Health Financing And Insurance Reform In Morocco

Legislation to expand health insurance coverage offers hope for reducing health financing gaps in Morocco.

by Jennifer Prah Ruger and Daniel Kress

ABSTRACT: The government of Morocco approved two reforms in 2005 to expand health insurance coverage. The first is a payroll-based mandatory health insurance plan for public- and formal private–sector employees to extend coverage from the current 16 percent of the population to 30 percent. The second creates a publicly financed fund to cover services for the poor. Both reforms aim to improve access to high-quality care and reduce disparities in access and financing between income groups and between rural and urban dwellers. In this paper we analyze these reforms: the pre-reform debate, benefits covered, financing, administration, and oversight. We also examine prospects and future challenges for implementing the reforms. [*Health Affairs* 26, no. 4 (2007): 1009–1016; 10.1377/hlthaff.26.4.1009]

The government of Morocco legislated two reforms in 2005 to expand health insurance coverage. The first is a payroll-based mandatory health insurance plan, l'Assurance Maladie Obligatoire (AMO) for public- and formal private–sector employees, which seeks to extend coverage from the current 16 percent to 30 percent of the population. The second, Regime d'Assistance Medicale (RAMED), creates a publicly financed fund to cover services for the poor.[1] The Moroccan government is now implementing these reforms. Both measures aim to improve access to high-quality care and reduce disparities in access and financing between income groups and between rural and urban areas. This paper analyzes the historical debate leading to the reforms, the benefits covered, financing, administration, and oversight. It also explores the prospects and future challenges for implementation of the reforms.

■ **Health system configuration and infrastructure.** The Moroccan health care system includes a mix of public and private financing and delivery. In this respect, it is similar to health systems in many developing countries in which the government assumes responsibility primarily for basic public health activities and for manage-

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ment and regulation of the health sector.

The government of Morocco, largely through the Ministry of Health (MOH), is a major provider of services. Financed chiefly by the public budget, the MOH offers the entire population access to clinics, health centers, dispensaries, diagnostic centers, and public hospitals. Formal health insurance coverage is voluntary and covers only 16 percent of the population—primarily civil servants and some formal private–sector employees. Financing and services offered by the private sector are major components of the system, and individuals are free to choose either public or private providers. Consumers prefer private providers to public ones.

All Moroccans are eligible to receive care in MOH facilities. Through their local government, the poor can obtain a *certificat d'indigence,* which permits them to receive free care in public facilities. The nonpoor can also receive care in MOH facilities, at subsidized rates. Concern exists, however, over the quality of care these facilities provide. Also of concern are the incentives on the supply side to require "extra charges" for services and, on the demand side, to "game the system" to obtain free rather than fee-based services.

Benefits vary by insurance coverage, but in principle and on paper, the MOH network provides a comprehensive set of services to meet people's health needs. Payments to public health care providers are standardized and set by the government in consultation with medical professionals. In the private market, insurers negotiate directly with private providers to determine a fee-for-service rate. Individuals pay a 20 percent coinsurance rate, although this copayment can be as high as 50 percent in practice. The cost of both health care and pharmaceuticals is quite high for individuals relative to household income. For example, the average cost of a prescription is 250 Moroccan dirhams (MAD) (US$28), which equals roughly four days' work at minimum wage, or 2 percent of per capita gross domestic product (GDP). The average cost of a visit to a specialist is 150 MAD (US$17)—roughly 2.5 days' work at minimum wage, or 1.2 percent of per capita GDP.[2]

■ **Health insurance coverage.** Morocco does not have a universal or compulsory health insurance system. Only 16 percent of the population has medical or insurance coverage. Morocco has a voluntary health insurance system for certain segments of the population, including civil servants, workers at public enterprises, and certain professionals. Nine public-sector mutual insurers provide health insurance for civil servants, covering roughly 11 percent of the population. Each mutual is associated with a different category of employee. An administrative entity, Caisse Nationale des Organismes des Prevoyance Sociale (CNOPS), coordinates and operates the mutuals, although the CNOPS does not perform risk pooling or risk adjustment. The CNOPS determines a standard set of benefits by illness and treatment categories and establishes fees and coinsurance rates for public-sector mutuals. Individual mutuals provide supplementary coverage, which may vary by mutual and may include coverage of coinsurance costs. The CNOPS contracts with both public and private providers, and people are free to choose either.

