69710

KINGDOM OF MOROCCO

HEALTH POLICY NOTE TOWARDS A MORE EQUITABLE AND SUSTAINABLE HEALTH CARE SYSTEM - POLICY CHALLENGES AND OPPORTUNITIES

POLICY NOTE (P104274)

MIDDLE EAST AND NORTH AFRICA
SOCIAL AND HUMAN DEVELOPMENT GROUP (MNSHD)

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ACRONYMS AND ABBREVIATIONS

ALC	*Affectations longues et coûteuses*
ALD	*Affectations de longue durée*
ALOS	Average Length of Stay
AMI	*Assurance Maladie des Indépendants*
AMO	*Assurance Maladie Obligatoire*
ANAM	*Agence Nationale de l'Assurance Maladie*
BBP	Basic Benefit Package
BOR	Bed Occupancy Rate
CAS	Country Assistance Strategy
CHU	*Centre Hospitalier Universitaire*
CMB	*Couverture Médicale de Base*
CMIM	*Caisse Marocaine Interprofessionelle des Mutuelles*
CNOPS	*Caisse Nationale des Organismes de Prévoyance Sociale*
CNSS	*Caisse Nationale de Sécurite Sociale*
DALY	Disability Adjusted Life Years
DH	Dirham
DHSA	*Direction des Hôpitaux et des Soins Ambulatoires*
DPRF	*Direction de la Planification et des Ressources Financières*
DRG	Diagnosis-related Rroups
EDL	Essential Drug List
EC	European Cooperation
EIB	European Investment Bank
ENCDM	*Enquête Nationale sur la Consommation et les Dépenses des Ménages*
ESSB	*Etablissements de Soins de Santé de Base*
EU	European Union
FMIM	*Fonds mutuel interprofessionnel marocain*
GDP	Gross Domestic Product
GLP	good laboratory practice
HDR	Human Development Report
HECS	Household Expenditure and Consumption Survey
HIV	Human Immunodeficiency Virus
IMF	International Monetary Fund
IMR	Infant Mortality Rate
INDH	*Initiative nationale pour le développement humain*
LBW	Low Birth Weight
MCH	Maternal and Child Health
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MED	Ministry of Economy,
MMR	Maternal Mortality Ratio
MLSPP	Ministry of Labor and Social Protection
MOEF	Ministry of Economy and Finance
MOH	Ministry of Health
MOI	Ministry of Interior
MTEF	Medium-term Expenditure Framework
NCD	Non-communicable Diseases
NGO	Nongovernmental Organization
NHA	National Health Accounts
OECD	Organisation for Economic Co-operation and Development
PAGSS	*Programme d'Appui à la Gestion du Secteur de la Santé*
PARL	Public Administration Reform Development Policy Loan
PARP	Public Administration Reform Program
PER	Public Expenditure Review
PFGSS	*Programme de Financement et de Gestion du Secteur de la Santé*
PHC	Primary Health Care
PIP	Public Investment Program
PPP	Purchasing Power Parity
RAMED	*Régime d'Assistance Médicale*
RDU	Rational Drug Use
RH	Reproductive Health
SEGMA	*Services de l'Etat gérés de manière autonome*
STP	Standard Treatment Protocol
TB	Tuberculosis
U5MR	Under-five Mortality Rate
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations International Children's Emergency Fund
VHI	Voluntary Health Insurance
WDI	World Development Indicators
WHO	World Health Organization

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EXECUTIVE SUMMARY

Health and Demography: the Protracted Transition and the Unmet Needs

1. *Since independence, Morocco has made impressive progress in improving health and life expectancy.* Over the last 40 years there have been significant reductions in infant, under-five, and maternal mortality, and increase in life expectancy at birth from 47 to 70 years.

2. *However, these achievements compare unfavorably with those of countries with similar socioeconomic development.* The maternal mortality ratio (MMR) remains high—one of the highest in the MENA region and 45 times higher than the EU average (5 per 100,000 live births). Only 4.3 percent of pregnant women in the poorest quintile deliver their babies with the assistance of a doctor, 37 percent preferring delivering them at home. The under-five mortality rate (U5MR) is also high in Morocco—one of the highest in the MENA region and nine times higher than the EU average (6 per thousand live births).

3. *Most determinants of high maternal and under-five mortality, two of the health-related Millennium Development Goals (MDGs), are imbedded in socio-structural inequalities in access to care.* Being poor and living in rural areas where access to care is far from being acceptable are highly predictive of child and maternal mortality. For instance, in rural Morocco, maternal mortality is 43 percent higher. Children under the age of five of the poorest segment of the population are three times more likely to die as a result of an often easily treatable childhood illnesses or preventable injuries.

4. *Morocco is in the midst of a demographic and epidemiologic transition at a time when major inequalities in health and access to healthcare persist.* Beyond the MDG agenda, urbanization and changing lifestyles do affect people's health behavior. As the prevalence of high blood pressure, smoking and obesity rise so does the prevalence of Non-communicable diseases (NCDs). Recent data shows that overall more Moroccans die of NCDs than in other causes. Circulatory diseases are the main cause of mortality, affecting men and women equally. As the population will gradually get older, while eating more, exercising less and smoking, it is inevitable that the ensuing burden of illness will tax health care system's coping capacity and responsiveness, and increase costs.

Responsiveness of the Health Care System; Meeting the Needs, Fulfilling the Expectations

5. *At present, the publicly financed and run health care system does not meet healthcare needs of the majority of the Moroccans.* Only half of the population uses health services when experiencing an illness, indicating that people who live outside big cities either cannot or will not pay for poorer quality services in rural health facilities. While in the short term limited use of healthcare services because of inability or unwillingness to pay may not significantly affect levels of morbidity and mortality resulting from non-communicable diseases, the impact is likely to grow exponentially in the next two decades.

6. *The main reason for low responsiveness is the mismatch between the supply of health services and the demand for care.* Most essential health services are either inaccessible to, or underutilized, by those who need them because of financial, social, physical and geographic barriers. While most of the unmet healthcare needs are in rural areas and amongst the poor, most well-endowed facilities, doctors and other health professionals are located in big cities. To make the matter worst, public funds does not follow the patient, but is directed to where the facilities and doctors are located. Consequently, the better-off, the urban and those with the right connections have easier access to care whereas the majority must pay out-of-pocket either to have better access to public providers or simply use the services of private providers where the quality is better.

7. *System responsiveness could be improved at the margins by targeted programs.* While it will take longer to alleviate socio-structural inequalities, Morocco could easily bring down the unacceptably high child and maternal mortality rates with well-funded programmes geared towards the needs of the rural poor for nutrition, immunization, and timely and proper treatment of childhood illnesses. Despite the paucity of data, the main causes of maternal deaths would be acute severe bleeding, eclampsia, unsafe abortion and obstructed labor, which could be prevented and/or properly treated if expecting mothers received proper antenatal care and the facilities were properly equipped and the staff well trained, all feasible and affordable in today's Morocco.

8. *Responsiveness could be further enhanced with pro-activity and foresight for developing, properly financing and implementing large-scale disease prevention and health promotion programs.* The epidemiologic transition will require a different set of facilities and technology, and a different mix of social and medical skills and competence that need to be envisaged, planned and invested in without delay. To move forward, Morocco must adopt policies that increase government financing and improve allocation of public funds in line with its epidemiologic and demographic profile and the burden of risk factors and illness.

9. *However, large-scale reforms are needed to make the health care system truly responsive in the future.* Despite recent attempts by the government to expand population coverage, improve system governance, and increase the quality of care, Morocco's health care system remains predominantly state owned and managed, yet highly fragmented. On one hand, the system is not truly pluralistic because of negligible participation of providers and consumers in system governance. On the other hand, the execution of all main healthcare functions are segmented across several government agencies, or applicable to different population segments. In addition, low and poorly allocated public outlays for health care result in inefficiencies in the allocation and use of public resources, as well as in high private out-of-pocket expenditures. If a publicly funded health insurance scheme is intended to provide universal coverage for an essential package of services, a significant restructuring of the existing institutional architecture and of the legislative and regulatory framework will be needed to make it a reality.

An Agenda for Health Sector Reform

10. *This note identifies three main issues and proposes a set of short- and longer-term policy measures for each* (Please see the policy matrix at the end of the note for an integrated summary of all short and longer term policy measures).

Equity - Implementation of the "Couverture Médicale de Base"

11. While targeted programs (TB, HIV/AIDS, MCH etc.) and mobile intervention strategies may improve access through increased supply and consequently help improve health outcomes, the solution, as amply recognized by the Government, is the achievement of universal coverage in an equitable and fiscally and financially sustainable manner. This will require, first and foremost, an agreement on the content of the Basic Benefit Package that RAMED will have to cover. Given the extensive amount of preparatory analytical and advisory work conducted thus far, what is needed is more than simply defining broad categories (e.g., inpatient care, or "affections de longues durées") but rather adopting standard treatment and referral protocols and informing the beneficiaries to reduce ambiguity and therefore mitigate access problems and informal payments.

12. A second issue is the agreement on the eligibility criteria, and on finding optimal trade-offs between fairness in patient contribution and fiscal viability on one hand, and, on the other, ease of administration, enforceability and convenience for the clientele in getting in and out of the two categories (i.e., the poor and the vulnerable) and making the initial payments for the *carte d'indigence* and user fees. Once RAMED is up and running, and AMI-Inaya becomes fully functional,

harmonization of the premium rates, eligibility, benefit packages, reimbursement rates and co-payments should gradually be carried out for a "virtual" merger of all the insurance schemes. The harmonization process would also include the fee schedule that is negotiated with the providers.

13. Another parallel activity would be defining the role of private health insurance. Ideally, given the extensive "*mutualisation*" of health insurance in both the private and public sector, one would expect that private insurance scope and coverage will be geared towards offering insurance packages to complement or supplement what is already covered rather than competing on the basis of the same package of services by various schemes. Therefore, the competition will not be on the content, but rather on the quality and price of the complementary package.

Good governance – Segmentation of Stewardship, Financing and Service Provision

14. A *sine qua non* for good governance is the functional segmentation of the main roles and responsibilities of the Ministry of Health, ANAM (RAMED) and the AMO implementing agencies. A good start would be the issuance of the Strategy document "Santé Vision 2020" which - it is hoped – will set the stage for the necessary restructuring of the Ministry of Health from being mainly a financing agent – albeit through the Ministry of Finance – and a provider of health services, to becoming a policy making, planning, standard setting, regulating, enforcing, intelligence gathering and evaluating agency. Once there is an agreement on its renewed mandate towards "more *steering and less rowing*", the MOH would have to restructure its organization set-up, create new units and recruit and/or train new staff to effectively fulfill its new functions. In parallel, an effort would also be needed to complete the on-going regionalization process and making sure that the transfer of authority and accountability to the new regional departments will not be purely administrative, but rather would hold them to account for due diligence in financing and delivery of health programs. As such, the recently instituted budget based programming is in the right direction provided that there will be a rigorous and external evaluation mechanism for proper assessment of their effectiveness.

15. Three other policy measures need to be undertaken in tandem: (i) the autonomization of public hospitals with full financial and managerial autonomy as a prelude to subsequent contracting arrangements with the payers; (ii) revision of stature of the professional associations to redefine and clarify their roles in licensing, and certification of health workers and to allow them formal participation in major policy and administrative personnel decisions; and (iii) issuance of a patients' rights law for consumer protection against medical malfeasance.

Allocational and Technical Efficiency

16. Improved access to care by the poor will inevitably put pressure on the supply side. Morocco's present endowment in physical, technological and human resources barely copes with the existing low level and intensity demand for health care - approximately 0.6 visits *per capita* per year – and that at the expense of a shift in resource use away from ESSBs towards regional hospitals and CHUs. This report advocates for the preparation and adoption of a "*carte sanitaire*" which would need to also consider prospects for private sector investment outside Rabat and Casablanca and obtain consensus and adopt the human resources development strategy that has recently been drafted. Hopefully, with the concurrent progress in rural development, and through the "*Initiative nationale de développement humain*" there will be a significant improvement in poverty, maternal education and child schooling which also will contribute to improved health outcomes. Regardless, investment in rural health facilities (ESSBs) and finding the right financial and professional levers to match the supply of good quality essential health care services such ante- and peri-natal care, integrated management of childhood illnesses, immunization and micro-nutrient supplementation with a demand which need to be induced by proper public information education and communication will be required.

17. A complementary measure would be to develop and adopt a resource allocation formula, weighted by demographic and epidemiologic profile of the regions as a basis for the *contrat-programmes* with the regional authorities. Such a measure, if properly designed and executed, is very likely to improve efficiency in the allocation and use of resources. A number of studies would need to be conducted first, such as a second Burden of Disease study and a Risk Factor study with large enough samples for dis-aggregated assessment of the burden at the communal level. Adoption of the formula will also help with implementation of the Medium-Term Expenditure Framework in the longer run. Additional measures may include the issuance of financial and non-financial incentive packages to entice the deployment of health personnel to underserved areas and a new policy for price setting and reimbursement of generic drugs.

18. At a more micro level, the adoption of standard treatment protocols for improved technical quality of care, a new policy on rational use of drugs and pay-for-performance measures for physicians in the short run would also be valuable in increasing technical efficiency. In the longer term, however, other more expansive measures such as the institutionalization of accreditation of hospitals and health care technology assessment, and above all ANAM's ability to constantly monitor and audit technical quality and appropriateness of care provided by the contracting provider would be essential as a basis for moving towards an output-based (i.e., case mix, diagnosis-related groups, etc) payment modalities.

19. All these options carry significant political risks and institutional capacity challenges, more so than fiscal constraints. However, with strong leadership and a vision for the future as well as the adoption of a consensual process fully involving all public agencies and representatives of the providers and population groups, there is no reason why these policy measures cannot be undertaken. What is crucial is the realization that the health sector is in dire need of investment, mostly in its workforce but equally importantly in its "info-structure" to generate and manage health information for sound decision making.

A Way Forward

20. The first step is for the MOH to take the lead in managing the reform process by redefining its vision, mission, mandate, roles and responsibilities, all of which would form the basis of the draft document *Santé-Vision 2020*. Its completion will require a consensus-building exercise among all stakeholders in the healthcare system and the preparation of an implementation plan for reform, including the costing of necessary inputs.

21. The preparation and the issuance of the *Santé-Vision 2020* should have the backing of the Royal Court and be supported by an interagency steering committee. The array of options presented therein should be fed back to all stakeholders to build consensus on their specific content and, equally important, to facilitate agreement on the timing, sequencing and financing of reform elements.

22. The proposed reform agenda is admittedly ambitious in its scope and reach. The issue is whether the government has the capacity and/or the political will to follow through and deliver on its commitments. Granted, some of the reform initiatives would depend largely on the availability of additional resources. Others would require difficult policy decisions. Ultimately, success will depend on how central will the goal of building an equitable and responsive healthcare system become on Morocco's human development agenda.

INTRODUCTION: SCOPE AND PURPOSE OF THE POLICY NOTE

1. This Policy Note aims at providing policy makers and senior government officials with a comprehensive yet internally coherent policy reform framework as one input to the ongoing efforts to develop their own vision of the future for a high performance health sector in Morocco.

2. The Note comprises four chapters. Chapter 1 provides an overview of health and healthcare in Morocco. Its focus is on documenting inequalities in health, or, more specifically, the causes and consequences of the structural and social determinants of ill-health and access to health care in a context of demographic and epidemiological transition and significant distributional inequalities in human, financial and physical resources across the country. It has three sections: (i) a description of the health and demographic status and their evolution over time; (ii) an assessment of health and poverty and of the resultant inequalities as a result of its distal and proximal determinants; and (iii) a synthesis of patterns and trends in supply of health care since Independence and the recent attempts at reforming the health care system.

3. Chapter 2 builds on the findings and observations made in the previous chapter to document and highlight main sectoral issues and preoccupations with regard to four desiderata: good governance; equity in access to care; efficiency in the allocation and use of limited resources; and population and provider satisfaction. The emphasis is on governance, financing and resource allocation and use. The delineation of the roles and responsibilities of the State at the central and sub-national levels, and with its various payer and regulator agencies vis-à-vis key functions in health care (policy making, resource allocation, management, regulation etc.) is one issue that is highlighted. Another is the role that providers (professional associations, representatives of the private sector) and the citizens play towards a more pluralistic, transparent and accountable governance model.

4. The remit of Chapter 3 is the "what" question, or the content of the reform agenda, focusing on the expansion of population coverage and improved governance with a view to reducing inequities while safeguarding overall efficiency and fiscal sustainability. Chapter 4 tries to answer the "how" question, by proposing a comprehensive, integrated and hopefully internally coherent policy matrix to highlight the interconnectedness of policy measures. The importance of sequencing the short and longer term policy measures on an admittedly ambitious reform agenda tackling at once the shortcomings in equity, efficiency and governance is emphasized.

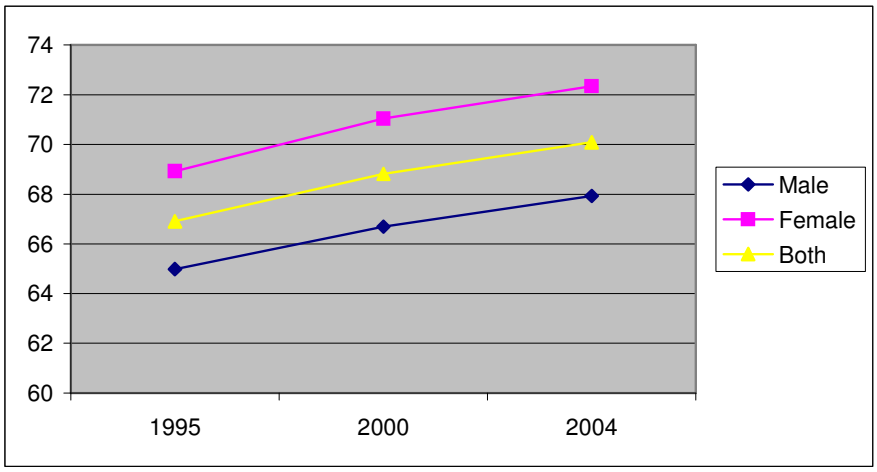
5. This Policy note is expected to advise and assist: (i) the Royal Cabinet and the Council of Ministers in their deliberations vis-à-vis the evolving role of the State and the private sector in health care and the delineation of the functional responsibilities of the MOH and para-statal agencies; (ii) the Ministry of Health in its attempt to redefine its own role and functions in a more pluralistic healthcare system and restructure its central and sub-national entities; and (iii) other national (e.g., private providers, professional associations, trade unions, consumer advocates, etc.) and international (UN agencies and donors) partners in seeking and building consensus over what needs to be done and how to do it for a more effective and vigorous partnership with the Government of the Kingdom of Morocco in these times of rapid socioeconomic transition. It is our sincere hope that it will play a role in implementing the proposed reform policy and strategies in a timely and well-sequenced manner to satisfy the aspirations for a high performance yet affordable health care system in Morocco.

CHAPTER 1: HEALTH AND HEALTH CARE IN MOROCCO – AN OVERVIEW

1.1. Health and Demography

1. **Since independence, improvement in health outcomes has been impressive.** Over the last 40 years there have been significant reductions in infant, under-five, and maternal mortality, and increased life expectancy at birth from 47 to 71 years[1] (Figure 1.1). Morocco is expected to achieve 2/3 reduction in infant mortality and ¾ reduction in maternal mortality in 2015, the target date for the attainment of Millennium Development Goals (MDGs) (see Annex 1).

Figure 1.1: Trends in Life Expectancy, Morocco, 1995-2004



Source: World Bank HNP stats Data Query

2. **Despite significant progress, however, Morocco's health achievements remain below those of countries with a similar level of socioeconomic development** (Table 1.1 and Figure 1.2). Morocco's overall performance in human development remains below its global ranking by economic development and growth.[2] Morocco has the highest maternal mortality in the region at 227 per 100,000 live births. Similarly, the infant mortality is amongst the highest in region. According to the WHO's World Health Report 2000, Morocco was ranked 111th out of 191 countries in terms of disability-adjusted life years (DALYs) lost (See Annex 2 for rankings of Morocco and comparable countries).

Table 1.1: Basic Health Indicators, MNA, 2004/5

Countries	Life Expectancy at Birth (in years, 2004)	Infant Mortality Rate (per 1,000 live births, 2004/5)	Maternal Mortality Ratio (per 100,000 live births, 2004/5)
Algeria	71	30.4	96.8
Morocco	**71**	**40.0**	**227.0**
Egypt	68	20.5	62.7
Saudi Arabia	71	19.1	12.0
Lebanon	70	18.6	88.4
Tunisia	72	20.6	48.0
Kuwait	77	8.2	4.0
Jordan	71	22.0	40.3
Oman	74	10.3	15.4

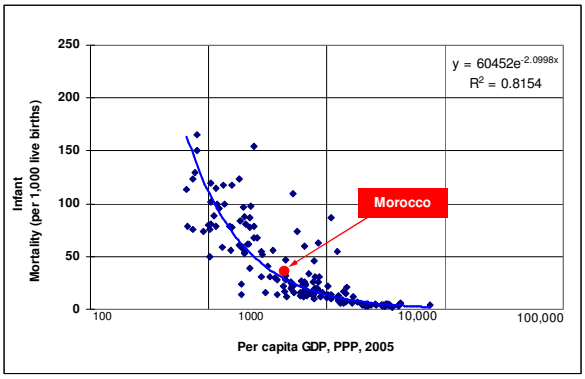
Source: WHO-EMRO 2005.

[1] Please see "le rapport thématique sur le système de santé et qualité de vie" prepared in the context of the Moroccan initiative "50 Ans de Développement Humain – Perspectives 2025."

[2] Morocco is ranked 108th in terms of GDP *per capita* PPP, but 123rd in terms of Human Development Index (*Source:* UNDP's Human Development Report 2006).

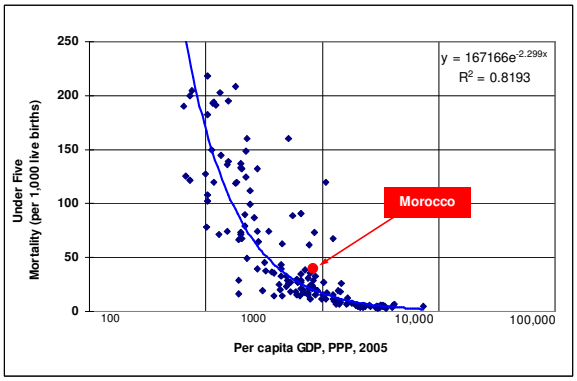
Figure 1.2: Global Trend Analysis, IMR and U5MR, 2005

Panel A: Infant Mortality Rate, 2005



Source: World Development Indicators 2007, UNICEF State of the World Children

Panel B: Under-five Mortality Rate, 2005



Source: World Development Indicators 2007, UNICEF State of the World Children

3. **Like other countries in the region, Morocco is going through demographic transition characterized by decreasing fertility and increasing life expectancy, leading to a youth bulge and pending shift in the age composition.** As a result of active reproductive health policies, the total fertility rate dropped significantly (Table 1.2), albeit with large differentials between the lowest and highest income quintiles (3.3 versus 1.9 children per woman) and urban and rural populations (2.1 versus 3.0). Assuming a net reproduction rate of 1 in 2010, the population is expected to reach 39.7 million in 2025. The life expectancy will reach 73 years for both sexes, and the dependency ratio will decrease from 57 (in 2005) to 45.5 (Please see Annex 3 for an overview of the demographic profile in Morocco).

