Morocco's Challenging Healthcare

In the wake of the Arab Spring, Moroccan citizens approved, in July 2011, a new constitution that promised a range of new rights, including universal healthcare and access to quality health services.

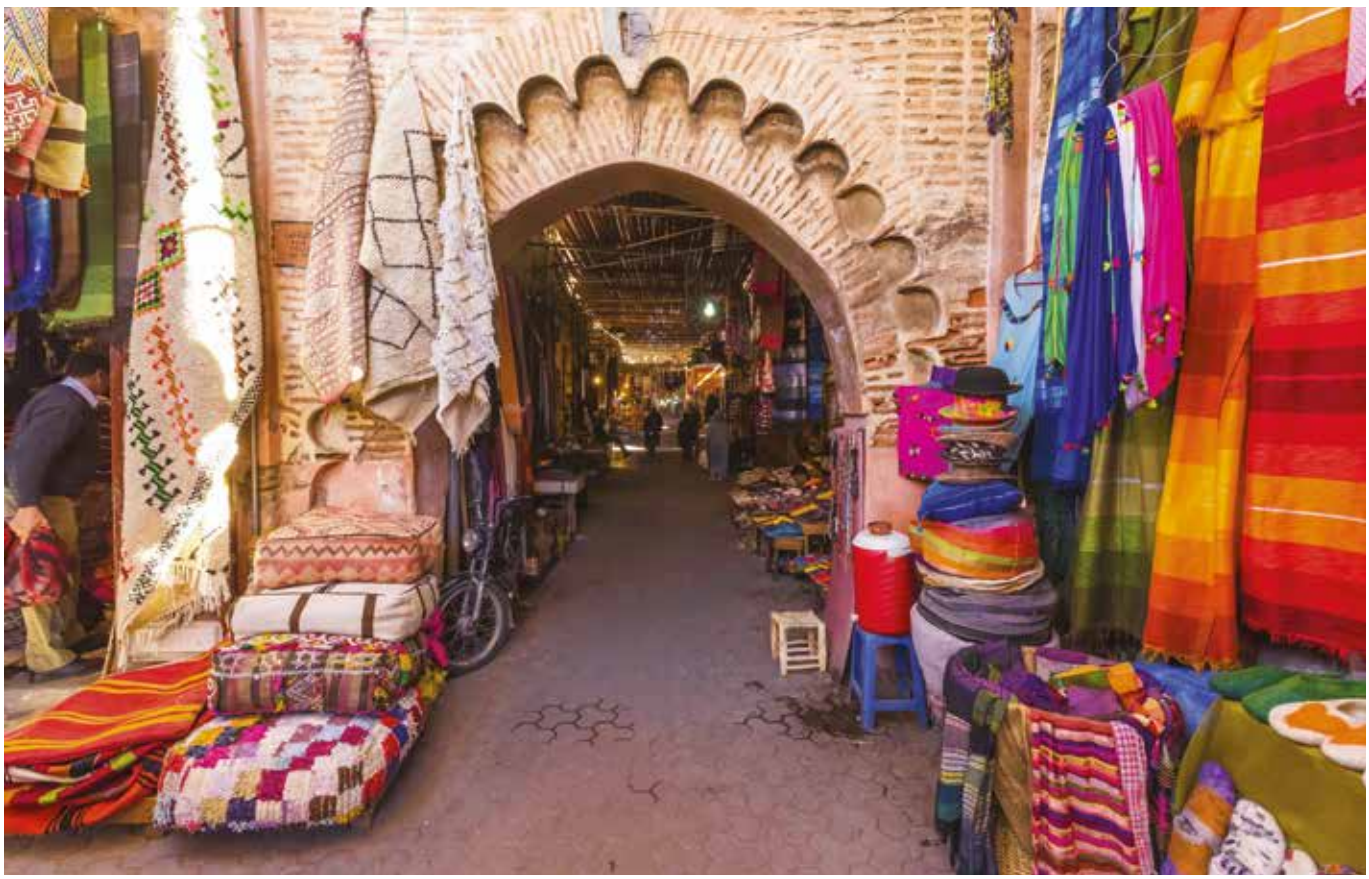
The authorities have since taken steps to increase coverage, reduce costs, improve service quality and extend services in rural and otherwise isolated areas. Significant progress has been made but a number of critical challenges remain, including chronic staff shortages, particularly in the public health system; disparity in service quality; lack of financial resources; gaps in governance, especially regarding efforts to decentralize control of the public health system; and additional issues created by the burgeoning private health segment.

