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THE RIGHT TO HEALTH IN MOROCCO

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Key issues and challenges

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This report is published as part of the Arab NGO Network for Development's Arab Watch Report on Economic and Social Rights (AWR) series. The AWR is a periodic publication by the Network and each edition focuses on a specific right and on the national, regional and international policies and factors that lead to its violation. The AWR is developed through a participatory process which brings together relevant stakeholders, including civil society, experts in the field, academics, and representatives from the government in each of the countries represented in the report, as a means of increasing ownership among them and ensuring its localization and relevance to the context.

This 6th edition of the AWR focuses on the Right to Health. The AWR 2023 on the Right to Health is a collaboration between the Arab NGO Network for Development and the Faculty of Health Sciences at the American University of Beirut. Through this report we aim to provide a comprehensive and critical analysis of the status of the Right to Health in the region and prospects in a post COVID-19 era. It is hoped that the information and analysis presented in this report will serve as a platform to advocate for the realization of the right to health for all.

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NOTE

This report is based on a literature review of national documents related to the right to health in Morocco. It incorporates discussions and comments from civil society actors. Through a critical economic and public health analysis of the health situation in Morocco, it highlights key issues and challenges of the right to health in the country. Finally, given the various health elements analyzed, it proposes recommendations to improve the right to health for the entire population in Morocco.

CONTENTS

HISTORICAL BACKGROUND OF MOROCCO AND KEY SOCIOPOLITICAL FACTORS RELEVANT TO THE RIGHT TO HEALTH

Morocco, a low-middle-income country, has experienced significant democratic, economic, and social changes in recent years.

COUNTRY OVERVIEW

The Kingdom of Morocco is located in North Africa, in the Maghreb region, on the Atlantic Ocean and the Mediterranean Sea. The neighboring countries are Algeria and Mauritania.

Morocco is a constitutional, democratic, parliamentary, and social monarchy led by King Mohammed VI since July 1999. It is considered one of the world's oldest monarchies, in which the King, with executive powers, is the Head of State, the Supreme Chief of the Armed Forces, and the Commander of the Faithful. The King appoints the Head of Government, the equivalent of the Prime Minister, who is responsible for i) advising on the formation of the government, ii) chairing the Government Council, and iii) enacting legislation.

The 1997 reform decentralized the Moroccan administration (Official Bulletin of Morocco, 1997). The country now has 12 regions (comprised of a total of 75 provinces), each headed by a Wali (or governor) and a Regional Council composed of the vital forces of the region. These regional councils elect assemblies responsible for the democratic management of their affairs under the conditions laid down by law.

This decentralization aimed to respond to the country's socioeconomic needs on the one hand and, on the other, to ensure that the region's territorial framework was better adapted and more coherent to its new status as a local authority. The need to revise the division is also explained by the persistence of inter-regional imbalances linked, in large part, beyond natural factors, to spatial differentiations inherited from the colonial period. It reflects the evolution towards regionalization as indicated in the constitutive texts, but also given the improvement of the region's status and the adoption of the law relating to its organization. The regions created thus constitute a significant improvement on the former economic

regions, which merely reproduced the French experience of the 1930s.

NEW CONSTITUTION

Since July 2011, Morocco has had a new constitution which, for the first time, enshrines the right of access to healthcare and medical coverage as fundamental rights, in the same way as access to education and employment (General Secretariat of the Government of Morocco 2011). This new constitution also has the particularity of strengthening governance through establishing several governance bodies or through the link between responsibility and accountability.

Article 31 of the new constitution reads as follows:

> "The State, public institutions, and local authorities shall work to mobilize all available means to facilitate equal access for citizens to the conditions enabling them to enjoy the rights: to healthcare, social protection, medical coverage, and mutual solidarity or organized by the state, to modern, accessible, and quality education, to education on the attachment to the Moroccan identity and the immutable national constants, vocational training, and physical and artistic education, decent housing, work and support from the public authorities in finding employment or self-employment, access to public functions according to merit, access to water and a healthy environment, and sustainable development..."

Indeed, the 2011 constitution allows the promotion of rights as one of the major contributions of this new constitution. It is the first constitution to explicitly include the right to health (Article 31). The word right(s) is cited 88 times, [Constitution(s): 158 times and Law(s): 152 times].