Table 1.2: Total Fertility Rate, Select countries, 1980 vs. 2005

	1980	*1990*	*2000*	*2005*
Morocco	5.6	4.0	2.6	2.4
Algeria	6.8	4.6	2.7	2.4
Tunisia	5.2	3.5	2.1	2.0
Egypt, Arab Rep.	5.4	4.3	3.4	3.1
Jordan	7.0	5.4	3.8	3.3
Syrian Arab Republic	7.3	5.2	3.7	3.2
Turkey	4.3	3.0	2.6	2.2
Iran, Islamic Rep.	6.6	4.8	2.3	2.1

Source: World Development Indicators 2007.

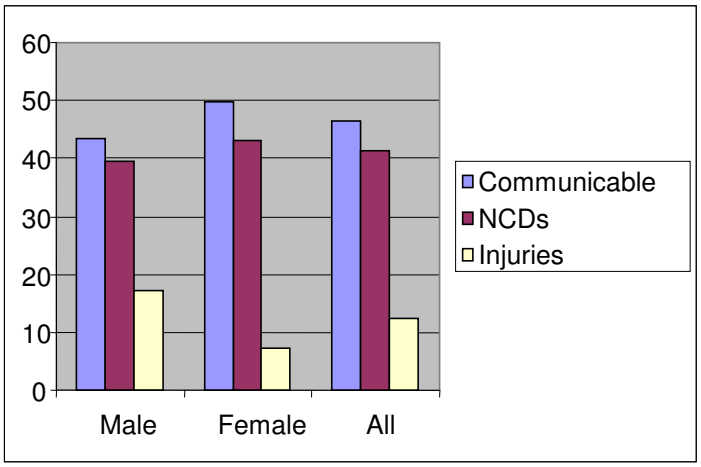
4. **The demographic transition, overall socio-economic development and improved quality of life led to an epidemiologic transition.** Demographic transition and reduced overall mortality brought an increase in youth and adult population, representing both an opportunity and a challenge to social and economic growth,[3] but also to the health care system as a consequence of the ensuing epidemiologic transition.[4] The first burden of disease study conducted in early 1990s showed an increase in the NCDs and injuries (Figure 1.3). In 2003, undefined symptoms and signs as a disease category was reported as the cause of 34.7 percent of all deaths, followed by diseases of the cerebro-vascular system (18.1 percent), tumors (7.1 percent), endocrinological disorders (5.8 percent), and respiratory diseases (5.1 percent) accounting for about two-thirds of all deaths. Since then there has been steady increase in the share of NCDs in overall mortality, mostly as a result of an increase in the

[3] In 2003, the unemployment rate in urban areas was 19.3 percent. In 2006, the youth (15 to 29 years of age) constituted 42.5 percent of the population whereas the elderly (65 y and above) accounted for 4.8 percent of the total population.

[4] It is a protracted epidemiological transition given the continuing burden of communicable diseases along with the increasing burden of non-communicable diseases (NCDs) and injuries. In 2005, there were 2,221 cases of measles, 1099 of meningitis, 1497 of typhoid fever and over 26,000 of TB. In 2004, only 71 percent of the population had sustainable access to improved water, and 76 percent to improved sanitation (WHO EMRO Country Profile Morocco, 2005).

prevalence of cardiovascular diseases which account for about 60 percent of adult mortality (Figure 1.4). Non-Communicable Diseases will increasingly account for a large share of the Burden of Illness. It is expected that the trends will continue with continuous increase in the share of NCDs and injuries in the overall burden of illness in Morocco (Figure 1.5) due to increased urbanization,[5] changing lifestyles (Figure 1.6), and a decline in the prevalence of communicable diseases.

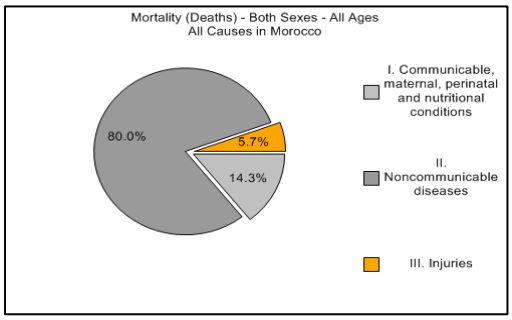
Figure 1.3: Percentage of Life Years Lost due to Premature Mortality, Morocco, 1992

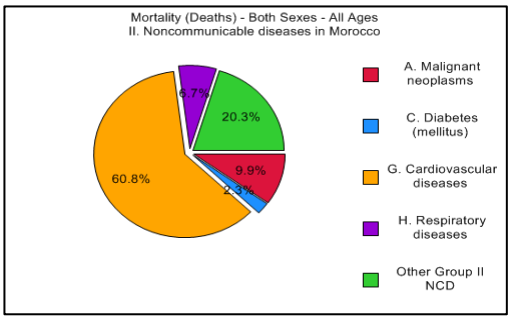


Source: MOH, Morocco, 1992

Figure 1.4: Causes of Mortality in Morocco, 2002

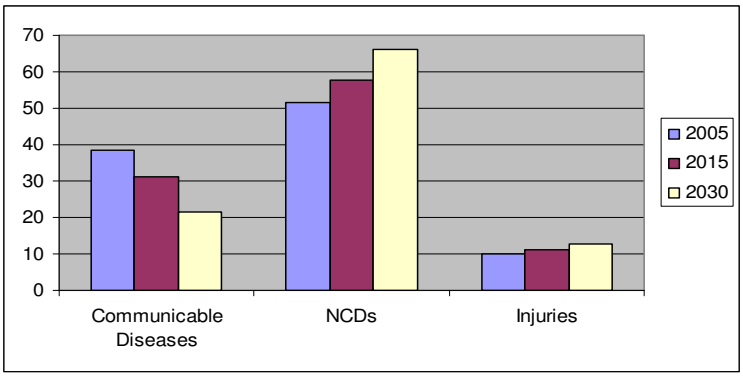
Panel A: All Causes **Panel B: Non-Communicable Diseases**





Source: WHO –EMRO, 2002

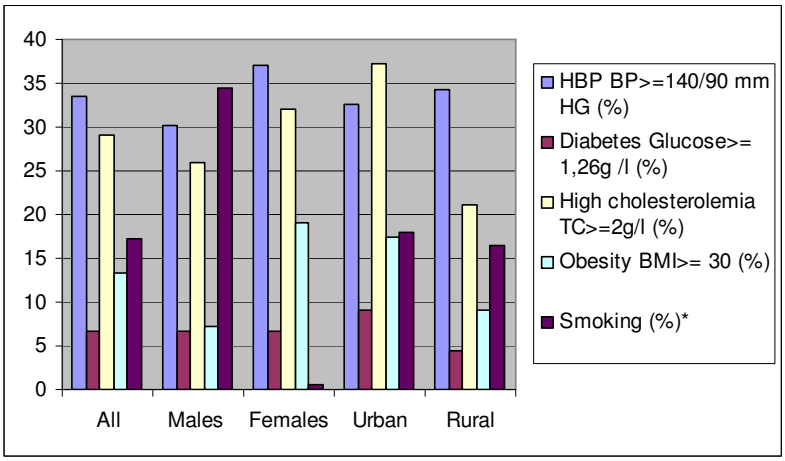
Figure 1.5: Projected Trends in Life Years Lost, Morocco, 2005-2030



Source: WHO-EMRO, 2005.

[5] Between 1994 and 2003, the urban population increased by 28.5 percent vs. 1.5 percent in rural areas. As of 2002, 56.6 percent of the population lived in urban areas. While poverty is largely rural (25 percent vs. 12 percent in urban areas), it is becoming increasingly urbanized.

Figure 1.6: Prevalence of Main NCD Risk Factors in Morocco, 2000

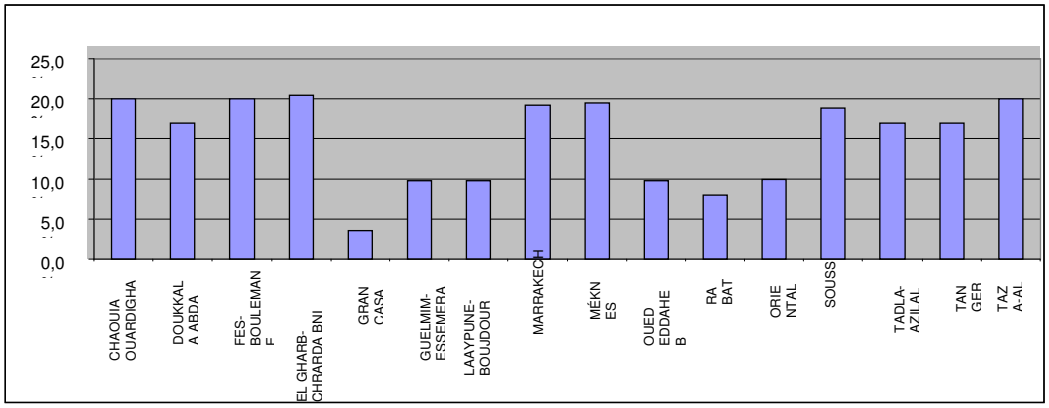


Source: Tazi, M.A., Lahmouz, F., Abir-khalil,S., Chaouki, N., Arrach, M.L., Charqaoui, S., Srairi, J.E., Majhou, J. Enquête nationale sur les facteurs de risque des maladies cardiovasculaires – 2000. Dans Ministère de la santé du Maroc, DELM. Bulletin épidémiologique no 53-54. 1er et 2e trimestres 2003

1.2. Poverty and Inequalities in Health and Health Care; Patterns and Trends

5. **Despite recent decline, poverty is still high with a significant urban rural gradient.** Between 1994 and 2004 there was a reduction of 14 percent in the national poverty rate (from 16.5 percent to 14.2 percent) albeit with a significant differential between rural (22 percent) and urban (7.9 percent), maily due to the reduction in rural areas of only 4 percent during the same time period vs a reduction of 24 percent in urban areas. Overall, out of 1298 communes only 30 has a poverty rate less than 5 percent while 348 have more than 30 percent. At the regional level, three regions with the highest poverty rates are Massa Dra (18,9 percent), Marrakech-Tensift-Al Haouz (19,2 percent) and Meknès Tafilalet (19,5 percent), albeit with significant differentials within the regions between the urban and rural populations. At the provincial level, it varies between 2,4 percent in Rabat prefectorate and 33,6 percent in the province of Zagora (Figure 1.7). An additional 25 percent of the population who live at or below 50 percent above the poverty line is considered "economically vulnerable" to illness, natural disasters, or unemployment. Poverty, both as a cause and consequenct of ill-health and lack of education has a strong gender gradient. About 2.5 million children, a majority of whom are rural girls, do not attend school, and thus are more likely to marry at a younger age, perpetuating the vicious cycle of poverty. In rural areas, 83 percent of women are illiterate (Box 1).

Figure 1.7: Regional Distribution of Poverty in Morocco, 2004



Source: Haut-Commissariat au Plan. Morocco, December 2005

Box 1: Poverty, Gender, Education and Health

Acute or chronic illness, disability of a family member or death of a breadwinner limits upward mobility and is a frequent catalyst of downward mobility. Temporary illness or longer term disability can seriously disrupt the income of people whose work depends on their good health and physical strength. Households experience downward mobility when illness forces them to sell off assets to cover costs of treatment and/or transport to distant urban hospitals. Although the non-poor also experiences illness and disability, they either have health insurance or sufficient savings to pay for treatment without impoverishing the household.

Poverty also has a strongly gendered character - 2.5 million children, a majority of whom are rural girls, do not attend school. Gender indicators in literacy and health, especially in rural areas, are among the worst in the region. In rural areas, 83 percent of women remain illiterate.

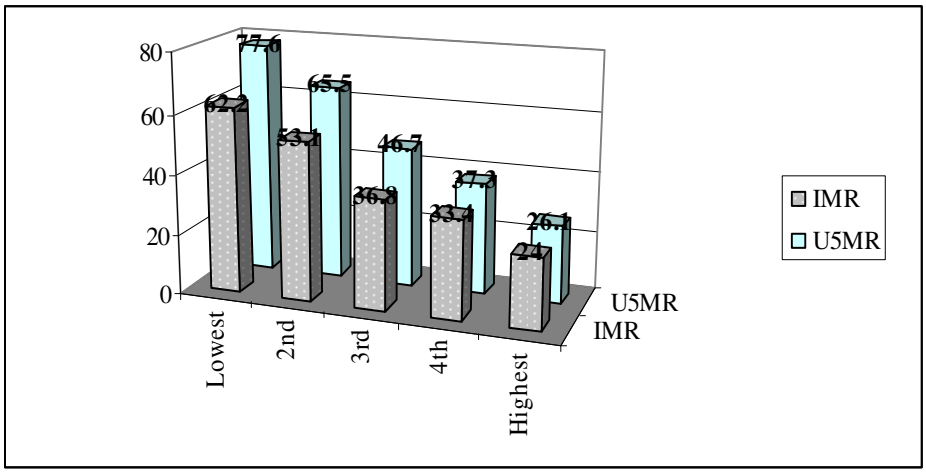
Women are particularly vulnerable to impoverishment and downward mobility when their husbands become disabled or ill. This effect is more noticeable in the poorest, agriculture-dependent and traditional communities. It is less marked in the urban and/or more prosperous rural communities that offer more economic opportunities for women (for example in the service sector), and where it is more accepted and common for women to work outside the home.

Women and girls are particularly vulnerable to the impacts of poor education and health services. In communities without schools, it is generally the poorest families who refuse to send their children, especially girls, far to study. Lack of health adequate health facilities, as in Khalouta, Ait Hammi, Ait Messaoud and Igourramene Tizi particularly hurt women. Many are reluctant to consultant male practitioners, and lack of local childbirth facilities, combined with poor roads and expensive transport, put them at risk during childbirth.

Excerpt from: World Bank: Kingdom of Morocco; Moving out of Poverty, March 2007

6. **High poverty rates in Morocco are inducive to poor health outcomes**.[6] Under-five mortality for the poorest quintile is more than twice the rate for the richest quintile (Figure 1.8). The proportion of underweight children in the poorest quintile is more than four times higher than in the wealthiest (Figure 1.9). The adolescent fertility, both a cause and a consequence of poverty, is also four times higher in the lowest quintile compared with the wealthiest (Figure 1.10).

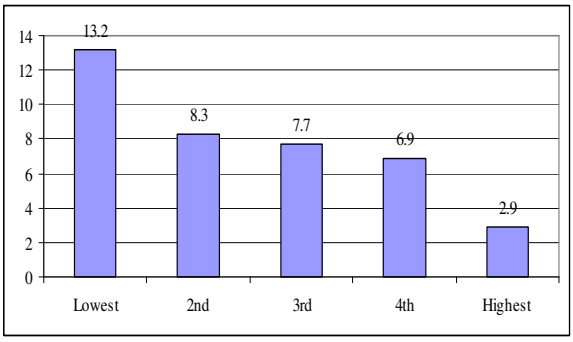
Figure 1.8: Child Mortality by Wealth Quintile (per 1,000 live births)



Source: Davidson R. Gwatkin et al (2005) Socioeconomic differences in health, nutrition and population in Morocco, derived from DHS 2003/04 data.

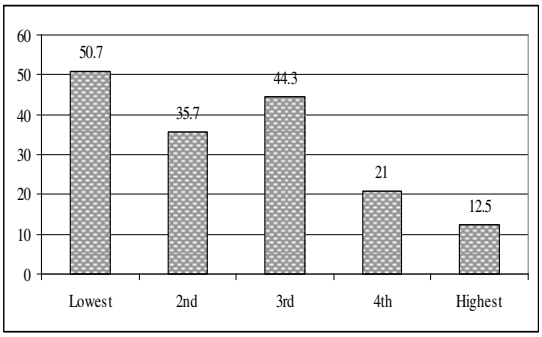
[6] For a detailed analysis of inequalities in health by wealth quintiles see Annex 4.

Figure 1.9: Prevalence of Underweight in Children Under Five by Wealth Quintile(*)



(*) Percent of Moderate Underweight

Figure 1.10: Adolescent Fertility Rate(*) by Wealth Quintile



(*) Annual number of live births per 1,000 girls aged 15-19

Source: Davidson R. Gwatkin et al (2005) Socioeconomic differences in health, nutrition and population in Morocco, derived from DHS 2003/04 data.

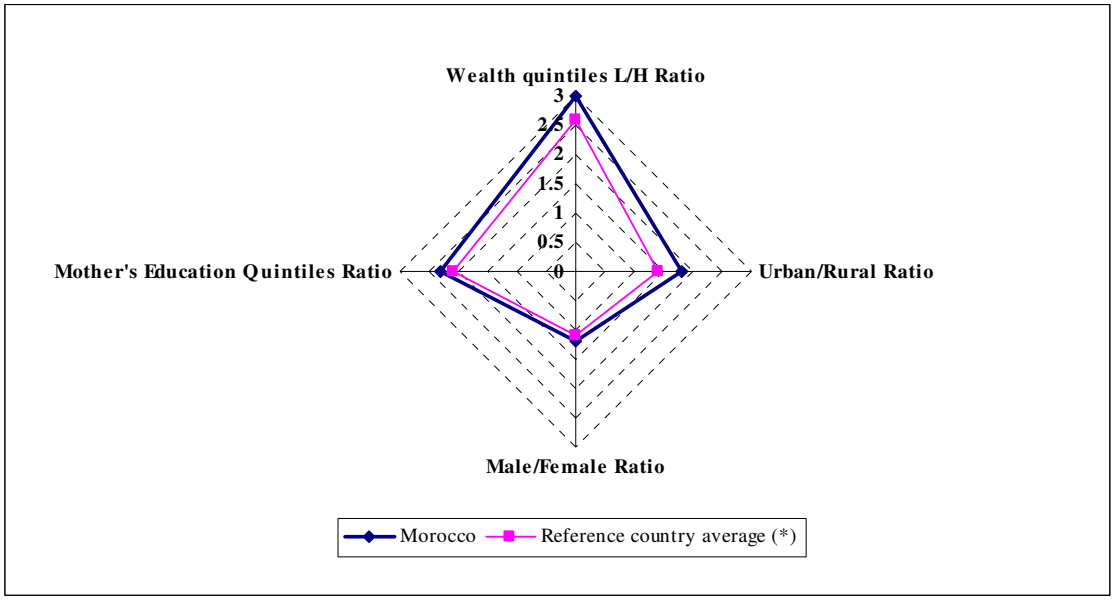
7. **There also is a large gradient in health outcomes between the urban and rural populations.** Life expectancy in rural Morocco is, on average, six years shorter, mainly due to higher infant, under-five and maternal mortality, pointing out to unmet health care needs (Table 1.3). Maternal mortality, one of the eight MDG goals, is 43 percent higher in rural areas. Finally, the roles of gender, area of residence, mother's education and poverty in explaining the variation in under-five mortality are higher in Morocco than their averages for five comparator countries, pointing out to the role of social determinants of health despite the existence of effective interventions to reduce their effects (Figure 1.11).

Table 1.3: Urban Rural Inequalities in Health, 2004

Indicators	Urban	Rural	National
Total fertility rate	2.1	3.0	2.5
Crude birth rate	18.8	22.6	20.4
Crude death rate	4.7	6.7	5.5
Population growth rate	1.4	1.6	1.5
Infant mortality rate	33	55	40
Under-five mortality rate	38	69	47
Neonatal mortality rate	24	33	27
Post-neonatal mortality rate	9	22	13
Maternal mortality ratio	187	267	227
Life expectancy at birth	73.4	67.4	70.3

Source: Ministère de la Santé, La santé en chiffres 2004 et EPSF 2003-2004.

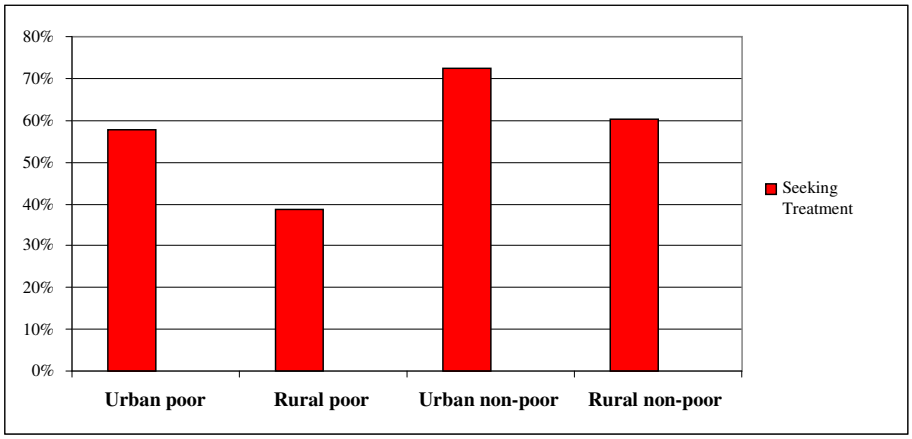
Figure 1.11: Social Determinants of Child Mortality in Morocco



Source: World Health Report 2007
(*) The unweighted average of the sum of ratios for each indicator in Colombia, Egypt, Jordan, Tunisia and Turkey.

8. **Inequalities in socioeconomic and geographic access to health care are the most important proximal determinants of mortality differentials, especially for infant, child, and maternal mortality.** The poor, especially the urban poor, are less likely to seek healthcare when ill as a result of inability, or unwillingness to pay (Figure 1.12), indicating limited social, economic and geographic access,[7] and responsiveness, [8] especially to the basic health and care needs of the rural and the poor (Figure 1.13 and 1.14).

