

***RAMED: a key step towards UHC***  
***or***  
***How to reform health financing in Morocco to reach UHC<sup>1</sup>***

*RAMED* (Régime d'Assistance Médicale)<sup>2</sup> and *AMO* (Assurance Maladie Obligatoire)<sup>3</sup> are key to the progression of Morocco towards Universal Health Coverage (UHC). By supplementing and deepening the reforms, the country can achieve the right to health for all Moroccans.

What is essential now, however, is to support these reforms, without which there is a danger that UHC may fail to materialise.

The aim of this memo is to consider how to transform these promises and initial efforts into access to high-quality healthcare for the entire population. It focuses firstly on the significant progress made, before briefly presenting the health financing reforms that should be accelerated or implemented<sup>4</sup>.

## **1. Morocco's progress towards UHC**

Morocco has made significant advances in health, in particular by eliminating some infectious diseases, increasing the life expectancy of the population by ten years in the last thirty years and reducing maternal and infant mortality by half.

Moreover, through *AMO* and *RAMED*, Morocco has introduced social welfare systems for some target groups: active employees and pensioners in the formal sector (34% of the population of Morocco), those on low incomes (27% of the population of Morocco), specific population groups (0.7% of the population of Morocco). Other systems for the self-employed and for students are also being prepared (30.8% and 1.5% of the population respectively).

Thus the population covered increased from approximately 16% to almost 53% of the total population from 2006 to 2013 (see illustration 1: population covered), which represents a significant progression.

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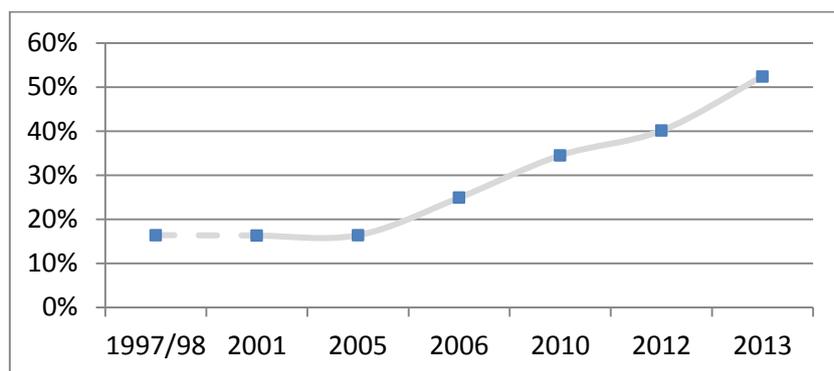
<sup>1</sup> This note was presented at the *RAMED* anniversary on 14<sup>th</sup> of March 2015 in Rabat

<sup>2</sup> The *RAMED* targets the poor and vulnerable and offers access to a basic package of services free at the point of use in public facilities.

<sup>3</sup> The *AMO* includes for the moment two insurance packages: *CNOPS* (Caisse Nationale des Organismes de Prévoyance Sociale) for employees of the private sector and *CNSS* (Caisse Nationale de Sécurité Sociale) for employees of the public sector.

<sup>4</sup> This memo is based on the analyses conducted by Oxford Policy Management (OPM) for the Ministry of Health in order to prepare a health financing strategy. The study was conducted with the financial support of the African Development Bank.