NATIONAL LEGISLATION AND REGULATIONS

Morocco has a bicameral legislature:

1. the House of Representatives, Majlis Al-Nuwab, composed of 395 members elected directly by universal suffrage for a five-year term, and

2. the House of Councilors, Majlis Al-Mustacharin, composed of 120 members elected indirectly by local authorities, professional organizations, and trade unions.

Two-thirds of its members are elected for a six-year term, the others for a three-year term. Parliament has the authority to examine budgetary matters, approve draft legislation, hold ministers to account, and set up ad hoc committees of inquiry to examine government action.

DEMOGRAPHICS FEATURES

The current total population of Morocco is approximately 37 million (The World Bank 2021). The annual population growth rate is estimated at 1.1%, and the median age is around 29 years. Almost 26% of the population is under 15 (The World Bank 2021). Life expectancy at birth is about 74 years (higher for women than men). The gender distribution of the population is balanced, with women accounting for about 50% of the population. Just over half of the population (about 60%) lives in urban areas (The World Bank 2021).

ECONOMIC SITUATION

According to the latest statistics, Morocco's Gross Domestic Product (GDP) in 2021 is around 143 billion current United States dollars (USD). The country went through a period of economic stagnation. However, since the 1990s, it has experienced a more prosperous period and has gradually recovered an average growth rate of 5% in recent years. The Moroccan economy remains dependent on the agricultural sector. The poverty rate (4% of the population, poverty headcount ratio at national poverty lines) and the unemployment rate (11% of the population) remain controlled (The World Bank 2021).

SOCIOCULTURAL CHARACTERISTICS

Morocco is ranked 121st in the 2019 Human Development Report, with a Human Development Index of 0.686 (UNDP 2019). The government has invested heavily in education since the 1990s when the literacy rate was low (50% of the total population and only 30% of women). Since then, the adult literacy rate has increased significantly, and it now exceeds 90% (but is still higher for men than women) (The World Bank 2021).

Arabs and Berbers, also known as Amazighs, make up 99% of the population. The country's official languages are Arabic and Berber, although French is also widely used in government institutions.

KEY ISSUES AND CHALLENGES MOST RELEVANT TO DISCUSS THROUGH A CRITICAL ANALYSIS OF A RIGHT-TO-HEALTH FRAMEWORK

Some national reports point out that the impact of the qualitative and quantitative developments recorded in the legislative system and institutional structures may remain limited in terms of guarantees of the effective protection of rights and freedoms (Economic, Social and Environmental Council 2018; National Council for Human Rights of Morocco 2022).

Strengthening the effectiveness of the right to health is central to implementing the national strategy. The basis for understanding the right to health is generally the definition of the World Health Organization (WHO), which defines health as "a state of complete physical, mental, and social well-being and not only the absence of disease or infirmity." Achieving this goal requires the development of multidimensional public policies that work in harmony with each other to achieve the "maximum" level of physical and mental health.

Implementing the right to health in Morocco and effective access to the right to health face several structural obstacles. We focus in this report on the development of five main issues facing the right to health in Morocco today. These are regional inequalities, financial difficulties in terms of universal health coverage, the shortage of health professionals, the lack of integration of the private sector, the absence of coordinated care pathways, and the weakness of the approach to prevention. These are discussed further below.

GEOGRAPHICAL AND SOCIOECONOMIC DISPARITIES

Morocco has significant disparities between the 12 regions that make up its territory. These disparities concern demographic growth, social sectors, and economic dynamics. Indeed, there is a demographic and economic concentration along the Atlantic coastline and divisions between the central and peripheral regions on the one hand and between the highly urbanized and the agricultural regions on the other. This situation creates disparities in healthcare supply with a concentration of hospital structures and health professionals in large cities and on the

coast, particularly in the Rabat-Casablanca axis.

HEALTH FINANCING AND UNIVERSAL HEALTH COVERAGE

Although health financing is considered a key factor for effective access to the right to health, the budget of the Ministry of Health in Morocco is still between 6% and 7% of the general State budget. It, therefore, remains below international standards (15% of the general State budget according to the Abuja Declaration and 12% according to the WHO) or in comparison with other countries with a comparable economy.