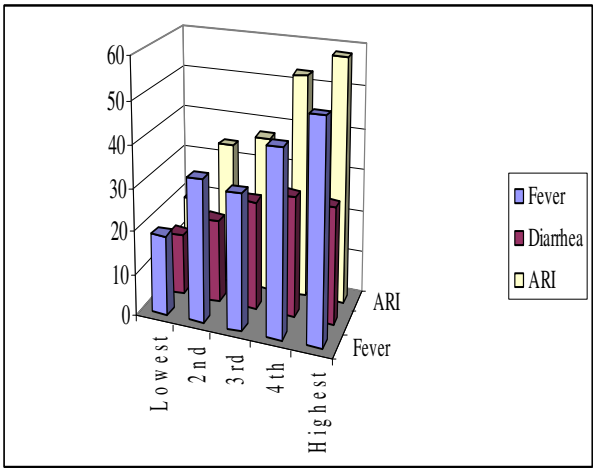
Figure 1.12: Disparities in Health Care Seeking Behavior



Source: LSMS 1998/99, Ministry of Health (2000), and WB Staff Calculations

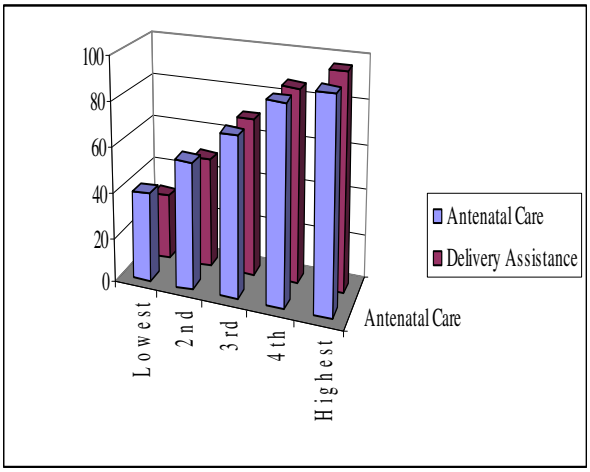
[7] As of 2002, 85 percent of the population had access to primary health care, 65 percent in rural and 100 percent in urban areas (Source: WHO EMRO Morocco Country Profile).
[8] According to the WHO World Health Report 2000, Morocco ranked 125th out of 191 countries in equitable access to care (see Annex 2).

Figure 1.13: Poverty and Sick Child Care by Health Professionals



Source: Davidson R. Gwatkin et al (2005) Socioeconomic differences in health, nutrition and population in Morocco, derived from DHS 2003/04 data.

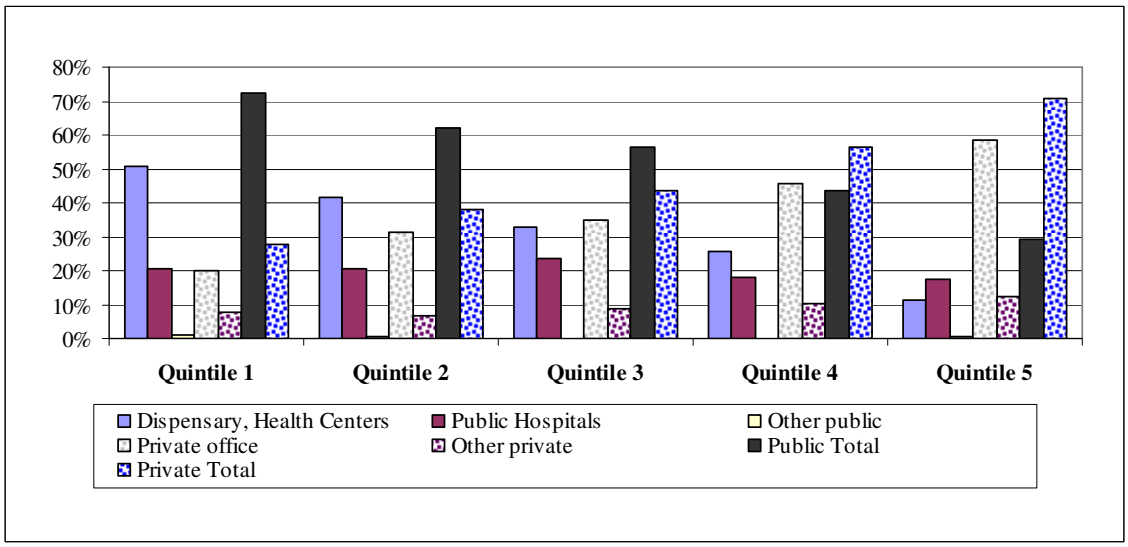
Figure 1. 14: Poverty and Perinatal Care by Health Professionals



Source: Davidson R. Gwatkin et al (2005) Socioeconomic differences in health, nutrition and population in Morocco, derived from DHS 2003/04 data.

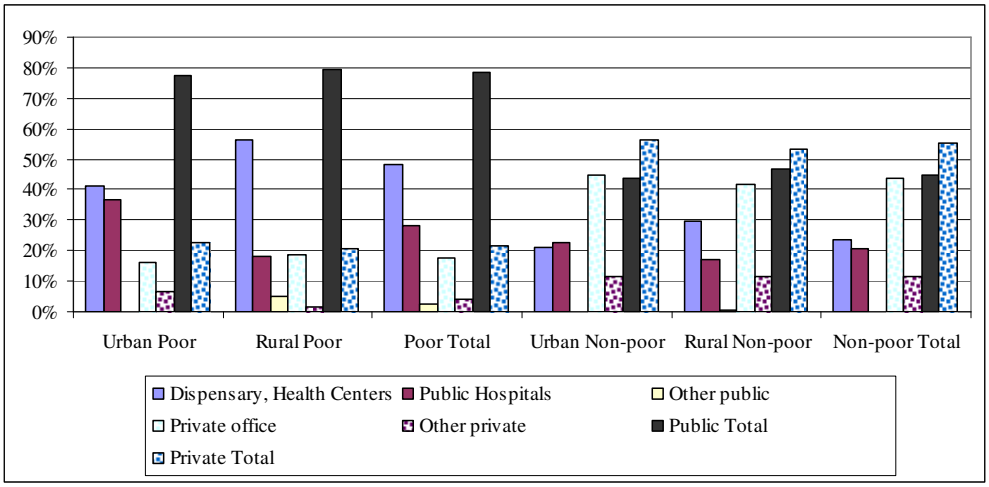
9. **The urban and those who can afford it prefer using private providers whereas the rural and the urban poor rely on public health centers, dispensaries and polyclinics.** Only 30 percent of the wealthiest quintile use public providers compared to 70 percent of the poorest quintile (Figure 1.15). Amongst the poor, men use public health facilities more often than women, especially in rural areas (Figures 1.16 and 1.17). There is an implicit hierarchy in the levels of care across the public delivery network. While the Primary Health Care (PHC) is in place, access to most essential services are constrained, especially for the poor and the rural, as a result of limited availability of well-endowed PHC facilities, inadequate distribution of the health workforce, lack of coordination and referral system between levels of care, and perverse incentives in full-time work in the public sector for qualified specialists (Figure 1.18 and Box 2).

Figure 1.15: Utilization of Health Facilities by Wealth Quintile – Public vs. Private



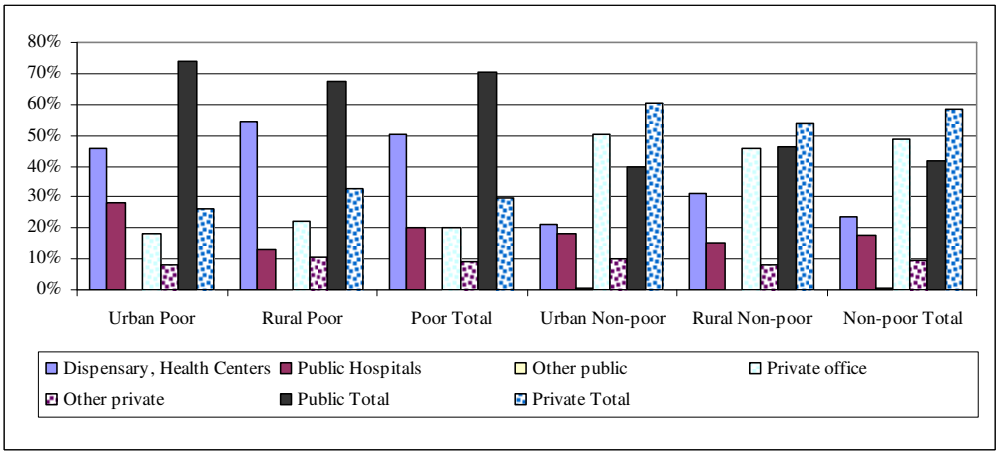
Source: LSMS 1998/99, Ministry of Health (2000), and WB Staff Calculations

Figure 1.16: Utilization of Health Facilities by Wealth Quintile – Public vs. Private (Male Population Only)



Source: LSMS 1998/99, Ministry of Health (2000), and WB Staff Calculations

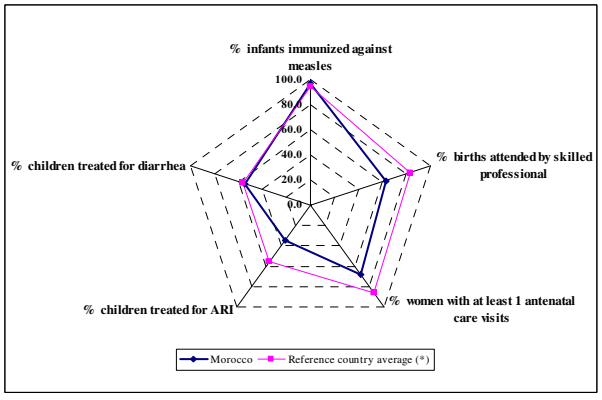
Figure 1.17: Utilization of Health Facilities by Wealth Quintile – Public vs. Private (Female Population Only)



Source: LSMS 1998/99, Ministry of Health (2000), and WB Staff Calculations

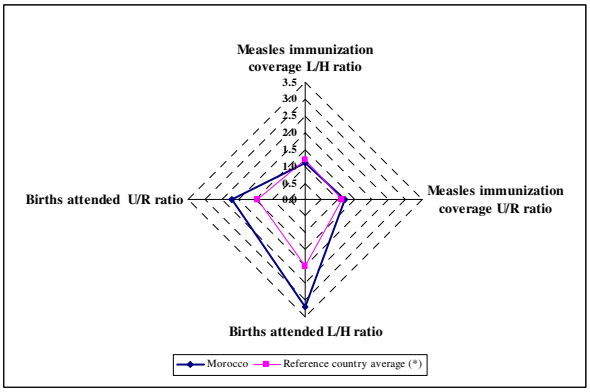
Figure 1.18: Inequalities in Access to Primary Health Care

Panel A: Access to PHC – Overall



Source: World Health Report 2007

Panel B: Inequalities in Access to PHC



Source: World Health Report 2007

Box 2: Inequalities in Access to Primary Health Care in Morocco, 2004

Morocco has a large network of primary health care facilities, called ESSBs (*Etablissements de soins de santé de base*). In 2004, there were 2510 ESSBs, or one per 11,909 inhabitants, with a higher ratio in rural areas (1862 ESSBs, or one for 8,900 inhabitants, compared to 649 ESSBs in urban areas, or one per 20,900 inhabitants). However, this does not translate into full geographic, socio-organizational and economic access to quality and appropriate health care. According to the Département des soins ambulatoires et hospitaliers (DHSA), in 2003 about half of the population lived less than 3 km from an ESSB, 46 percent lived farther than 6 km, and 25 percent lived more than 10km away from one. In the same year, most ESSBs did not have a physician, and 258 ESSBs closed from lack of personnel.[9] Only 30 percent of the general practitioners on the MOH payroll worked in rural ESSBs. The nurse population ratio varied from 0.29 per thousand in Doukkala Abda to 1.24 per thousand in Laayoune, three to five times lower than in comparable countries. There was a large variation in the ESSB population ratio across the 16 regions, from 4,936 in Guelmim-Essemara to 17,049 in Doukkala Abda, with many ESSBs not having any physician. These data excluded the developed regions of Casa and Rabat where most health care is either provided in CHUs or private settings, obviating the need for ESSBs as a result of higher insurance coverage and income and education levels. The per capita median annual number of visits to a physician is 0.6 (2005 data), very low by international standards. Less than 10 percent of pregnant women received full prenatal care, compared with 40 percent in Egypt and more than 70 percent in Jordan and Tunisia. Only 63 percent of births were assisted by a health professional, compared with 74 percent in Egypt, 90 percent in Tunisia, and 100 percent in Jordan, with high urban-rural (2.2, compared with 1 in Jordan and 1.7 in Tunisia) and richest-poorest (3.2) ratios.

1.3. Patterns and Trends in Supply of Health Care

10. **The State plays a predominant role in health care financing, organization and delivery.** At independence, Morocco opted for a tax-based and state-run system with public ownership, management and financing of health facilities and providers, and public delivery of health services. The evolution of the health care system is characterized by increasingly expanding and centralizing the roles and responsibilities of the Ministry of Health (MOH) across all functions. Three distinct phases mark this evolution: (i) Phase I, from independence in the early 1960s to the 1980s, characterized by heavy investment in infrastructure and expansion of the number of health professionals; (ii) Phase II, from the 1980s to the late 1990s, characterized by hospital-centered investment and expansion of targeted health programs; and (iii) Phase III, from the late 1990s to date, characterized by a debate on how to reform the system to increase population coverage and improve efficiency and quality of care.[10]

11. **Continuous investment in health facilities and training of health professionals has resulted in better health outcomes.** Coverage of, and access to, essential health services such as immunization and primary health care have also improved. As a consequence of heavy public investment, the MOH emerged as the predominant force in charge of financing, managing, and operating the publicly-owned health care delivery network of facilities. A parallel sub-sector of private facilities and practitioners gradually built up to compete on quality, at the least for wealthier and more educated urban dwellers.[11]

12. **Over the last five years the government has expanded population coverage, improved system governance, and increased quality of care.** As part of its drive to reduce poverty through the National Human Development Initiative (Initiative Nationale de Développement Humain, INDH), the government enacted a law in 2002 on "basic health care coverage" (Couverture Médicale de Base, CMB). The Law foresaw the creation of two insurance schemes, a compulsory health insurance scheme, or AMO (Assurance Maladie Obligatoire) and a medical assistance scheme or RAMED (Régime d'Assistance Maladie aux Economiquement Démunis, or more recently, Régime d'Assistance Médicale). In addition, a new agency was established, the Agence Nationale d'Assurance Maladie (ANAM), to regulate CMB and manage RAMED. While the AMO has operated

[9] The number of closed ESSBs has since been reduced to 197.
[10] From "le rapport thématique sur le système de santé et qualité de vie" in the context of Morocco's initiative "50 Ans de Développement Humain – Perspectives 2025."
[11] In 2004, there were almost as many doctors working in the private sector (7,644) as in the public sector (9,544).

since September 2005, covering civil servants (Caisse Nationale des Organismes de Prévoyance Sociale or CNOPS)[12] and those formally employed in the private sector (Caisse Nationale de Sécurité Sociale, CNSS), the regulatory and institutional mechanisms necessary to render RAMED operational are still under preparation.

13. **Decentralization of health services management at the regional level is progressing, albeit slowly.** Sanitary regions were created that do not follow administrative borders, but are based on socioeconomic, geographic, and health criteria. A successful pilot in the Oriental region had financial and technical support from the EU to upgrade facilities, build a management information system, and train health professionals; but scaling it up has been uneven, partly from limited capacity, but also because the central level resisted transferring power and responsibilities.

14. **Other reforms are in process.** These include *la réforme hospitalière*, financed first by the World Bank, and more recently by the European Investment Bank, to improve physical and technical infrastructure in select hospitals and pilot new planning, management, and hospital information tools for improved quality and efficiency.

15. **These reforms have been in the right direction.** The government and MOH need to complete piloting programmatic and instrumental reforms such as decentralizing system management in the Oriental region and adopting tools developed to enhance hospital autonomy, and complete their evaluation. Otherwise, the extensive preparatory technical assistance provided to MOH through PFGSS and PAGSS[13] for expanding these reforms will become obsolete without any documented impact on access to care, service quality, system governance, or efficiency.

16. "**Santé, Vision 2020" is likely to boost the reform process and enhance coordination.** Many financing reforms, such as establishing AMO and RAMED, were undertaken after policy and legislative initiatives to expand the CMB, rather than being conceived or planned in harmony with broader reforms encompassing system governance, human resources development, and the role of the private sector. Cognizant of these shortcomings, the government launched, at first, an initiative entitled "Santé, Vision 2015" which encompassed 11 strategic tracks.[14] This was soon to be followed by another impressive effort, called "Santé, Vision 2020", to seek and build consensus amongst all public, non-governmental and private stakeholders on the underlying principles of the healthcare system in Moroccco as "equity", "solidarity" and "participation and responsibility". The latter, made public very recently, reiterates that all citizens should have access to healthcare according to their needs and not their ability to pay, and that the services should be of quality, effective, and centered to the patient. It defines eight strategic tracks ("Axes stratégiques")

[12] CNOPS does not cover all civil servants. It is a federation of eight "*mutuelles*," each associated with a state enterprise, but other state enterprises are not affiliated with CNOPS, notably Royal Armed Forces, Royal Air Maroc and State Tobacco Company.

[13] PFGSS and PAGSS are the Bank-financed Projet de Financement et de Gestion du Secteur de la Santé and the EU-financed Projet d'Appui à la Gestion du Secteur de la Santé, respectively, the two largest health projects through which MOH received technical support and financing for infrastructure.

[14] They include: (i) reinforcement of disease prevention, consolidation of programs to control commuicablediseases and development of programs to combat Non-Communicable Diseases; (ii) improved equity and reduced disparities in access to care and resource allocation; (iii) reduction of shortage in health workforce and revalorization of human resources (iv) promoting public health; (v) increased financing; (v) improved governance; (vi) improved resource management; (vii) expanded and financially sustainable health insurance; (viii) development of partnership with the private sector; (ix) higher ethical standards and elimination of illegal practices; (x); and (xi) guaranteed access to and rational use of pharmaceuticals.

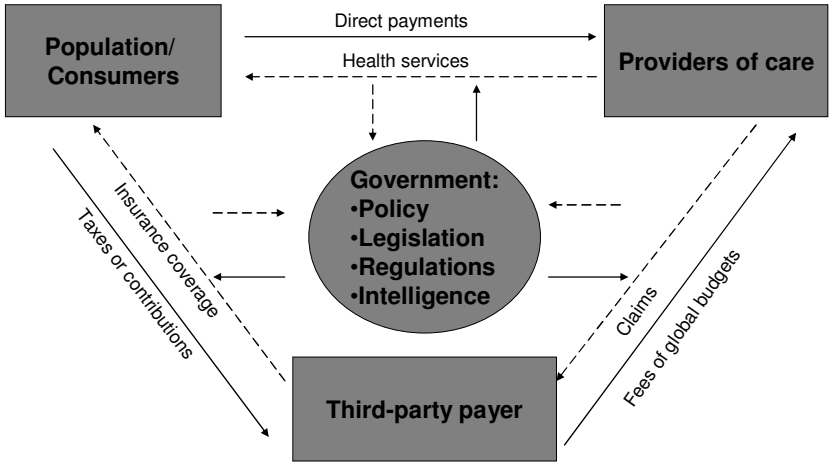
CHAPTER 2: MAIN SECTORAL ISSUES

2.1. Stewardship and Governance

17. **Stewardship refers to good principles of health and healthcare governance, a responsibility that is usually assigned to the Ministry of Health**.[15] Stewardship is considered a core function of healthcare, together with financing, human resource generation and service delivery. Four conceptual issues are important to stewardship:

- the specific functions of stewardship, including;
    - providing strategic direction for policymaking in health and healthcare;
    - (setting up and enforcing a legal and regulatory framework, as well as mechanisms and tools for the operationalization and implementation of policies;
    - ensuring a coherent institutional and organizational structure and culture to support the achievement of policy objectives; and
    - generating intelligence to monitor and evaluate policy implementation. In a truly pluralistic system, the State assumes the role of stewardship by making policies, legislating and regulating transactions among the payers, providers and consumers and collecting information to ensure that each party respects the rules and regulations (i.e., payment compliance, quality of services, etc.). This role in turn requires active involvement of all stakeholders in system governance and management (Figure 2.1).
- the contextual factors that enable or hinder the fulfillment of these functions;
- the actors and/or stakeholders involved in stewardship; and
- the level of governance where responsibilities for specific functions are assumed and executed.

Figure 2.1: Institutional and Functional Linkages between Main Stakeholders in Health Care



Source:Modified from Reinhardt U.E. In health care system in transition. OECD, 1991 p.105.

[15] The World Health Report 2000 defines stewardship as "the careful and responsible management of the well-being of the population."

18. **Pluralism is limited due to predominance of State and Para-statal agencies, with limited participation by providers and population.** [16] The role of providers in system governance is very limited. Provider associations as true representatives of all the professionals do not have a formal platform to participate in policy decisions affecting them directly (e.g., human resources policy and planning; salary negotiations; curriculum development; licensing, certification and registration; definition of financial and non-financial incentives; development and enforcement of ethical standards; malpractice issues; and the management of patient grievances). They do engage in negotiations pertaining fee schedules, but the final decision is administrative rather than being consensual.[17]

19. **System governance is segmented due to overlapping functional responsibilities between the MOH and payers.** Since the passage of the Law on CMB, the establishment of ANAM and the expansion in the mandate of CNSS to also provide health insurance to blue collar workers in the formal sector, there has been a c*hevauchement* in the roles and functional responsibilities of the payer agencies and the MOH. In theory there is both horizontal (i.e., functional) and vertical (i.e., population groups) segmentation in that the MOH, CNOPS and CNSS (and soon ANAM) are each involved in financing for their own population groups (e.g., the blue collar workers, civil servants, etc) and, to a varying degree, in service provision (Figure 2.2).[18] While governance at the central level is fragmented, with MOH and ANAM having overlapping responsibilities in regulating the health care system, the MOH plays a predominant role in the execution of all key functions, i.e., policy making, regulation, financing and service provision despite the existence of separate payer agencies, each with a mandate for a different segment of the population. Three other agencies, in addition to MOH, are also involved in financing, management and regulation—CNOPS, CNSS, and ANAM—each defining entitlements and obligations of their contributors, or more specifically, the benefit packages, premium rates, and pricing, and reimbursement of health and related social services. However, as mentioned above, their power and accountability in matters of financing, resource allocation and purchasing is limited due to lack of full autonomy and independence from the MOH. The ANAM, essentially a regulatory agency, was asked to manage RAMED, thus assuming a managerial function for one segment of the population, the poor, while developing its institutional capacity as an insurer and purchasing agency, albeit under the purview of the MOH through which it is set receive a large part the budget. Yet, services which RAMED will ensure will be provided in facilities owned and managed by the MOH.