**Graph 1: Population covered**



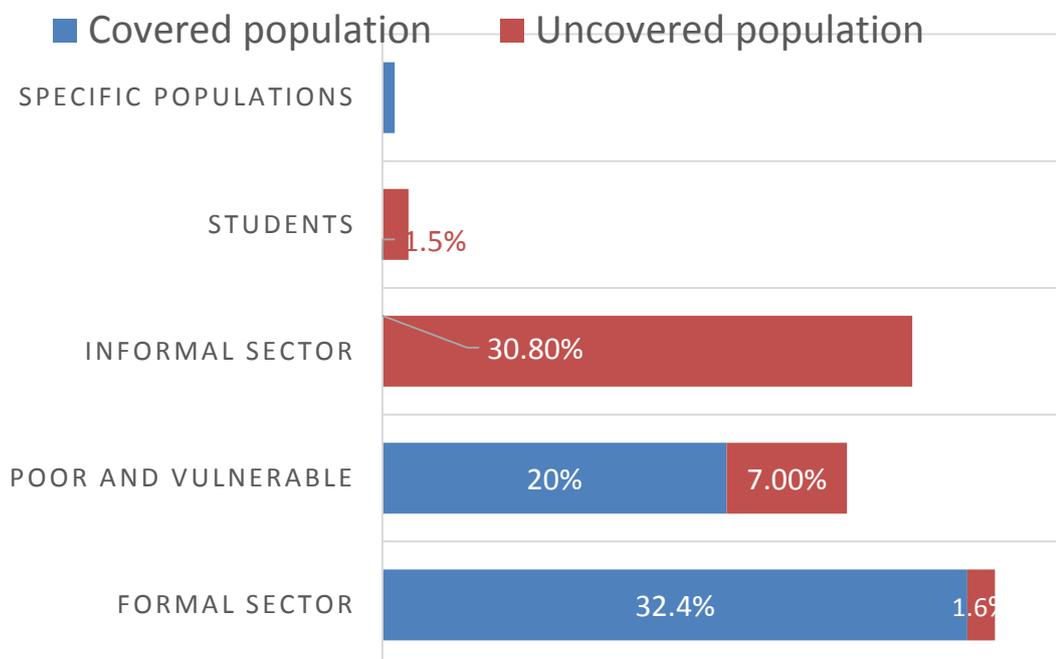
Sources: Ministry of Health, National Health Accounts 1997/98, 2001, 2006 and 2010; Ministry of Health, RAMED Report, Day of celebration for the 2<sup>nd</sup> anniversary of the launch of RAMED February 2014; ANAM, AMO balance sheet (2012);

## 2. Still a long way to go in the path towards UHC

Despite this progress, there are still challenges: a large part of the population is still not covered, and the existing systems, in particular RAMED, must still be consolidated. Moreover, and crucially, these ambitions will only be realised through financing that better matches the country's political ambitions.

- **A large proportion of the population is still not covered** (see illustration 2).

**Graph 2: Population covered and not covered in Morocco**



Sources: Ministry of Health, National Health Accounts 1997/98, 2001, 2006 and 2010 ; Ministry of Health, RAMED Report, Day of celebration for the 2<sup>nd</sup> anniversary of the launch of RAMED February 2014; ANAM, AMO balance sheet (2012);

- **The insurance systems and RAMED remain incomplete**

Despite the undeniable progress made by Morocco, a number of challenges continue to slow down the pooling of risks and resources. Firstly, the process of identifying the poor remains problematic: the lack of coherence between the scoring system and the decision of the Local Permanent Commission (CPL) means that some people in vulnerable situations are not properly identified; furthermore the administrative complexity of the documentation that has to be submitted in order to be eligible for RAMED undoubtedly excludes the more vulnerable populations such as the illiterate and those in more remote areas.

Moreover, the scoring system used to target vulnerable people is not yet able to precisely identify the eligible population. Errors of exclusion and inclusion persist and the motivation to join RAMED appears limited.

The population covered by a basic compulsory health insurance scheme (CNSS and CNOPS amongst others) also remains limited and the priority given to the population of salaried workers poses problems of fairness and contributes to the introduction of a two-tier healthcare system. Self-employed workers are not always covered and to think about schemes to encourage this section of the population to join is crucial.

Consequently, the pooling of risks remains limited. It applies only to the population covered by an insurance scheme, i.e. 53% of the population of Morocco, and only operates within each scheme rather than across them.

Finally, the pooling of resources through interlocking mechanisms accounts for only 44% of total health expenditure and thus remains limited. This pooling is non-existent across schemes.

- **Addressing the underfunding of the system**

A comparative analysis of different indicators shows unequivocally that Morocco underinvests in health. Public health expenditure is 2.1% of GDP and shows a significant disparity between the political will displayed to achieve UHC and the public budget made available to realise this project.

Moreover, the sources of financing remain regressive, as they are largely based on the contribution of households, which is contrary not only to the policy of universal coverage, but also to the government's goal of reducing direct household contributions to 20%-25% of total health expenditure.

