An excerpt from:
Better Health & Social Care: How are Co-ops & Mutuals Boosting Innovation & Access Worldwide?
An International survey of co-ops and mutuals at work in the health and social care sector (CMHSC14)
Volume 2: National Cases

For the research framework, the analysis of the national cases, and other research components, including a description of the research team members, refer to Volume 1: Report.

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MOROCCO[1]

2014

HEALTH SYSTEM & THE ROLE OF MHOS[2]

Population (in thousands): 32,521

Population median age (years): 26.7

Population under 15 (%): 27.85

Population over 60 (%): 7.61

Total expenditure on health as a % of Gross Domestic Product: 6.3 (2011 data)

General government expenditure on health as a % of total government expenditure: 6.0

Private expenditure on health as a % of total expenditure: 66.5

The Moroccan health system is undergoing profound changes in epidemiological, demographic, and socio-economic terms. Overall health expenditure is low: $59 USD per capita per year and 6.3% in relation to GDP. In the awareness that the cost of medical goods and services are high, the public's use of care remains low. The main source of health financing remains the direct payments from households (52%), against 44% from collective health funding, national and local taxes (28%), and insurance (16%). With 80% of the bed capacity of the country, the Ministry of Health receives only about 31.4% of the national health system's funding. Of the total expenditure of the Ministry of Health in 2001, 49% went to profit hospitals, 37% to the health care network base, and 10% to central and local government. Of all the direct payments from various health insurance plans, public hospitals receive only 6%, whereas the share of private firms (34%) as well as private clinics (32%) is quite large. In addition to the diagnosis and treatment of illness and the rehabilitation of disabilities, promotion of health and prevention are generally carried out by the health care system.

The Ministry of Health adheres to a public health policy which relies heavily on public health programmes. The most important are:

- Programmes of Maternal and Child Health
- Programmes of Collective Sanitary Prevention
- STI- AIDS Programme
- Other programmes (diabetes, tuberculosis, oral hygiene, school and university health, etc.)

Through its budget, the Ministry of Health also provides support to those in need. In principle, all patients presenting themselves as poor, regardless of their place of residence and regardless of the type (i.e., governance) of the hospital that receives them, should receive free medical care upon presentation of a certificate of need issued by the local authority.

International cooperation organizations also fund some of these programmes. The UN has set up a dedicated Multilateral Fund to fight STI-AIDS. NGOs (including associations) are involved in prevention, education, and even funding health programmes for the general population (against AIDS, cancer, etc.) or those targeted to benefit specific populations or regions.

The budgets of other ministries also enable them to engage in health financing to a minor degree (approximately $7,057,328 in 2001 USD).

The health activities of local governments are of the order of 1% of total health expenditure, in the form of in-kind contributions (personnel, assets, logistical support, etc.) to the Ministry of Health and direct financial aid to NGOs. Transition to a system of compulsory basic medical coverage has been gradually realized. Until August 18, 2005, the date on which Law No. 65-00 on basic medical coverage came into effect, Morocco knew no compulsory health insurance scheme.

The country chose to generalize basic medical coverage using existing structures. The first initiative was Basic Mandatory Health Insurance (AMO). It targeted active employees and pensioners of the public and private sectors with two executive agencies (CNOPS and CNSS) and other medical coverage. Together they have increased coverage of employees from 16% to 34%. Basic health insurance for certain employees remains the responsibility of other entities (and mutual insurance companies), at least during the five-year transitional period. From 2006, fraternal benefit societies are responsible for two components:

- The Mutual Health Organization (MHO) component of CNOPS continues to manage the supplementary medical coverage of AMO. In this context, the MHOs are conducting actuarial studies to assess contribution levels which will enable them to balance their books. In addition, they are responsible for the management of certain tasks of CNOPS under AMO.

- The other MHOs continue to manage basic medical coverage in addition to supplementary medical coverage. Some of these MHOs have also commenced actuarial studies to assess feasibility.[3]

Individual contracts or groups offer health insurance coverage, underwritten by individuals or by employers, supplementary to the guaranteed base coverage benefits (compulsory insurance contracts or plans). Coverage and premium levels vary according to the needs of the insured.