20. **There is a burgeoning private provider network.** The private sector is relatively new, but expanding in a lax regulatory environment with limited, albeit growing opportunities for contractual arrangements with the main payer agencies, especially since the arrival of AMO. There are several private hospitals, often called clinics, with a legal stature defined as "Société civile professionelle" and having limited liability through their owners or shareholders who by law are obliged to be health professionals. Thus direct private investment into the health sector by non physicians is not permitted. On the other hand, there are no tax incentives or other subsidies for those who would consider investing in private service provision.[19] In addition they are not allowed to surcharge beyond the negotiated fee with the insurers. As such there is a tendency to invest in high-tech equipment and specialize in surgical disciplines (e.g, cardiac surgery, lithotripsy) and medical imagery.

[16] Actually, labor unions are represented in the management board of ANAM and providers do negociate with payer agencies (CNSS and CNOPS) for setting the fees. However, power sharing is not equitable in ANAM management with Minister of Health having the prerogative in all major decisions.

[17] The providers have to accept the administrative decisions of the payer agencies on the fee schedule, but than go on to charge the balance to the patient.

[18] Only recently that CNOPS ceased to provide health care services, but they still provide medication to the chronically ill. The CNSS is in the process of tendering its 13 health facilities to the private sector.

[19] There are a few exceptions, as in the case of foreign investment from the GCC countries in high-tech modern hospitals where even foreign doctors are allowed to practice.

Figure 2.2: Functional Segmentation in Health System Governance

Main Functions	MOH	ANAM (*)	CNOPS	CNSS	Population /Patients	Providers
Policy/ Regulation	++++	++	+	+	-	+
Financing	+++	+	++	++	+++	-
Purchasing/ Payment	++++	+	++	++	+	++
Service Delivery(**)	++++	n/a	+	++	-	+++
Organization/ Management	++++	++	++	++	+	-
Human Resources Development	+++++	-	-	-	-	-

Legend: (+) minimal responsibility to (+++++) exclusive responsibility
N.B. responsibility does not equate to actual execution.
(*) Including its responsibility for the management of RAMED
(**) CNOPS and CNNS are in the process of reducing their involvement in service provision.

21. **Centralization hinders effective governance.** MOH directly oversees administration and financing of all health agencies and facilities in the public sector. At present, there is limited decision power transferred to sub-national and local authorities for more integrated and multisectoral planning at the local level. As such, the deconcentration of administrative responsibilities to local health authorities and the devolution of managerial responsibilities to regional authorities remain protracted. A technical audit of MOH conducted in 2004 to assess the extent of decentralization concluded that while the centralized structure set in place in 1994 to respond to health challenges has been effective, it has outlived its usefulness and it now impedes system governance. The study concludes that MOH's structure remains hierarchical and fragmented, hindering therefore integration at the central level and coordination with lower levels of MOH administration. Other observations include: (i) the separation of outpatient and inpatient care service delivery that undermines gate-keeping, continuity of care, hierarchy in access to different levels of care and patient referral; (ii) absence of mechanisms or responsible administrative units to fulfill core functions such as regulating the private sector, standard setting, licensing, contracting, and technical audit; and (iv) lack of separation of financing/purchasing from service delivery.

22. **Provider compensation mechanisms do not value productivity, quality of care or performance.** Physicians, nurses and other health professionals in the public sector are paid fixed salaries. Although less poorly than many other countries of similar economic level, the amount of payment is more proportional to seniority than productivity or performance. Highly paid and thus coveted senior positions in teaching hospitals are rare. Apart from this elite group, most physicians have very little voice in decisions affecting their career opportunities and compensation levels. Accordingly, those who can generate revenues outside the confines of civil service positions (mostly physicians, but to a lesser extent nurses and midwives), may be tempted to resort to charging informal fees, a practice that undermines the authority and legitimacy of the healthcare system. While better-skilled physicians leave the public sector entirely and practice only in the private sector, a large majority remain on public payroll, mainly for job security, pension and other benefits, but "moonlighting" without paying taxes on the additional income.

23. **The population has very little involvement in system governance or policymaking.** Apart from a few pilot initiatives to empower communities in community-based financing schemes, no mechanism exists for more formal public participation in system governance in general, or that of health facilities in particular.[20] Accordingly, their involvement is reduced to paying taxes and premiums for social protection services, as well as formal and informal out-of-pocket payments to healthcare providers (Box 3).

Box 3: Informal Payments in the Health Sector

"*Mon mari s'est blessé au doigt dans son travail, il a été transporté à l'hôpital. Ce n'est que lorsqu'il a donné 300 Dhs qu'ils lui ont fait des radios et encore 200 Dhs pour être recousu. Il s'est fait soigner dans un hôpital public et a du débourser 500 Dhs* » (an interviewee in Casablanca)

According to a survey conducted in 2002, 88 percent of households believe that the public health care system is a major problem, especially in the northern part of the country where the rate reaches 97 percent. Forty nine percent of the heads of households think that corruption in the health sector is very common amongst the health workers, especially the nurses and the administrative staff, and another 31 percent think that it is common. These rates are somewhat higher amongst the owners of small enterprises in the informal sector who commonly lack health insurance. The health sector is ranked third on the list of most corrupt sectors, after the transport sector and the "moqqadems et chioukhs", again at a higher frequency by the population in northern provinces. Unlike in other sectors, though, about 31 percent of heads of households believe that it is acceptable to make an informal payment to cover hospitals costs of a family member, potentially a constraint to attempts to contain informal payments in the health sector.

Translated from: Transparency Maroc: La corruption au Maroc; Synthèse des résultats des enquêtes d'intégrité. L'Université de Transparence, 2002.

2.2. Health Financing and Expenditures

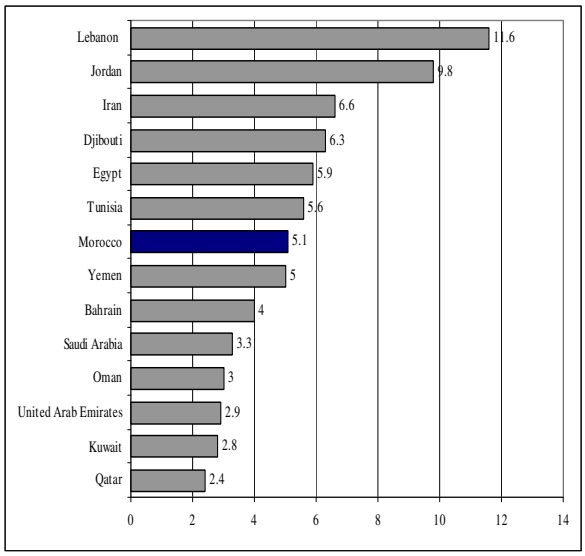
24. **Morocco spends less on health care compared with countries of similar socio-economic development.** Despite recent increases in total health expenditures[21], Morocco spends less on health care, about 5.1 percent of its GDP in 2004, or US$ 82 per capita (US$ 234 international dollars) (Figures 2.3 and 2.4).[22] While one could argue that once controlled for the Purchasing Power Parity (PPP), total health expenditures may be close to what would be expected for its level of socio-economic development (Figure 2.5 and 2.6), one needs to keep in mind that about 1/3 of expenditures are for drugs and other supplies which are priced internationally.

[20] During the last five years a number of community-based insurance schemes, the "les *mutuelles* communautaires" have been set up with assistance from WHO, UNFPA and UNICEF, covering 22 communes in seven Northern provinces. They basically cover essential drugs and medical evacuation. In general, the participation rates are not high and often declines after the first year. is

[21] In early 1990s Total Health expenditures in Morocco accounted for 3.4 percent of GDP versus 3.7 percent in Egypt, 4.8 percent in Iran, 5.9 percent in Tunisia and 6.5 percent in Jordan.

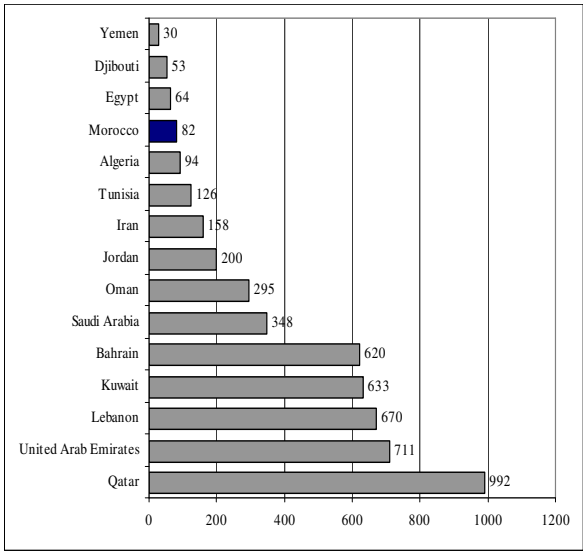
[22] Compared with 6.1 percent in Egypt, or $66 *per capita* ($258 PPP); 9.8 percent in Jordan, or $200 *per capita* ($502 PPP); and 6.2 percent in Tunisia, or $175 *per capita* ($502 PPP). Please see Annex 4 for a global comparison of health expenditures.

Figure 2.3: Regional Comparison of Total Health Expenditures as Percentage of GDP, 2004



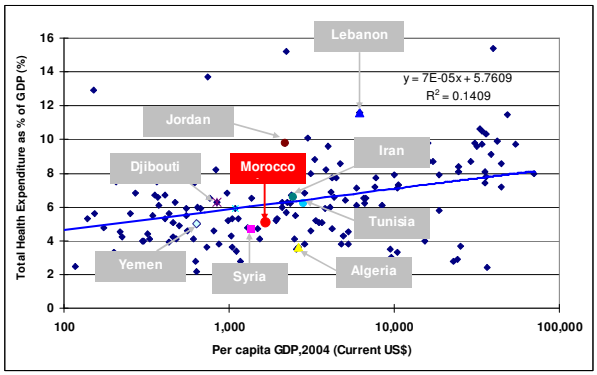
Source: World Development Indicators 2007, World Health Report 2006

Figure 2.4: Regional Comparison of Per Cap Health Expenditures, 2004 (Current US$)



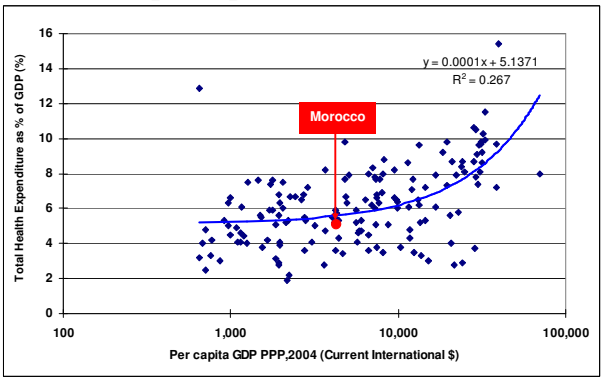
Source: World Development Indicators 2007, World Health Report 2006

Figure 2.5: Global Trend in Total Health Expenditures, 2004



Source: World Development Indicators 2007, World Health Report 2006

Figure 2.6: Global Trend in Total Health Expenditures, 2004 (per capita GDP in PPP)

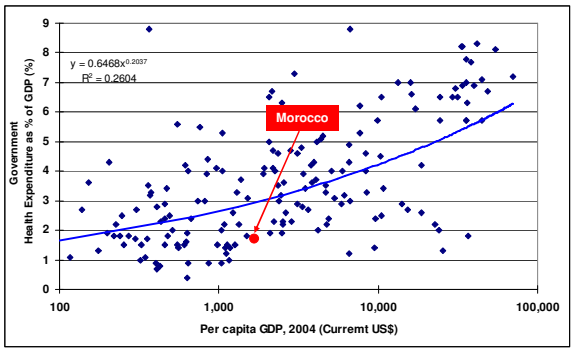


Source: World Development Indicators 2007, World Health Report 2006

25. **Public expenditures on health are low relative to total health expenditures.** In 2005, public expenditures on health accounted for 34.3 percent of total health expenditures, or 1.75 percent of the GDP, both in terms of current and after adjustment by PPP. This rate is quite low by international standards (Figure 2.7 and 2.8), considering the fact that in 2002, government revenues as a share of the GDP was 26.8 percent, higher than that in Jordan (24.7 percent), Iran (26.5 percent), Egypt (19.5 percent) and Lebanon (19.1 percent) and slightly lower than that in Tunisia (29.9 percent).[23]

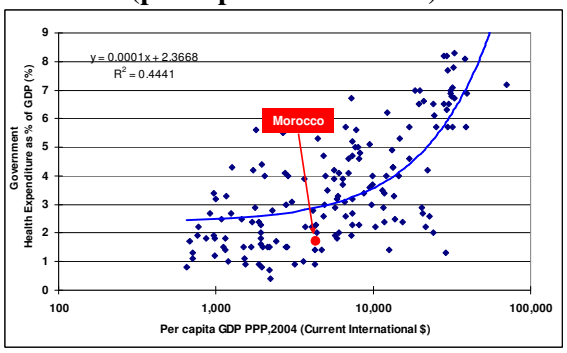
[23] Source: World Development Indicators 2007. N.B: Revenue figures exclude the amount of grants.

Figure 2.7: Global Trend in Government Expenditures on Health, 2004



Source: World Development Indicators 2007, World Health Report 2006

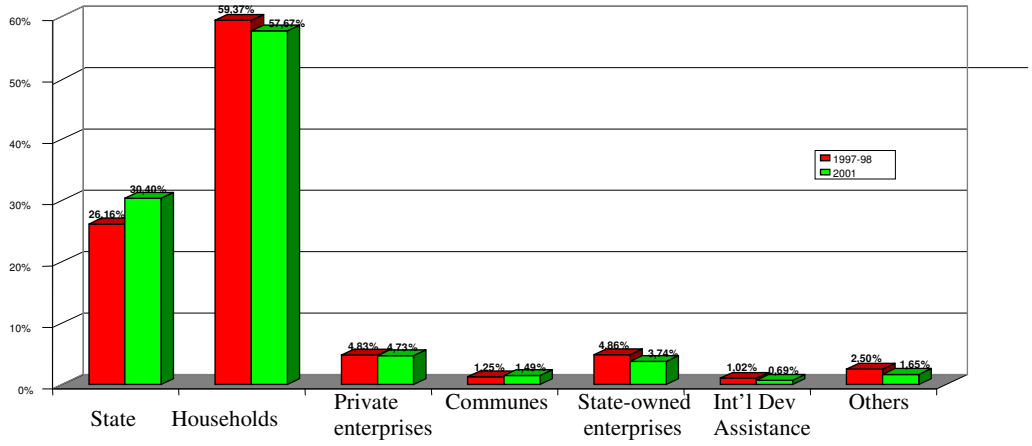
Figure 2.8: Global Trend in Government Expenditures on Health, 2004 (per capita GDP in PPP)



Source: World Development Indicators 2007, World Health Report 2006

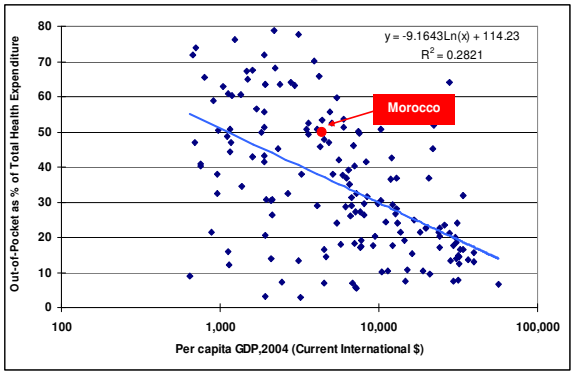
26. **Out-of-pocket expenditures account for a larger share of total health expenditures.** About 65.7 percent of total health expenditures are private. Direct out-of-pocket expenditures accounting for 76 percent of total private expenditure, or 49.9 percent of total health expenditures (Figure 2.9), quite high especially relative to Morocco's fiscal capacity, in relation to what government spends as a percentage of the GDP (Figure 2.10), indicating less-than expected public financing of health care. Private health expenditures account for 65.7 percent of total health expenditures, predominantly out-of-pocket payments that are 76 percent of total private health expenditures (see Annex 5 for details).

Figure 2.9: Health Financing in Morocco 1998-2001



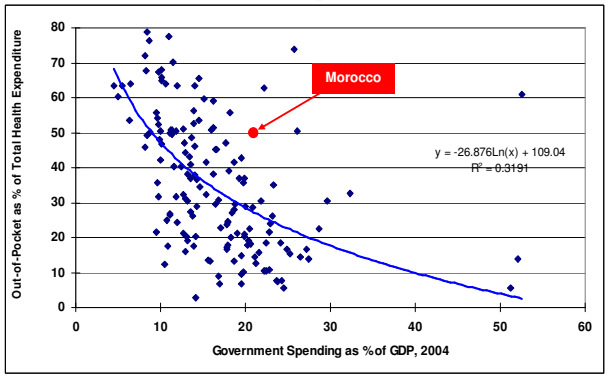
Source: MOH, National Health Accounts, 2001.

Figure 2.10: Global Trend Analysis of Out-of-Pocket Health Expenditures, 2004



Source: World Development Indicators 2007, World Health Report 2007

Figure 2.11: Out-of-Pocket Health Expenditures and Fiscal Capacity, 2004

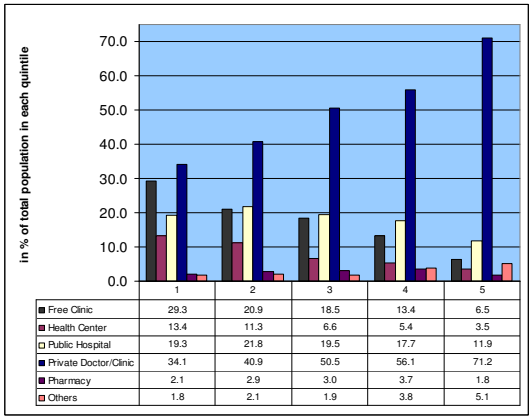


Source: World Development Indicators 2007, World Health Report 2007

27. **Morocco has a two-tiered health care system.** One tier is for the formally employed, living in large cities and enjoying full access to a generous package of healthcare services paid for or subsidized by the state[24] and predominantly provided by the private sector,[25] and the other is for the rest of the population working in informal sectors or living in rural areas where geographic and financial access to basic services is limited to existing public health facilities where the quality of care is lower (Figure 2.12).

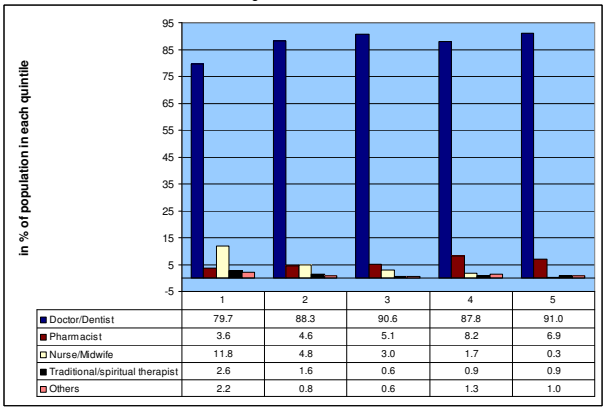
Figure 2.12: Gradient in the choice and use of health service by expenditure quintiles

Panel A: by Health Facilities



	1	2	3	4	5
Free Clinic	29.3	20.9	18.5	13.4	6.5
Health Center	13.4	11.3	6.6	5.4	3.5
Public Hospital	19.3	21.8	19.5	17.7	11.9
Private Doctor/Clinic	34.1	40.9	50.5	56.1	71.2
Pharmacy	2.1	2.9	3.0	3.7	1.8
Others	1.8	2.1	1.9	3.8	5.1

Panel B: by Health Providers



	1	2	3	4	5
Doctor/Dentist	79.7	88.3	90.6	87.8	91.0
Pharmacist	3.6	4.6	5.1	8.2	6.9
Nurse/Midwife	11.8	4.8	3.0	1.7	0.3
Traditional/spiritual therapist	2.6	1.6	0.6	0.9	0.9
Others	2.2	0.8	0.6	1.3	1.0

Source: National Survey on Household Consumption and expenditures (ENCDM), 2001

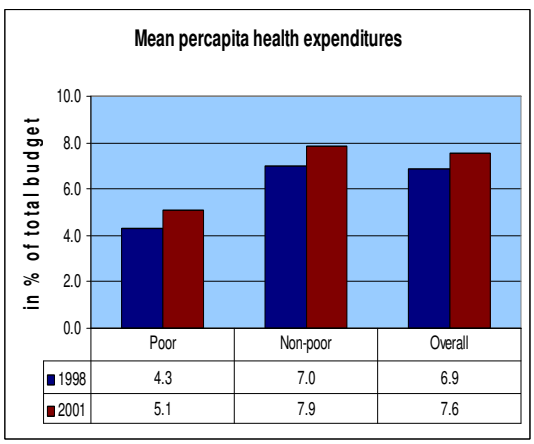
28. **The second group's access to quality care comes at the expense of large out-of-pocket payments for those who can afford them.** Private health expenditures are about 67 percent of total health expenditures, three-fourths of which is out of pocket, putting considerable strain on household budgets, especially for the poor and the rural whose means of survival are much more meager and who cannot afford additional expenses for essential health care (Figure 2.13).

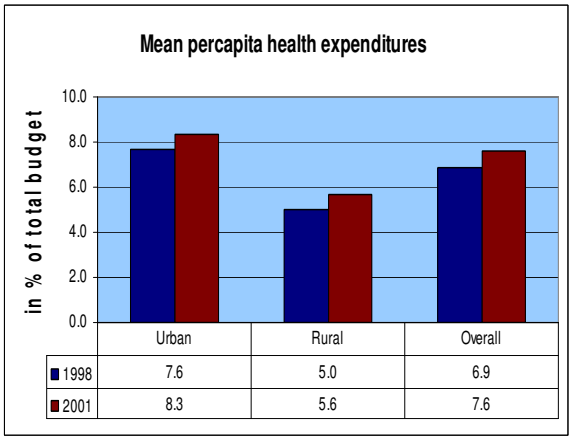
[24] A benefit incidence analysis using 1998/89 LSMS data indicates that the share of state subsidies on health care for the richest quintile was 25 percent vs. 13 percent for the poorest, reaching 32 percent for outpatient care and 24 percent for inpatient care for the richest, compared with 9 percent for both, respectively. Overall 87 percent of the subsidies went to the non-poor and 64 percent went to urban residents.

[25] About 90 percent of the services consumed by CNOPS beneficiaries are provided by the private sector. Only about 6 percent of the funds reimbursed by CNOPS are made to public providers, although this may increase as CNOPS management plans to increase the public sector share as a result of higher private provider tariffs.

