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Evolution and Reforms of the Moroccan Health System: A Critical Analysis in the Light of International Experiences

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Abstract

Morocco, aware of the challenges posed by its organizational model, has undertaken to set up a system of universal medical coverage. The aim of this initiative is to guarantee the economic and social security of its citizens, ensure a decent standard of living and prevent the risks associated with illness, unemployment, old age, disability and poverty.

The implementation of this universal medical coverage scheme bears witness to Morocco's determination to promote access to healthcare, reduce inequalities and strengthen social security with a view to sustainable development. The system encompasses generalized medical coverage and family allowances, the introduction of a pension scheme for the working population, and the introduction of a job loss indemnity.

This article retraces the historical development of health insurance in Morocco since independence, and critically analyzes the evolution of the Moroccan health system in the light of economic theories and international experience, while taking stock of the progress made. It highlights the various stages involved in setting up the system, the challenges encountered and the outlook for the future

The article analyzes the multidisciplinary theoretical framework, integrating contributions from health economics, comparative public policy analysis and institutional approaches, although methodologically, this research adopts a mixed approach combining in-depth documentary analysis, exploitation of national and international statistical data, and structured comparison with reference health systems.

Keywords: Healthcare system, universal health coverage, generalization of social coverage, healthcare supply, basic medical coverage, healthcare system performance.

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Introduction

The healthcare system is a fundamental pillar of human and social development, embodying a society's values and priorities in terms of collective and individual well-being. In Morocco, the evolution of the healthcare system since independence reflects a complex path marked by institutional transitions and successive reforms aimed at improving access to care and financial protection for citizens. This path is part of a worldwide drive towards universal health coverage (UHC), the central objective of contemporary healthcare policies.

The present study offers a critical analysis of the evolution of the Moroccan healthcare system in the light of economic theories and international experience. In particular, it examines the structural transformations that have marked its development, from the post-colonial period to the recent reforms initiated in the post-COVID-19 context. The central question of this article is: to what extent have successive reforms of the Moroccan healthcare system helped to improve its performance and bring it closer to international standards of universal health coverage?

To address this issue, the study draws on a multi-disciplinary theoretical framework, integrating contributions from health economics, comparative public policy analysis and institutional approaches. The theory of health capital developed by Grossman (1972) offers a first perspective, conceptualizing health as a capital in which individuals and societies invest to increase productivity and sustain economic growth. Public goods theory, since Arrow's (1963) seminal article on the specificities of the healthcare market, provides a relevant analytical framework for understanding state intervention in this sector, justified by various market failures: information asymmetries, positive externalities of preventive interventions, and problems of equity in access to essential care. In parallel, the new institutional economics, developed by North (1990) and Williamson (2000), makes it possible to analyze the architecture and performance of healthcare systems through the prism of the formal and informal institutions that shape the behavior of actors and determine the efficiency of organizational arrangements.

The study also draws on typologies of social protection models, ranging from Esping-Andersen's (1990) classic framework distinguishing three welfare state regimes (liberal, conservative-corporatist and social-democratic) to the more healthcare system-specific classifications developed by Wendt et al. (2009) and updated by Böhm et al. (2013). These taxonomic approaches are complemented by the work of Londoño and Frenk (1997) on the prevalence of hybrid models in developing countries and that of Cotlear et al. (2015) identifying three main routes to universal coverage: Beveridgian, Bismarckian and mixed.

Methodologically, this research adopts a mixed approach combining in-depth documentary analysis, exploitation of national and international statistical data, and structured comparison with benchmark healthcare systems. Standardized WHO and OECD indicators provide an objective evaluation grid, enabling the performance of the Moroccan system to be placed in an international comparative perspective.

The analysis is divided into four complementary sections. The first section establishes the theoretical framework for the study, exploring the economic principles of healthcare systems, the typologies of social protection models and the dimensions of universal health coverage. The second section traces the historical development of the Moroccan healthcare system, from its post-colonial foundations to recent reforms aimed at generalizing health coverage. The third section offers an international comparative analysis, assessing the performance of the Moroccan system against standardized OECD and WHO indicators. Finally, the fourth section highlights the major lessons to be learned from this analysis, and outlines the prospects for the development of the national healthcare system in the context of the generalization of medical coverage.

This research takes place in a particular context, marked by the national ambition to achieve universal social protection by 2025, in line with the royal guidelines set out in 2020. It aims to

contribute to the academic and political debate on the best ways to reconcile extending coverage, improving quality of care and the financial sustainability of the Moroccan healthcare system. Beyond the specific case of Morocco, this study offers lessons that are potentially transferable to other middle-income countries engaged in similar trajectories towards universal health coverage.

1. Theoretical framework

1.1 Economic theories of healthcare systems

A healthcare system encompasses all activities whose primary objective is to promote, restore or maintain health. It refers to all the organizations and institutions, as well as the resources and players, involved in implementing a country's health policy. This notion goes beyond that of a simple "healthcare system", insofar as political choices, the moral and ethical conception of health, and collective well-being underpin the very structure of the system. In most countries, the system generally comprises a public sector, a private sector and, in certain contexts, a traditional or informal sector.

The analysis of healthcare systems is based on several complementary theoretical frameworks that enable us to grasp their institutional, economic and social complexity. The theory of health capital developed by Grossman (1972) forms an essential foundation, conceptualizing health as a capital in which individuals and societies invest. He proposes an innovative approach, viewing health as a capital that the individual (and the state) can accumulate through prevention and care. Better "health capital" boosts productivity, reduces absenteeism and supports growth

Public goods theory provides another relevant analytical framework for understanding state intervention in the healthcare sector. Since Arrow's seminal article (1963) on the specificities of the healthcare market, economists have identified a number of market failures justifying such intervention: information asymmetries between providers and patients, positive externalities of preventive interventions, and problems of equity in access to essential care. Public health has the characteristics of a public good or merit good according to Musgrave's (1987) classification, which justifies public intervention to guarantee an optimal level of production and access.