Also, out-of-pocket (OOP) expenditure represents about 50% of health expenditure, and more than 60% of this includes contributions to medical coverage, which constitute a real obstacle to access to care. This also contributes to the fact that a significant proportion of the population finds itself in a situation of fragility and precariousness due to health problems.

These financial barriers compromise the generalization of universal health coverage in Morocco. Universal health coverage for the entire population should require adequate financing mechanisms that guarantee individuals partial coverage of health expenses. This will allow people living in precarious conditions, including those with long-term chronic diseases, to access primary healthcare services. Today, health coverage systems in Morocco suffer from three significant imbalances: the challenge of financial balance, the challenge of efficiency, and the lack of a third-party payment system.

DEMOGRAPHY OF HEALTH PROFESSIONALS

There is an insufficient number of health professionals in Morocco. The overall number of doctors working in the country is estimated at 2,300, of which almost half are concentrated in the regions of Rabat and Casablanca (Ministry of Health of Morocco, 2022). Also, Morocco needs 32,000 doctors and 65,000 nurses to meet the population's needs according to WHO standards. In addition, we also observe a weakness and underutilization of human resources due to management difficulties.

There is also a "flight" of doctors and health executives. The number of doctors trained in Morocco and working abroad is between 10,000 and 14,000 (Ministry of Health of Morocco 2022).

PRIVATE SECTOR AND PUBLIC-PRIVATE PARTNERSHIP

The private sector has been developing steadily in recent years. It is thus becoming an important part of the national health system, which has a large capacity for care supply and takes care of a significant part of the population. However, the private sector is not sufficiently regulated and controlled. Also, it is not well integrated into the national health system. Public-private partnerships are thus very limited. This situation considerably limits the accessibility to the right to health and remains a fundamental issue for overhauling the national health system.

COORDINATED CARE PATHWAY AND PREVENTION

There is an absence of a coordinated care pathway and inadequate management of human resources. The absence of this care pathway is one of the main reasons for inadequate human resources management (doctors and other health professionals). Similarly, the opacity of the care process may lead to problems in diagnosing and treating sick populations, thus putting the prognosis of patients at risk.

The preventive approach is not effectively implemented and does not address all the axes of targeting socioeconomic and environmental determinants of the right to health. Also, it does not always adopt the primary healthcare strategy, often does not establish coordinated care pathways, and does not significantly promote sexual and reproductive health.

RECOGNITION OF THE RIGHT TO HEALTH IN MOROCCO

The organization of health as a public service in Morocco originates from the reforms introduced by French colonial rule. The first regulatory text organizing the services of the Ministry of Health after independence was issued in August 1956. In the same year, Morocco joined the WHO on 14 May 1956. After that, there were several key stages in developing the national health system.

THE FIRST NATIONAL HEALTH CONFERENCE IN APRIL 1959

The guiding principles of health policy in Morocco were laid down at the meeting of the first national conference on health following the country's independence in 1956. These principles are: "The health of the nation is the responsibility of the State"; and "The Ministry of Public Health is responsible for its design and implementation" (Ministry of Health of Morocco, 2013). These major principles, which form the basis of the national health system, were operationalized in the various economic and social development plans adopted from independence until 1980.

THE DEVELOPMENT OF PRIMARY HEALTHCARE FROM 1981 TO 1994

The starting point of this second phase was Morocco's subscription to the Alma-Ata declaration on primary healthcare in 1978. The primary healthcare policy became a national priority. It was implemented with the adoption of the 1981-1985 development plan, which promoted the establishment and development of primary healthcare structures throughout the country.

THE THIRD PHASE BEGAN IN 1994

This third phase is characterized by the restructuring of the Ministry of Health and the beginning of hospital reform. New central directorates were created for hospitals, drugs, and regulation. In addition, the reform process initiated during this period led to the start of the basic medical coverage project.

This phase was initiated by the National Colloquium on Health in Morocco: "Health development in Morocco, realities and prospects," Ouarzazate 13-16 July 1992. During this colloquium, which was attended by almost 1,200 people, 16 commissions dealt with various themes (High Commission for Planning of Morocco 1992).