Figure 2.13: Private Health Expenditures in Morocco

Panel A: Poor vs. Non-poor **Panel B: Urban vs. Rural**

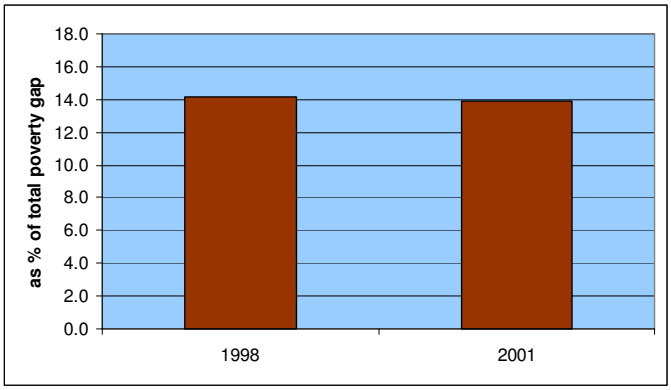




Source: Calculated based on data from HECS 1998 and ENCDM 2001 household surveys

29. **Private health expenditures constitute a significant proportion of the poverty gap.** A more meaningful demonstration of the impoverishing effect of private health expenditures is reflected in the proportion of the poverty gap that would be reduced if the poor did not pay for healthcare. In other words, if it takes 100 dollars per poor person per year to eradicate poverty in a country, i.e., if perfectly targeted and distributed, this amount should suffice to bring everyone below the poverty line to just above the poverty line, per capita health expenditures of the poor per year amount to about 14 dollars. This gives us a good way to benchmark health spending against the depth of poverty as it magnitude is a significant percentage of the poverty gap. In other words, about one-seventh of the total poverty gap can be bridged if poor were to be exempted from their health care expenditures, and was unchanged during 1998-2001 (Figure 2.14).

Figure 2.14: Per Capita Health Expenditures of the Poor (Percent of Poverty Gap)



Source: Calculated based on data from HECS 1998 and ENCDM 2001 household surveys

30. **While the government has extended health insurance coverage, it still covers the formal sector.** At present, about 32 percent of the population is covered, compared with 16.3 percent before AMO was introduced (then 3.6 percent of the rural population and 21.8 percent of the urban population), but most of the expansion has been in the formal sector.[26] This was expected, as Morocco is reinforcing the institutions of social protection, including health insurance, for the formally

[26] While expansion of coverage under CNSS and CNOPS moves ahead, progress with RAMED is at a standstill. CNSS aims to expand its coverage from about 1.8 million to full coverage of 4.5 million workers by the end of 2008 with additional coverage of about 1.35 million a year. Since the passage of AMO, there has been a steady increase in the number of civil servants, retirees, and their dependents covered by CNOPS, from about 2.5 million to 3.2 million.

employed, to reach several social and economic policy objectives. Recognizing the limited and inequitable coverage for the poor, the government has, in addition to expanding AMO to all formally employed, retired, and their families, introduced RAMED to cover the poorest. By 2010, the government expects that RAMED will cover about 8 million poor and vulnerable Moroccans, or 21 percent of the population, and AMI-INAYA,[27] the new scheme for the self-employed, will cover another 6 percent, increasing total coverage from 16.3 to 61 percent of the population. However, with the low institutional capacity and fiscal constraints on one hand and the current emphasis on the formal sector through AMO is likely to limit progress in introducing and operationalizing RAMED and accentuate structural inequalities rather than diminishing them.[28] The emphasis should be on what can be achieved in the short run with the existing institutional framework, while institutional build-up and financing for RAMED are delayed.

31. **Private health insurance is burgeoning**. Health insurance coverage in the private sector which varies considerably in scope is more generous than what is offered in the public sector. For instance, the Moroccan Inter-professional Mutual Fund (IMIM) offers coverage to the employees of 256 companies in the oil and banking sectors. Premiums are equally paid for by the employees and employers and the reimbursement rates are higher. As for purely private insurance, rather than a *mutuelle*, its scope is very limited, covering a few private companies where employees and employers co-share premium costs equally. Again, their reimbursement rates are better. However, they typically run deficits, offset by profits generated from other insurance products.[29]

2.3 Resource Allocation and Purchasing

32. **Low Public expenditures on health exacerbate inefficiencies in resource allocation and use, leading to high private expenditures.** The share of public expenditures on health is 34.3 percent, lowest among the MENA countries and at par with low-income countries.[30] Government expenditures on health was about 5.5 percent of total government expenditures, and the MOH budget was 5.4 percent of the government budget in 2004, low compared with similar countries. And yet, most of the public funds benefit the better off.[31] In 2004, only 7.6 percent of total public expenditures on health came from premiums collected by CNOPS and CNSS beneficiaries, which then covered 16.2 percent of the population, reflecting a large state subsidy of the formally insured, especially considering the volume and mix of services they receive, albeit with some co-payments. The rest of the population was not covered, except for indigents who are certified by the Ministry of Interior for free access to public health care facilities.[32] This scheme, however, is prone to abuse, for it is often the richest who receive free access, again indicating the structural inequalities in care.

33. **Public funds go where the resources are, not where the needs are.** A 2004 report by RAMED indicated that 67 percent of the free services provided in hospitals benefited the richest quintile and only 5 percent benefited the poorest. The Bank's own benefit incidence analysis of the health sector, carried out based on 1998 data shows that public subsidies benefit the wealthiest and the urban the most (Figures 2.15, 2.16 and 2.17).

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[27] INAYA is an Arabic word meaning "taking care or you" (*prendre soins de vous*). This new scheme will offer three packages of services, be managed through private insurance companies or a *mutuelle*, and will eventually cover 10 to 13 million people. At present, only the basic package is offered, aimed at people with income just above the poverty line.

[28] The government will find it difficult to pay for the increasingly costly demands of the AMO beneficiaries and at the same time introduce RAMED, which may cost up to 2.5 percent of GDP, all at a time when the pension system has a large deficit and unfunded liabilities. See David A. Robalino (2007) for a discussion of the demand for fiscal support to cover the deficit of mandatory pension schemes.

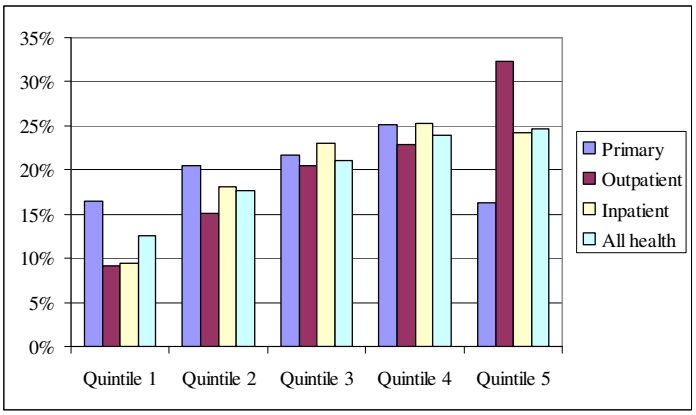
[29] Waters *et al* claim that their income amounts to about 70% of their expenditures.

[30] In 2003, the average GDP *per capita* for low-income countries was US$481 whereas in Morocco it was US$1,349 (adjusted by exchange rates).

[31] Resource allocation is already inefficient as the beneficiaries in the formal sector who tend to live in urban areas, consume more expensive hospital-based care, and have easy access to pharmaceuticals.

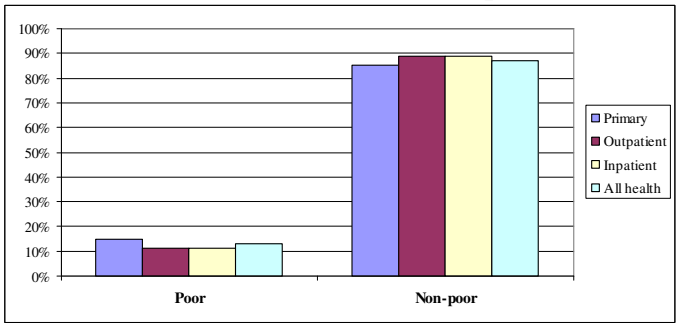
[32] Certification is open to corruption, and it is rumored to cost 140 DH to buy one (*Rapport de revue/d'identification de l'appui de la Commission européenne à la consolidation de la couverture médicale de base au Maroc*, February 2007).

Figure 2.15: Distribution of Public Subsidy on Health by Type of Service and Quintile



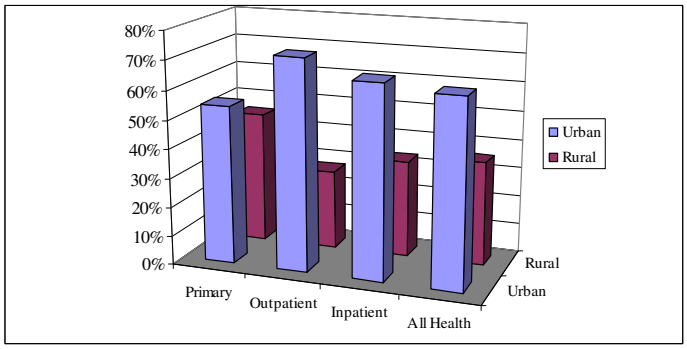
Source: LSMS 1998/99, Ministry of Health (2000), and WB Staff Calculations

Figure 2.16: Distribution of Public Subsidy on Health by Type of Service and Poor/Non-Poor



Source: LSMS 1998/99, Ministry of Health (2000), and WB Staff Calculations

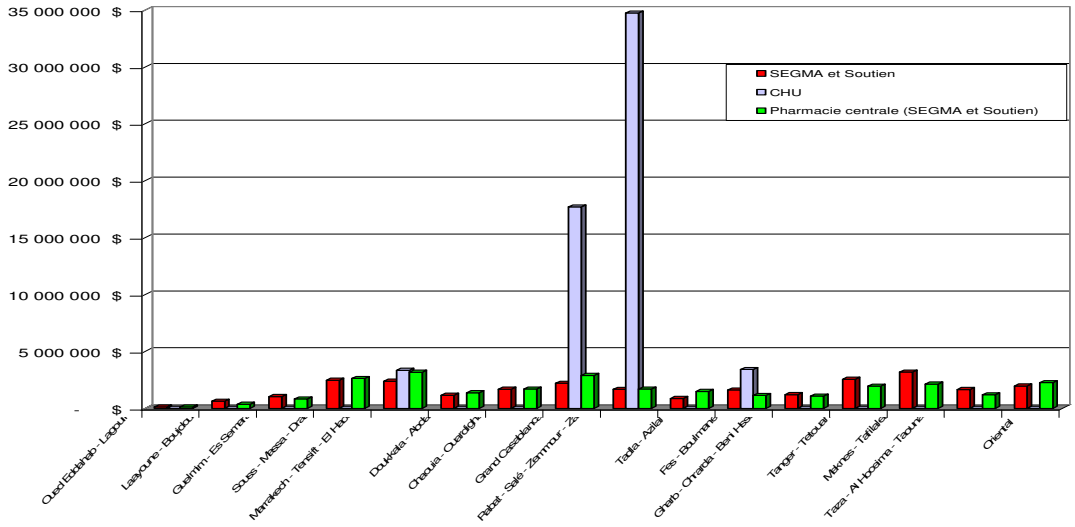
Figure 2.17: Distribution of Public Subsidy on Health by Type of Service and Urban/Rural



Source: LSMS 1998/99, Ministry of Health (2000), and WB Staff Calculations

34. **One consequence of poor resource allocation is that CHU's receive the lion share of public outlays.** Limited public funds are poorly allocated across levels of care, with 40 percent going to *centres hospitalo-universitaires* (CHUs), 27 percent to SEGMA hospitals, and only 22 percent going to ESSBs. This would have been understandable if the CHU's had truly a national vocation and their services were accessible to all including those referred from the ESSBs. While more detailed analyses are needed to document to what extent admissions and outpatient visits in CHUs originate from the cities where they are located, the existing evidence on the share of budgetary allocations to CHUs points out towards a mismatch of resources in favor of the two CHUs in Rabat and Casablanca simply because they are better endowed in terms of modern equipment and competent health professionals (Figure 2.18).

Figure 2.18: Budgetary Allocations for Public Hospitals, 2005



Source: MOH, 2005

35. **Absence of a "carte sanitaire" exacerbates inefficiencies. A** bias in resource allocation towards hospital-based care resulting from practices based on inputs (beds, health professionals) undermines the quality of care and makes the system unlikely to respond to preventive and curative healthcare needs.[33,34] Other inefficiencies include:

- *The size of the wage bill.* In a country with large human resource deficits, with only one doctor for every 2,000 people,[35] salaries and wages are 75 percent of public health expenditures, high for middle income countries.
- *Mismatch between public supply and private demand.* The private sector accounts for 62 percent of all expenditures even though 80 percent of the hospital beds are in the public sector.
- *Mismatch between a relatively large supply of inpatient care and demand for outpatient care.* Hospitals account for 31 percent of total health expenditures, outpatient care for 33 percent, and drugs and consumables for 36 percent, indicating that most expenses are for outpatient visits to private providers.
- *Low level of budget execution,* at about 80 percent for materials and consumables and 50 percent for investment.

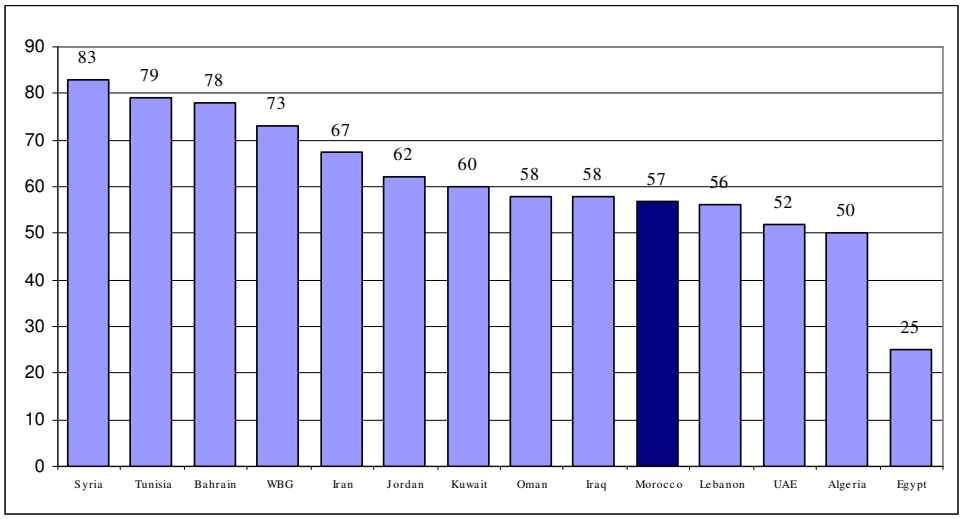
36. **Money does not follow the patient, let alone the population**, but is allocated based on what is already there and historical expenditure patterns. While there have been efforts to improve allocational efficiency, such as SEGMA, or autonomous management of health facilities (*chartes communales*) to make local authorities responsible for health promotion, *la contractualisation* in hospitals, and *la loi sur la régionalisation* for hospital investment, these have not been fully implemented as a result of lack of political will and limited central and local capacity. There has been no pooling of resources and purchasing, or careful design of financing, benefits and eligibility conditions, delivery and payment systems, or management/governance structures of health facilities to provide incentives for efficiency, improved quality, increased provider and citizen satisfaction, and reduced informal payments. As a result, the average bed occupancy rate in public hospitals is quite low (Figure 2.19).

[33] At present, 47 percent of MOH's budget is spent on inpatient care (15 percent on CHUs and 32 percent on other public hospitals), and only 38 percent on primary care (preventive and ambulatory care). Only 36 percent of births in rural areas are attended by a skilled health professional compared with 83.1 percent in urban areas. Immunization coverage is less than 60 percent for the poorest quintile and 95 percent for the richest.

[34] See the variation in Caesarian rates as a proxy for quality of care, accounting for 58 per 1,000 of all births in Casablanca, but only 10 in Tadia Azilal compared with a national average of 27.

[35] Compared with 0.7 physicians in Tunisia, 0.85 in Algeria, 2.05 in Jordan and 2.12 in Egypt per 1,000 inhabitants.

Figure 2.19: Comparison of Bed Occupancy Rates (BORs) in MENA 1995-2005



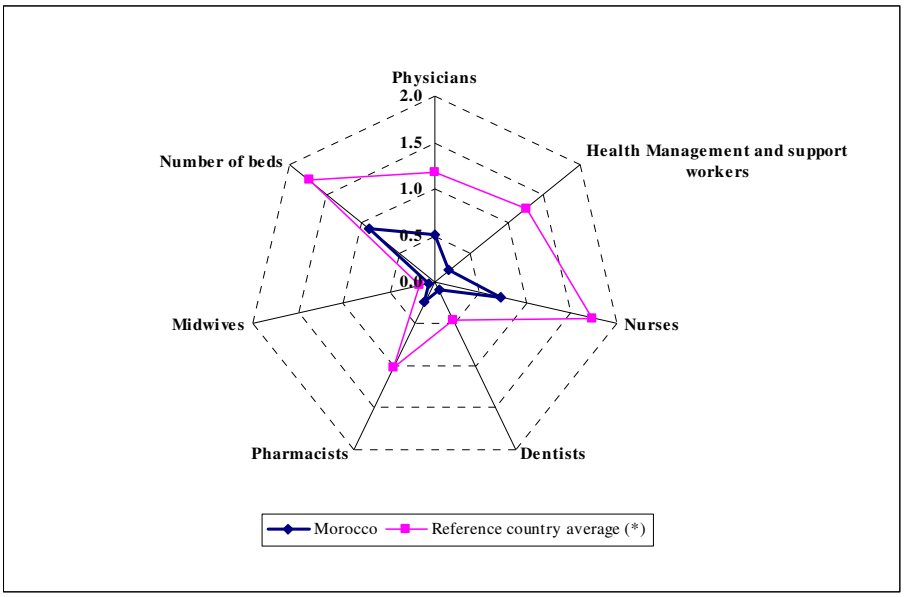
Source: World Development Indicators 2005 and World Bank Staff calculations

CHAPTER 3: AN AGENDA FOR HEALTH SECTOR REFORM

3.1 Reducing inequalities in health and access to healthcare

37. **Investment in ESSBs and human resources development is essential.** Inequalities in health and access to health care are complex, reflecting both financial constraints on the demand side and geographic and organizational imbalances resulting from the lack of physical and human resources in ESSBs and effective targeted programs on the supply side (Figure 3.1).[36] To reduce these inequalities, the government must adopt a two-pronged strategy. Introducing RAMED will not be sufficient unless there is sufficient investment in ESSBs to improve access to quality care. This requires understanding the risk factors and illnesses affecting the poor and the rural, and developing and adopting a *carte sanitaire* as a basis for investment in socio-sanitary regions. In the medium term, the private sector will not invest and establish in areas where financial returns are not enticing. Public investment is needed to establish gate keeping and a hierarchy of levels of care (population-based disease prevention and health promotion, primary health care, and basic secondary health care services) to be provided in public health polyclinics and provincial hospitals. Preparing and adopting the *carte sanitaire* should be carried out in tandem with preparing and adopting a longer-term human resources development policy and strategy for improved access and quality.

Figure 3.1: Human and Physical Resources in Morocco, 2005



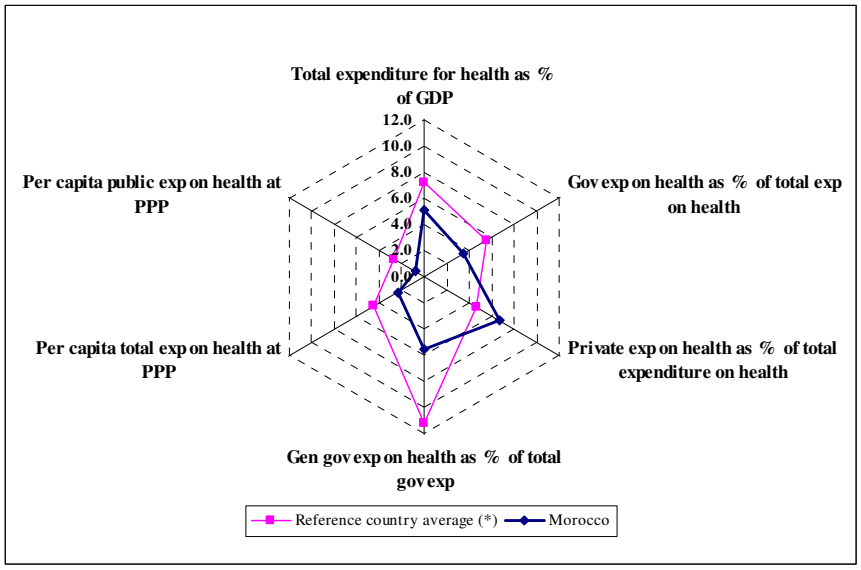
Source: World Health Statistics, 2007

38. **Additional public financing is needed to expand population coverage to the poor.** At present, public financing of health care in Morocco is inadequate (Figure 3.2). Cognizant of its limited role in financing, the State intends to finance RAMED properly, albeit with some with some cost sharing by beneficiaries and communities. According to ANAM, the additional costs for 2007 amount to DH 2.6 billion to cover the health care needs of a population of about 8.5 million through access to a basic benefit package (BBP) of outpatient visits, diagnostics (laboratory and imaging), inpatient care, and case management of chronic diseases, including medication. These estimates cover two groups of beneficiaries, the absolute poor (4.0 million) and the vulnerable (4.5 million) and two types of services, inpatient care (DH 2.9 billion) and outpatient care (DH 1.7 billion). The source of financing would be

[36] MOH estimates there is a shortage of 7,000 physicians and 9,000 nurses in the public sector. With production rates of 800 physicians and 1,500 nurses a year, average duration of nine years to train a physician, and the attrition expected in the next ten years, the health workforce deficit will not be covered in next 10-15 years unless the government defines a new human resource policy and strategy and invests in producing health care workers of all levels.

three-fold: (i) DH 562 million to be paid for by beneficiaries through an annual fee of DH 100 per capita up to a maximum of DH 500 per household for an estimated total of DH 421 million and a user fee of DH 10 up to a maximum of DH 300 for outpatient visits, lab tests, and imaging, for an estimated sum of DH 141 million; (ii) contributions by local communities to cover annual fees for *pauvres absolus*, estimated at DH 587 million; and (iii) state contribution of DH 1,469 million, including DH 1,048 million, or 38 percent of the MOH budget, excluding salaries, subsidies to the CHUs (DH 564 million), SEGMAs (DH 374 million), r*égie* hospitals (DH 70 million), and for insulin procurement (DH 40 million). These estimates exclude wages and benefits, estimated at DH 800 million, and 10 percent of the total as administrative costs. According to ANAM, an annual increase of about 1.7 to 3.7 percent of total expenditure is forecast for increases in service use, aging and sectoral price increases, despite the expected decrease in poverty levels, that is, in the number of RAMED beneficiaries.