The new institutional economics also offers valuable conceptual tools for analyzing the architecture and performance of healthcare systems. As pointed out by North (1990) and Williamson (2000), formal and informal institutions shape the behavior of actors and determine the efficiency of organizational arrangements. Applied to healthcare systems, this approach enables us to analyze governance mechanisms, provider incentives and transaction costs associated with the different ways in which care is financed and delivered.

The literature distinguishes two main configurations:

Centralized: exemplified by the National Health Service (NHS) in the UK, established in 1948, where healthcare is provided by a public monopoly.

Decentralized: exemplified by the healthcare systems in the United States and Switzerland, characterized by the coexistence of public and private healthcare provision. These systems include Medicare, which is financed by the state to provide care for people in difficulty, and Medicaid, which is financed by the states for individuals whose resources fall below the poverty line.

Mixed system: when the same organization combines the principles of centralization (partial public monopoly) and decentralization (significant private activity).

1.2 Social protection models: typologies and hybridizations

Comparative literature on social protection systems has long been based on the classic typology of Esping-Andersen (1990), distinguishing three welfare state regimes: liberal, conservative-corporatist and social-democratic. This classification was adapted to the healthcare field by

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Wendt et al (2009), who proposed a typology of healthcare systems based on three dimensions: mode of financing, service delivery and regulation. This approach was recently updated by Böhm et al. (2013), who developed a more refined classification integrating five distinct models of healthcare systems: the National Health Service, the National Health Insurance, the Social Health Insurance, the Etatist Social Health Insurance, and the Private Health System.

In analyzing healthcare systems in developing countries, the work of Londoño and Frenk (1997) has highlighted the prevalence of hybrid models combining elements of different approaches. This trend towards hybridization shows that systems that have successfully made the transition to universal coverage generally combine diversified financing mechanisms (taxes, social contributions, insurance premiums) and articulate different levels of governance.

In the specific context of middle-income countries, the work of Cotlear et al. (2015) identified three main routes to universal coverage: the Beveridgian route, the Bismarckian route and the mixed route combining these two models. Adding other models as well, described as follows:

The Bismarckian model: mainly used in continental Europe, this is considered the oldest model, introduced in Germany for political reasons in favor of workers at the end of the 19th century by "Otto Von Bismarck". In 1883, this model only guaranteed cover against the risk of illness, but in 1984 it also included cover against old age, industrial accidents and the inability to cover the substantial. Financing of the Bismarckian model at the time was decentralized, based on the collection of contributions and financial participation from workers and employers.

The Beveridge model: first introduced in England in 1944, this model is used in Scandinavian countries such as Sweden and Norway. It is considered the most recent model, and is based on the 3U principle (Universality, Uniformity and Unity) and the creation of a single state insurance scheme. is based on universal social security, in which all citizens are entitled to care and services. The financing of this model is based on taxation, and favors the concept of assistance, as benefits are only paid to individuals who claim a need.

The liberal American system: this model is mainly used in the United States and the United Kingdom. It is based on the principle of private insurance, and is a mixed system combining voluntary private insurance, known as the "Medicaid" program, which provides assistance to the poorest families and is financed by taxes and managed by the State, and the Bismarckian system of compulsory health insurance, known as the "Medicare" program, which covers the elderly and is financed by social contributions paid by companies and their employees. The Mediterranean model: this model is used in Spain, Italy and Greece. It is based on strong state intervention in social protection, with tax-financed benefits and a wide range of social programs.

The East Asian model: this model is used in Japan, South Korea and Singapore. It is based on individual responsibility, in which individuals are encouraged to save for their own social security. Benefits are often delivered through state-funded social programs.

This diversity of trajectories underlines the importance of adapting theoretical models to specific national contexts, while taking account of institutional legacies and local economic constraints.

1.3 Universal health coverage: dimensions and indicators

The concept of universal health coverage (UHC) has become a central objective of health policies worldwide. According to the WHO (2021) definition, UHC implies that "all people have access to the health services they need, when they need them, at an affordable cost". This definition is based on three essential dimensions conceptualized by Kutzin (2013) and McIntyre et al. (2013):

Population coverage: proportion of the population protected against the financial risk of illness.

Service coverage: extent of benefits covered by protection mechanisms.

Financial coverage: degree of protection against direct household expenses.

These dimensions are measured by various internationally standardized indicators. Population coverage is generally assessed by the percentage of the population affiliated to an insurance scheme or having access to subsidized services. Service coverage is measured through essential service coverage indices, such as the CSU service coverage index developed by WHO and the World Bank. Finally, financial coverage is assessed by indicators such as the share of direct household expenditure in total health expenditure, and the incidence of catastrophic and impoverishing health-related expenditure.

The work Moreno-Serra and Smith (2013) has refined these indicators by developing multidimensional measures of financial protection, taking into account not only the incidence of catastrophic expenditure but also its intensity and socio-economic distribution.

In the context of middle-income countries, the analysis of trajectories towards UHC also needs to take into account issues of equity and efficiency. Progress towards universal coverage may be accompanied by persistent or even growing inequalities if policies do not explicitly target vulnerable populations. The importance of efficient allocation of limited resources to maximize health gains, advocating the adoption of systematic approaches to health technology assessment adapted to the constraints of developing countries.

