Morocco, A Transforming Health Sector

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Reading time

As in many health systems, the COVID-19 pandemic revealed the weaknesses of the health system in Morocco, particularly of its social protection networks. Before the crisis, the country struggled to implement Universal Health Coverage actions for many years. In the aftermath of the pandemic, a window of opportunity opened for structural reform, not only following the global recommendation to "Build back better" but also due to a rising national political will to significantly transform the health system. Over the last years, Morocco took historical actions, one related to generalizing health insurance for the whole population and the second to launch a structural health system reform, aiming to improve accessibility and the equitable distribution of care throughout the country, to enhance quality and safety of health services.

Morocco's healthcare system is a mix of public and private services, with the public sector playing a dominant role, primarily providing services through public hospitals and clinics. **Regardless of nationality or administrative situation, every individual is entitled to free access to basic public health services in public primary health centers**. Specialized care often requires referral to provincial, regional, or university hospitals. **Although 85% of supply is provided by public hospitals and 15% by private centers, spending remains unbalanced. In 2022, the public system accounted for only 40% of healthcare spending, while the private sector accounted for 60%**. In Morocco, the "basket of care" refers to the range of health services covered by **mandatory health insurance (AMO) and the Medical Assistance Plan for the Economically Disadvantaged (RAMED) – now merged into a unified health insurance scheme, AMO-Tadamon. The social protection and public healthcare system provides coverage for all those who seek care for sickness, maternity, invalidity, and retirement. Those who are incredibly needy, have access to the Medical Assistance Scheme, which is based upon the principles of national solidarity and social welfare. Even those who cannot contribute any money towards the scheme benefit treatment offered in public healthcare centers**. These services provide access to basic medical care, including preventive and curative care, particularly those related to the state's priority programs, pregnancy and childbirth, hospitalization and emergency services. The specific services included in the basket are subject to reimbursement within the framework of the respective insurance schemes. Occupational diseases and accidents at work are not covered. Even if Morocco is working towards universal health coverage (UHC), it still faces challenges in terms of financial sustainability, efficiency, and equitable access to care with people often having problems in receiving care, and with challenges in accessing secondary and tertiary care. **The state formarly covers between 70%- 90% of healthcare costs, with the remaining portion being paid by the patient out-of-pocket (cost sharing), however, government coverage can vary, and there may be limitations in terms of equipment, staffing, and infrastructure, particularly in rural areas, leaving many reliant on out-of-pockets payments or private insurance**.

Expected to be fully implemented by 2025, the universal health coverage systems (UHC) is one of the main reforms introduced in the health sector, supported by health Insurance schemes, offering subsidized healthcare to all residents regardless of income.
In 2002, just 17% of Morocco's population was covered by health insurance. That year, the government began its healthcare reform process to achieve universal healthcare. **Morocco's Contributory Health Insurance Scheme, *Assurance Maladie Obligatoire* (AMO), was launched in 2005 to provide comprehensive healthcare coverage only for formal public - and private- sector employees.**
Launched the same year, the *Régime d'Assistance Médicale* (RAMED), was designed to provide health insurance for those outside the formal employment, especially the poor, those with disabilities, and the elderly; a social health insurance program designed to ensure access to care for vulnerable and low-income populations, for those who

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Compulsory Health Insurance (AMO):
Mandatory health insurance system, designed to provide basic health coverage for citizens in the following categories:

- **AMO for Workers**:
specifically covers salaried employees, both in the public and private sectors, and their dependents.

- **AMO-General**:
a more encompassing term that refers to the overall AMO system, including the various categories of beneficiaries, such as workers, self-employed individuals, and others covered by the mandatory insurance

Medical Assistance Plan for the Economically Disadvantaged (RAMED):
Medical Assistance Scheme designed to ensure access to care for vulnerable and low-income populations, for those outside the formal employment, especially the poor, those with disabilities, and the elderly. Based upon the principles of national solidarity and social welfare. Even those who cannot contribute any money towards the scheme benefit treatment offered in public healthcare centers.

Since 2022

AMO-Tadamon

United under one platform, AMO-Tadamon is the basic mandatory health insurance that combines the benefits and coverage of both the former RAMED (medical assistance for the poor) and AMO (Compulsory Basic Health Insurance) programs, providing healthcare coverage for all citizens. This new program allows beneficiaries, including those previously under RAMED, to access both public and private healthcare facilities, a significant change from the previous system where RAMED beneficiaries were largely limited to public facilities.