The Ministry of Finance determines the financing for the CNOPS and public-sector mutuals. On average, employees contribute 2.5 percent and employers contribute 3.5 percent of base salary. Employee and employer contributions are nonprogressive, in that the percentage of contribution does not rise as income rises. In recent years, these contributions have not been sufficient to cover the costs of providing care, and the CNOPS has run a budget deficit, requiring MOH subsidies to sustain operation. Private-sector mutuals, providing insurance to employees and their families, cover about 1 percent of the population. Another 3 percent is covered by private nonmutual insurance. Private insurance is typically offered through larger corporations for those able to afford coverage payments. Private-sector mutuals and insurers determine their own benefit packages.

Morocco does have a compulsory social security system, Caisse Nationale de Securité Sociale (CNSS), which provides family allowance, disability, sickness, maternity, and pension benefits but not health insurance. It operates about a dozen health clinics providing subsidized care for uninsured people and limited health care benefits for children. Despite the lack of coverage through the CNSS, having a compulsory system in place can be an advantage in providing the administrative infrastructure for expanding coverage.

National Debate On Health Insurance

Moroccans have debated national health insurance for the past fifteen years. This broad debate has involved politicians, international donors and agencies (particularly the World Bank, the World Health Organization [WHO], and the European Union [EU]), physicians and other providers, employers, insurers, mutual benefit societies, trade unions, the national social security funds, nongovernmental organizations (NGOs), and the public at large.

■ **Rethinking public- and private-sector roles.** One major theme in this debate has been rethinking the role of the state vis-à-vis the private sector in the financing, provision, and regulation of the health care system. Various constituencies have raised competing concerns. These include the uninsured (represented by government), the insured (concerned that they would suffer under reform), government officials (concerned with financial costs and regulatory infrastructure required for reform), health professionals (concerned about their own financial interests and reimbursement under reform), and public- and private-sector mutuals and insurers (unsure as to whether reform would leave them better or worse off). Despite these competing interests, however, there has been substantial agreement around the need for greater solidarity and equity in access to high-quality care and for additional financial resources and government oversight to achieve this goal.

■ **International dialogue.** With support from the international community, the government convened a number of national and international gatherings. For example, it and the World Bank jointly sponsored the 1999 Symposium on Health Sector Financing in Morocco, bringing together government officials, academics, providers,

insurers, and the press for debate. Because agreement on equity and solidarity and the need for more financial resources had solidified to a certain degree, these consultations focused on the next step: how to achieve reform and practical considerations for implementation. Issues included who should be covered and how, the goods and services to be included in a benefit package, compulsory health insurance financing, and what entity should administer and oversee it.

■ **Foundation for the reforms.** Proposed legislation in 1991 and 1995, although unsuccessful, laid the foundation for the measures adopted in 2005. In particular, the ensuing debate over specifics fostered policy development by testing policy options among key constituents. In response to various concerns, the latest reforms include health insurance for more economically disadvantaged people and a broader group of workers. In 1999, the government developed a broad vision of a future health financing and insurance system in the "Strategie Sectorielle de Santé," outlining policy reforms going forward. The government recommended a council for management, appointed by the prime minister, with representatives from employers, labor and trade unions, industry, and insurers and mutuals and an advisory voice for citizen input.

Policy Reforms

As a result of this long debate, in 2005 the government of Morocco passed AMO and RAMED. Separate framework laws apply to each. A new administrative structure, l'Agence Nationale d'Assurance Maladie (ANAM), will focus on the regulation, legal structure, and oversight of the national health insurance system. To address funding issues, the government had already established a Committee of Experts, chaired by the prime minister, to develop a systematic approach and recommendations for financing health insurance. The committee defined the scope of health insurance coverage, the benefit package, and the structure of regulatory oversight for both AMO and RAMED.

■ **AMO, or l'Assurance Maladie Obligatoire.** AMO is to be phased in gradually; coverage includes salaried employees from the public sector (for example, local governmental officials). It also covers salaried private-sector employees within the realm of the CNSS social security system and those eligible for old-age assistance. AMO projects expanding coverage to approximately 30 percent of the total population (about ten million people). AMO maintains individual choice of insurers and providers. The CNSS plans an increase in local offices to reach a growing client base.