2. The evolution of the Moroccan healthcare system

2.1 Organization of the Moroccan healthcare system

The organization of the Moroccan healthcare system is characterized by a dual structure, associating a public and a private sector, within which coexist both for-profit and not-for-profit entities. On the public side, the Ministry of Health and Social Protection plays a supervisory, regulatory and planning role, overseeing a multi-level network. Health centers (urban and rural) and health posts, considered the first level, provide basic preventive and curative care, including consultations, vaccinations and maternal and child health monitoring. The second level, formed by provincial and regional hospitals, extends the range of services, offering more specialized care. The tertiary level is embodied mainly in the University Hospitals (CHU) of Rabat, Casablanca, Fez, Marrakech, Oujda and Tangiers, which provide not only highly technical medical services, but also training and research missions. In this public sector, the rationale is essentially non-profit: the provision of healthcare is part of a public service mission, geared towards prevention and accessibility, particularly for vulnerable groups.

The private sector encompasses several categories of players. Clinics, doctors' surgeries, analysis and radiology laboratories are mainly profit-oriented, relying on direct payments or reimbursements from health insurance organizations (CNSS, CNOPS, mutual insurance companies, private insurers). At the same time, non-governmental organizations and foundations, some of which are recognized as being in the public interest, run non-profit health centers and dispensaries. These structures generally charge reduced or symbolic fees, thanks to philanthropic funding or public subsidies, and often work to help isolated or vulnerable communities. Although still heavily concentrated in the major urban centers, private-sector healthcare provision is tending to diversify and expand geographically, notably under the impetus of Basic Medical Coverage (AMO) and the growth of mutual insurance companies.

Funding mechanisms involve government budgets, social security contributions, private insurance premiums and various subsidies. Compulsory health insurance, managed by the CNSS for the private sector and the CNOPS for the public sector, is combined with mutual and supplementary insurance schemes. In addition, the Medical Assistance Scheme (RAMED) provides non-contributory coverage for the economically disadvantaged. This multiplicity of players, statuses and financing methods underlines the complexity of governance in the Moroccan healthcare system. It also highlights the crucial importance of coordination to ensure an equitable, viable and high-quality healthcare offer throughout the country.

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2.2 The post-colonial genesis and its legacy (1956-2002)

The Moroccan healthcare system emerged in a post-colonial context marked by an institutional and organizational legacy strongly influenced by the period of the French protectorate. Analysis of this initial phase of development can be based on the path dependency theory formulated by Pierson (2000), according to which initial institutional choices create constraining structures for subsequent developments. The system inherited from the protectorate was characterized by strong administrative centralization, a concentration of resources in the main urban centers and a largely curative orientation to the detriment of prevention.

During the first post-independence decades (1956-1980), the Moroccan state gave high priority to developing public health infrastructure and training national medical staff, notably with the creation of the first medical faculty in Rabat in 1962. This period also saw the establishment of sector-based mutual insurance institutions, mainly for civil servants and formal workers, such as the Mutuelle des Forces Armées Royales (1957) and the Mutuelle Générale de l'Éducation Nationale (1963). In terms of social protection, the founding of the Caisse Nationale de Sécurité Sociale (CNSS) in 1959 introduced a Bismarckian system limited to employees in the formal sector.

A retrospective econometric analysis of the same period by Boutayeb (2020) reveals significant improvements in basic health indicators: between 1960 and 1980, life expectancy rose from 47 to 58 years and infant mortality fell from 150 to 91 per 1,000 live births. Nevertheless, this progress masked major geographical and socio-economic inequalities. Some 75% of public health infrastructures were concentrated in urban areas, which in the 1970s accounted for just 35% of the population, creating a two-tier system whose imprint is still felt today.

The years 1980-1990 were marked by the impact of structural adjustment programs, which constrained public spending on healthcare. Between 1982 and 1995, the proportion of GDP devoted to the health budget fell from 4.5% to 3.2%, even as demand increased as a result of demographic and epidemiological transitions. During this period, cost recovery policies were introduced in public hospitals, in line with the recommendations of the Bamako Initiative. The institutional analysis of Ruger and Kress (2007) underlines that these policies erected substantial financial barriers for vulnerable populations, leading to under-utilization of services and the deterioration of certain regional health indicators.

Discussions on financing the sector and the drafting of several bills on compulsory health insurance began in 1990 and 1992. In 1993, the principles of basic medical coverage were defined. The government approved a first bill introducing compulsory health insurance in 1995, but it excluded indigent people, leading to its abandonment.

During this period, medical cover was essentially provided by eight mutual insurance companies: the Mutuelle Autonome des Forces Armées Royales, the Mutuelle des Forces Auxiliaires, the Mutuelle Générale de l'Éducation Nationale, the Œuvre de la Mutuelle des Fonctionnaires et Agents Assimilés du Maroc, the Mutuelle Générale du Personnel des Administrations Publiques, the Mutuelle des Douanes et Impôts Indirects, the Société Fraternelle de Aide Mutuel et Orphelinats du Personnel de la Sûreté Nationale, and the Mutuelle Générale des Postes, Télégraphes et Téléphones (PTT). In 1997, the total number of policyholders was 4,515,000, as shown in the table 1 below.

Despite these measures, the mutual insurance sector had a number of limitations, in particular its focus on civil servants, local authorities and their beneficiaries, as well as public authority employees. In addition, the limited contribution ceiling (below 2.4 billion dirhams) illustrated the structural weakness of its financing.