Figure 3.2: Health Financing in Morocco, 2005



Source: World Health Statistics, 2007

39. **Future growth projections of GDP and of government revenues may open the needed fiscal space for the expansion of AMO and RAMED.** During the next 4-5 years, the real annual GDP growth is expected to remain above 5 percent. Government revenues are forecasted to reach 26 percent of the GDP and the public debt ratio to GDP is expected to decrease from 69.9 percent in 2005 to 52.5 percent in 2010 (Table 3.1).

Table 3.1: Macroeconomic Projections, Morocco, 2006-2011

	2006	2007	2008	2009	2010	2011
GDP (billion USD)	63.3	70.0	73.0	76.1	78.4	83.0
Real GDP growth (%)	9.3	3.8	5.1	5.4	4.8	5.3
Exchange rate: US$ (average)	8.8	8.4	8.6	8.9	9.2	9.3
General government expenditure (% of GDP)	26.6	27	27.1	27.1	27.3	27.5
General government revenue (% of GDP)	24.8	25	25.5	25.5	25.9	26.3
General government budget balance (% of GDP)	-1.8	-2.1	-1.6	-1.6	-1.4	-1.1
General government debt (% of GDP)	67.0	62.9	59.4	55.7	52.5	49.1
Government consumption (annual growth %)	5.9	4.2	5.4	5.0	4.5	4.4

Source: The Economist Intelligence Unit, Morocco Country Forecast 2007, June 2007

Longer term growth projections are equally favorable, forecasting an average annual GDP growth of 4.6 percent between 2007 and 2030, or 3.3 percent *per capita* per year based on a labor productivity

growth of 3 percent *per annum.* Two actuarial studies estimated that RAMED would cover about 8.5 million Moroccans at a total cost of about DH 4.6 billion. Government would only have to pay for about DH 2.6 billion. Using the latter figure which equates to 0.45 percent of the GDP in 2007, or 1.6 percent of the total government expenditures, there should be sufficient fiscal space in the government budget to cover for the additional fiscal burden of expanding health insurance to 8.5 million RAMED beneficiaries.[37, 38]

40. **ANAM as the implementing agency for RAMED, should become an active purchaser.** On the demand side, introducing RAMED could catalyze the development of rural health services delivery, if RAMED funds were allowed to follow the patient. This entails additional financing, not only to provide the services in the benefit package, but also an investment and maintenance allowance to ensure expansion and sustainability of the ESSBs. ANAM could act as an independent insurance agency, with sufficient autonomy to purchase services from the ESSBs rather than becoming, eventually, a passive payer, in addition to being as it is at present, an administrator. These contractual agreements with each ESSB should be made under the overall umbrella of *budget-programmes* with regional health departments which are drawn on the basis of epidemiologic and demographic profiles of beneficiaries in each region. Such an arrangement will, on one hand, delegate accountability for allocational efficiency to regional departments while developing their own institutional capacity to ensure that they get good value for its money, and on the other, will preserve the advantages of direct contracting of ESSBs by ANAM for better technical efficiency. This would require developing an information system to track the amount, volume, and mix of service use of beneficiaries at different levels of care. ANAM would also need unambiguous policies and procedures for referring patients to higher levels of public and private care, possibly outside the regional catchment area.

41. **ANAM should become a truly independent regulatory agency.** ANAM, the agency designated to run RAMED, and several commissions established under the Prime Minister are working to define eligibility criteria, the basic benefit package, administrative rules and regulations for certifying the eligible population, and the information management system. ANAM should complete the regulatory framework, guidelines for eligibility, coverage and piloting RAMED. ANAM is preparing a circular that defines the procedures for issuing certificates of indigence, registering beneficiaries, and the roles and responsibilities of the Ministry of Interior, ANAM, service providers, and patients, and the financial, human and informational resource needs as a first step to piloting the scheme at the provincial level.

42. **AMI-Inaya should be prioritized because of its labor market implications.** In Morocco youth unemployment rates are particularly high among the educated. This is so, because educated women often may choose to wait for a job in the public sector which admittedly offer better wages and benefits such as maternity leave. While the wage differentials for men between the public and private sector is less, though still substantial, they also prefer the public sector because of job security and other advantages such as health insurance. However, in Morocco, public sector employment is less then 10 percent of total employment and it is more likely to gradually decrease as a result of the on-

[37] In 2007, Morocco is expected to spend about US$3.6 billion in total, only 34.3 percent of which, or US$1.23 billion, is public. The additional costs of DH 2.6 billion (US$ 310 million at 2007 exchange rate) implies a 25 percent increase in government expenditures on health, or 11.2 percent increase in total health expenditures if all 8.5 million RAMED beneficiaries were covered at once. Obviously this is a rough estimate of the additional fiscal burden based on a number of assumptions made in the actuarial studies. More detailed analyses would need to be carried out once there is an agreement on the entitlements and obligations of RAMED beneficiaries in terms of the benefit package, user fees, co-payments etc., which then need to be imputed over time based on other assumptions such as increase in service use, changes in service mix, and general and sectoral inflations. In any case, given serious constraints on the supply side, an out-of-control in cost increases would be unlikely.

[38] On the other hand, RAMED is first and foremost a social assistance program, rather than a health insurance scheme, and as such its fiscal and financial probity should be assessed together with the other social protection schemes that impose a heavy burden on government coffers. For instance, the indebtedness of the pension plans, the Caisse marocaine de retraite (CMR) and the CNSS, amounts to 77 percent and 64 percent of GDP, respectively.

going public administration reform.[39] Given the 30 percent unemployment rate among the highly educated and close to 25 percent among the secondary level graduates, a proactive labor policy should identify mechanisms to expand social insurance coverage to the self employed and casual and seasonal workers in the agricultural sector through AMI-Inaya together a fair cost-sharing mechanism to minimize the amount of public transfers (e.g., matching contributions).[40]

43. **A pilot could provide valuable experience. F**inding the right balance between coverage in terms of publicly financed volume and mix of services and spread in terms of eligibility (full, partial) will be a challenge. A pilot experiment will be needed in one of two newly established regions or in a poor region where there is high degree of political commitment and effective leadership,[41] with a view to reducing inequities while safeguarding overall efficiency and fiscal sustainability with constant fine-tuning on the basis of feedback from a rigorous ongoing evaluation. Such a pilot would also allow ANAM to acquire pertinent experience, albeit limited to RAMED at the onset, to test and showcase its institutional capacity and competence in managing an insurance scheme which could, over a much longer period, prove useful in the case of an eventual virtual harmonization and subsequent real consolidation of the entitlements and obligations of all insurance schemes under a single payer.

3.2 Improving allocational and technical efficiency in health care

44. **Expanding health insurance coverage is the main policy issue which cuts across all other reform initiatives in the health sector.** While the legal basis for expanded population coverage exists, several reforms should be carried out before a road map and a time frame are issued improved allocation efficiency. These include, first and foremost, the preparation and adoption of supply side micromanagement tools such as the *carte sanitaire* and a human resources development strategy to train the health workforce based on an assessment of healthcare needs. Thereafter, the following actions will be needed: (i) adopting a formula for resource allocation based, on regional epidemiology and demography; (ii) switching from input-based payment to providers to output-based, performance, and results driven modes of payment; (iii) designing and enforcing an appropriate algorithm and financial incentives for gate keeping and patient referral across levels of care; (iv) allocating sufficient financial and human resources to high priority national health programs; and (v) introducing a generic drug policy (setting prices and reimbursement rates, allowing substitution by pharmacists), standard treatment protocols, and guidelines for rational drug use. Annexes 6 and 7 provide a summary of advantages and disadvantages of examples of resource allocation and hospital payment mechanisms, respectively, used in OECD countries.

45. **"*Contractualisation*" is a step in the right direction.** A good example is the ongoing piloting of contracting out between the MOH, through the Department of Planning and Human Resources and the regional health departments, and the SEGMA hospitals in the regions. The c*ontractualisation* involves three phases: (i) developing a strategic framework as the basis for a "*budget programme*"; (ii) allocating and executing an annual budget on the basis of a contract; and (iii) ex-post performance evaluation. While the introduction of the *contractualisation* is a major development, its effectiveness depends on separating purchasing and provision functions and providers (such as SEGMA hospitals) assuming some financial and reputational risk in case of lower-than-expected performance in the form of annulment of the contract or other measures with financial and non-financial implications. Involving local authorities in establishing the strategic framework and defining performance criteria and indicators is a step in the right direction towards pluralism.

[39] Actually, Morocco has a lower youth and adult unemployment rates than most MENA countries, slightly over 15 percent in the 15-24 age group and about 10 percent in the 25-64 age group. However, this is probably so because the uneducated in Morocco who live in rural areas has lower unemployment rates than the highly educated living in urban areas. Please see the recent World Bank report "Youth – An Undervalued Asset: Towards a new Agenda in the Middle East and North Africa", Draft version, May 2007 for more details.

[40] Such programs need to be developed without further fragmentation of the social insurance system while ensuring fiscal sustainability and an efficient and equitable allocation of subsidies. Please see the recently issued Bank report on "Skills Development and Social Protection within an Integrated Strategy for Employment Creation", Draft version, May 2007.

[41] Such as Meknes-Tafilalet or Fes-Boulman, two regions with the highest poverty.

However, it is difficult to foresee, so long as MOH remains—directly or indirectly through the regional health departments—both purchaser and provider, how the "*contractualisation*" could become fully functional and effective.

46. **"Virtual" integration of payers and harmonization of the basic benefit package are first steps toward a universal health coverage.** Once RAMED and AMI-Inaya become fully operational, there will be at least five large insurance schemes, a number of smaller *mutuelles* and a few private insurance companies.[42] At present the premium rates, the benefit packages and the reimbursement rates are quite different across the schemes which not only raise an equity issue, but also has implications for labor market and mobility (Box 4). Their harmonization will reduce segmentation in the sector, improve equity and efficient allocation of resources and simplify administration not only for the insurance agencies and *mutuelles*, but equally importantly for the providers. It will also pave the way first for a "virtual" integration all operating under the same rules, and eventually, institutional integration under ANAM's regulatory umbrella.

Box 4: Variations in Premium Rates, Eligibility Criteria and Benefit Packages in Morocco

There are important variations across various public and private insurance schemes. In the public sector (CNOPS), the premium rate is 5 percent of the total wage, paid equally by the civil servant and the State as employer. The minimum and maximum monthly payments are 70 DH and 400 DH, respectively. The benefit package is quite comprehensive with seven categories of services including, all outpatient and inpatient services, drugs and prostheses and dental care. CNOPS reimburses between 70 and 90 percent of the costs, depending upon the category, the balance being either paid for the patient or his/her own sickness fund ("*mutuelle*"). In the private sector (CNSS) the premium rate is 4 percent, again equally paid by the employee and the employer. However, the benefit package is not as comprehensive, with age limits for some services and the reimbursement rate is 70 percent, except for ADLs and ACCs. AMI-Inaya offers three options each with its own premium rate and package of services, the premium rates varying between DH 45 to 86 for adults and 36 to 69 for children, depending upon the package. Package 1 gives access only to the public facilities, Package 2 to both public and private with a package identical to that offered by CNSS and Package 3 to all outpatient and inpatient care. The user fee is set at 10% of the prices in the fee schedule with a minimum of DH 10 and a maximum of DH 300 per episode of care. In the case of RAMED, there will not be any premiums for obvious reason, but the beneficiaries will have to pay an annual fee of DH 100 for each member of the household, up to a maximum of DH 500. However, the local communities will pay for the "pauvres absolus" whereas the "vulnerables" will have to pay themselves. Finally, they are expected to pay a 10 percent with a minimum of DH 10 and a maximum of DH 300 per episode of care.

47. **Several issues are outstanding.** A list of reimbursable drugs has been developed for AMO, and a new law on pharmaceuticals has recently been enacted. However, there still are several outstanding issues, namely: (i) reforming centralized drug procurement; (ii) setting prices for generic drugs; (iii) pharmacist rights and obligations regarding substitution of branded drugs with generic drugs; (iv) use of prices at country of origin for reference pricing; and (v) absence of an integrated information system for recording and invoicing prescriptions for the *affectations de longue durée* (ALD) and "Affections longues et coteuses" (ALC), two categories of disease for which patients have free access to expensive drugs (insulin, cancer drugs).[43]

48. **Implementation depends on political will and consensus building.** Several of these policy measures have been studied or piloted through Bank-, EU- or other donor-financed projects. Their scaling-up and successful implementation will depend on political will and on compliance from regional authorities and providers. This will require an open and transparent consensus building

[42] CNOPS, CNSS, RAMED, AMI-Inaya and the Moroccan Inter-professional Mutual Fund are the largest schemes. In addition, there are independent *mutuelles*, e.g., the Military, Royal Air Maroc and so on.

[43] CNOPS prefers buying expensive drugs in bulk to avoid wholesale and retail surcharges that distort the pharmaceutical market. The existing price setting mechanism, which relies on market prices in the country of origin with a mark-up for importation and profit, often results in prices a few times higher. Augmentin, a frequently used antibiotic, is 2.5 times more expensive in Morocco than in France. There are no positive or negative lists and no incentives for physicians to prescribe generic drugs. While 70 to 80 percent of all drugs used in Morocco are produced locally, generics are only 24 percent of the market (percentages are expressed in terms of number of units and not prices).

process across stakeholders and piloting as needed, together with deploying sufficient resources and developing the necessary legal, technical, and administrative competencies for results-based contractual agreements with regions and health facilities.

3.3 Reforming system governance and regulatory framework

49. **Political commitment and leadership is essential.** Improving governance of the health care system requires explicit political commitment to reform, backed by strong leadership and political will for a major realignment of the roles and responsibilities of MOH and health insurance agencies.

The proposed alignment has two components:

(i) Redefinition of MOH's role and moving from being a service provider and a payer to being a policy maker, planner, standard setter, and regulator.[44] This requires repositioning MOH and its administrative units vis-à-vis other ministries and government agencies,[45] its regional, provincial, and lower administrative units,[46] and ANAM.[47] MOH would have to leave financing and service provision and restructure itself to become an effective policy maker, planner, and regulator.[48]

(ii) Consolidating the mandate and functional responsibilities of ANAM, and strengthening its institutional capacity while increasing its autonomy. ANAM has a dual mandate, defined by Articles 59 and 60 of Law 65-00: (i) act as a regulatory agency for AMO in charge of oversight of its financial viability, regulation, and contractual negotiations with providers; and (ii) financial and administrative management of RAMED. It has two separate boards of administration, one for AMO and another for RAMED, each with its own configuration in terms of representation, distribution of power, and membership requirements. In both cases, ANAM, being under the tutelage of MOH, enjoys limited autonomy in making crucial policy decisions to harmonize obligations and entitlements.[49] Under the current legal and regulatory framework ANAM does not have the authority to pool revenues under its tutelage and benefit from economies of scale, administrative simplicity, reduced administrative costs, or increased negotiation power vis-à-vis providers to truly become an active purchaser.[50] Increased autonomy would also allow ANAM to use RAMED as a testing ground, learn from experience, and build its institutional capacity by combining regulatory and management functions. Increased autonomy would also result in the separation of purchasing from provision and level the playing field between public and private providers, leading to more competition and better choice for patients.[51]

50. **An explicit statement of vision is needed.** While several reform initiatives have been launched that define broad strategic directions,[52] there is a need for a "White Paper" with an explicit

[44] "Steering rather than rowing" is an analogy often used to describe this shift in functional responsibilities.
[45] In relation to human resources development, education and science, food hygiene and nutrition, water supply and sanitation, and biological, chemical, and environmental threats to health.
[46] In relation to policy development, planning and performance evaluation for health, and health care issues of sub-national relevance and remit.
[47] In relation to the harmonization and rationalization of the financing of the CMB and all related managerial, administrative, and monitoring and evaluation functions.
[48] Several studies and audits review the institutional strengths and weaknesses of the MOH and its affiliated agencies and proposals have been made to restructure its central and regional organization. See the technical report financed by WHO and prepared by CREDES, issued in January 2006.
[49] It is not ANAM, but CNOPS, its *mutuelles* and CNSS who are the main parties to decisions regarding premium rates on the revenue side, and the eligibility criteria, package of services, and co-payment rates for services rendered on the expenditure side.
[50] Fragmentation of financing is so extensive that despite the recent attempts such as MTEF exercise and the budget program for the regions, it is impossible to allocate limited resources according to health needs, nor does the money follow the patient.
[51] Rather than those covered by AMO using mainly private providers in large cities where the quality of care is undeniably better and those covered by RAMED having access to a less generous package of services available only in public facilities.
[52] The "Horizon 2015" initiative defines 11 "Axes stratégiques" and the "Vision développement humain 2025" initiative identifies three prerequisites (purchaser provider split, defining national health policies, and developing a national health map).

statement of mid- and long-term vision, mission, policies and strategies, clearly delineating the role of the state and the nature and extent of the public-private mix in financing and service delivery. This is particularly crucial as the Palace and the Government increasingly recognize the dissatisfaction of the people with the democratization process. Morocco deserves to score and rank higher for the main health and human development indicators relative to its higher level of governance (Annex 8). Indeed, there seems to be genuine interest in increasing the legitimacy of the current governance structure, making it more accountable to the population, improving transparency, and curtailing corruption to maintain social peace and stability and respond to unmet human development needs, be they education, health or overall social protection,

CHAPTER 4: A WAY FORWARD

51. The success of any proposal for reform depends, first and foremost, on the accuracy of the diagnostics and the willingness to accept the final diagnosis. Overall, Morocco's performance on human development in general and in health attainment and health system performance in particular compare unfavorably with those of countries at a similar level of socioeconomic development (Figure 4.1). This is especially so, because of inequalities in geographic, financial, socio-organizational access to quality heath care that result in a two-tiered healthcare system. In other words, it is not poverty and its determinants alone, but unresponsiveness, rather than inability, of the current healthcare system in providing the most essential healthcare services to the totality of the population.[53]

52. Our analysis shows that the lack of responsiveness has two sets of determinants: (i) those related to supply side issues, i.e., whether there is a health center within a walking distance to the settlers in a remote urban area where there is physician, a nurse and some amenities for the most essential care and these are accessible to any health care seeker either freely or at an acceptable price; and (ii) those related to demand side, i.e., whether the healthcare seeker will be cared for in a dignified manner[54]; that s/he will not be subject to any requests for informal payments or be denied of care simply because s/he cannot afford to pay for part or all of it; that's/he will be given the necessary information which will improve his/her confidence in the technical competence of the provider and ensure his/her compliance with the prescription and counseling. The literature tells us that health care seeking behavior, itself has three sets of determinants: (i) those that predispose an individual to seek care, i.e., education, sex, attitudes and beliefs; (ii) the perceived need for healthcare, i.e., feeling or being ill or being told so; and (iii) those that enable the individual to actually demand healthcare, i.e., having an indigent card, or insurance and the tradeoff between the perceived benefits of seeking care and the time, cost and other inconveniences. Therefore, people will refrain from using health services, or from using them in a timely manner, unless they feel that they are "covered", a necessary condition, but also if they believe that they are not going to be subject to arbitrariness or lower standards in the way technical and psycho-social care is provided, a sufficient condition.

53. In Morocco, the latter seems to be only partly a resource issue; but rather a governance issue, more than anything else, requiring thus measures beyond building more health facilities, training doctors, or simply increasing public budget for health, but rather empowering the patient in a way that the public funds will go to the provider of his/her choosing and leveling the playing field that that all providers, public or private, play by the same rules, or be subject to same entitlements, risks and obligations. How could this be done?

[53] Poverty in Morocco is experienced as a complex of exclusion from economic, social, and political life as well as low income and poor access to services. Morocco as a country and society in transition the importance of a safety net for helping people to avoid spiraling into poverty during periods of illness or unemployment the problem of poor access to services (as opposed to simply the existence of services) - in health, for example, actual access is affected by corruption (Ref: Moving out of poverty, March 2007)

[54] *Health care:* Many women are reticent to consult male health workers (particularly concerning reproductive health issues); this plus the fact that maternity facilities are often located in urban centers has puts women at real risk. This issue could be addressed by the more proactive encouragement of women to become rural health practitioners and improvements in affordability and physical access to quality reproductive health services and hospital facilities (Ref: Moving out of poverty, March 2007)

Figure 4.1: Health Status in Morocco relative to other Low- and High- Middle Income Countries In MENA and Other Regions, Trends 1990-2005

Position	1	2	3	4	5	6	7	8	9	10	11	12	Morocco (2005)	Selected country average (2005)	Lowest [1] (2005)	Highest[2] (2005)
Life expectancy at birth (years)											→	→	70.4	72.1	70.4	74.2
Infant mortality rate (per 1,000 live births)											→	→	36	24	14	36
Adult mortality rate (male) (per 1,000 male adults)[3]		←	←	←	←	←	←	←	←				156	172	151	237
Adult mortality rate (female) (per 1,000 female adults)[3]			←	←	←	←	←	←	←	←			101	106	87	155
Births attended by skilled health personnel (% of births)(*)									→	→	→	→	63	82	63	100
Number of physicians per 1,000 population(*)									→	→	→	→	0.5	1.5	0.5	3.3
Number of beds per 1,000 population											→	→	0.9	2.0	0.9	6.6
Public / private health expenditure ratio										→	→		0.52	1.49	0.38	6.14
Per capita total expenditure on health (in international dollars) (**)									→	→			234	388	109	817
←	**Improvement in ranking of health indicators between 1990 and 2005**															

Note: The following countries were used as reference countries: Syria, Egypt, Jordan, Algeria, Iran, Tunisia, Lebanon, Oman, Colombia, Venezuela, Turkey, Romania.

1. Lowest value observed among twelve reference countries in 2005 or around 2005.
2. Highest value observed among twelve reference countries or around 2005.
3. Unstandardized mortality rates.

(*) In 1990 Morocco ranked 9th out of nine countries for which data was available and 12th in 2005.

(**) In 1990, Morocco ranked 9th out of ten countries for which data was available and 10th in 2005.

54. One could conceive the scope and purpose of health sector reform at four levels: (i) *instrumental* reforms to improve day-to-day management of the system, such as introducing and using various better information systems, new rules and standards for licensing facilities, or adopting new guidelines for rational use of drugs; (ii) *organizational* reforms to improve technical efficiency by focusing on productivity and quality of care to get better value for money within a given envelope, such as enforcing a gate-keeping and referral system, changing the mode of payment for physicians or hospitals; (iii) *programmatic* reforms, to improve allocative efficiency, or getting better value for public funds, such as introducing medium term budgeting, allocation of funds to high priority diseases or services; and (iv) *systemic* reforms to improve equity, mostly through changes in system governance encompassing a certain degree of realignment in the mandate, roles and responsibilities of the main stakeholders.