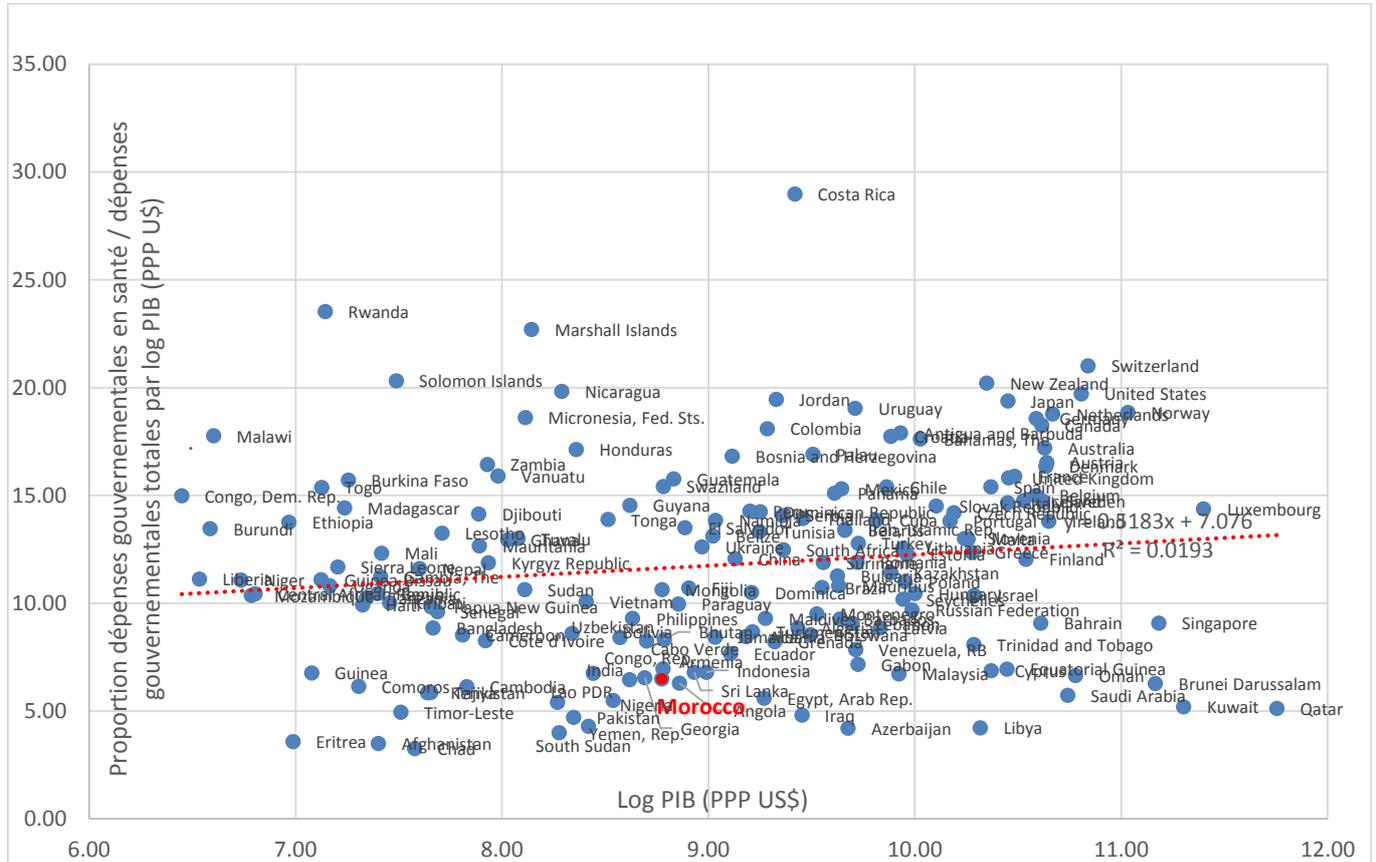
- Despite recent budgetary efforts, Morocco allocates a minimal amount to health compared to similar countries: total health expenditure as a percentage of GDP remains low (6.2% of GDP allocated to health in 2011). In 2010, the Moroccan government allocated only 2.1%<sup>5</sup> of its GDP to health, compared with 1.2% in 2000,

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<sup>5</sup>This figure includes government expenditure and the contributions of households, employers and local authorities to compulsory insurance.

which represents little more than one-quarter of total health expenditure. Compared with other countries within a similar income bracket, this is obvious underinvestment.