AMO-Tadamon covers services to insured persons and their dependents, including medicines, doctor's consulations, preventive and curative care, maternity care, medical treatment for children under 12, chronic diseases, diagnostic tests, X-rays, hospitalization, outpatient surgery, and basic dental and optical treatments. It also ensures public hospital visits are free. The program is designed to be inclusive, with the state covering contributions for individuals who cannot afford to pay, ensuring that everyone has access to healthcare.

couldn't pay fees for their medical care. Based on the principle of national solidarity, RAMED was implemented in 2011, then extended in 2017. A non-contributory scheme, under the RAMED program, households with incomes less than MAD 300 (USD 34) per person per month (including those with no incomes at all), are eligible for free health insurance. Those with monthly per-person incomes of MAD 300–600 (USD 34–68) are eligible to purchase health insurance in accordance, based on their income. RAMED beneficiaries can receive subsidized or free healthcare not subject to caps on coverage.

Originally, AMO beneficiaries could use both public and private facilites under the health insurance scheme. Contrary to RAMED beneficiaries who could receive subsidized or free healthcare but were only eligible to receive it at public hospitals, raising concerns about the existence of a two-tier healthcare system. Additionally, the expansion of the program, without a corresponding increase in public healthcare resources, resulted in an overburdening of public hospitals.

In 2022, in an effort to reduce some of the burdens on public health facilities, and to achieve universal healthcare under a single system, the government launched the AMO-Tadamon program, a new platform that merges the existing RAMED and AMO programs into one. The 11 million beneficiaries of RAMED were transferred to the newly consolidated scheme and now benefit from the same health coverage as those in the formal sector, but are not required to contribute towards it. Importantly, this new program allows RAMED patients to receive subsidized care from private healthcare institutions, instead of only being allowed to use public facilities.

The AMO-Tadamon is part of the Government's broader effort to expand healthcare coverage. Despite its expantion, challenges remain, including a significant number of uninsured individuals not enrolled in the program, and high out-of-pocket expenses for those who are insured, potentially creating barriers to access for some individuals. In spite fo the big progress, a quarter of Moroccans still don't have medical insurance. According to a report by the Morocco Economic, Social, and Environmental Council (CESE), in 2024, 4 in 5 Moroccans reported to have medical insurance. That's up from less than 3 out of 4 in 2020. The insurance plan aims to include everyone – especially low-income groups – with new systems created to make it easier for people to join. But there remain problems. **Out of 8.5 million uninsured, 5 million aren't signed up. Another 3.5 million are signed up but don't receive benefits. Even those insured pay half of their medical costs out of pocket, twice what the WHO recommends**. Many skip treatment because it's too expensive. Meanwhile, some insurance programs are financially struggling. The AMO-Tadamon plan is stable, but others are losing money. For example, the self-employed workers' plan (AMO –General) has a 72% deficit. Additionally, most health spending goes to private clinics, not public hospitals. As private care can cost five times more than public care, this puts pressure on the system's finances. In addition to expanding healthcare plan options, the government has also worked on improving hospitals and making public healthcare more accessible.

The Health Insurance System is financed by a combination of employee and employer contributions and government financing. Employees in the formal sector contribute one to four percent of their incomes, depending on whether they already have private health insurance coverage.
AMO-Tadamon is managed by the National Social Security Fund, known as Caisse Nationale de Sécurité Sociale (C.N.S.S.). Under the new system, employed individuals make contributions via a single unified payment, which covers tax, social security, and healthcare obligations, and is called the "contribution professionnelle unique (CPU)." Contribution amounts are based on income and range from MAD 300 to 3,600 (USD 29 to 352). Within its first six months of existence

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in 2006, AMO enabled 3.5 million Moroccans to access health insurance for the first time. **Since the establishment of these programs, Morocco has witnessed a significant increase in healthcare coverage. The percentage of citizens with coverage grew from 15% in 2005 to 78% in 2022. However, because there was not a correlated improvement in healthcare resources, particularly in rural areas, the impact of these reforms has been somewhat limited**. Many beneficiaries reported challenges accessing hospital care and high rates of out-of-pocket payments. It remains to be seen if consolidating AMO and RAMED (through the AMO-Tadamon), thereby allowing all beneficiaries to access private health resources, in addition to the public clinics, will alleviate some of these challenges. These reforms have been greatly facilitated by developing a unified social registry (Registre social unifié – RSU), launched in 2019. The Minister of Health and Social Protection has noted that the RSU allowed for the effective targeting of families and has enabled the extension of coverage to needy segments of the population.

