

1 EXECUTIVE SUMMARY

Kingdom of Morocco is situated on the northwest side of the African continent. This geo-strategic situation makes it an amalgam of Europe and Africa, Arab - Moslem orient and Euro – Mediterranean cultures, one of the more versatile countries of the region. The Moroccan population is a harmonious ethnologic assemblage of Berber, Arabic, and andalouses cultures. Morocco's varied geography includes mountain ranges, valleys, coasts, and wide expanses of desert. Its climate is relatively dry, although small amounts of rain do fall between November and March. Temperatures, however, vary considerably by season and locale.

As with other developing nations, Morocco is undergoing a transition in the form of urbanization. In 1960, Moroccan population living in cities used to account for barely 30% of the total population, while now more than 51% of inhabitants live in cities. The countryside environment, in which most of the Moroccan population lives, very clearly determines their demographic and health profile apparent through the high fecundity index and the structure of families.

Overall, there has been a marked improvement in the health status indicators of the Moroccan population during the last fifty years, indirectly evident through a rise in life expectancy to 68 years and fecundity reduced to 2.3. However, some selected indicators like Maternal Mortality Ratio remained stagnant over the past decade; the results of the last investigation on the population and the family health (EPSF, 2003-2004) give an indication of maternal mortality of 227 for 100.000 live births. Similarly, the under-five mortality rate remained the same 37% between 1997 and 2003, rising to 40% for the period 1999-2003, with neonatal mortality is posing a major problem.

Restraining government spending, reducing constraints on private activity and foreign trade, and achieving sustainable economic growth are some economic issues that Morocco faces currently. Long-term economic challenges include: preparing the economy for free trade with the EU and US, attracting foreign investment to boost the living standards and job prospects for Morocco's youth and improving educational status.

Although education in Morocco is free and compulsory through primary school (fundamental course until age 15), many children (particularly girls in rural areas) still do not attend school. The country's illiteracy rate has remained at around 50% for some years, reaching as high as 90% among girls in rural regions. Morocco has about 230,000 students enrolled in 14 public universities.

Since the formulation of the first health policy in 1959, the Moroccan health system is organized with a predominance of the public sector, characterized by the free health care services and the centralized management. The State is positioned at the midpoint of the health system performing at once the functions of financial source, administrator and health care provider. The Ministry of Health runs the Basic Care Health Network, Hospital network and the National Institutes and Laboratories. The Defense department runs its own hospitals and services and local governments have Municipality health services. Over the years, the private sector developed progressively, functioning independently in most cases.

The health system is organized according to a pyramidal hierarchy. Structures of primary healthcare (clinics, urban and rural health centers and local hospitals in rural districts for the public sector; medical offices and infirmaries for the private sector) represent the first resort for the patients. They provide preventive and promotional cares as well as

ambulatory curative cares. The second recourse corresponds to the provincial and prefectorial hospitals for the public sector and the specialized offices and clinics for private one. The third recourse includes regional hospital centers. Fourth recourse is the university hospital centers, one each in Rabat, Casablanca, Fez and Marrakech, where secondary healthcare requiring high technical supplies and logistics is being provided.

The health sector is governed by a set of ruling texts for the administrative, sanitary legislation and regulation of professional bodies. The overall responsibility for the public and private sectors lies with the Ministry of Health. A Regulation and Claims department within Ministry of Health is responsible for regulating the public healthcare institutions, legal aspects of medical and paramedical professions, and sanitary legislation. Morocco has over 269 private hospital units which make up a total capacity of about 5,500 beds. Half of this capacity is located in Casablanca and the rest is distributed between Rabat and the other main cities of the country. The private sector is ruled in part by a governmental department, the Government's General Secretary, and partially by a Professional Council (physicians, pharmacists and surgeons dentists).

The non profit sector is represented by health care establishments run by two mutual benefit societies, the National Social Security Fund (CNSS) and the National Fund for Social Security organisms (CNOPS). These health care institutions take care of employees of private and public sector respectively. Currently, 13 CNSS polyclinics are functional with 1138 beds (98). The sector employs 305 physicians, 1720 male nurses, and 6 pharmacists on permanent basis, while 127 physicians work part time.