**Graph 3: Proportion of government health expenditure/total government expenditure by log of GDP (PPP US\$)**

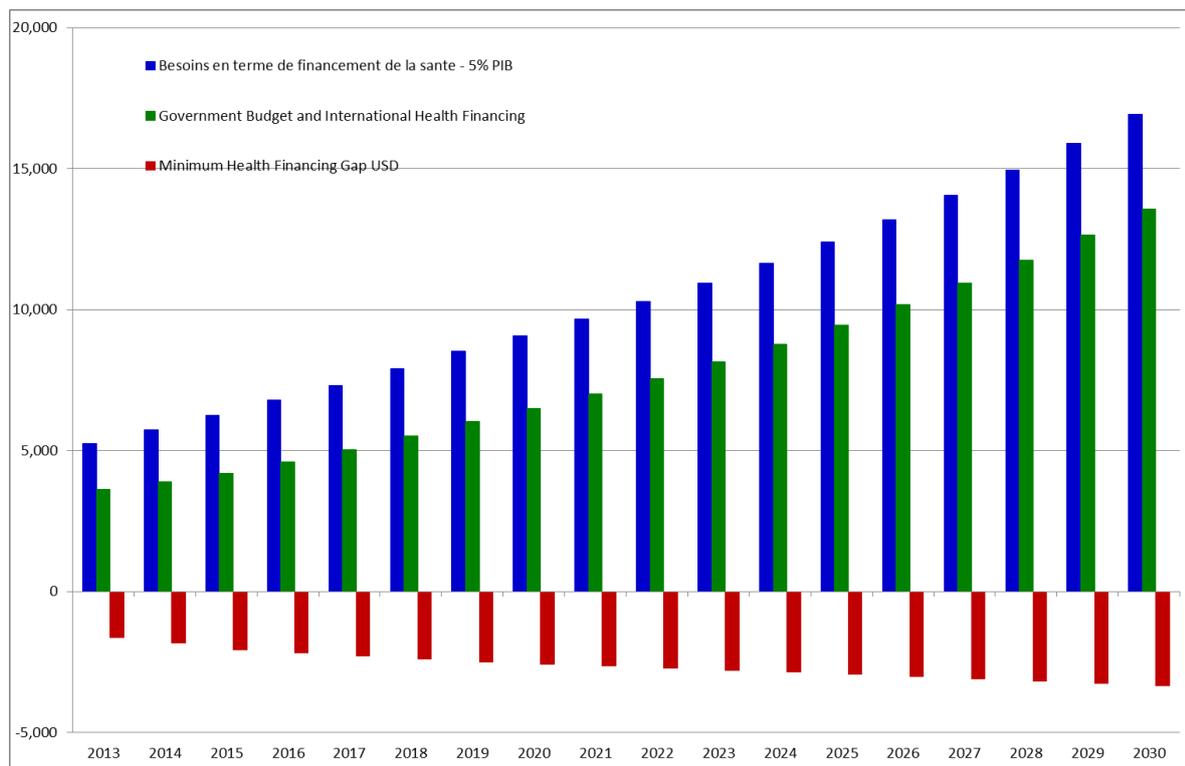


Source: OPM (2014), Final Report, health financing study

- **Direct payments by households remain a major funding source, and the government is not likely to achieve its aim of reducing direct payment to 20%-25% of total health expenditure by 2020.** Indeed the direct contributions of households are still likely to correspond to 46% of total expenditure in 2020<sup>6</sup>.
- UHC of a basic healthcare package is underfinanced by approximately **16 billion dirhams** in 2013, rising to **27 billion dirhams in 2030** (see graph 4: financing shortfall).

<sup>6</sup> Based on OPM's projections (see OPM (2015) Financement de la sante au Maroc – rapport final