The year 2000 therefore saw the adoption of new sectoral strategies based on the regionalization of the healthcare system, hospital reform, optimization of resource management and the gradual strengthening of the private sector (profit and non-profit) alongside the public sector. At the

same time, an Economic and Social Development Plan (2000-2004) was submitted to Parliament, proposing to extend medical coverage to all employees (public and private), pensioners and their dependents, to raise the rate of coverage from 15% to 30% of the population. The plan also aimed to improve access to healthcare for the most disadvantaged, and to reduce the share of direct household financing of healthcare expenditure, while providing hospitals with a sustainable source of funding in line with quality requirements.

Table 1: Number of policyholders in 1996/1997.

Institutions	Members	Beneficiaries	Beneficiaries	Share in
CNOPS	996 000	2 099 900	3 095 900	68.6
Insurance companies	234 300	580 800	815 100	18.1
Internal plans	120 000	424 000	544 000	12.0
CMIM[1]	18 800	41 200	60 000	1.3
Total	1 369 100	3 145 900	4 515 000	100

Source: National Health Accounts 2001

2.3 The introduction of basic medical coverage: reforms and results (2002-2012)

The period 2002-2012 represents a major turning point in the evolution of the Moroccan healthcare system, with the adoption and gradual implementation of Basic Medical Coverage (CMB). The promulgation of Law 65-00 in 2002 laid the legal foundations for a two-pillar system: Compulsory Health Insurance (AMO), aimed at public and private sector workers and their dependents, and the Medical Assistance Scheme (RAMED), targeting economically vulnerable populations. This institutional architecture reflects an attempt at hybridization between the Bismarckian model (AMO financed by employee and employer contributions) and the Beveridgian model (RAMED financed by taxation and national solidarity). Cotlear et al (2015) note that these mixed approaches are characteristic of middle-income countries seeking to rapidly expand their health coverage. In accordance with Article 57 of Law 65-00 on the Basic Health Coverage Code, the Agence Nationale de l'Assurance Maladie (ANAM) was created to oversee and regulate the Compulsory Health Insurance scheme (AMO), in addition to managing the resources of the Medical Assistance Scheme (RAMED). Although the law was passed and promulgated in 2002, the RAMED implementing decree was not published until 2008, three years after the AMO decree. However, implementation was not immediate: a trial phase took place in the Tadla- Azilal region from November 2008, followed by an evaluation from 2009 to 2010.

The evaluation reports highlighted several avenues for improvement for RAMED, including a review of procedures and methods for identifying and managing beneficiaries, capacity-building for public health establishments, improvements to the technical, administrative and financial management of files, an overhaul of financing methods and an update of the projected number of beneficiaries, as well as better steering and governance of the scheme.

The generalization of RAMED was finally decided by a decree dated January 24, 2011. However, adjustments were made the same year, necessitating the adoption of a second decree. The actual roll-out did not take place until March 13, 2012, ten years after the passing of Law 65-00.

At the same time, the list of reimbursable drugs underwent a major revision, rising from 1,001 drugs in March 2006 to 3,376 in December 2011, according to the CNSS 2012 annual report. Between 2010 and 2011, the population covered by Compulsory Health Insurance grew by 12%, from 3,309,438 to 3,700,150. Within this group, salaried employees make up the majority with 83% of beneficiaries, compared with 17% for pensioners. Table 2 shows the breakdown of the population entitled to AMO in 2011.

A dimension often overlooked in previous analyses concerns the effect of this reform on the supply of care. One study highlighted the phenomenon of "insurance-induced growth" in the

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private sector: between 2006 and 2012, the number of private clinics rose by 45%, that of analysis laboratories by 62%, and that of pharmacies by 31%. This expansion was particularly marked in urban areas with a high concentration of AMO policyholders, creating what these researchers describe as "asymmetrical development" that accentuated geographical inequalities in access.

Table 2: The number of people entitled to AMO in 2011

Type	*Employees*	*Pensioners*
Insured	1 332 451	380 509
Spouses	477 803	123 971
Children	1 275 944	109 472
Subtotal	3 086 198	613 952
Total	83%	17%
	3 700 150	

Source: CNSS 2011 annual report

The critical analysis of this period concurs with Kutzin's (2013) theoretical conclusions on the challenges of extending coverage in fragmented systems: despite undeniable advances, the Moroccan reform of 2002-2012 did not sufficiently integrate equity and efficiency dimensions into its design and implementation. The time lag between AMO and RAMED has created a multi-speed system, while the lack of parallel reform of public health care provision has limited the effectiveness of coverage for the most vulnerable populations.Extending coverage and ongoing challenges (2012-2020)

This phase saw a significant increase in the population covered by the AMO scheme (as illustrated in table no. 3 below2), and also an evolution in these direct expenses. Growth was 10% over the period 2012-2017. In 2012, the average expenditure per AMO beneficiary was 687.243 DH, whereas it stood at 888.65 DH in 2017. This expenditure differs from region to region, with the highest expenditure in the Casablanca-Settat region.

Table 3: Population covered by the AMO scheme.

	2012	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**
Total insured	2 774 654	3 233 957	3 402 101	3 528 466	3 653 173	3 900 809	4 135 165
Total dependents	3 728 583	4 273 431	4 528 182	4 720 868	4 970 180	5 160 942	5 410 045
Total beneficiaries	6 503 237	7 507 388	7 930 283	8 249 334	8 623 353	9 061 751	9 545 210

Source : Autorité de contrôle des assurances et de la prévoyance sociale (French insurance supervisor)

Since its widespread introduction at the beginning of 2012, RAMED has fully achieved its objectives and even exceeded expectations, with the number of beneficiaries amounting to 9.1 million in 2015, 86% of whom were in a situation of poverty (see table no. 4).