55. The attached policy matrix is prepared with the understanding that what is needed in Morocco is a systemic reform. It outlines the preoccupations and issues with the current health care system, defines the scope and purpose of the reform, lists a series of short- and long-term policy measures, identifies risks and prerequisites for adoptability and states at the end the outcome indiciators. Given the comprehensiveness of the reform agenda the role of the State will be primordial, Figure 4.2. below provides an example of how that role may change in the next decade and through what mechanisms.

Figure 4.2: Changing Role of the State in Healthcare

Main Functions	Spain	Egypt	Turkey	Morocco Today	Morocco in 2020 (?)	Remarks
Policy/ Regulation	++++	++++	++++	+++++	++++	Through more autonomy to ANAM
Financing	+++	+++	++++	++	++++	Increased State Financing through RAMED and tax subsidies to SME
Purchasing/ Payment	+++	+++	++++	++	+++	Through ANAM and indirectly CNOPS and complementary private insurance
Service Delivery	++++	++++	+++	++++	++	Through increased autonomy to hospitals and public/private mix
Organization/ Management	+++	+++	+++	++++	++	Lesser involvement through regionalization
Human Resources Development	+++	+++	+++	+++++	+++	Liberalization of formal education in health sciences

Legend: (+) minimal responsibility ➔ (+++++) exclusive responsibility
N.B. Responsibility does not equate to actual fulfillment of the assigned role.

56. **Successful implementation of the healthcare reform requires full support from all parties and proper sequencing.** The first step of the process would be to issue the a draft policy document Santé –Vision 2020, followed by a consensus-building exercise among all stakeholders in the healthcare system. The second step would be the preparation of a timed-bound and costed implementation plan. Both of these steps, which are mainly political in nature, should have the backing of the Royal Court. The array of reform options should be fed back to all stakeholders to facilitate agreement on the timing, sequencing and financing of their implementation, as well as pre-requisites for their introduction (e.g., required legislation, regulation and training). A thoroughly consensual process needs to be followed including the population and the providers to explain what is stake, and jointly find the right levers and

mechanisms for full ownership. Two regions have demonstrated a high level of commitment to the reform process could then be selected to pilot the reforms.

57. **Finally, a public information campaign, preferably conducted through the media, would be needed and should be developed and properly financed.** The campaign should explain to the populations of the two regions the main tenets of the reform, the nature and timetable of reform activities and emphasize those actions likely to produce tangible results in the short run (e.g., improved access to and quality of care, as well as reduced out-of-pocket expenses for essential services). This step is very important to galvanize public support and help people understand and endure the distortions that are likely to occur during implementation of the reforms. A similar approach will be needed to fully inform health professionals and thus lessen misconceptions, alleviate fears, mitigate bureaucratic and professional resistance and assure their cooperation. Last but not least, collaboration with international partners throughout the process will be needed to secure their political, technical and financial support.

A policy matrix for improved health sector performance

Preoccupation; issue(s)	*Scope and purpose*	*Policy Measures*		*Risks*	*Prerequisites for Adoptability*	*Outcome indicators*
		Short Term	*Long Term*			
EQUITY: • Protracted inequalities in health and access to healthcare in times of demographic and epidemiological transition.	**SYSTEMIC:** • Achievement of universal coverage in an equitable and fiscally and financially sustainable manner; • Fairness in financial contribution.	• Policies that define the eligibility criteria and the content of the Basic Benefit Package for RAMED beneficiaries. • Policy measures that define the eligibility criteria and the content of the Basic Benefit Package for AMI-Inaya beneficiaries. • Revision of MOH mobile health care unit deployment policy for areas where geographic	• Harmonization of the BBP and patient entitlements and obligations across CNOPS, CNSS, AMI-Inaya, RAMED and independent *mutuelle*s. • Policy and guidelines for private sector involvement in service provision for all insured regardless of their affiliation. • Issuance of a long term Public Investment Plan for all regions. • Human resource deployment policy to improve socio-organizational access to care for women and children.[55] • Limiting the scope and boundaries of private health insurance to exclude BBP.	• **Political:** (i) Divergent views on State's role and obligations in heath financing and service delivery; (ii) Disagreement on the optimal balance between the spread and breadth of coverage for RAMED, and its subsequent harmonization with the current rights and entitlements of CNOPS and CNSS beneficiaries. • **Fiscal**: In relation to government revenues and intersectoral trade-offs in investment and expenditures.	• Political commitment from highest political level equity in access to care as a human developmen t goal. • Increased State financing through RAMED and health sector investment in rural Morocco.	• Full implementation of CMB with a virtual harmonization and integration of population groups.

[55] This is mostly in relation to rural women of reproductive age who prefer being seen and examined by, or taking their children to, female doctors and other health professionals.

Preoccupation; issue(s)	*Scope and purpose*	*Policy Measures*		*Risks*	*Prerequisites for*	*Outcome indicators*
		access is limited or non-existent.				
GOOD GOVERNANCE: • The governance and institutional structure of the healthcare system is fragmented, reflecting the duality of the two-tiered system with overlapping roles and responsibilities across providers and payers.	**SYSTEMIC:** • Achievement of pluralism in system governance through realignment of the functional roles and responsibilities across of the main stake holders; • Increased participation of providers and consumers in system governance. • Responsiveness to expectations.	• Adoption of "Vision 2020" • Policy decision on the restructuring of the MOH and revision of its mandate, roles and responsibilities to reinforce its stewardship, regulatory and population health and system intelligence functions.[56]	• Redefinition of the institutional mandate and functional responsibilities making ANAM the sole policy setter and regulator in health financing with CNOPS, CNSS, AMI-Inaya becoming paying agents under the oversight of ANAM. • Completion of regionalization with the establishment of the remaining seven socio-sanitary regions.[57] • Completion of the on-going hospital reform with full managerial and financial autonomy. • Redefinition of the privileges and obligations of the Professional associations vis-à-vis self regulation, licensing, certification, litigation and representation in contractual arrangements with ANAM. • Policy statement on consumer rights, protection and obligations in system management.	• **Highly political**: Significant reduction in MOH's power base and sphere of influence. • **Institutional:** • ANAM's current institutional capacity is not at par with the increased scope and responsibilities; • Sub-national self governance capacity in the health sector is limited. • **Value-laden:** Citizen participation in system governance is an emerging concept.	• Political leadership, commitment and support at the highest level. • Constructive and consensual attitude and behavioral response from all stake holders. • Evaluation of the Regionalization Pilot	• Functional segmentation across MOH, ANAM and providers through gradual separation of financing, provision and stewardship functions. • Integration of revenue collection, pooling and purchasing functions under ANAM. • Financial and managerial autonomy of all public and private health facilities. Improved consumer participation and protection.

[56] Several technical proposals have been made to date, including organizational charts, but they need to be reviewed by the Government and eventually adopted.

[57] A decree on "deconcentration" was adopted on December 2, 2005 and line ministries were asked to prepare their "schémas directeurs de déconcentration". However, there still is soe confusion over the scope and extent of decentralization, i.e. political, managerial or simply administrative. At H.M King's request a deconcentration strategy is being prepared by a task force which further delayed the implementation of the decree. In addition, the delineation of the socio-sanitary regions does not follow the administrative boundaries, thus further complicating its implementation.

Preoccupation; issue(s)	*Scope and purpose*	*Policy Measures*		*Risks*	*Prerequisites for*	*Outcome indicators*
ALLOCATIONAL EFFICIENCY: • Low and poorly allocated public outlays for healthcare resulting in inefficiencies in resource allocation and use, and high private OOP expenditures.	**PROGRAMMATIC:** • Health improvement or attainment of the optimal health outcomes with the available resources, or the "best value for money".	• Revision of the Medium Term Expenditure Framework[58] to include: (i) a resource allocation formula prorated by regional demographic and socio-epidemiologic profiles; (ii) within regional allotments, outcome-based programmatic budgeting against regional health objectives.	• Adoption of a "carte sanitaire".[59,60] • Institutionalization of the "budget-program" as a policy tool for improved resource allocation to newly established socio-sanitary regions.[61] • Issuance of a financial and non-financial incentive package to improve human resource deployment in Regional Health Departments and rural ESSB.[62] • Adoption of policies and institutional mechanisms for improving price setting and reimbursement rates for brand and generic drugs.	**Political:** • Lack of clarity and/or disagreement on the role of the State in the health sector; • Resistance to relinquishing centralized power and authority; • Delays in public administration reform program.[63] • **Institutional:** • Bureaucratic resistance in MOH; • Limited capacity in the newly created regions for planning and programming; • Delays in the public administration reform law and the reimbursement	• Piloting new programming, purchasing and resource allocation mechanisms at the regional level.	• Increased government financing and improved allocation of public funds in line with the epidemiologic and demographic profile of the country and the burden of risk factors and illness.

[58] MOH as a pilot line ministry already adopted a three year rolling MTEF for 2007-09, a successfully met trigger of PRAL-III.
[59] In line with the revision of the "Plan d'Extension de Couverture Sanitaire, or PECS" and the extension of the "Schéma Régional de l'Offre de Soins (SROS) from three to all regions.
[60] On the other hand, however, the MOH has not yet completed the drafting and approval of its "deconcentration master plan", a trigger under the first PARL operation.

Preoccupation; issue(s)	*Scope and purpose*	*Policy Measures*		*Risks*	*Prerequisites for*	*Outcome indicators*
TECHNICAL EFFICIENCY: • Low and/or uneven productivity and quality of care resulting in suboptimal value for money and provider and patient dissatisfaction.	**ORGANIZATIONAL:** • Responsiveness to patient's needs and expectations with the appropriate mix of medical, psycho-social, comprehensive and continuous care.	• Policy on development and use of (STPs) and the applicable level of care; • Policy on rational use of drugs • Policy on inpatient care quality improvement (QA/QC). • Pay-for-Performance for physicians.[64] • Revision of the fee schedule.[65]	• Adoption of a performance-based provider payment policy and modalities for hospitals and physicians as a basis for contractual agreements with the payers.[66] • Policy on medical malpractice and patient grievance (e.g., ombudsman). • Setting up an independent accreditation agency. • Licensing and accreditation of health facilities as a pre-requisite for contracting with ANAM. • ANAM empowered to conduct technical quality audits. • Review/revision of the Patient's Right Law.	**Political:** • Continent on the progress with PARP. • Resistance from both public and private hospitals to independent accreditation and quality audits. **Institutional:** • ANAM's current institutional capacity is limited vis-à-vis new purchasing requirements and technical quality audits; • MOH's current organizational set up and capacity is not conducive to carrying out acitivites related to accreditation and licensing.	• Piloting contractual purchasing, QA/QC and payment mechanisms at the regional level. • A research unit in ANAM for continuous monitoring and research on trends, patterns and variations in service use.	• Increased population and provider satisfaction. • Improved health outcomes.

[61] MOH is the only line ministry that has so far been able to adopt a performance-based contracting with three regional authorities as part of the PARL-supported drive for greater responsibility in budgetary programming and execution for regional and provincial branch offices, with results accountability.
[62] This should go hand in hand with MOH's work on strategic staffing through the development of the "Référentiel des Emplois et des Compétences" or RECs, another trigger for PARL-III.
[63] Especially with regard to civil service reform, wage policy and containment of public payroll.
[64] This could be dovetailed to the ongoing government initiative to introduce performance evaluation in civil service for promotion and salary increases. Continuous medical education could be one of the prerequisites.
[65] The update of the fee schedule has just been completed and fees are upwardly revised. However they need to be constantly updated on the basis of utilization patterns and new evidence on cost-effectiveness.
[66] Please See Annex 6 and 7 for pros and cons of various payment schemes and examples from OECD countries.

Preoccupation; issue(s)	*Scope and purpose*	*Policy Measures*		*Risks*	*Prerequisites for*	*Outcome indicators*
INSTITUTIONAL ENHANCEMENT; • Shortage and/or uneven distribution of qualified and competent health personnel and managers; deficiencies and limited transparency in collection, distribution and use of data and system intelligence across all stakeholders. Limited country-specific health policy, system and services research for policy and decision support.	**MANAGERIAL:** • Managerial, administrative and informational support for effective and efficient stewardship and transparent governance.	• Rigorous evaluation of hospital management and information tools and policy measures for their wide-scale implementation.	• Long-term human resources policy and strategy.[67] • E-government for improved public services delivery and enhanced budget transparency and anti-corruption.[68] • New State-funded research policy for needs-based attribution of grants.	**Political:** • Delays in seeking consensus on the scope and reach of e-government. • **Financial:** Fiscal constraints to build up an "info-structure". • **Institutional:** Harmonization of cost, patient and medical information across all public and private payers and providers.	• Constructive and consensual attitude and behavioral response from all stake holders. • Allocation of adequate resources for investment in "info-structure'.	• Increased responsiveness to political, fiscal, financial, medical, technological, demographic and epidemiologic challenges.

[67] There already exists a HRD strategy but it needs to be expanded in scope to cover all allied health professionals and managers and IT system analysts as well as ANAM's particular skills mix requirements.

[68] In conjunction with the PARL-supported public administration reform program. Morocco has adopted a national strategy for ICT entitled *Stratégie e-Maroc 2010,* launched in 2001 by H.M. King Mohammed VI. E-Government is a key component of this strategy. A National Committee on e-Government was set up in 2003, chaired by the Minister for Public Sector Modernization to devise an action program known as IDARATI, *Programme National e-Gouvernement 2005–08*) and an implementation plan.

References

Commission Européenne (2007). Rapport de revue/d'identification de l'appui de la Commission européenne a la consolidation de la couverture médicale de base au Maroc. Brussels, Belgium.

EU Consultant Report (2006). "Rapport de revue/d'identification de l'appui de la Commission européenne a la consolidation de la couverture médicale de base au Maroc."

Gwatkin, Davidson R. et al (2005). "Socioeconomic Differences in Health, Nutrition and Population in Morocco, 2003/04." World Bank, Washington, DC.

Ottaway, M. Rily M (2006). Morocco: From Top-down Reform to Democratic Transition? Carnegie Endowment for International Peace. Washington, DC.

Robalino, David A (2007). "Labor Market and Social Protection in Morocco." Policy Note (Draft version, June 2007).

Royaume du Maroc, Ministère de la santé (2006). "Santé, Vision 2015." Rapport technique préparé par CREDES.

Royaume du Maroc, Ministère de la santé (2006). "Stratégies proposées à l'Horizon 2015." Septembre 2006.

The Economist Intelligence Unit (2007). Morocco, Country Forecast, London, United Kingdom.

Theme report on "Système de santé et qualité de vie" in the "50 Ans de Développement Humain – Perspective 2025." http://www.rdh50.ma/fr/pdf/rapport_ thematique/Sante/systsantequdeviecorri.pdf

Transparency Maroc: La corruption au Maroc (2002) : Synthèse des résultats des enquêtes d'intégrité. L'Université de Transparence.

United Nations Development Program. 2006. *Human Development Report 2006*. New York: UNDP.

Université de Montréal (2007). "Revue du système de santé au Maroc." Consultant report, June 2007.

Velenyi E.V (2007). Resource Allocation and Purchasing in the Middle East and North Africa (MNA) Region. A Regional Case Study in "Public Ends, Private Means: Strategic Purchasing of Health Services" Preker AS, Liu X, Velenyi EV and Baris E (Eds). 2007. Washington, DC.

Waters, H. Rahola A, Hulme, J (2005): Health Insurance Expansion in Morocco. Draft Consultant Report, Washington, DC.

World Bank (2006). Royaume du Maroc; Rapport sur la politique du médicament. Policy Note. Washington, DC.

——— "Rapport sur la fixation du prix des médicaments au Maroc." World Bank, Washington, DC.

World Bank (2007). "Third Public Administration Reform Adjustment Loan". Initiating Memorandum, Draft Version (May 17, 2007). Washington, DC.

World Bank (2007). "Youth – An Undervalued Asset: Towards a new Agenda in the Middle East and North Africa", Policy Note. Draft version. Washington, DC.

World Bank (2007). “Moving out of Poverty in Morocco”. Policy Note. Washington, DC.

World Bank (2007). “Skills Development and Social Protection within an Integrated Strategy for Employment Creation”, Draft version (May 2007). Washington, D.C.

World Health Organization (2000). *World Health Report, 2000*. Geneva, Switzerland.

World Health Organization (2005). “Country Profile Morocco.” Eastern Mediterranean Regional Office (EMRO), Cairo, Egypt

World Health Organization (2006). “Mutuelles communautaires de santé ; Proposition de projet pilote. Rabat, Morocco.

World Health Organization (2007). *World Health Statistics 2007*. Geneva, Switzerland.

TO BE ADDED:

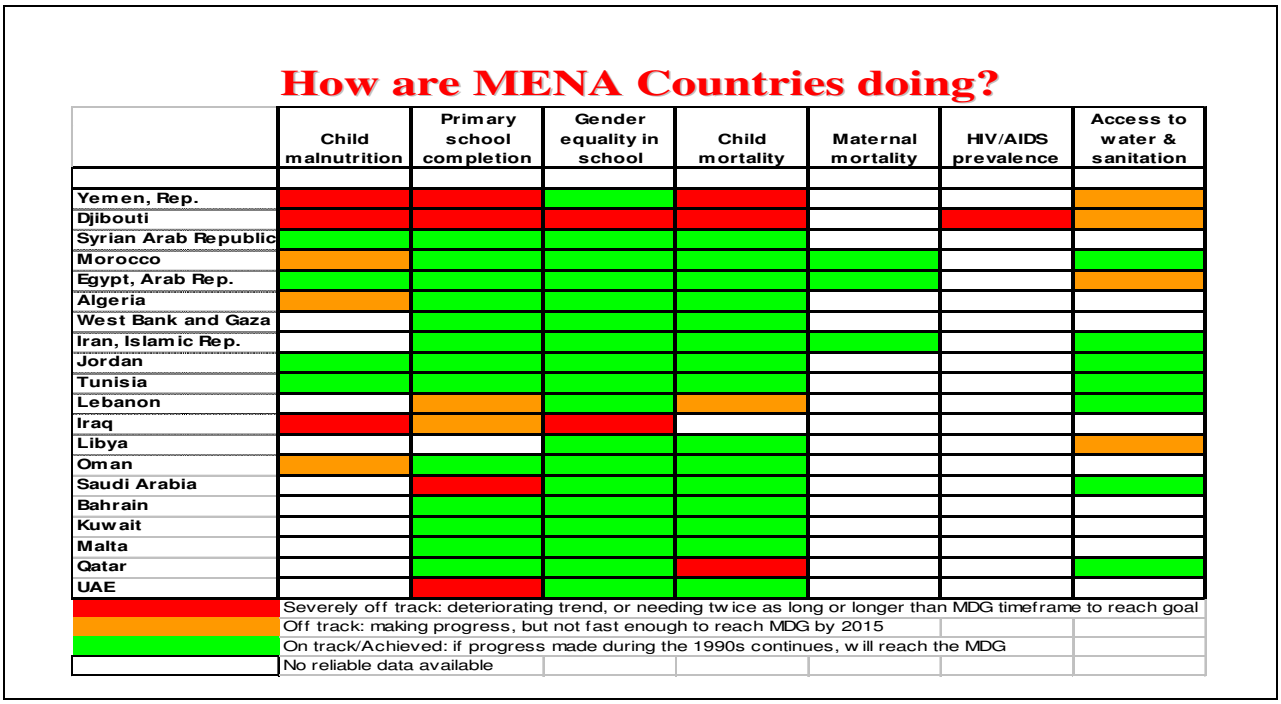
The three EU documents
Vision 2020
MTEF 08-10
MOH Human resources presentation
Pharmaceuticals policy re New Law.
Hospitals organization decree

More emphasis on:

More on l’allocation des resources hospitalieres PGFSS (nuances, e.g., SROS, PEH, etc)
More Regionalisation
More MOH reference
Maybe more on hierarchisation des soins – cinq filieres aboutissant a un CHU.
Piloting separation of power
Perennisation du RAMED

Cross cutting issues re reform of public administration; rural development, agriculture
Accountability; public relations
Horizontalite
L’identification des indigents
Experimentation du RAMED en cours; seulement hopitaux publics pour le moment; ticket moderateur; communatutes locales
Augmentation du budget pour le RAMED a travers le MS MTEF 2008-2010. Il faut voir la morasse.

