4. HEALTH SYSTEM ORGANIZATION

4.1 Brief History of the Health Care System

In 1956, when Morocco became independent, there were only about 300 public health physicians and 400 private practitioners in the country. Since then, the government has made health care services more widely available and improved their quality. By 1992, health care was available to 70% of the population. Health education courses at schools and colleges, and programs to teach hygiene to children and parents, have also helped raise the quality of health. The current life expectancy is 66.5 years for men and 70.6 years for women.

Most health providers and health care centers are located in urban areas. In rural areas, mobile medical teams and a group of pharmacies and clinics provide outpatient care. Efforts to improve health care in Morocco have been hampered by problems with waste disposal, the limited availability of safe drinking water and the rapid growth of the population. The government has been working to improve sanitation and the quality of drinking water.

In 1982, the Ministry of Public Health was formed. Since then, smallpox has been eliminated, typhus outbreaks are less frequent, and malaria and tuberculosis have been brought under control. The World Health Organization and UNICEF also support the government's campaigns to reduce eye disorders and sexually transmitted diseases. Employers in industry and business are required to register their workers for benefits, but many workers are still not covered. Many other programs aiming at extending medical care to needy Moroccans are under way.

During the early eighties, there was a decline in the overall state supremacy. With the world economic crisis, the State had to face a profound financial crisis leading to the adoption of restrictions and reforms. The coming of Alma-Ata declaration offered the opportunity to focus on the prevention of disease and the development of basic health care and health programs. Since then, prevention became the state priority while hospitals were left in the shadow of health policies. The Medical Doctors showed a growing interest in the liberal medicine. The development of the private sector increased in the urban area and in the most promising regions of the country, independently from the State.

4.2 Public Healthcare Delivery System

Organizational structure of public system

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 Basic Health Care network comprises of 2458 Health Facilities responsible for curative and preventive ambulatory care + Collective health prevention.

The Hospital network comprises of 124 hospitals with 25,000 beds, including single specialty hospitals, semi-autonomous hospital centers, University and hospital centers.

The National Institutes and Laboratories are primarily responsible for preventive activities and research and extend their expertise in hospital and ambulatory care and training.

Key organizational changes over last 5 years in the public system, and consequences

Public sector has undertaken a modernization of its infrastructure and management processes regarding human resources and information technologies in use. Responsibility and anticipatory management are gradually replacing a rigid and less reactive bureaucracy. However, salaries in government services reduce considerably the resources allocated to development strategy to alleviate this salary mass is currently being contemplated.

Planned organizational reforms in the public system

Since 90's Morocco has initiated a process of reforms in some vital sectors of the public administration and its political, economic and social environment. Reforms of public administration, public expenditure, labor code, family code and other legal reforms make way for the public sectors to modernize themselves and try to adjust their actions to satisfy the population requirements and to meet national and international politico-economic changes.

4.3 Private Health Care Systems

Modern, for-profit

Morocco has over 269 private 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. Some infrastructures are of medium size and possess some of the most sophisticated equipment with a capacity of 50 to 100 beds, whilst the vast majority is small clinics with a capacity of less than 30 beds and limited resources. Despite major development during the 90's, the sector is now in crisis due to competition amongst hospitals belonging to the Department of Social Security, over-concentration in big cities, the limited purchasing power of the large majority of the population and the lack of financing. Government control is exercised at equipment level. In clinics that have been practicing for at least 10 years, specifications have been imposed which define the minimum technical level required.

Modern, not-for-profit

This sector is represented by health care establishments run by mutual benefit societies, the National Social Security Fund (CNSS) and the National fund for social security organisms (CNOPS). These institutions provide health care to 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.

Traditional

Traditional medicine sector remain active, particularly in the disadvantaged suburbs and among the populations with low socioeconomic level. There is lack of reliable data about expenses assigned to the care prescribed by the healers and traditional midwives. The impact on users' health status is also unknown.

Key changes in private sector organization

During 80's and 90's, private medical sector underwent an important development. Centers of specialized cares, with advanced healthcare technologies appeared in the big urban centers, especially in the cities with university hospital centers.

Public/Private interactions (Institutional)

In the recent years, many projects of partnership have been developed between the Ministry of Health and the NGOs operating in the sector of the reproductive health or the enhancement of rural women's status. Other memorandums of agreement focus on youth health or the protection of the environment. MoH leads a survey to assess the potentialities and the profits of a public—private partnership in health activities.

Public/private interactions (Individual)

In Morocco, the legislation controls the employ of physicians of the public sector in the private sector. University physicians are allowed to work two half days per week in private health institutions. This rule is often contravened and the liberal physicians often show their dissatisfaction about facing an unfair competition.

Other mode of partnership between the two sectors is agreements passed between the Ministry of Health and the liberal physicians, in order to reduce medical training insufficiency in public hospitals.

Leasing is another example of public-private interaction. This rental procedure allows public healthcare institutions to make available services involving costly health care equipments such as haemodialysis generators.

Planned changes in the private sector organization

The advent of the obligatory health insurance (AMO) will obligate the state to implement regulation measures of healthcare supplies and costs in private and public sectors. A recent World Bank report estimates that AMO will necessitate an adjustment of payment system and tariffs applied in the private sector.

4.4 Overall Health Care System

Organization of health care structures

Diagram (see annex)

Current overall structure

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-tech equipment and logistics is being provided.

The semi-public sector comprises of health care institutions managed by health insurance organization (CNOPS and CNSS) and other semi-public institutions (office chérifien of the phosphates; national office of the railways etc). They provide curative ambulatory and hospital cares.