Benefit package. The committee discussed a number of options for the AMO benefit package. Three possible scenarios under consideration included catastrophic coverage (coverage only for catastrophic risks and services such as surgery and chronic illnesses); catastrophic and ambulatory coverage; and coverage for hospitalization, ambulatory care, and drugs. The committee also discussed whether coverage would be standardized or allowed to vary by insurer. In the end, it recommended that the AMO benefit package be standardized and include hospital-

ization, ambulatory care, and drugs. Reimbursement is set for 70 percent of the national reference price for health care provided in private clinics or hospitals and 90 percent for services provided in public clinics and hospitals.

Financing. AMO financing is expected to come from both employee and employer contributions toward total premium costs, along with some initial funding from the government. Premium rates will be 1 percent or 4 percent of payroll and vary by whether insured people also have private insurance coverage. As a result of expanded coverage and the resulting increased demand for health care, the plan anticipates increased government revenues of approximately MAD 1.3 million (US$148,000), from increased fees paid to public hospitals and higher fees and taxes paid by private hospitals. The government also anticipates a higher recovery rate for mutual insurers (up to 80 percent), reaping additional annual revenues for the public sector of roughly MAD 335 million (US$38 million).

Potential repercussions. The plan is expected to cap basic coverage at MAD 40,000 (US$4,550) per insured person per illness, except for certain illnesses that the CNSS exempts from the cap. The government anticipates that employees and their families will transfer from the indigent care category to AMO, yielding an estimated shift of MAD 381 million (US$43 million) in costs from current government financing of indigent care through public hospitals to health insurance coverage paid by employees and employers. However, the government does not appear to have anticipated the trend in an employer-related health insurance system for employers to shift the costs of mandated health insurance premium payments to their employees in the form of lower wages or reduced rates of increase in wages over time. Additionally, if the government offers tax incentives for health insurance premiums, they would constitute a cost to the government in lost revenues from tax deductions and subsidies. The government has not been concerned with economywide and individual repercussions (for example, job lock—when individuals are locked in jobs because of the fear of losing coverage if they take another job) from linking health insurance to employment.

Oversight. In terms of administrative and regulatory oversight, the committee discussed three options: a single-payer system, thus eliminating existing health insurers; a managed competition model involving private insurance companies; and a combination of two administrative entities, the CNSS and CNOPS, to regulate and oversee AMO. The committee decided that the CNSS would oversee the private sector and the CNOPS, the public sector. Within the CNSS, the Compulsory Health Insurance Department is the point of contact and oversight.

■ **RAMED, or Regime d'Assistance Medicale.** Real-world results have revealed the inadequacies in past efforts to finance and provide health care services for Morocco's poor. The lowest 40 percent of income, for instance, receives only 20 percent of the public financing, even though on paper the indigent have free access to needed health care. One problem has been the difficulty in identifying and properly classifying the poor who are eligible for free goods and services. Another has been

the linking of health insurance costs for the poor with public hospitals' operating budgets.

Under RAMED, households with an income of less than MAD 300 (US$34) per capita per month will receive a *carte d'indigence* and be eligible for free health insurance. Households with monthly per capita income of MAD 300–600 (US$34–$68) will purchase insurance according to a sliding scale. To protect the poor from financial ruin, there will be no caps on coverage, but people will not have a choice of insurers or providers, and concerns arise about a two-tier health system. The government will finance health insurance at a projected increased cost of roughly MAD 2.2–3.2 billion (US$250–$275 million). The new national health insurance agency ANAM will administer RAMED. RAMED has just begun this year; there is yet little information on results.

Results Of AMO Phase-In

To enable implementation of AMO, the CNSS has undergone major reforms to bolster its financial capacity. Financial contributions to AMO reached nearly MAD 372 million (US$42 million) in the first four months of 2005 and were expected to reach MAD 1.5 billion (US$168 million) by the end of 2006. Despite these contributions, the government estimates a financing shortfall and is currently discussing a 10 percent increase in the MOH budget going forward. Additionally, government efforts are under way to raise an additional 6 percent of the MOH budget through domestic and international partnerships with the World Bank, WHO, and other institutions.

By mid-2006, roughly six months after it began, AMO enabled 3.5 million people to obtain health insurance coverage for the first time. Ten million people are currently targeted for full coverage. Nearly eight million are expected to receive coverage in the first phase—4.5 million in the public sector and roughly 2.7 million in the private sector. The government is also considering expanding AMO to include family allowances for the agricultural sector.