Annex 1: Progress with Achievement of MDGs in MENA



Source: World Bank, 2007

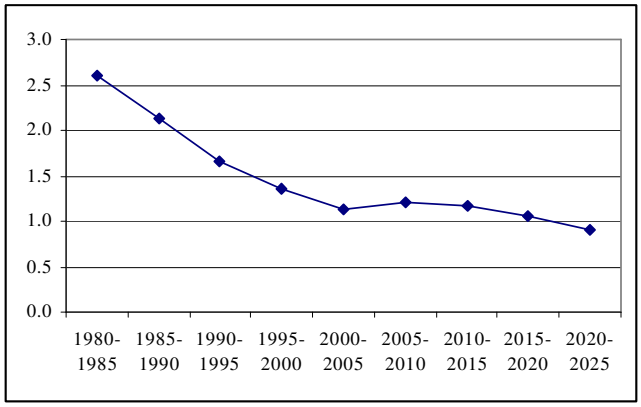
Annex 2:
Health System Attainment and Performance in MENA, Spain and Turkey, 1997

Member State	ATTAINMENT OF GOALS							PERFORMANCE	
	Health		Responsiveness		Fairness in financial contribution	Overall goal attainment	Health expenditure per capita in international dollars	On level of health	Overall health system performance
	Level (DALE)	Distribution	Level	Distribution					
Algeria	84	110	90-91	50-52	74-75	99	114	45	81
Bahrain	61	72	43-44	3-38	61	58	48	30	42
Egypt	115	141	102	59	125-127	110	115	43	63
Iran, Islamic Republic of	96	113	100	93-94	112-113	114	94	58	93
Iraq	126	130	103-104	114	56-57	124	117	75	103
Jordan	101	83	84-86	53-57	49-50	84	98	100	83
Kuwait	68	54	29	3-38	30-32	46	41	68	45
Lebanon	95	88	55	79-81	101-102	93	46	97	91
Libyan Arab Jamahiriya	107	102	57-58	76	12-15	97	84	94	87
Mauritania	158	163	165-167	123	153	169	141	151	162
Morocco	**110**	**111**	**151-153**	**67-68**	**125-127**	**94**	**99**	**17**	**29**
Oman	72	59	83	49	56-57	59	62	1	8
Qatar	66	55	26-27	3-38	70	47	27	53	44
Saudi Arabia	58	70	67	50-52	37	61	63	10	26
Spain	5	11	34	3-38	26-29	19	24	6	7
Syrian Arab Republic	114	107	69-72	79-81	142-143	112	119	91	108
Tunisia	90	114	94	60-61	108-111	77	79	46	52
Turkey	73	109	93	66	49-50	96	82	33	70
United Arab Emirates	50	62	30	1	20-22	44	35	16	27
Yemen	141	165	180	189	135	146	182	82	120

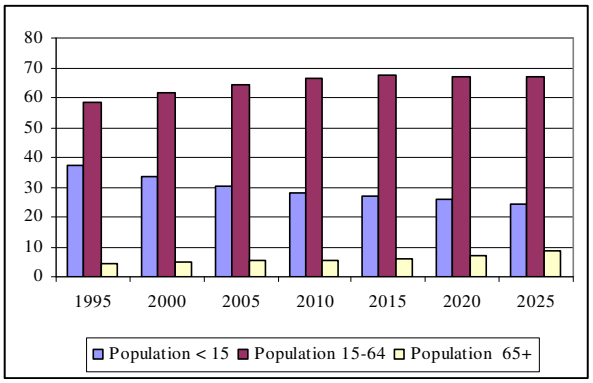
Source: World Health Report, 2000, WHO, 2000

Annex 3: Demographic Profile in Morocco

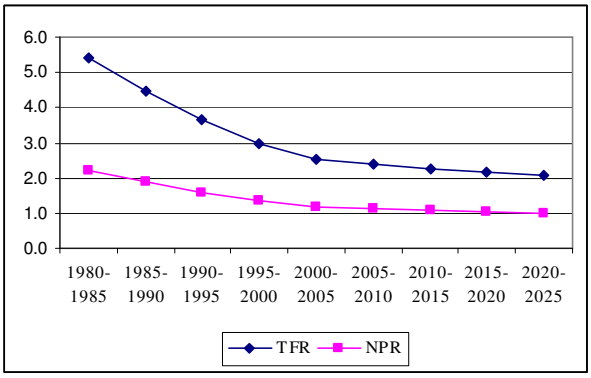
Population Growth Rate, 1980-2025



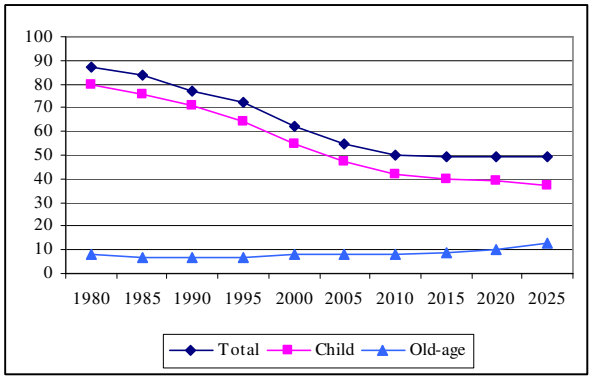
Composition of Population by Age Group, 1995-2025



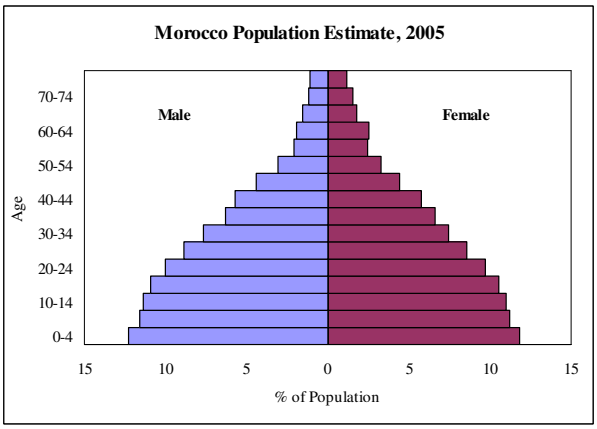
Trends in Total Fertility and Net Reproduction Rates, 1980-2025



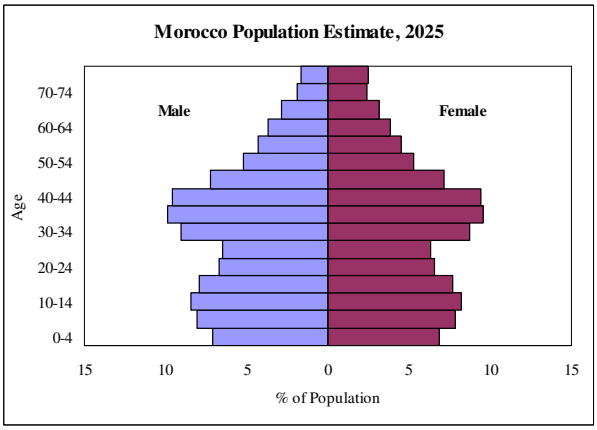
Trends in Dependency Ratios, 1980-2025



Morocco Age Pyramid 2005



Morocco Age Pyramid 2025



Source: UN Population Division, World Population Prospects: The 2006 Revision Population Database

Annex 4: Inequalities in Health, Morocco, 2003-2004

	Wealth Quintiles					Population	Low/High
Indicator	Low	Second	Middle	Fourth	High	Average	Ratio
HNP Status Indicators							
IMR	62.2	53.1	36.8	33.4	24.0	44.0	2.59
U5MR	77.6	65.5	46.7	37.3	26.1	53.6	2.98
Children stunted (% moderate)	17.2	12.4	11.6	7.8	6.9	11.7	2.50
Children underweight (% moderate)	13.2	8.3	7.7	6.9	2.9	8.2	4.57
Women malnutrition (%)	7.8	7.9	7.1	6.9	5.7	7.0	1.37
Total fertility rate	3.3	3.1	2.5	1.8	1.9	2.5	1.70
Adolescent fertility rate	50.7	35.7	44.3	21.0	12.5	32.4	4.05
HNP service indicators							
Childhood immunization coverage (%):							
-- Measles	83.1	87.2	91.3	96.7	97.5	90.5	0.85
-- DPT3	89.0	94.9	96.7	97.1	98.1	94.9	0.91
-- Full basic coverage	80.7	85.7	90.6	95.6	97.3	89.3	0.83
-- No basic coverage	2.8	1.9	0.4	0.7	0.7	1.4	3.98
Treatment of childhood illnesses							
Treatment of fever (%):							
-- medical treatment of fever	18.7	33.4	31.6	42.9	50.8	34.3	0.37
-- treatment in a public facility	17.0	30.2	27.6	33.0	22.3	26.1	0.76
-- treatment in a private facility	1.7	3.3	4.0	9.9	28.5	8.1	0.06
Treatment of diarrhea (%):							
-- use of oral rehydration therapy	43.1	55.2	59.1	59.4	57.1	54.0	0.75
-- medical treatment of diarrhea	14.5	19.6	25.6	28.3	27.4	22.1	0.53
-- treatment in a public facility	13.9	16.1	24.6	21.8	15,3	18.2	0.91
-- treatment in a private facility	0.6	3.6	1.1	6.6	12.1	4.0	0.05
Treatment of Acute Respiratory Infection (%):							
-- medical treatment of ARI	19.2	34.1	37.0	52.9	58.1	37.8	0.33
-- treatment in a public facility	17.3	27.0	33.4	31.7	28.5	27.1	0.61
-- treatment in a private facility	1.9	7.1	3.6	21.2	29.6	10.7	0.06
Antenatal Care Visits (%):							
-- to a medically trained person	39.7	56.4	70.6	86.8	93.1	67.8	0.43
-- to a doctor	17.1	24.8	35.9	53.3	78.7	40.2	0.22
-- to a nurse or trained midwife	22.6	31.7	34.7	33.5	14.4	27.6	1.57
-- multiple visits to a medically trained person	20.7	38.1	52.5	71.0	82.3	51.1	0.25
-- iron supplementation	17.3	28.7	37.9	49.7	64.6	38.3	0.27
Delivery Attendance (%):							
-- by a medically trained person	29.4	49.4	70.3	86.1	95.4	62.6	0.31
-- by a doctor	4.3	5.8	14.0	20.7	43.1	15.7	0.10
-- by a nurse or trained midwife	25.2	43.6	56.3	65.4	52.3	46.9	0.48
-- % in a public facility	28.3	47.0	65.8	74.4	59.6	53.0	0.47
-- % in a private facility	0.1	0.8	1.9	9.3	34.2	7.8	0.00
-- % at home	70.5	51.4	31.8	15.9	6.0	38.5	11.84
Contraceptive prevalence							
-- Females	51.4	55.2	55.4	54.8	56.8	54.8	0.90

Source: Davidson R. Gwatkin et al. 2005. Socioeconomic Differences in Health, Nutrition and Population in Morocco, 2003/04.

Annex 5: Levels and Composition of Health Expenditures in WB Regions and Income Categories, 2004

Regions	Per capita GDP[1] (US$)	Per capita health expenditures[1] (US$)	Per capita health expenditures (PPP adjusted)	Total health expenditures (THE) as % GDP	Public health expenditures (PHE) as % of total health expenditure	Social security as % of public health expenditure	Private health expenditure as % of total health expenditure	Out of pocket as % of private health expenditure	Out of pocket as % of total health expenditure	External resources as % of total health expenditure
EAP	1,267	64	276	5.1	37.5	42.8	62.5	84.2	52.7	0.9
ECA	2,976	194	521	6.2	62.0	43.8	38.0	81.2	30.8	1.3
LAC	3,325	225	535	6.9	49.3	33.1	50.7	72.7	36.8	1.1
South Asia	545	24	122	4.4	26.1	8.9	73.9	95.8	70.8	2.9
SSA	608	38	116	5.2	40.8	4.9	59.2	80.1	47.4	14.8
MNA	2,360	101	289	5.7	47.4	22.6	52.6	86.4	45.4	1.1
Income levels										
Low income	481	22	102	4.6	31.2	7.7	68.8	91.9	63.2	7.1
Lower middle income	1,659	97	342	5.6	43.6	38.3	56.4	81.1	45.7	0.6
Upper middle income	5,596	341	677	6.4	55.5	56.8	44.5	79.0	35.1	0.3
High income	30,811	3,466	3,427	10.7	64.8	43.3	35.2	57.0	20.1	0.0
Global average	5,969	602	752	6.0	42.9	29.0	57.1	81.3	46.5	2.9
Morocco	***4,309***	***82***	***234***	***5.1***	***34.3***	***0.0***	***65.7***	***76.0***	***49.9***	***0.9***
Algeria	6,603	63	226	3.6	72.5	33.2	27.5	94.6	26.0	0.0
Tunisia	7,768	175	502	6.2	52.1	19.4	47.9	83.0	39.8	0.2
Jordan	4,688	200	502	9.8	48.4	0.5	51.6	73.8	38.1	7.1
Egypt	4,211	66	258	6.1	38.2	26.7	61.8	94.3	58.3	0.9
Spain	25,047	1971	2,099	8.1	70.9	7.4	29.1	81.0	23.6	0.0

Sources: World Bank 2006 and World Health Organization 2007.
Morocco, Algeria, Tunisia, Jordan, Egypt and Spain:
Per capita health expenditure PPP adjusted. *Source:* UNDP, 2000 data
Per Capita HE, THE as % of GDP, Public Health Expenditure as % of GDP, Private Health Expenditure as % of THE. *Source:* WHO, 2004 data
Per Capita GDP: constant 2000 US$. *Source:* World Bank
Out of pocket as % of total health expenditure. *Source:* WHO, 2004 data
Social security as % of public health expenditure. *Source:* WHO, 2004 data
External resources as % of total health expenditure. *Source:* WHO, 2004 data
[1]Adjusted by exchange rates, except for Morocco, Algeria, Tunisia, Jordan, Egypt and Spain where it represents GDP in PPP for 2004.

Annex 6: Resource Allocation for Improved Efficiency

Population-based	**Facility-based**	**Case mix based**	**Global**	**Line-by-line**	**Policy based**	**Project-based**	**Ministerial discretion**
Demographic Epidemiological Socio-economic	Size, type, vocation, location of the facility	Case and or or service volume and intensity	Factor applied to a previous spending figure	Factors applied on a line-by-line basis to previous cost estimates	To address to specific policy initiatives	Single healthcare organization for one time funding	Self-explanatory
Outcome oriented	Outcome oriented	Outcome oriented	Outcome oriented	Output oriented	Outcome oriented	Output oriented	Outcome oriented
Ability to respond changes High	Ability to respond changes High	Ability to respond changes High	Ability to respond changes High	Ability to respond changes Low	Ability to respond changes Low	Ability to respond changes Low	Ability to respond changes Medium
Stability of funding High	Stability of funding High	Stability of funding High	Stability of funding Medium	Stability of funding Medium	Stability of funding Low	Stability of funding Low	Stability of funding Low

Adapted from: McKillop I: Financial Rules as a Catalyst for Change in the Canadian Health Care System. Discussion Paper No. 19. Commission on the Future of Health Care in Canada, Sept 2002

Annex 7: Hospital Payment Mechanisms: Incentives and Risks

Payment mechanism	Basket of services paid for	Risk borne by		Provider incentives to			
		payer	by provider	increase no. of patients	decrease activity per consul-tation	increase reported illness severity	select healthier patients
FFS	each agreed item of service and consultation	all risk borne by payer	no risk borne by provider	yes	no	yes	no
Case payment (e.g. DRG)	payment rates vary by case	risk of no. of cases and severity classification	risk of cost of treatment for a given case	yes	yes	yes	yes
Admission	each admission	risk of number of admissions	risk of no. of services per admission	yes	yes	no	yes
Per diem	each patient day	risk of number of days	risk of cost of services per day	yes	yes	no	no
Capitation	all covered services for one person in a given period	amount above 'stop-loss' ceiling	all risk borne by provider up to a given ceiling (stop-loss)	yes	n/a	no	yes
Global budget	all services provided by an institution in a given period	no risk borne by the payer	all risk borne by provider	no	n/a	n/a	yes

Annex 8: Governance and Human Development in Morocco. 2005

Figure 1: GRIS Composite Index and IMR, 2005

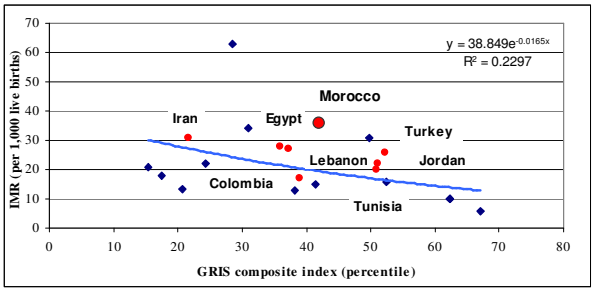


Figure 2: GRIS Composite Index and U5MR, 2005

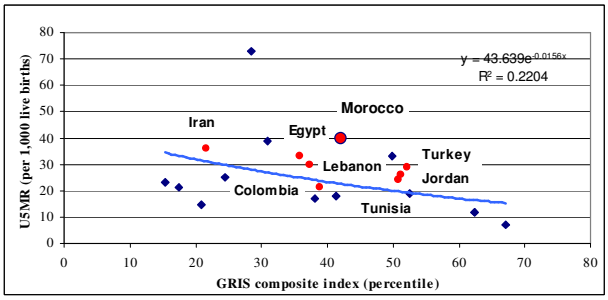


Figure 3: GRIS Composite Index and Life Expectancy, 2005

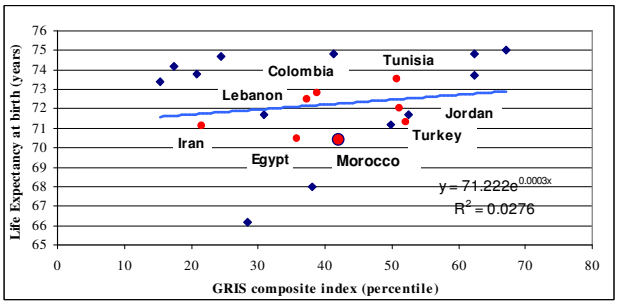


Figure 4: GRIS Composite Index 2005 and HDI 2004

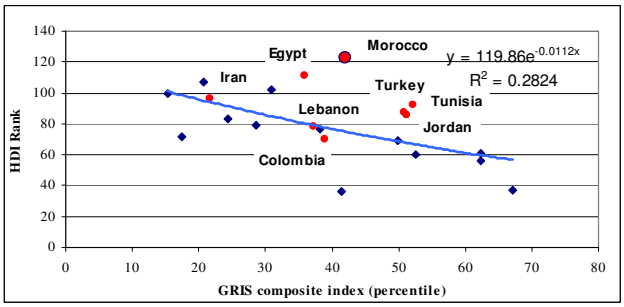
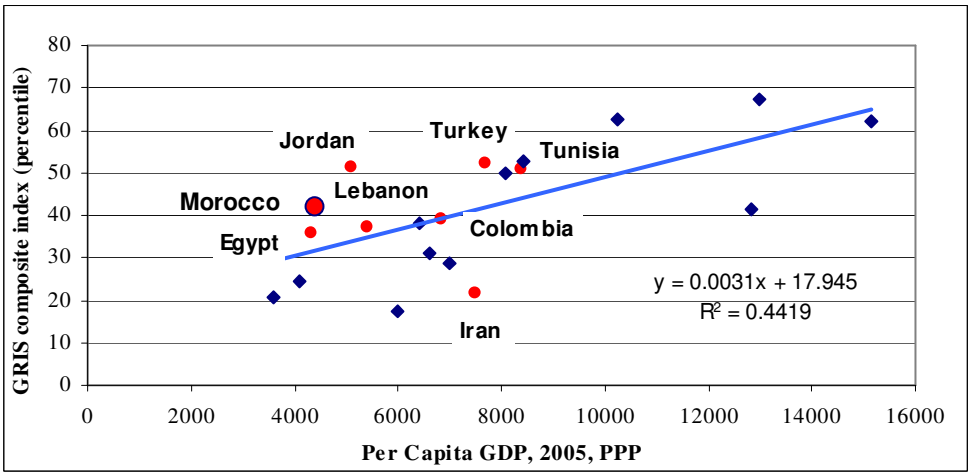


Figure 8.5: GRIS Composite Index and Per Capita GDP (PPP), 2005



Source: UNICEF State of the World Children 2007,
Kaufmann, D., A. Kraay, and M. Mastruzzi 2003: Governance Matters III: Governance Indicators for 1996-2005.

Table 8.1: Governance Research Indicators of Selected Middle Income Countries in the MENA and other regions

MENA	Voice & Accountability		Political Stability		Government Effectiveness		Regulatory Quality		Rule of Law		Control of Corruption		Composite[1]		HDI Rank
	1996	2005	1996	2005	1996	2005	1996	2005	1996	2005	1996	2005	1996	2005	2004
Lower Middle Income Countries															
Syria	9.1	5.8	21.2	20.3	25.7	8.6	18.6	10.4	31.6	42.5	25.4	36.9	21.9	**20.8**	**107**
Egypt	25.0	18.4	25.5	21.2	48.6	43.1	44.6	34.7	60.3	54.6	62.9	43.3	44.5	**35.9**	**111**
Morocco	27.4	26.6	27.4	31.6	58.6	48.3	52.0	39.1	59.3	51.7	65.4	54.7	48.4	**42.0**	**123**
Jordan	44.7	27.5	50.5	35.8	63.3	57.9	51.0	57.9	59.8	62.3	58.0	65.5	54.6	**51.2**	**86**
Algeria	14.4	24.6	0.5	17.9	31.9	42.6	18.1	26.2	30.1	31.9	42.4	42.4	22.9	**30.9**	**102**
WBG	2.9	13.5	N/A	5.2	N/A	11.0	N/A	12.9	N/A	39.1	N/A	9.9	N/A	**15.3**	**100**
Iran	17.3	9.7	25.9	16.0	42.4	26.3	6.4	6.9	20.1	29.0	18.5	41.4	21.8	**21.6**	**96**
Tunisia	30.3	18.8	46.2	49.5	71.4	67.0	60.3	51.5	56.9	58.5	59.5	60.1	54.1	**50.9**	**87**
Brazil	55.3	57.0	31.6	40.6	51.4	55.0	53.4	55.0	46.4	43.0	57.1	48.3	49.2	**49.8**	**69**
Colombia	47.1	36.7	7.5	4.2	65.7	53.1	66.7	54.0	34.4	32.4	35.6	53.2	42.8	**38.9**	**70**
Ukraine	36.1	40.1	30.2	32.1	18.1	40.2	24.0	47.0	28.2	34.8	23.9	34.5	26.8	**38.1**	**77**
Ecuador	51.4	41.5	19.3	22.6	13.3	13.9	48.5	20.8	36.4	22.7	23.4	24.6	32.1	**24.4**	**83**
Kazakhstan	19.2	15.0	34.9	46.7	12.4	29.2	31.9	35.1	23.0	26.6	18.0	18.2	23.2	**28.5**	**79**
Upper Middle Income Countries															
Lebanon	34.1	28.5	26.9	15.6	46.7	46.4	58.3	44.1	45.5	44.4	51.7	44.8	43.9	**37.3**	**78**
Oman	27.9	23.2	62.3	73.1	78.6	67.9	69.1	65.8	83.7	71.0	64.4	72.9	64.3	**62.3**	**56**
Argentina	64.9	59.4	51.4	37.7	78.1	47.8	78.4	25.2	62.2	36.2	54.1	41.9	64.9	**41.4**	**36**
Poland	76.0	83.6	53.8	54.2	72.4	71.3	63.2	72.3	65.6	59.9	73.2	61.1	67.4	**67.1**	**37**
Malaysia	48.1	34.3	73.1	62.3	79.5	80.4	80.4	66.8	78.5	66.2	75.6	64.5	72.5	**62.4**	**61**
Romania	50.5	56.5	52.4	46.2	17.1	56.9	25.0	58.4	44.5	45.4	51.2	51.7	40.1	**52.5**	**60**
Turkey	34.6	46.4	9.9	29.7	55.7	63.2	67.2	58.9	56.0	55.6	62.0	59.6	47.6	**52.2**	**92**
Venezuela	51.0	31.9	17.9	11.8	20.5	23.0	37.3	12.4	28.7	9.2	24.9	16.7	30.1	**17.5**	**72**
MENA	**24**	**24.8**	**34.8**	**35**	**51.1**	**45**	**41.7**	**41.8**	**50.8**	**50.3**	**49**	**52.1**	**43.3**	**41.5**	**91**

Source: Kaufmann, D., A. Kraay, and M. Mastruzzi 2003: Governance Matters III: Governance Indicators for 1996-2005.[69]

[69] Note: The governance indicators presented here reflect the statistical compilation of responses on the quality of governance given by a large number of enterprise, citizen and expert survey respondents in industrial and developing countries, as reported by a number of survey institutes, think tanks, non-governmental organizations, and international organizations. The aggregate indicators in no way reflect the official position of the World Bank, its Executive Directors, or the countries they represent. As discussed in detail in the accompanying papers, countries' relative positions on these indicators are subject to margins of error that are clearly indicated. Consequently, precise country rankings should not be inferred from this data (Kaufmann et al 2003, http://info.worldbank.org/beeps/kkz/gov2001map.asp).