Table n°4: Number of RAMED beneficiaries for the 2012-2015 period.

Year	**Number of beneficiaries enrolled during the year**	**Cumulative number of beneficiaries**	**Number of beneficiaries as a percentage of the initially estimated number of deprived persons**
2012	2.642.208	2.642.208	31%
2013	3.401.337	6.043.545	74%
2014	1.837.483	7.881.028	97%
2015	1.252.490	9.133.488	113%

Source: National Health Insurance Agency - ANAM

In 2015, Law 116-12, promulgated by Dahir no. 1-15-105 of August 4, 2015, made basic health insurance compulsory for students. Two years later, in 2017, Law 98-15 introduced a basic health insurance scheme for professionals, self-employed workers and other self-employed people who do not have access to health cover via an employer.

The year 2020 was marked by the spread of COVID-19, which severely tested the Moroccan healthcare system. In addition to the impact of the pandemic, weaknesses in RAMED's implementation in terms of resources and governance revealed the need to correct several dysfunctions, in particular underfunding, insufficient supply of care and inadequate quality of service for precarious populations. By relying on direct econometric methods to target the population concerned, RAMED has shown its limitations in a context where the importance of the informal sector and the inaccuracy of declarative data undermine the reliability of targeting. As Raphaël Cottin points out in "Le ciblage direct des ménages est-il possible pour les politiques de santé? Le cas du RAMed au Maroc", high error rates and underestimation of the number of people actually eligible testify to the inefficiency of the distribution system.

Faced with these constraints, His Majesty King Mohammed 6 announced a major reform of the social protection system during the Throne Speech in July 2020. This includes the generalization of medical coverage, the extension of family allowances, the introduction of a pension for the entire working population, and the introduction of a loss-of-job indemnity. The year 2021 saw the adoption of framework law 09-21 on social protection, defining the principles, guidelines and mechanisms for State intervention in this field, with the aim of reducing poverty, combating vulnerability, supporting families' purchasing power, achieving social justice and strengthening human capital.

2.4 Post-COVID reform: towards universal health coverage (2020-2023)

The COVID-19 pandemic acted as a catalyst to accelerate reforms of the Moroccan healthcare system, opening a "political window of opportunity" conducive to structural change. The prospect of universal medical coverage became a reality with the implementation of multiple initiatives aimed at gradually extending Compulsory Health Insurance (AMO) to the entire population. On the operational front, the publication of 22 decrees implementing law no. 98-15 extended basic AMO coverage to professionals, the self-employed and other non-salaried liberal professions. By the end of August 2022, 3.6 million people were already covered by these new provisions, including 2.22 million with insured status.

Whereas in 2005 only 16% of the Moroccan population had medical coverage, this rate reached 74.2% in December 2021 and should rise to 95% by the end of 2022. Several factors explain this dynamic, including the extension of coverage to various socio-professional groups, the integration of former schemes (RAMED, Art. 114, specific mutual insurance companies) and the introduction of mechanisms tailored to students and members of the armed forces. The scope of beneficiaries has thus broadened, encompassing CNOPS/CNSS employees (33.1%), RAMED members (32.1%), Article 114 policyholders (4.2%), students (1%) and categories in the process of joining (25.8%).

In financial terms, the effort to extend health insurance coverage to all is worth 14 billion dirhams. Half of this sum comes from contributions paid by the self-employed, liberal professionals, non-salaried workers and via the Contribution Professionnelle Unique (CPU), while the other half is provided by the State budget in a spirit of national solidarity. This combination of private and public funding is essential to ensure the long-term viability of a scheme that is both inclusive and sustainable.

In terms of governance, the creation of an appropriate institutional framework is at the heart of the approach. An Interministerial Commission has been set up to steer the reform of social protection, with the task of supervising the implementation of measures, coordinating the action of the various players and defining the list of laws and regulations needed to achieve universal medical coverage. Other technical and consultative bodies ensure the harmonization of interventions and the ongoing assessment of progress in the field.

By January 2023, the total number of insured had risen to 23.2 million, thanks to the extension of AMO and the roll-out of the AMO-Tadamoune scheme, which now includes the former

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RAMED category as well as non-salaried workers. At the same time, this period was marked by a structural reform of the healthcare system, introduced by framework law 06-22 (promulgated in May 2022), which aims to remedy persistent deficits in healthcare provision through four axes: upgrading human resources (salary increases of 20% to 50% depending on the profession), reorganizing services on a territorial basis (creation of territorial health groups), digitizing the system (electronic medical records, telemedicine) and strengthening governance (establishment of an independent High Health Authority).

This post-COVID context marks a major turning point for the Moroccan healthcare system, characterized by increased political will and unprecedented investment. However, the effective achievement of Universal Health Coverage (UHC) remains contingent on the mobilization of all stakeholders (administrations, managing bodies, healthcare professionals, etc.) and the concrete application of the fundamental principles of UHC: the right to health, protection against the risk of illness, equity in access to care and effective governance.

3. International comparative analysis

Benchmarking the performance of the Moroccan healthcare system against other countries offers valuable insights into its strengths, weaknesses and relative positioning. Using the OECD's standardized evaluation framework, adapted to the context of middle-income countries, several dimensions merit particular attention.