BASIC HEALTH COVERAGE IN 2002 AS A MEANS OF IMPLEMENTING THE RIGHT TO HEALTH

In principle, basic medical coverage aims to ensure universal access to healthcare and thus constitutes a means of implementing the right to health. Technically, it is a response to the problem of financing healthcare services, which was the subject of specific reflection in the context of the 1992 national symposium on health in Morocco (High Commission for Planning of Morocco 1992). The reform of basic medical coverage led to the promulgation of Law No. 65-00 of 3 October 2002. The generalization of the Basic Medical Assistance Scheme (RAMED) was officially launched in March 2012. It aims to guarantee the right to healthcare to economically disadvantaged people who do not benefit from compulsory health insurance.

THE FRAMEWORK LAW NO. 34-09 OF 2011 ON THE HEALTH SYSTEM AND HEALTHCARE SUPPLY

In the history of health legislation in Morocco, the framework Law No. 34-09 is the first of its kind (Official Bulletin of Morocco 2011). It lays down the fundamental principles and objectives of the state's action in the health field and the health system's organization. Article 1 states that the right to health protection is the responsibility of the state and society. The law also defines the health system as a set of interdependent and complementary elements, largely in line with the WHO concept.

THE RIGHT TO HEALTH IN THE NEW CONSTITUTION OF 2011

The constitution of July 2011 expressly enshrines for the first time the right to "healthcare" and "medical coverage." Indeed, Article 31 considers the right to healthcare as a comprehensive right, linking it to the determinants of health (General Secretariat of the Government of Morocco 2011). Thus, the same article also places the responsibility on public authorities

to facilitate the enjoyment of other rights, such as the right to education, decent housing, work, access to water, and a healthy environment.

HEALTH SECTOR STRATEGY OF THE 2012-2016 PERIOD

The 2012-2016 health sector strategy comes from the governmental program prepared by the government appointed in the framework of the 2011 constitution (General Secretariat of the Government of Morocco 2011). In its preface, the document "Health Sector Strategy 2012-2016" announces that it is part of the political and social transformations that Morocco has experienced, which requires the adoption of a new approach based on human rights and health democracy, and thus gives a sectoral echo to the provisions of the new constitution, and in particular those relating to the rights of access to care and medical coverage (Ministry of Health of Morocco 2012).

TOWARDS A NATIONAL HEALTH CHARTER IN 2013

Fifty-four years after the first national health conference in 1959, a second conference was organized by the Ministry of Health in July 2013. The overall stated objective of the conference is to reform to address current shortcomings and emerging needs in health.

The objective of this conference was to set the major priorities for action in the field of health for the next thirty years, to seek a national consensus on the major challenges and the main priorities for action in health, to initiate a collective approach to integrate the concern for health into all public policies, and to develop visibility in the field of health financing with a view to the generalization of medical coverage.

This second Conference of Health in Morocco brought together more than 500 people composed of health actors and partners of the sector to discuss the priority axes of the reform of the health system, which emerge from the expectations of the citizens, the ambitions of the health professionals, and the perspectives of development of the national health system. The event was attended by representatives of government sectors, civil society organizations, social partners, elected bodies, international organizations, and national and international experts.

HEALTH PLAN FOR THE 2018-2025 PERIOD

The Health Plan 2025 aims to adapt to the new challenges of the 21st century, including demographics, aging, and new technologies, and to meet the needs of citizens better (Ministry of Health of Morocco 2018). It prioritizes primary healthcare and health promotion and advocates the development of hospital centers of excellence and strengthening skills and innovation. This plan proposes an innovative mode of governance and financing, a mobilization and valorization of human resources, with the involvement of citizens and the commitment of local authorities.

THE GENERALIZATION OF SOCIAL PROTECTION IN 2021

The year 2021 was marked by the launch of the reform of the generalization of compulsory health insurance to achieve universal health coverage, which is one of the main pillars of the project for the generalization of social protection. The aim is to enable 22 million additional beneficiaries to access compulsory health insurance, which covers the costs of care, medicines, and hospitalization.

This major project will mobilize an annual budget of 51 billion dirhams (1 USD corresponds to approximately 10 dirhams) from 2025 distributed between the generalization of compulsory health insurance, the generalization of family allowances, the enlargement of the beneficiaries of the pension scheme, and the generalization of access to compensation for job loss (Ministry of Economy and Finance of Morocco 2022).