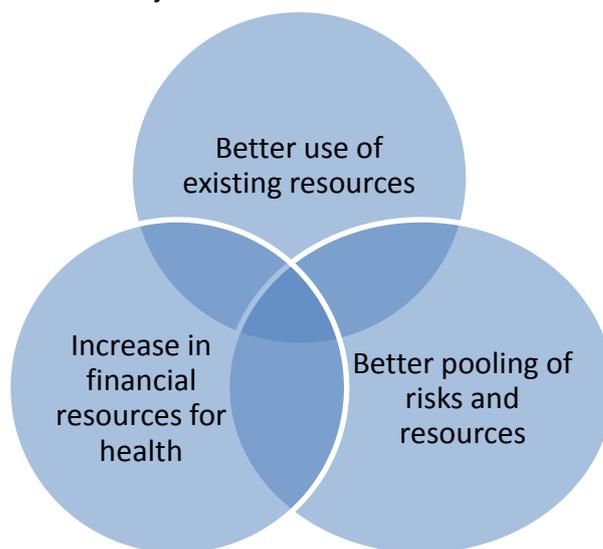
**Graph 4: Financing shortfall to achieve UHC (in USD millions)**



Source: OPM (2014), Intermediate Report, health financing study

### 3. Progressing towards a more complete coverage: three priority health financing reforms

To further current progress requires concrete actions in three priority areas: better use of existing resources (improvement in efficiency), better pooling of risks and resources, and finally and crucially, more money allocated to health.



### 3.1. Better use of existing resources

Optimum use must be made of the resources that the Moroccan Ministry of Health already has at its disposal, i.e. the existing resources must be spent as efficiently as possible and with maximum impact on the health of the population.

A study<sup>7</sup> has looked at the efficiency of health systems in 173 countries between 2010 and 2011 through a data envelopment analysis<sup>8 9</sup>. This analysis suggests that Morocco is a relatively inefficient country in the use of its resources. Indeed, its expenditure efficiency rate is close to 75% compared with more efficient countries. This implies that Morocco could make consistent savings of up to **1.5 billion dirhams (i.e. USD 200 million)**. This could rise to **30 billion dirhams (i.e. USD 3.7 billion) in 2030**. The average annual savings would be **0.6% of GDP**.

In concrete terms, for Morocco, making efficiency savings and improving the efficiency of the health system primarily involves addressing human resources and drugs. Not only because human resources and the drugs represent approximately 75% of total health expenditure, but also because these two components present the greatest challenges with regard to the ability of the system to generate health savings. Finally, reforming the mechanisms by means of which healthcare is purchased would also enable consistent efficiency savings to be made<sup>10</sup>.

#### How to improve the efficiency of human resources for health

- *Take into account the performance dimension when granting productivity bonuses:*

The medical consultation rate per person per year, in the public healthcare system, and the number of surgical interventions per surgeon, are low. The granting of productivity bonuses provided for in the sectoral strategy must take into account the performance dimension.

- *Review the law on the general status of the civil service:*

The payment of salaries by the management, whatever the standard of the performance (good or poor) must be reviewed.

- *Strengthen the autonomy of the managers:*

Despite the creation of regional health boards in 2011<sup>11</sup> the prerogatives of the regional managers remain limited because of the centralisation of most of the human resources management activities.

- *Improve the geographical distribution of health professionals:*

This is particularly crucial for some core specialisms (presence of paediatricians in the health centres in Rabat even if entire provinces have none).

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<sup>7</sup> Zeng 2014 (under publication)

<sup>8</sup> Data Envelopment Analysis - DEA

<sup>9</sup> This type of analysis does not provide a precise answer as regards the types of efficiency savings that might be made but it does give an indication of the realisable potential<sup>9</sup>.

<sup>10</sup> The recommendations below are based on the analysis of the Moroccan health system conducted by Oxford Policy Management (OPM) in 2014 under the aegis of the health financing study.

<sup>11</sup> Ministry of Health decree n°1363-11 of 16 May 2011

- *Strengthen the control of the ban on working in the private sector*

The practice of private medicine by doctors and nurses in the public sector and the informal payments of patients contribute to the dysfunctional nature of the sector and represents a loss of resources. The policy of banning these practices must be applied in accordance with the legislative and regulatory texts currently in force. In this context, the Ministry of Health must re-energise the work of the inspection committees already established.

### **How can the efficiency of drug-related expenditure be improved?**

- *Improve the operation of the drug supply chain*

The operation of the drug supply chain can be improved by adapting the configuration of the system itself. The role of the government is to ensure the availability of high-quality drugs at affordable prices. This can be achieved by using different approaches, through the public sector or the private sector, or a combination of the two.