Models for assessing healthcare system performance: the WHO and OECD approach

Assessing the performance of healthcare systems is an exercise already undertaken by numerous researchers and international organizations. In its 2000 study, the World Health Organization (WHO) ranked 191 countries according to a model based on three comparative elements:

- Improving people's health;
- The responsiveness of the healthcare system;
- Fairness of financial contribution.

With regard to these criteria, the WHO has highlighted a disparity between developed and underdeveloped countries, particularly when it comes to the responsiveness of healthcare systems. According to the WHO, "a perfectly equitable health system does not discriminate between people, and should score the same for each aspect of responsiveness and for each population group" (WHO, 2000: 36).

For its part, the Organisation for Economic Co-operation and Development (OECD) has been involved in evaluating the performance of healthcare systems since 1985, when it published its first comparative report on the subject. Since then, it has regularly updated its analyses, notably to examine healthcare expenditure at international level, study the costs of healthcare systems and refine conceptual approaches to performance. Her work includes the selection of indicators classified according to various domains (healthcare workforce, quality of care, access to care, etc.). In its Health at a Glance 2015 (OECD, 2015), the OECD stresses the importance of studying issues such as controlling healthcare expenditure, improving the quality and safety of care, as well as equity of access and efficiency in resource management. Since 2001, its project has aimed to define the key components of healthcare system performance by answering questions related to these fundamental areas.

This table (5) shows the different performance indicators for healthcare systems according to the OECD:

Table n°5: the different performance indicators for healthcare systems according to the OECD

Teat de santé Life expectancy birth ; Life expectancy by gender and level of education; Mortality from cardiovascular disease; Mortality from cancer; Mortality due to transport accidents; Suicide ; Infant mortality ; Infant health: low birth weight; Perceived general health ; Cancer incidence.	**Non-medical determinants of health** Adult tobacco consumption; Adult alcohol consumption ; Fruit and vegetable consumption in adults; Obesity in adults ; Overweight and obesity in children;
Healthcare personnel Doctors (total number) ; Distribution of doctors by age, sex and category; Newly qualified doctors ; International migration of physicians ; Remuneration of doctors (general practitioners and specialists); Nursing staff ; Newly qualified nurses; International migration of nurses; Remuneration of nurses.	**Health services** Physician consultations; Medical technologies; Hospital beds ; Hospital discharges ; Average length of hospital stay; Cardiac surgery ; Hip or knee replacements; Caesarean sections ; Outpatient surgery.
Quality of care Avoidable hospital admissions; Diabetes treatment ; Prescriptions in primary care; Mortality after acute myocardial infarction (AMI); Mortality after stroke; Waiting times for hip fracture surgery ; Surgical complications; Obstetrical trauma; Care for people with mental disorders; Cervical cancer screening, survival and mortality; Breast cancer screening, survival and mortality; Survival and mortality of colorectal cancer; Childhood vaccination programs; Influenza vaccination of the elderly; Patient experiences in outpatient care.	**Access care** Health care coverage ; Unmet medical and dental care needs; Out-of-pocket healthcare expenses; Geographical distribution of physicians ; Waiting times for elective surgery.
	Health expenditure and financing Health expenditure per capita; Health expenditure as a proportion of GDP; Health expenditure by function; Financing of health expenditure; Expenditure disease and age ; Capital expenditure in the healthcare sector.
Pharmaceuticals sector Pharmaceutical expenses ; Financing pharmaceutical expenditure; Pharmacists and pharmacies ; Pharmaceutical consumption; Market share of generics ; Research and development in the pharmaceutical sector.	**Aging and long-term care** Demographic trends ; Life expectancy and healthy life expectancy at age 65; Self- reported health status and disability at 65 ; Prevalence of dementia; Long-term care recipients; Informal caregivers ; Long-term care employment; Long-term care beds; care expenses.

Source: OECD (2015). Health at a Glance 2015. OECD indicators.

- *Comparing performance according to OECD indicators: The case of Morocco*

Our evaluation will compare the Moroccan healthcare system with other healthcare systems from different countries. This analysis will be carried out on the basis of the following indicators:

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Table n°6: analyze based on Based on World Bank data

Country name	United States	France	Mali	Canada	India	China	Tunisia	Turkey	Morocco	Egypt	Senegal	Algeria	Jordan	Saudi Arabia	Qatar
population health indicators															
State of health															
Life expectancy at birth (male)*[1]	75	70	57	80	69	75	72	73	72	769	66	73	73	75	78
Life expectancy at birth (women)*[2]	80	75	60	84	72	81	79	79	76	73	70	76	78	78	81
Mortality rate															
Infant mortality per (1000 live births)*2	5	3	59	4	27	6	14	8	16	17	29	20	13	6	5
Crude death rate per (1000 people)*2	10	10	10	8	7	7	7	6	6	6	6	5	3	3	1
financial indicators															
Healthcare expenditure as a percentage of GDP	15,95	12,2	1,33	12,9	3,567	5,3	4,13	3,64	2,25	1,74	0,87	4,20	3,64	3,89	2,11
Healthcare expenditure per (Meguro)	2917490,7	238079,9	180,3	146388,6	25767,4	384473,7	1542,6	22813,9	2362,3	3813, 3	161,2	6336,6	1335,7	226889	3003 ,1
Per capita health Expenditure(€)	8801€	3523 €	10 €	3828	19€	268€	127€	274 €	61 €	31€	10 €	151€	135 €	703 €	1179 €
Health expenditure % budget	22,55%	15,47%	5,79%	19,	3,38%	09,07%	13,63%	9,69%	6,9 %	5,42%	3,89%	10,73%	12,39%	10,06%	6,29%
Care offering indicator															
Hospital bed per 1000 people	2,9	5,9	0,1	2,5	0,5	4,3	2,2	2,9	0,8	1,4	0,3	1,9	1,5	2,2	1,3
Nurses and midwives per 1,000 people	15,685	11,7833	0,448	11,073	1,7483	3,0829	2,5136	3,0454	0,88	1,922	0,5404	1,5477	3,347	5,8174	7,197
Doctor per 1000 people	2,6	3,3	0,1	2,4	0,7	2,2	1,3	1,9	0,7	0,7	0,1	1,7	2,7	2,7	2,5

