,000 pharmaceutical pharmacies, more than 3,200 general practitioners, 19 private cardiovascular surgery clinics, 168 haemodialysis centres and 320 medical transport companies (FCE, 2017). Recently, in a context of rapid changes in births, 28 private clinics have been contracted to take care of deliveries. (MTESS, 2020)

IV. Loss of revenue of health insurance funds in Algeria:

The social security contribution rate for employees is set at 34.5%. However, the collection of premiums does not always achieve its objective due to some recalcitrant employers refusing to contribute or report their employees. As illustrated in Table 2 on "the missed revenue of the CNAS", a significant part of the wage bill is not covered by social security. In numerical terms, the shortfall represents nearly 2.78 times the revenues of the CNAS in 2017, indicating that a large proportion of employees are not affiliated or are not declared to the CNAS. The shortfall-to-revenue ratio has continued to increase since 2010. In 2019, a social affairs expert pointed out that there are 7.6 million wage earners in Algeria, but only 5.5 million of them contribute. (Mehenni, 2019)

According to the information in Table 2, if the entire wage bill were subject to social security contributions, at a rate of 34.5%, the potential revenues of all systems would amount to 1903572 million dinars in 2018. CASNOS, the Social Insurance Fund for the Self-Employed, is also experiencing operational difficulties due to the low collection of contributions from the self-employed.

**Table 2 "The shortfall of the CNAS (in millions of Dinars)"**

Years	CNAS Recipes (1)	Payroll (2)	Potential revenue (3) = (2) *34.5%	Loss of Profits (4) = (3)-(1)	Ratio 4/1
2010	290835,00	2907500,00	1003087,50	712252,50	2,44
2011	374138,00	3866400,00	1333908,00	959770,00	2,56
2012	477285,00	4291300,00	1480498,50	1003213,50	2,10
2013	429838,00	4390800,00	1514826,00	1084988,00	2,52
2014	459757,00	4659900,00	1607665,50	1147908,50	2,49
2015	474944,00	5005900,00	1727035,50	1252091,50	2,64
2016	482065,00	5308200,00	1831329,00	1349264,00	2,79
2017	492340,00	5401000,00	1863345,00	1371005,00	2.78
2018	489094	5517600	1903572	1414478	2,89203711

Source: Figures calculated by us from data from the National Statistics Office (Algeria in a few figures)

Table 3 below highlights the potential revenues of CASNOS compared to the revenues actually received by this body. In 2018, the shortfall amounted to 11.16 times CASNOS' actual revenue. In 2017, the Fund had 1,806,125 active self-employed members, an increase of 92% compared to 941,825 members in 2009 (ONS, 2018). It should be noted that some traders, farmers and craftsmen do not contribute enough, although the number of farmers' affiliates is currently doubling, especially in a sector employing 1.102 million people, or 10.1% of the labour force (bank of algeria, 2018). In 2019, the employed population is estimated at 11,281,000, with the private sector absorbing 62.2% of total employment, or a volume of 7,014,000 (ONS, 2019). It should be noted that a significant number of workers in the private sector do not have any social security coverage, amounting to approximately 3.6 million Algerians working without registration in the social security services. (Saadi, 2018)

Table 3 "CASNOS' shortfall (in millions of dinars)"

Years	CASNOS Recipes (1)	Independent Income (2)	Potential revenue (3) = (2) *15%	Loss of Profits (4) = (3)-(1)	Ratio 4/1
2010	23668,00	3049100,00	457365,00	433697,00	18.32
2011	25394,00	3487900,00	523185,00	497791,00	19.60
2012	30789,00	4007400,00	601110,00	570321,00	18.52
2013	35448,00	4580800,00	687120,00	651672,00	18.38
2014	38572,00	4954900,00	743235,00	704663,00	18.26
2015	43709,00	5301600,00	795240,00	751531,00	17.19
2016	71780,00	5661000,00	849150,00	777370,00	10.82
2017	63895,00	5719800,00	857970,00	794075,00	12.42
2018	69830	5661000	849150	779320	11,1602463

Source: Figures calculated by us from data from the National Statistics Office (Algeria in a few figures)



V. The financial situation of social security in Algeria: Post-covid

1. Evolution of CNAS revenues:

The value of contributions to the National Social Security Fund (CNAS) has risen sharply over the past three years. In 2023, these contributions reached 1,634 billion dinars, representing a significant increase compared to previous years. This growth has had a positive impact on the stability of the National Pension Fund (CNR), helping to reduce its financial deficit by 55%.

This increase in CNAS revenue is the result of efforts to improve workers' social security coverage. It is also due to the broadening of the membership base of the CNAS, in particular through the integration of new companies and the increase in the number of contributors.