THE NEW FRAMEWORK LAW NO. 06-22 OF 2022 ON THE NATIONAL HEALTH SYSTEM

The recently adopted framework Law No. 06-22 on the national health system repeals and replaces the framework Law NO. 34-09 on the health system and the supply of care (Official Bulletin of Morocco 2022).

It aims to reform the sector using a multidimensional approach and is based on four pillars: good governance, development of human resources, upgrading of the health offer, and digitalization. This text sets out an overall plan for an in-depth reform that should, in particular, enable the completion of the project to generalize social protection.

The aim is to “facilitate citizens’ access to health services and

improve their quality, and to ensure an equal and equitable distribution of healthcare throughout the country." This reform also aims at "a territorial implementation of the public health service and the improvement of its governance through the establishment of territorial health groups, and the guarantee of medical sovereignty and the availability of medicines and health products as well as their safety and quality."

CREATION OF THE HIGHER AUTHORITY FOR HEALTH IN 2023

The government is preparing to ratify the law establishing the High Authority for Health and which defines the roles and powers of the institution on which the government relies heavily in the health system reform project. This independent high authority will replace the National Health Insurance Agency, which will be dissolved immediately after the enforcement of this law.

The new institution will assume the task of technical supervision of basic compulsory insurance for illness, as well as evaluate the services of health institutions in the private and public sectors and the conditions of medical care for patients, accreditation of health institutions, and periodic evaluation for medicines, health products, and professional business based on their effectiveness and feasibility.

This institution will also be entrusted with tracking, analyzing, and evaluating epidemiological data, evaluating programs related to disease control, and conducting studies and research, in addition to expressing an opinion on public policies in the field of health, as well as submitting proposals to public authorities regarding the necessary measures to be taken to prevent any threat to the health of the population.

Since its independence, Morocco has implemented various successive reforms to ensure the entire population's right to health. As described above, several legislative texts reflect this national will. In particular, the new constitution of 2011 indicates the right to access care as a fundamental right, the responsibility of which lies with the state. Moreover, the reform to generalize universal health coverage for the benefit of all citizens was recently launched to ensure equitable access to care for all. Also, the overhaul of the health system is underway to ensure better quality and greater efficiency of health services. However, what is the reality regarding the right to health? Through data and evidence, we attempt to make an inventory and analyze the current situation, the difficulties, and the challenges regarding the right to health in Morocco.

DESCRIPTIVE SUMMARY OF THE HEALTH SYSTEM IN MOROCCO, ITS ACHIEVEMENTS AND SHORTCOMINGS

As described below, Morocco is undergoing a demographic and epidemiological transition with an overall improvement in health indicators leading to new health needs. The health system is of the Bismarckian type, still relatively centralized, and with poorly integrated public and private sectors.

POPULATION GLOBAL HEALTH SITUATION

Morocco is experiencing a significant change in its epidemiological profile, characterized by an increase in the burden of non-communicable diseases, which currently accounts for 75% of the total population (the three leading causes of death being: cardiovascular diseases (34%), diabetes (12%), and cancers (11%)). Injuries account for 7% of mortality, and the remaining 18% of deaths are due to communicable diseases and maternal, perinatal, and nutritional conditions (Ministry of Health of Morocco 2016).

In recent decades, Morocco has shown an advanced level of epidemiological transition. The transition in the healthcare sector in Morocco is characterized by overall economic growth, the increase in life expectancy (74 years in 2021), the decrease in the fertility rate, the regression of communicable diseases (with the persistence of some specific infectious diseases such as tuberculosis and HIV/AIDS), and the emergence of non-communicable diseases such as cardiovascular diseases, diabetes, and cancers. In addition, despite the significant reduction in maternal and child mortality over the past decade, there is still room for improvement.

ORGANIZATION OF THE NATIONAL HEALTH SYSTEM

The Moroccan health system comprises a public and private sector (including profit and non-profit sectors). It is mainly the Ministry of Health that manages the national health system. Under the supervision of the Minister, the central administration of the Ministry of Health is organized into eight central directorates (Population, Epidemiology and Disease

Control, Hospitals and Outpatient Care, Human Resources, Equipment and Maintenance, Regulation, Financial Resources and Planning, Pharmacy and Medicines) under the direct supervision of the Secretary-General. The Directorate of Epidemiology and Disease Control is responsible for disease surveillance and public health issues in coordination with the other technical directorates. The Directorate of Population is responsible for health promotion and monitoring the health of populations, including those with special needs.