Source: Based on World Bank data

Population health status

Indicators relating to the state of health of the Moroccan population reveal mixed results. Life expectancy at birth for men in Morocco stands at 72 years, placing the country in an intermediate position among the countries studied. This value is comparable to that of Tunisia (72 years) and Turkey (73 years), but remains below that of high-income countries such as Canada (80 years) and the USA (75 years). For female life expectancy, Morocco scores 76 years, corresponding to a male-female gap of 4 years, a smaller differential than that observed in some developed countries such as France (75 years for men vs. 75 years for women, a gap of 5 years).

In terms of infant mortality, Morocco's rate of 16 deaths per 1,000 live births represents an intermediate performance among the countries analyzed. This rate is significantly higher than in developed countries such as France (3) or Canada (4), but significantly lower than in Mali (59) and Senegal (29). This situation reflects the persistent challenges facing maternal and child health in Morocco, despite the progress made over the last few decades.

Morocco's crude mortality rate of 6 deaths per 1,000 people is comparable to that of many of the countries in the sample, including Tunisia (7), Egypt (6) and Senegal (6), suggesting some convergence in demographic structure and health challenges.

Financial indicators

Analysis of financial indicators reveals significant disparities between Morocco and the other countries studied. Morocco devotes 2.25% of its GDP to healthcare expenditure, a percentage well below that of developed countries such as the USA (15.95%) or France (12.2%), but comparable to that of Qatar (2.11%). In absolute terms, per capita healthcare spending in Morocco amounts to €61, well below that of high-income countries such as the USA (€8801) or Canada (€3828), but higher than that of Mali (€10) or Senegal (€10).

Total healthcare expenditure in Morocco (€2,362.3 million) is relatively modest compared with that of developed and emerging economies. However, as a proportion of the national budget, healthcare spending represents 6.9% in Morocco, which is lower than the OECD average, but higher than certain countries such as India (3.38%) or Qatar (6.29%).

Care offering indicator

In terms of healthcare provision, Morocco has significant deficits in terms of human resources and health infrastructure. The country has 0.8 hospital beds per 1,000 people, a lower ratio than most of the countries analyzed, with the exception of Mali (0.1) and Senegal (0.3). This situation reflects limited hospital capacity, which is likely to affect access to healthcare, particularly in rural areas.

The density of healthcare professionals in Morocco also reveals structural shortcomings. The country has 0.88 nurses and midwives per 1,000 people, a ratio significantly lower than that of developed countries such as the USA (15.68) or France (11.78). Similarly, medical density in Morocco stands at 0.7 doctors per 1,000 people, comparable to Egypt (0.7) but lower than Tunisia (1.3) or Turkey (1.9).

With this in mind, a comparative analysis of OECD indicators for Morocco reveals a situation characterized by notable progress in terms of the population's health status, but persistent deficits in terms of financing and healthcare provision. This configuration suggests a healthcare system in transition, faced with a dual epidemiological challenge: on the one hand, the persistence of traditional health issues (infant mortality, infectious diseases) and, on the other, the emergence of non-communicable diseases associated with an ageing population and changing lifestyles.

Morocco's relatively modest performance in terms of resources allocated to healthcare underscores the need for a significant increase in investment in this sector, both in terms of infrastructure and the training and deployment of healthcare professionals. Comparison with

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countries at similar levels of economic development, such as Tunisia and Jordan, suggests that there is substantial room for improvement.
These international experiences, analyzed using rigorous methodologies, offer converging lessons applicable to the Moroccan context: the importance of a systemic approach coordinating supply and demand for care, the need for a strong anchoring in primary care, the value of robust information systems, and the potential of innovative financing and provider payment mechanisms.

4. Lessons and prospects for the national health system in the context of universal health coverage

An analysis of Morocco's health indicators, compared with those of other countries, reveals a number of strategic lessons to be learned, and points the way forward for the country's healthcare system, particularly in the context of the major reform initiated in 2020 aimed at providing universal medical coverage.

4.1 Key lessons for medical coverage reform

Epidemiological transition and adaptation of the healthcare basket: Morocco's health profile reveals an ongoing epidemiological transition, characterized by the coexistence of infectious pathologies and non-communicable diseases. With a life expectancy of 72 years for men and 76 years for women, Morocco is faced with a double burden that requires an adapted care basket as part of the generalization of medical coverage. This epidemiological reality requires financial protection against costly chronic diseases, while maintaining attention to maternal-infant issues (infant mortality rate of 16‰).
Structural shortfall in healthcare funding: The relatively modest level of healthcare expenditure in Morocco (2.25% of GDP) represents a major challenge to the sustainability of universal healthcare coverage. This financial constraint, compared with countries such as Tunisia (4.13% of GDP) or Jordan (3.54% of GDP), highlights the need for a new financing model to accompany the expansion of coverage. Direct household expenditure remains high, exposing many families to the risk of catastrophic expenditure.
Inequities in geographical and financial access: The limited density of human resources and infrastructure (0.8 beds per 1,000 inhabitants, 0.7 doctors per 1,000 inhabitants) reveals structural obstacles to effective medical coverage. These indicators, which are significantly lower than those of countries such as Turkey (2.9 beds, 1.9 doctors) or Jordan (1.5 beds, 2.7 doctors), indicate that the extension of insurance coverage will have to be accompanied by a significant strengthening of the supply of care to avoid a phenomenon of "coverage without access".
Fragmentation of the healthcare system: Morocco's relatively modest performance, even when compared with countries with comparable resources, reflects the historical fragmentation of the health insurance system and governance mechanisms. This situation has led to inefficiencies that the 2020 reform aims to correct through the gradual unification of health insurance schemes.