CURRENT DEVELOPMENTS

In terms of medical care, the mutual sector is still underdeveloped in Morocco. Its focus is mainly dental care, optical centres, and certain specialized consultations. However, 14% of payments go to the CNOPS mutual sector.[4] Under Article I of statute 1963 Dahir 1-57-187 on the status of mutuality, "friendly societies are non-profit groups, which ... propose to conduct ... a share of providence, solidarity and mutual aid designed to cover the possible risks to the human person". Article 138 of the Royal Decree[5] states that MHOs can "sign agreements with doctors, dentists, pharmacists and even create social works such as dispensaries, maternity and baby clinics for the benefit of their members."

The reform of the Code of Mutuality, currently under discussion,[6] includes a restriction to the scope of MHOs. Chapter II (Social Oeuvres), Article 144, states that MHOs "can create and manage social works for the protection of children, family, elderly, or disabled dependent, with the exception of institutions providing services for diagnosis, care or hospitalization and/or establishments for the supply of medicines, equipment, and medical devices as well as any work of a commercial, profit-making or under an organized and/or governed by specific legislation."

The current range of care across all sectors does not respond satisfactorily to the needs of the population in terms of basic health care. The development and organization of the mutual sector is required to improve the access to care.

CASE STUDY[7]

After a rescue that lasted more than a year (2011-2012), the **Mutuelle Générale du Personnel des Administrations Publiques (MGPAP)**, an MHO for public administration personnel, has undertaken a programme of restructuring and development to improve the services it provides to 1.2 million beneficiaries, including 360,000 members. (It has yet to pay off its deficits.)

The board of directors has decided to raise premiums and benefits in order to align them with those of other mutual funds. Other new services will be decentralized to enable members residing in cities remote to the Rabat-Casablanca axis to avoid long and expensive trips. Currently, most hospitalization centres are concentrated at the administrative capital.

Now MGPAP is posting representatives to remote cities to bring services closer to members. The choice of locations was made on the basis of the results of a member survey as well as information collected from hospital centres.

This extension of MGPAP's network has not required large investments, but has relied primarily on public bodies. It has necessitated an insignificant increase in the contribution rates which now range from $3 to a maximum of $6.078 USD for the mutual sector.

MHO Medical & Social Performance (2013)[8]

Facilities	#	Staff							Beneficiaries
		Doctors		Paramedical					
		Non-Permanent Employees	Permanent Employees	Non-permanent Employees	Permanent Employees				
					Assistants	Professionals	Others	Total	
Dental Hospitals	165	-	148	-	143	246	171	560	395,621
Clinics	3	26	8	55	-	-	-	16	15,760
Polyclinics	1	37	12	33-	-	-	-	31	23,608
Optics	1	-	-	-	-	-	-	11	8,700
Consultations/ Infirmary Care	24	54	16	-	-	-	8	23	83,986
Labs	1	-	2	3	-	-	-	28	28,076
Centre for the Disabled	2	-	1	-	-	-	-	30	123
Centre for Dialysis	1	-	2	-	-	-	-	4	306[9]
Total	198	117	189	91	143	246	179	703	556,180

SOURCES

[1] A more detailed version of this case is available upon request.
[2] More details at Himmich, Hakima, and Jaouad Chouaib. 2013. "Les soins de santé de base: Vers un accès équitable et généralisé." Conseil Economique, Social et Environnemental. Saisine no. 4. Rabat, Morocco. Retrieved August 18, 2014 (http://www.ces.ma/documents/pdf/rapport%20ssb%20vf.pdf).
[3] This will roll over into Basic Mandatory Health Insurance (CNOPS or CNSS), after the transition period provided by Law 65-00.
[4] More details at Caisse Nationale des Organismes de Prévoyance Sociale. 2014. Website. Retrieved August 18, 2014 (http://www.cnops.org.ma/).
[5] Royal Decree No. 187-7-5-1 issued in November 1996, concerning the Mutual Aid Scheme.
[6] For the text of the project go to Conseil Economique, Social et Environnemental. 2013. "Projet de loi n° 109-12 portant code de la mutualité." Avis du Conseil Economique, Social et Environnemental Saisine no. 6. Rabat Morocco. (http://www.ces.ma/Documents/PDF/Avis-S-6_2013-VF.pdf).
[7] Source: Challot, Hakim. 2010. "Mutuelle générale du personnel des administrations publiques : plus de cotisations pour améliorer les prestations." *La Vie éco,* December 12. Retrieved August 18, 2014 (http://www.lavieeco.com/news/economie/mutuelle-generale-du-personnel-des-administrations-publiques-plus-de-cotisations-pour-ameliorer-les-prestations-18318.html).
[8] Source: Union africaine de la mutualité (UAM).
[9] 2,613 sessions of dialysis.