This upward trend in CNAS revenues was also observed in the first eight months of 2023, with contributions estimated at more than 1101 billion dinars, an increase of 23.3% compared to the same period of the previous year. In addition, the number of employers affiliated to social security has also increased, reflecting better corporate compliance with social security regulations. (Louifi, 2023)

At the same time, the CNAS has launched a campaign to increase the number of members of the social security system. Under the theme "Membership of social security is an acquired right", this campaign focuses on the modernisation of CNAS services, in particular by allowing members to file their annual salary declaration online until 31 January 2023. This initiative aims to update files quickly and avoid penalties provided for by law. The campaign also targets recalcitrant employers operating in the informal sector, highlighting the importance of social security for workers' well-being and economic development. It highlights the impact of population ageing on pension systems, highlighting the crucial role of the social partners in the management of social security. (Algérie press service, 2022) The number of employers affiliated to social security was estimated, during the first 9 months of 2023, at 407,033, an increase of 23% compared to 2014 when there were 330,204 employers. (ADEL C, 2023)

2. Impact of COVID-19 on the labour market:

The COVID-19 crisis has had a significant impact on the economy and labour market in Algeria. Lockdown measures have led to major reductions in economic activity, leading to a significant decrease in the number of jobs and hours worked. Many sectors have been affected, including services and manufacturing, with disruptions in supply chains and a decline in revenue streams.

In February 2020, before the outbreak of the health crisis, Algerian companies employed around 16,193 full-time people, nearly 23% of whom were women. However, due to COVID-19, a significant number of layoffs and furloughs have been recorded, particularly affecting the industrial and construction sectors.

The situation of the informal economy has also been severely affected, with the shutdown of transport, the closure of shops and the paralysis of economic activities. Lower oil prices have also contributed to economic difficulties. Despite measures taken by the government to mitigate the impact, the crisis continues to



weigh heavily on the economy, jeopardizing the survival of many informal businesses and leading to an increase in unemployment.

Official statistics on the evolution of unemployment in 2020 are not yet available, but at the end of 2019, the unemployment rate in Algeria was 12.5%, affecting about 2.5 million people. (Bensalem, 2021) With ongoing economic challenges, it is likely that these numbers have increased since then. In conclusion, the repercussions of the Covid-19 pandemic on the labour market in Algeria have been disastrous. Indeed, in the document on the "**Economic Recovery Plan 2020-2024**" it is reported that 500,000 jobs were lost in 2020, which had a strong impact on the social security funds. (Algérie Eco, 2021)

3. The growing role of social security during the health crisis and the need for reforms:

During the Covid-19 health crisis in Algeria, the Social Security funds played an essential role by starting the payment of financial aid at the beginning of February. This measure, formalised by an interministerial order, aims to reimburse the costs of CT scans, PCR and antigen tests related to Covid-19. It responds to a government decision to grant financial aid, with specific amounts for each type of examination. (Algérie press service, 2021) However, despite this laudable initiative, some shortcomings remain, particularly in the private health sector.

In private clinics and medical imaging centres, access to examinations remains difficult for some because of the often-unaffordable prices. In addition, the rates of reimbursement by the social security system for these procedures are derisory and date back to 1987, which creates a significant financial burden for patients. Even though some private clinics have temporarily offered their services free of charge, this is still insufficient to meet the growing demand. In addition, essential medical examinations such as MRI are not covered, making the situation worse for many patients.

In the face of these challenges, reforms are needed to modernise the health system and ensure equitable access to care for all citizens. It is crucial to revise reimbursement rates, starting with radiological and biological examinations, to align them with the actual costs of services. This review should be carried out in collaboration with relevant stakeholders, including the Ministry of Health, social security funds and private health sector actors. In addition, it is important to reduce the out-of-pocket costs for households by increasing the share covered by health insurance, mutual insurance companies and the State. (SNOUSSI, 2020)

In conclusion, the Covid-19 health crisis has highlighted the growing importance of social security and the urgent need for reforms to ensure equitable access to healthcare in Algeria.



VI. Analysis of health insurance fund expenditure in Algeria

1. The share of the CNAS in the financing of public care structures (the hospital flat-rate):

Since 1974, the CNAS has been required by law to participate in the financing of the operating budgets of public health establishments through a flat-rate contribution set annually within the framework of the Finance Act. This obligation is supposed to cover the care of those insured by the CNAS. Since its inception, the hospital package has evolved considerably. (ZIANI & Zoulikha, 2012) It has increased from 13.551 billion DA in 1995 to 80 billion DA in 2018, i.e. a rate of evolution of 289.47% in 23 years. (See Table 4 below).

Table 4 "Participation of the CNAS in dinars in the budget of public health structures in Algeria"

Years	State participation	Participation of the CNAS	Rate of change in the State's participation	Rate of change in the participation of the CNAS
1995	21 278 280 000	13 551 000 000		
1996	25 536 787 000	16 576 000 000	20,01%	22,32%
1997	27 983 000 000	17 972 000 000	9,58%	8,42%
1998	28 780 880 000	19 652 000 000	2,85%	9,35%
1999	31 245 515 000	19 872 000 000	8,56%	1,12%
2000	33 036 043 000	20 540 477 000	5,73%	3,36%
2001	41 387 000 000	21 500 000 000	25,28%	4,67%
2002	49 223 279 000	25 500 000 000	18,93%	18,60%
2003	59 340 231 000	26 500 000 000	20,55%	3,92%
2004	63 232 080 000	27 021 274 000	6,56%	1,97%
2005	51 408 031 000	35 000 000 000	-18,70%	29,53%
2012	360 340 296 000	48 129 410 000	-	-
2013	258 178 634 000	49 629 410 000	-28,35%	3,12%
2014	313 525 878 000	57 818 524 000	21,44%	16,50%
2015	321 186 699 000	65 219 092 000	2,44%	12,80%
2016	312 245 153 000	64 815 511 000	-2,78%	-0,62%
2017	324 455 744 000	73 753 570 000	3,91%	13,79%
2018	327 034 008 000	80 000 000 000	0,79%	8,47%