All Moroccan citizens are required to be members of a basic public medical scheme through one of two state-financed healthcare schemes: The Mandatory Health Insurance Plan (Assurance Maladie Obligatoire, AMO) or the Medical Assistance Regime (Régime d'Assistance Médicale, RAMED).

Introduced in 2005, AMO began as a payroll-based mandatory health insurance program for public and formal private sector employees, covering all employees for sickness, maternity, invalidity and retirement. The scheme is financed by contributions from employer and employees as well as retired workers and from the government providing around Dh100m (€9.3m) per year in funding for the scheme.

RAMED was later launched, as a pilot program, in 2009 for the purpose of providing healthcare to most disadvantaged citizens of low socio-economic status and has later expanded to cover all regions of the country. The scheme is based on the principle of social welfare and national solidarity and it is a publicly financed fund, primarily through tax revenue, with the government allocating around Dh1bn (€92.6m) annually to the measure.

The CNSS (Caisse Nationale de la Securite Sociale or National Social Security Fund) runs the AMO and guarantees the reimbursement of a part of the care costs, the other part being borne by the insured. Basic oral care and facial orthodontics for children are among the services included in the current healthcare basket, which covers preventive and cura-



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tive care related to the priority program of the State. The reimbursement rates are set at 70% and can be up to 90% for serious and debilitating diseases requiring long-term care or when the related services are provided in public institutions. The reimbursement of a dental prosthesis is made up to a ceiling of 3,000 MAD every 2 years. In parallel, the private insurance companies have different offers that vary from one company to another and from one client to another.

Despite significant progress towards universal coverage, out of an estimated population of 34.8 million in 2017, only 16.2 million Moroccans have medical coverage, corresponding to only around half (46.6%) of the Moroccan population, according to a 2018 health coverage report from the Office of the Higher Planning Commission (HCP), with disparities by gender, age and place of residence. In an effort to move towards universal healthcare and to reach at least 90% coverage by 2021 as per the Health Sector Strategy introduced by the government in 2017, Moroccan authorities are taking steps to extend insurance to those who fall into coverage gaps – many citizens have too high an income to receive help from RAMED, yet do not receive AMO through their employer and cannot afford private health insurance. Authorities are now working to further extend the program to include independent workers, such as craftsmen and those in the liberal profession. The government remains the primary healthcare provider as 70% of the population uses public hospitals.

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A further small but growing share of Moroccans are covered by private health insurance. **For citizen able to afford it, private health has long been an attractive alternative to the public system, it is well developed, and treatment is of better quality but, prices are quite high compared to average purchasing power.**

A legislative change in 2015 permitted non-medical professionals (including financial investors) to establish health facilities in Morocco for the first time, which has dramatically altered the landscape of health services, liberalizing the ownership of private clinics. **This reform has greatly expanded the range of potential investors in private facilities, while also making it easier for foreign health service providers to establish a local presence, creating a more competitive landscape**. Public-private partnerships (PPPs) have also become a main feature of Morocco's healthcare landscape, starting in the early 2010s. Through PPPs, the public health system can close gaps in coverage by acquiring treatments for its patients from private providers.

The depth and dynamics of the private

Physicians	**22,900 (2016)**
Dentists	**4,655 (WHO, 2014)**
Physicians density	**6.2 per 10,000 inhabitants (world bank 2018)**
Hospital beds	**11 per 10,000 inhabitants**

healthcare sector give comfort to foreign investors in terms of sizeable market potential. Out-of-pocket spending accounts for over 54% of total Moroccan healthcare spending. **Also, the Moroccan Ministry of Health, which is the first care provider in the country, with approximately 77% bed capacity, only receives 28% of total health expenditure, while private spending accounts for about 60%.** Growth dynamics are supported by several sustainable drivers. The rapid growth of the middle-income class has contributed to the increasing demand for quality infrastructure and services; which in turn have driven the need to expand the current capacity of private clinics.

The medical device market is estimated at USD 236 million, with USD 181 million constituting imports. **Medical device imports supply approximately 90% of the market. Morocco does not manufacture medical equipment and the local production is limited to medical disposables.** The United States, Germany and France are the main suppliers. Recently, Italian products have been well accepted by the local population thanks to their good quality and attractive price however, there is an increasing demand for Turkish, Chinese and Korean equipment.