Since the start of the COVID-19 pandemic, Mo rocco has received over $4 billion in aid from domestic and international sources to bolster its healthcare infrastructure and curb the spread of COVID-19. **Upgrading public hospitals is a national priority, as well as public-private partnerships to support healthcare infrastructure and scientific research**. Morocco is also pushing to develop self-sufficiency/local manufacturing of drugs, vaccines, and PPE such as masks, gloves, gowns, overshoes, and head coverings.
The main hospitals and clinics are located in the larger cities such as Rabat, Casablanca and Tangier. The public sector runs over 2,689 primary health care facilities, 159 public hospitals and there are over 14,300 physicians in the public sector, according to data by the US Department of Commerce. There is also a separate healthcare system solely dedicated to the military, with six hospitals and a medical center. **The Moroccan government has several multi-year plans to strengthen the current healthcare system through the development of new hospitals, increasing the number of doctors and nurses in training, and opening the market to private investment**. To accelerate the sector's reformation, the government budget to the healthcare sector reached around MAD 30.7 billion (USD 3.4 billion), a 9.1% increase in 2024, to primarily focus on enhancing the healthcare infrastructure across the country, expecting to have a positive impact on healthcare accessibility and quality throughout Morocco.

Although the country has both public and private health facilities, private hospitals are preferred owing to long ques and lower quality medical care experienced at the public healthcare facilities. The private sector healthcare market on the other hand is growing rapidly with more than 400 private hospitals and clinics, heavily concentrated in the Casablanca-Settat and Rabat- Salé-Kénitra regions, and over 14,500 physicians. Until 2015, the healthcare sector was largely dominated by the public sector, only licensed doctors and practicing physicians were permitted to own private clinics. But a change in legislation and policy has opened up the possibility for foreign individuals to establish private clinics in an attempt to attract foreign investment, to address the shortage of healthcare resources, particularly in underserved areas, and to improve the overall quality of healthcare services.

The Moroccan healthcare system is in fact grappling with a pronounced lack of resources, particularly in terms of human personnel. **Presently, Morocco has between 27,600-28,892 physicians, a ratio of around 7.8 doctors per 10,000 inhabitants (the WHO recommends a minimum of 23 doctors per 10,000 inhabitants). More than half of these doctors work along the Casablanca-Rabat axis, underscoring a significant disparity between urban and rural areas**. In addition, about 270 rural municipalities find themselves in a state of critical medical isolation, denoting their location more than an hour away from a hospital facility. Among these municipalities, 160 are classified as priority, encompassing roughly two million inhabitants. In this context, several e-health services, such as telemedicine and electronic health records, have been developed to improve healthcare access and efficiency. **Standing out as one of the few countries in Africa and the Arab world, Morocco has established a regulatory framework outlining the rules for telemedicine practice**. Numerous initiatives have emerged, particularly within the public sector, such as the National Telemedicine Initiative launched in October 2018, with the aim of covering 80% of medical deserts (the 160 sites classified as priority) by 2025. Nevertheless, despite the concerted efforts, there remain challenges to overcome in order to make strides and achieve the objectives set forth by the Moroccan healthcare system. Among the challenges, non-communicable diseases (NCDs) are increasingly prevalent, posing a significant health burden, accounting for over 80% of deaths in Morocco. The prevalence of risk factors for NCDs, such as tobacco use, unhealthy diets, and physical inactivity, is also high in Morocco.

Global Comparison

	Morocco	Worldwide	EU
Life expectancy at birth, years	73.2 (men) / 77.6 (women)	70.9 (men) / 75.8 (women)	
Annual public health spending, per inhabitant	199.21 USD	1,234.59 USD	
Public health spending as percentage of GDP	5.7%	9.9%	
Hospital beds per 1,000 inhabitants	0.7	3.3	5.3
Doctors per 1,000 inhabitants	0.73	1.71	4.12
Direct access to tested and always available drinking water	75% [87% via springs and wells within a 30 min. max distance or supplied drinking water]	78%	97%

Source: worldata.info - Unless otherwise stated, data corresponds to information from the WHO Global Health Workforce Statistics, UNICEF State of the World Children program, Childinfo, the Global Health Observatory Data Repository and the OECD.

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