- *Develop a treatment manual*

As a first step, develop, set up and apply standard treatment plans for the most frequent diseases, thereafter for all diseases (treatment manual)

- *Develop a logistics management information system*

Currently there is little reliable information about drug consumption. A logistics management information system must be set up and applied. This system would record the movements of the pharmaceutical products.

- *Improve the logistics system*

The externalisation of logistical activities is recommended but will require the strict regulation of the private pharmaceutical sector and of the transport sector. The storage conditions in the healthcare establishments (hospitals and primary healthcare establishments) do not always satisfy the standards of Good Practice with regard to distribution as defined by WHO. This situation encourages pharmaceutical waste and must be improved.

- *Encourage rational prescription*

To achieve a more rational use of drugs, it is vital to have data on the use of the drugs. This data informs the government, so that it can refine the way in which it targets its interventions.

- *Encourage the purchase of generic drugs; and ensure their promotion*

The government can attempt to obtain more drugs by using the same budget. In other words it can reduce the overall cost of purchasing drugs through the encouragement of purchasing generic rather than brand drugs.<sup>12</sup>

- *Open the market to international suppliers*

In 2008, Morocco and South Africa were the only countries in a sample of 18 that covered all their drug requirements through local invitations to tender (laboratories or wholesalers).<sup>13</sup> The countries that had opened their market to international suppliers did so, among other reasons, because of competitive prices.<sup>14</sup>

- *Adapt the margin on the drugs*

If the margins for the wholesalers or the pharmacies are fixed, there is an incentive to sell the most expensive product. The conduct of the doctors may also be influenced by the pharmaceutical industry. In this case, patients are often encouraged to obtain brand-name drugs which are more expensive.

- *Adapt the VAT rate*

Some key measures aimed at adapting the VAT rate could be considered: introduce a reduction in the current VAT rate; exempt the importing of inputs used in the local production of drugs from customs duties and VAT; and the application of two rates of VAT: one rate for the essential drugs and the drugs eligible for reimbursement, and one rate for the other drugs.

### **How to improve the strategic purchase of hospital services**

- *Introduce a system of allocating financial resources by region based on the needs of the population*

The system of allocating financial resources based on the population is a way of distributing the resources fairly. This is not yet the case in Morocco.

- *Budgeting and a payment mechanism based on activities*

For the SEGMA and CHU hospitals to achieve the objectives set in terms of the provision of activities specified in the *budget programme*, their budgets must be determined according to these activities. However, the estimated level of provision of the hospitals at the start of the year is not expected to correspond to the actual level of provision during the year. Therefore, it is important to be able to modify the financial resources released over the course of the year in a more flexible way, and to increase or even reduce their budgets, within specific limits and according to specific rules.

- *Financial autonomy : Encouragement to recover costs and local funds for investment*

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<sup>12</sup> In the 2008 WHO study, Morocco and Nigeria pay on average four times more than average MSH prices. Sample of 17 countries and five drugs.

<sup>13</sup> Multi-Country Study of Public Sector Medicine Supply Strategies in the WHO African and Eastern Mediterranean Regions, OMS, 2008. Unpublished

<sup>14</sup> Ibid.

To maximise efficiency and effectiveness in hospital management, the financial autonomy of the hospitals should go even further than the provisions laid down in the draft organic law and the budget programme, i.e. they should be able to commit to providing a level of healthcare determined according to clearly defined quality criteria, for which they would receive reimbursement determined according to a payment mechanism agreed in advance.

All or part of the efficiency savings made by the hospital would remain at the disposal of the hospital, but without changing the payments that they receive. Currently in Morocco, a greater recovery of costs means a reduction in the government subsidy, and an increased service provision does not make any difference to the reimbursement received by the hospital. This method of allocating resources to hospitals is not likely to encourage the healthcare providers to maximise income generation, or to increase their provision or their efficiency.

- *A system to manage human resources performance*

It is essential for health managers to control the performance of their staff to be able to achieve the objectives of the action plan laid down in the budget programme.

- *Consolidation of the management skills of the hospital and regional managers and of the Ministry of Health*

The new provisions in the organic finance law and those proposed in these recommendations will only be really effective if the heads of the central and regional departments (regions, provinces, hospitals) have the skills to implement them.

- *Public-private partnership*

Private-public partnership can play an important role in health financing in Morocco by encouraging the private sector to invest in the regions where the healthcare available is insufficient to cover the needs of the population. The Ministry of Health should undertake, according to a formalised contract, to purchase services from the private sector. The areas of partnership with the health professionals in the private sector must be specified.