Public hospitals represent 85% of the demand and private clinics represent 15%. There are five University Hospital Centers in Rabat, Casablanca, Fez, Oujda and Marrakech and six military hospitals located in the large cities, such as Casablanca, Rabat, Fez and Marrakech. In addition, there are over 139 hospitals in the public sector; another 28 are being rehabilitated and equipped for a total of 65.1 million MAD. The private sector healthcare market is growing rapidly as there are more than 360 private clinics and 9,661 physician specialists in Morocco. In addition, the import of refurbished equipment is no longer allowed for both public and private entities. This is expected to improve the quality of medical equipment and offer a better quality of medical care to patients treated in Morocco.

The annual health budget, at approximately Dh14.3bn (€1.3bn), has changed little in recent years and accounted for just 5.7% of total public spending in 2017. This is less than half the 12% threshold the World Health Organization (WHO) recommends for countries such as Morocco that are trying to improve their health systems and it is behind its peer countries in North Africa such as Algeria and Tunisia that spend at around 10% of their national budgets on healthcare.

With so much at stake and with the implementation of appropriate measures, private and public healthcare in Morocco is a growing business for future investments for the healthcare industry.

Oral Health - Oral health is an indicator for overall health and quality of life but, in Morocco, it is an overlooked aspect of hygiene and healthcare as many Moroccans neglect visiting the dentist on a regular basis to monitor and examine their teeth. **According to the National Order of Dentists, the current national average of dentists is one dentist for every 7,000 citizens, with a geographic concentration in large urban centers.** Morocco's target for 2025 is to reach one dentist for every 5,000 people.

There is a high number of highly qualified dentists, many of whom have trained in France and the cost of good dentistry is remarkably inexpensive by European standards with many surgeries having all the modern equipment one would expect. Nonetheless, according to the National Order of Dentists, Morocco is also home to over 3,300 fake dentists, 1,800 of which are illegal even as only dental technicians. These therapeutic methods that do not conform to the rules of sterilization and safety, used by people who practice dentistry illegally, increase the severity of the oral health situation, also determining further burden on public healthcare by putting patients at risk of serious diseases such as hepatitis, tuberculosis, AIDS or even death. The Order of Dentists has asked the authorities to take urgent measures to deal with the fakes, claiming they are endangering "the image of the Moroccan dentistry." Fake dentists specifically target poor areas and neighborhoods where the population does not necessarily know the difference between a real and a fake dentist as well as isolated villages or remote mountain areas with no dentists. These interlopers carry out all sorts of operations, from extracting and removing teeth to deadening nerves for 40 or 50 dirhams (4-5 euros) compared with at least 200 charged by a doctor.

A national epidemiological research done by the Ministry of Health in 2012 in partnership with the Public Health Organization shows that 60% to 90% of children suffer from oral diseases. The risk of tooth decay is 81.8% by age 12, 86.7% by age 15, and 91.8% for those between 35 and 44 years old. Oral hygiene and the associated habits must be incorporated from a young age. In Morocco, low rates of toothbrush use are observed in studies of mothers and their children, demonstrating that children's oral health practices are dependent on their parents. In a specific study, carried out on 200 Mo-

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roccan school children and their mothers, the mothers displayed very inefficient brushing techniques (brushing, frequency and duration, equipment and methodology, frequency of changing toothbrushes) and the correlation between the plaque index of mothers and their children suggested that mother's oral hygiene behaviors influenced their children's oral health. With regard to adolescents, a research group from the Department of Odontology at Mohammed V University in Rabat showed that of a study, conducted between 2012-2013 with 450 participants, 86% had at least one untreated dental cavity even though 82.3% of the study population had dental health covered by their insurance. This indicates that oral health in Morocco is not only related to medical insurance, but possibly other factors.

Morocco has a high prevalence of periodontitis in young people. The national epidemiological research also noted that gum disease can affect 42.2% at age 12, 59.8% at age 15 and 79.2% between 35 and 44. About 30% of people aged between 65 and 74 no longer have natural teeth. In 2016, a Moroccan study group concluded that the young Moroccan population is at high risk for developing aggressive periodontal disease. Therefore, it is plausible that, due to the nature of the disease, the same applies to older populations. A Spanish oral health research group conducted a study on patients with periodontitis, wherein 62% had aggressive periodontitis and 14% had chronic periodontitis. The bacteria co-responsible for developing periodontitis was present in 60% of a study population consisting of Moroccan adolescents. It is assumed that Moroccans are more susceptible to periodontitis; biological elements such as genetics and the oral flora play a role in contributing to the increased risk. **Likewise, a lack of proper oral hygiene, limited access to dental healthcare, the irregular use of toothbrushes and toothpaste in rural settings and low-income families and inadequate knowledge on significance of oral health factor play a fundamental role into this widespread public health issue.**

Among Main Sources:

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