From its increased financial contributions to AMO, the government has set aside MAD 2.5 billion (US$280 million) to develop and expand some of Morocco's 126 hospitals and 2,510 medical facilities for basic care. Challenges remain in the number and variety of medical personnel available to staff facilities, although the government is committed to expanding human resources to an estimated additional 10,000 more medical staff by 2020. Despite there being 52,000 employees in the health care sector, current problems include understaffing, imbalance among medical teams, uneven geographic distribution, emigration of personnel, and regional differences in work conditions.

The government reimbursement plan for AMO was introduced in early 2006 by Prime Minster Driss Jettou. In its initial phase, AMO is reimbursing 90 percent of health care provided in public institutions and 70 percent in private institutions.

Discussion And Future Challenges

Morocco offers an opportunity to study the health system of a lower-middle-income country in the Middle East and North Africa region that, despite some unique features, has numerous similarities to many developing countries. Morocco has made major improvements in developing its health system capacity and dealing with communicable diseases over the past three decades, resulting in dramatic improvements in health status. Despite these trends, however, gaps in health status, access, utilization, quality, and financial protection exist between the rich and poor and between urban and rural areas.

Although the government recognizes its responsibility for indigent people and provides public health and clinical care for the poor in public facilities, inadequacies pervade the system. There are limited resources to cover basic and specialized care. The pattern and level of resources (human, financial, and physical), the scarcity of providers and basic clinic and hospital facilities, along with limited quality in facilities and providers, all contribute to difficulties in meeting the population's health needs. One of the most important problems is the system of insurance coverage for public-sector employees, coupled with the lack of financial protection for 84 percent of the population.

Morocco is implementing reforms to improve the efficiency and quality of care provided in selected hospitals, decentralize service provision, improve information systems, and rationalize future hospital investments and management. Reforms seek to rectify key problems by allocating more resources to essential preventive and curative care for the poor and those in rural areas, and strengthening the safe motherhood and priority public health programs.[3] RAMED aims to improve coverage for the poor, to better match needs with usage patterns.

Questions arise, however, as to the likelihood of success and potential effects of both AMO and RAMED. Will reforms produce positive results? It depends.

■ **Financial challenges.** First, for financing, the government of Morocco must be able to greatly increase the amount of public resources devoted to health care to expand coverage, meet the population's health demands, and broaden the scope of the benefit package. Morocco spends 4.5 percent of GDP, or US$50, per capita on health care, but roughly half of that funding comes from direct payments from households (net of reimbursement from mutuals or insurers), whereas only 5 percent comes from employees' contributions to insurance. Moreover, poorer households spend a higher percentage of income than wealthier households. To obtain sufficient financing for reforms, the government must not only raise additional funds but must also shift funding sources, by reducing funding from households and increasing funding from employers and the government.

■ **Distribution of public resources.** Second, the government will also need to change the distribution of public resources among regions, populations, and providers and provide a guarantee for financial commitments to local authorities, especially in rural areas. Policymakers will need to overcome vested and inequitable allo-

cation patterns, especially among providers, which now leave the MOH with only 27 percent of the resources raised by the health system, despite its role as the major provider of services. Current insurance spending focuses primarily on pharmaceuticals, medical goods and devices, and services provided in private offices and clinics. For reforms to succeed, especially RAMED, resources for MOH facilities and personnel—especially expansion to rural areas—must be sufficient.

■ **Institutional fragmentation.** Finally, the government must streamline and integrate institutional fragmentation. In the absence of an overall risk-pooling mechanism, Morocco's voluntary insurance structures have been subject to risk selection and segmentation. To pool and adjust for risk across populations, the government will need to promote the integration of public and employer-related financing sources and social security and regulatory agencies. Reforms must combine the current division of functions and funding streams between the CNOPS and the public mutuals and the fragmented and decentralized risk pools.

THE MOROCCAN HEALTH SYSTEM HAS IMPROVED dramatically over the past several decades and has achieved major milestones in health status, health care delivery, and financing. Despite these considerable gains, however, health system weaknesses reveal inequities and inefficiencies in both access and financing. To rectify these limitations and build on the strengths of the current system, the Moroccan government is implementing major policy reforms. These laudable efforts offer hope for closing health system gaps in Morocco and lessons for both developing and developed countries worldwide.

Jennifer Ruger co-organized and participated in the Government of Morocco/World Bank Symposium on Health Care Financing in June 1999 in Rabat, Morocco, where the current reforms were analyzed and discussed. Both authors advised the Government of Morocco on health insurance and financing policy and health-sector reforms.
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NOTES

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