### **3.2. Better pooling of risks and resources**

- Refine and rationalise the process for those registering for RAMED cards.
- Improve the process of eligibility for RAMED to reach the entire target population
- Identify the difficulties of renewing eligibility for RAMED and the reasons for the non-renewal of cards by beneficiaries in vulnerable situations.

Because of the partial satisfaction as regards the services offered by the public system, the eligibility renewal rate is approximately 40%. Barely 50% of cards are renewed by the vulnerable population. This can be explained by moral hazard, the sense of injustice and patients waiting until they are ill before renewing the card.

To remedy this situation, a study must be undertaken to evaluate eligibility criteria, strengthen local decentralisation and tighten up the operation of the CPLs.

- Develop public awareness and information mechanisms, particularly amongst rural and remote populations.
- Activate the inclusion of populations benefiting from the provisions in Article 114 of law 65-00 to the AMO scheme

The system is characterised by its fragmentation. This would be reduced if the populations benefiting from "provisional regimes" were integrated into the general AMO scheme managed by the CNSS and the CNOPS: private insurance companies, internal funds and the private health insurers would then be responsible for additional cover.

The inclusion of populations benefiting from the provisions in Article 114 of law 65-00 to the AMO scheme must be done gradually but managed in the short term by the CNSS or CNOPS. This would enable the discrepancies generated by these provisions to be ironed out.

The two-year extension to the transition period provided for by Article 114 should be used so that all the parties covered can be better prepared to integrate policyholders into healthcare consumption habits that are different, if need be, from those of the current policyholders. A further advantage of this extension would be to enable the private insurance companies themselves to play their part as insurers whose services complement the core schemes.

- Gradually integrate the self-employed into an AMO scheme<sup>15</sup>
- Simplify the procedures used to target beneficiaries
- Ensure the management of RAMED by a management body
- Harmonise the AMO schemes

The standardisation of the management rules and methods within the different management bodies is a prerequisite of the eventual achievement of a unified scheme. To this end, it is necessary to focus on moving towards the same basic healthcare package, the same subscription and cover rates and standardised and fair methods of remunerating services.

- Ensure coordination between the different participants

### **3.3. Increase the financial resources allocated to health**

There are still not enough resources allocated to health and a substantial increase is necessary if ambitions are to be met:

- *Increase in the 'traditional' tax revenue*

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<sup>15</sup> The work of the Interministerial Committee chaired by the head of government is moving in this direction. We have chosen to maintain this action in order to highlight its importance.

Focusing on increasing the collection of traditional progressive taxes would enable more resources to be generated for health on the one hand and increase the financial protection of the population on the other hand.

- *Increase in government tax revenue through innovative financing methods*

Part of the financing shortfall can be bridged by new "alternative" or "innovative" sources of financing. These are specific tax measures whose revenues are allocated to health. Seven types of tax have been explored: taxes on air travel, communication time, remittances, alcohol and tourism, private sector contributions and interest on dormant funds.