Two separate types of institutions train health professionals:

- Schools of Medicine and pharmacy: Four in total, one each in Rabat, Casablanca, Fez and Marrakech
- Schools for nurses and paramedics (IFCS): Ten in total.

The public basic healthcare network comprises of 2458 Health Facilities providing curative and preventive healthcare services as well as undertaking health promotion activities. The public hospital network included of general and single specialty hospitals, semi-autonomous hospital centers, University and hospital centers have total of 124 hospitals with 25,000 beds.

At each province or prefecture level, an administrative organization, named "Delegation of the Health Ministry" has the responsibility of the implementation of health policy, within its territory, through budget allocated by the central administration. This organization is the result of a type of decentralization called de-concentration, through which authority was delegated from central administration to the provincial and prefectorial levels. It also supervises public sector healthcare institutions and public schools of paramedical training. However, the human resource functions like recruitment, salary and career structure are still the responsibility of the central administration.

The Region is currently the interlocutor of the central government regarding to all health issues. Since the institutionalization of the Region as intermediate governance level, there is a new dimension of public sector involvement; there is more participation of local actors, improved proximity of the administration to the citizens and decentralization of the decision making processes. Some strategic functions reserved to the central administration are gradually being delegated to the regional level, such as the health care supplies planning (each Region Health administration develops its health care supplies diagram, called SROS¹). However, financial and human resources control is still

out of its scope of responsibilities. Recently, MOH set up the first regional health departmentⁱⁱ in the Region of the Oriental.

Healthcare financing in Morocco is characterized by inequity and lacks adequate regulation, being more in favor of the wealthy segment of the population than those less affluent. The financing system is optional and done on voluntary basis. It covers only 16.4% of the population, more than three fourth of them city dwellers (3.8% rural vs. 12.8% urban). Again, state and public sector employees and their dependants constitute more than two thirds of the covered population. Since the criterion for membership is income in the form of a salary or the retreat pension, economically disadvantaged people are excluded from this system. They are treated nearly free of charge at public health care establishments (automatically as concerns primary care and upon giving a certificate of indigence for hospital care). The rest of the population, neither insured nor indigent, must pay professionals directly for health care. An autonomous state sponsored public establishment called "National Agency of the Health Insurance (ANAM)" is the first organization to regulate health insurance system. It's mission is to supervise the obligatory health insurance system and to manage RAMEd resources allocation process.

According to the national health accounts, the private hospitals benefit from the largest flows (nearly two-thirds). This is particularly true of private clinics, which receive almost 51% of all payments. Despite the minimal participation of CNOPS, the share of private practice is quite high, mainly due to radiology and laboratory investigations included in different health insurance plans. Public hospitals receive just 6.2% of all direct payments from organizations that manage the various health insurance plans.

The sanitary human resources comprise of four types of professionals; the physicians, the pharmacists, the surgeon dentists and the paramedics, distributed between the public sector and the private one. Currently, there're about 16.000 physicians (1/1850 inhabitants) and nearly 30.000 paramedical (either 1/1000 inhabitants). In the public sector, the Ministry of Health is the main employer of the physicians, who represent one fifth (19%, n=8003) of the total of the staff of the Ministry of Health. More of the half of these physicians, both in the public and private sectors are condensed in the center (Casablanca), and regions of the northwest, Rabat, despite efforts by the Ministry of Health to orient the recruitment of the new physicians toward the less covered rural regions. The last two recruiting operations (2003 and 2004) were exclusively for the rural districts. The pharmaceutical industry, a group of twenty-six enterprises is controlled by ten laboratories, some funded by foreign donors. The industry caters to 80% of the local needs through it's production.

The public health sector reforms aim to correct sector dysfunctions and inequities that reduce its effectiveness and efficiency. Still the main challenges are improving equity in access to healthcare; enhancing coverage of secondary and tertiary care and healthcare financing; increasing responsiveness to emergent morbidity needs through public sector infrastructure and stewardship of Ministry of Health.