Source: Calculated by us using MSPRH data

The table above shows that both in absolute and relative terms, the State's share grew more than that of the CNAS, with rates of 889.93% and 289.47% respectively. In 2018, the State contributed 74.43% to the revenues of public health institutions, compared to 18.21% for social security institutions.



2. Transfers for care abroad:

In 2018, only 233 patients were sent abroad for care, compared to 8,000 in the 1990s. Today, this figure has been kept at a lower level thanks to the agreements of the CNAS with private clinics that have the adequate equipment and resources necessary to ensure adequate care for these patients. In addition, between 2009 and 2018, the CNAS spent more than 27.7 billion dinars on the care of 74,600 patients with heart disease in the 25 clinics with which it has an agreement. (APS, 2019). Indeed, arteriovenous malformations, complex congenital heart defects, complex adult heart diseases as well as liver transplantation in children are all specialties that require shipments abroad. However, transfers for care are decreasing year on year due to improved care in the country, with a 90% drop between 2000 and 2017. The agreements reached between the CNAS and private clinics for the surgical care of the heart have effectively supported the reduction of these expenditures, thus helping to alleviate the financial burden on the public treasury. (APS, 2019)

This holistic approach to the care and ongoing support of the insured is manifested in particular in the treatment of children with congenital malformations within the CMCI Clinic. This establishment, under the CNAS, is the only public structure in Algeria specialized in pediatric cardiac surgery for more than 30 years. By playing a crucial role in modernizing management and staff training, the clinic welcomes all patients with congenital heart disease from all regions of the country. This initiative has "significantly" contributed to the reduction of patient transfers abroad for care. (ELITEPRESSE, 2017)

3. The evolution of expenditure on medicines in Algeria:

Reimbursement of medicines is the largest item of expenditure for the CNAS, accounting for 7.45% of expenditure in 1990. In 2017, they reached 84% of total health insurance expenditure, recording sustained growth. This expenditure has seen a significant increase, from 0.94 billion DA in 1990 to 190 billion DA in 2016, a 202.12-fold increase. Variations in drug prices, due to successive currency devaluations, as well as the increase in the number of social insured persons, are major factors contributing to this trend. (ZIANI L. , 2020)

**Conclusion:**

Social security in Algeria is now facing substantial revenue losses due to the growth of informal work and frequent delays in payments by companies. These challenges significantly hamper the ability of health insurance bodies to recover contributions owed, generating systemic gaps both in terms of benefits in kind and in the management of the collection process.

It is imperative to undertake thorough audits at company level in order to carry out a comprehensive declaration of employees as well as the actual income of self-employed workers. This issue goes beyond the simple financial dimension of recovery, but also has a crucial aspect of mutual trust between policyholders, companies and the social security system.

The legitimate question arises from the point of view of insured persons and employers: why contribute when reimbursements for care in the private sector, with the exception of medicines, are not insured? This question highlights the need for a profound reassessment of the health and social security system, highlighting the need to restore participants' confidence through clarifications on benefits and a substantial improvement in the transparency of benefits.

Recommendations:

- **Optimization of Collection Mechanisms:** Establish more effective mechanisms for the collection of contributions, with a particular focus on the rigorous monitoring of enterprises and the regularization of informal work.
- **Enhanced Transparency:** Improve the clarity of healthcare reimbursement policies, both in the private and public sectors, in order to restore contributor confidence.
- **Structural Reform:** Undertake structural reform of the health and social security system, based on thorough assessments of needs, costs and efficiency of expenditure.

Research Perspectives:

- **Impact Analysis of Informal Work:** Conduct in-depth studies on the impact of informal work on social security revenues, identifying current gaps and proposing appropriate solutions.
- **Assessment of Stakeholder Perception:** Conduct surveys to understand the perception of policyholders and employers towards the health system, thus feeding into adjustments based on the real needs and concerns of stakeholders.
- **Research on Alternative Financing Models:** Explore innovative financing models that could help ensure the long-term sustainability of the health and social security system, while maintaining the confidence of participants.



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Notes de fin :

¹ CNAS : Caisse Nationale des Assurances Sociales des Travailleurs Salariés

² CNASAT : Caisse Nationale d'Assurance Sociale, Accidents du Travail et des Maladies Professionnelles

³ CNR : Caisse nationale de retraite

⁴ CASNOS : Caisse des assurances sociales des travailleurs non-salariés

⁵ CNAC : Caisse national des assurances chômage

⁶ CNRSS: CAISSE NATIONALE DE RECOUVREMENT DES COTISATIONS DE SÉCURITÉ SOCIALE