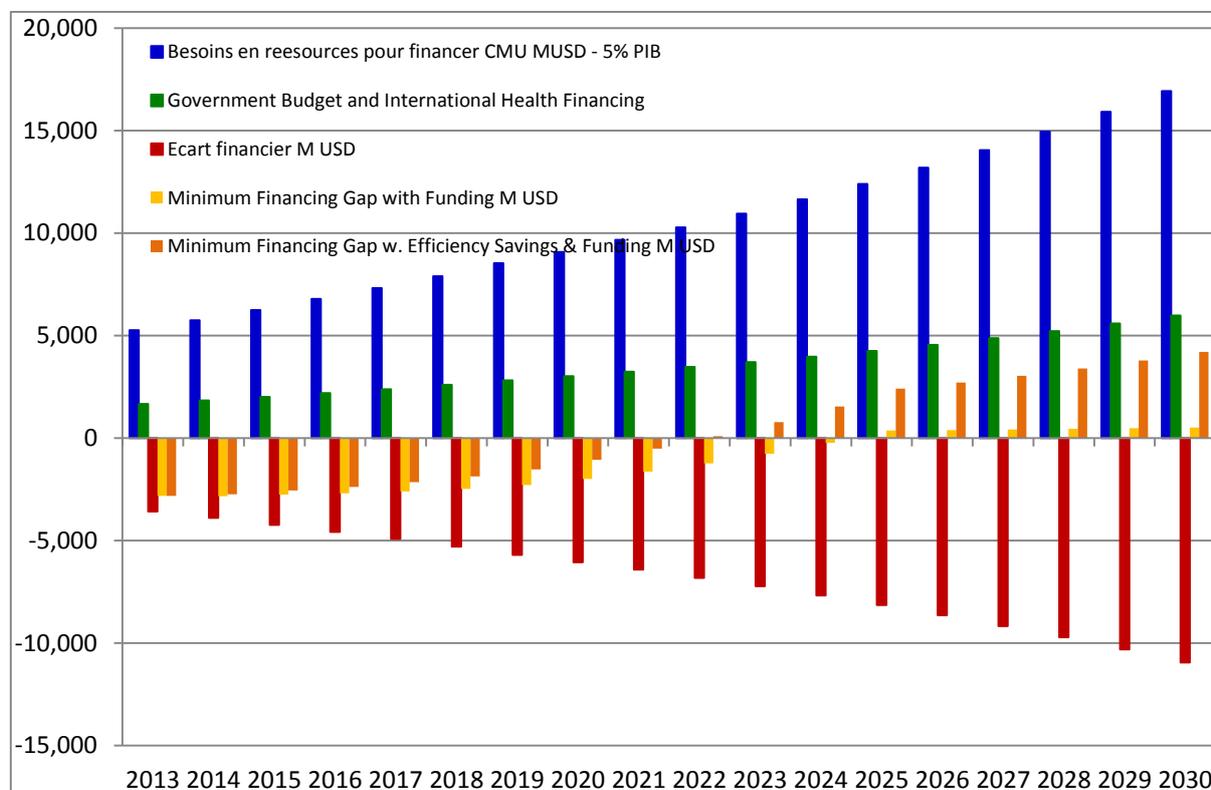
The calculations indicate that if Morocco introduced these seven mechanisms, they would generate **4.5 billion dirhams in 2015** (555 million USD), **rising to 12 billion by 2030** (1.5 billion USD).

- *Increase in the budget allocated to health*

If Morocco allocated the 15% promised in accordance with the Abuja Declaration to the health sector, this would be equivalent to an additional 4 billion USD in 2014 and almost 80 billion USD in 2030. This corresponds to 1.9% of GDP on average, which would be sufficient to bridge the financing gap in order to achieve UHC.

The introduction of all these reforms would enable the government of Morocco to bridge its financing shortfall in order to achieve UHC (see graph 5: Filling of the financing gap).

**Graph 5: Filling of the financial gap (in USD millions)**



### **3.4. Key accompanying measures**

In addition to these activities specific to health financing, other reforms should be introduced to support the work of the government towards UHC.

- *Re-evaluate the UHC package*

The package as designed is wide-ranging and goes beyond the basic primary healthcare packages generally covered by the countries who have achieved universal coverage or are on the path towards UHC. Morocco must either rethink its package or increase even more substantially its financial support for health.

- *Invest in a national information system for the healthcare system*

Without correct and up-to-date data, it is impossible to provide an efficient and effective healthcare system. It is therefore imperative to introduce a high-quality information system.

- *Consolidate and strengthen the system of governance of UHC*

To ensure that the reform of the UHC system is managed and the system monitored, an effective, standardised and accountable regulation must be introduced through the adaptation of cross-sectoral adaptation management tools.

## **4. The health financing strategy: a road map towards UHC**

The introduction of all these reforms will enable Morocco to achieve its aim, to consolidate the efforts made towards a realised UHC and to honour its political promises, by providing the entire population of Morocco with access to high-quality healthcare without facing negative financial consequences.

To support the Moroccan government in its progress towards UHC, it is essential that the government as a whole work together in following a clearly set out vision. This is why the Ministry of Health is developing a financing strategy that will implement the recommendations presented above through concrete actions, and will constitute a proper road map for the government as a whole over the next five years.

By implementing this financing strategy, the Moroccan government will transform the lives of all its citizens, particularly of the most vulnerable and will become one of the first middle-income countries to achieve the right to health for all.