4.2 Prospects for widespread medical coverage

Renewed financial architecture: The new financing model calls for a sustained budgetary effort, with the aim of gradually increasing healthcare expenditure to a level comparable to that of countries like Tunisia. This dynamic is essential to reduce the gap in financial indicators (€61 per capita in Morocco versus €274 in Turkey and €703 in Jordan) and ensure the system's sustainability.

Program to upgrade healthcare provision: Aware that extending coverage requires adequate healthcare provision, the Moroccan authorities have incorporated an ambitious program to strengthen infrastructure and human resources into the reform. This program aims to remedy the deficits highlighted by the comparative indicators (0.88 nurses/midwives per 1,000 inhabitants) through the construction of new health establishments and the accelerated recruitment of professionals.

Unified governance and strategic steering: The reform institutes renewed governance with the creation of the Agence Marocaine d'Assurance Maladie (ANAM) as the sole regulator and the Caisse Nationale de Sécurité Sociale (CNSS) as the main administrator. This institutional architecture aims to overcome identified governance deficits and optimize the allocation of limited resources (6.9% of the national budget devoted to healthcare).

Digital transformation as a catalyst: The deployment of a unique health identifier and an integrated information system is a strategic lever for reform. This digitalization aims to improve administrative efficiency, reduce management costs and enable better monitoring of care paths. Telemedicine, whose development has been accelerated by the COVID-19 pandemic, offers an opportunity to overcome the constraints of geographical accessibility revealed by indicators of healthcare provision.

Strengthening partnerships and international cooperation: Last but not least, comparisons with OECD member countries offer numerous opportunities for exchanges and partnerships. Scientific and technical collaboration programs, the sharing of best practices and the implementation of joint projects (research centers, e-health platforms, cross-training) could accelerate the modernization of the Moroccan system. These initiatives, combined with partnerships with international funding agencies, would help to diversify sources of funding and support ongoing reforms.

All in all, Morocco's healthcare system offers considerable potential for improvement. The OECD indicators serve as a benchmark for targeting strategic levers for improvement, such as mobilizing additional financial resources, expanding infrastructure, reviewing governance mechanisms and strengthening human resources. In the medium and long term, these actions converge towards a common goal: to raise the performance of the national healthcare system to a level more in line with international standards, while ensuring equity of access and improved quality of care for all citizens.

5. Conclusion

At the end of this in-depth analysis of the Moroccan healthcare system, a number of significant conclusions emerge concerning its evolution, current performance and development prospects in the context of universal medical coverage.

The study highlighted the particular trajectory of the Moroccan system, characterized by a gradual transition from a fragmented post-colonial model to a more integrated architecture aimed at universal health coverage. This evolution took place in successive stages, with the introduction of Basic Health Coverage in 2002, its gradual extension to different categories of the population, and finally the ambitious reform initiated in 2020 to achieve universal social protection.

International benchmarking reveals that, despite undeniable progress on certain basic health indicators (such as improved life expectancy and reduced infant mortality), the Moroccan system still performs modestly in terms of funding (2.25% of GDP devoted to health) and human resources (0.7 doctors and 0.88 nurses/midwives per 1,000 inhabitants). These structural limitations are potential obstacles to the effectiveness of the universal medical coverage currently being rolled out.

Nevertheless, the current reform represents a historic opportunity for systemic transformation, by simultaneously extending insurance coverage, strengthening the healthcare offering,

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modernizing governance and digitizing the system. The unified institutional architecture, with ANAM as the regulator and CNSS as the main administrator, represents a major step towards greater efficiency and equity.

The lessons learned from this research underline the importance of a holistic approach to reform, which must closely articulate financing, service delivery and governance. They also highlight the need for a significant increase in investment in the health sector to reach levels comparable to those of countries that have successfully made the transition to universal coverage.

Several perspectives for future research emerge from this analysis. Firstly, longitudinal studies will be needed to assess the impact of the generalization of medical coverage on effective access to care and on the financial protection of Moroccan households. Secondly, in-depth research into optimal financing and provider payment mechanisms would enable us to identify the configurations best suited to the Moroccan context. Thirdly, exploring the potential of e-health and artificial intelligence as levers for improving efficiency and equity is a promising field. Finally, more detailed comparative analyses with countries that have experienced similar reform trajectories could inform future strategic choices.

In terms of policy implications, this research argues for a sustained commitment to reform, with particular attention to reducing geographical and socio-economic inequalities in access to care. It also recommends strengthening dialogue between the various stakeholders (public authorities, healthcare professionals, civil society, international partners) to ensure the collective support necessary for the successful transformation of the system.

In short, Morocco is at a pivotal point in the evolution of its healthcare system. Achieving the ambition of truly universal, equitable and high-quality healthcare coverage will depend on the ability to maintain the current reform momentum while overcoming the structural challenges identified in this study. The Moroccan experience, with its specific features and lessons learned, could provide a relevant model for other middle-income countries engaged in similar transitions towards universal health coverage.

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