At the regional level, the Ministry of Health is represented in each of the sixteen regions by a Regional Health Directorate, which is also under the supervision of the Secretary-General. There is a provincial delegation in each province or prefecture. There is a policy of decentralization of the administration of health services from the central level to the regional health directorates. However, it appears that several tasks are still carried out by the Ministry of Health, such as the recruitment of health personnel, budgetary issues, and the development of regional health plans. The public health sector has 2,157 primary healthcare facilities, 155 hospitals (at different levels: local, provincial, regional, and tertiary) with 25,199 beds, and ten psychiatric hospitals with 1,512 beds. The private sector consists of about 11,928 private practices and 384 clinics with 12,534 beds, located mainly in urban areas and on the North Atlantic coast (Ministry of Health of Morocco 2022).

These numbers differ slightly from those reported in 2018 when the public sector included 2,860 primary healthcare facilities, 148 hospitals, including five university hospitals and 21,692 beds, ten psychiatric hospitals with 1,146 beds, 106 hemodialysis centers, and ten regional oncology centers. The private sector includes 356 clinics with 9,719 beds, 9,475 medical practices, 8,914 pharmacies, and 3,121 dental practices (Ministry of Health of Morocco 2021).

The public hospital sector remains the basis of the national health system in Morocco. The private sector also has an important place, even though it is not fully regulated and considered in the national health strategy, leading to a poor public-private partnership. There is still an inequitable geographical distribution of public and private hospitals between regions and rural and urban areas.

THE HEALTH SECTOR IN MOROCCO AND THE MAIN CHALLENGES OF THE RIGHT TO HEALTH

We present in this section an in-depth analysis of the different elements of the Moroccan healthcare system concerning the fundamentals of the right to health.

DETAILED HEALTH SITUATION OF THE POPULATION

The health status of the Moroccan population has significantly changed in recent years. Progress in living conditions and access to care has contributed to the improvement of many demographic and epidemiological indicators: control of population growth, increase in life expectancy, and decrease in the burden of communicable diseases, with however an increase in the burden of chronic diseases and trauma. Indeed, the overall health situation of the entire population has improved in recent years. However, health inequalities remain across social and geographic groups. Also, the preventive approach is still limited.

MATERNAL AND CHILD HEALTH

Since the 1990s, maternal and child health has been a top priority for the health sector. The maternal mortality rate has been reduced to 73 deaths per 100,000 live births. Preventable causes remain predominant: postpartum hemorrhage, hypertensive disorders including pre-eclampsia/eclampsia, infection, and abortion complications. Moreover, this progress was more observed in urban than rural areas: the annual reduction in maternal mortality is 8% in urban areas compared to 5% in rural areas, and the supervised delivery rate is 97% in urban areas compared to 74% in rural areas. Postpartum care is still provided to less than 30% of women (Ministry of Health of Morocco 2018).

The neonatal mortality rate fell 38% between 2011 and 2018, from 21 to 14 deaths per 1,000 live births. The main causes identified are respiratory distress, infections, and prematurity (Ministry of Health of Morocco 2018). On the other hand, infant and child mortality due to neonatal tetanus (elimination certified by the WHO in 2002) and measles and whooping cough in children aged 1 to 12 months have decreased sharply.

No cases of poliomyelitis and diphtheria have been reported since 1987 and 1998, respectively. Since the introduction of the specific vaccine in 2007, an 85% reduction in cases of Hemophilus Influenza type b meningitis has been noted. For measles, Morocco is considered by the WHO to be in the pre-elimination phase (Ministry of Health of Morocco 2018).

Family planning among married women aged 15-49 has shown good progress, reaching 71% in 2018. Modern method use is 58%, and unmet need is 11% in 2018 compared to 20% in 1992 (Ministry of Health of Morocco 2018). Priorities for the future include changing the contraceptive structure (48% in 2018 compared to 4% in 2011 for the intrauterine device), addressing unmet needs, and improving the quality of services. In addition, infertility and pre-marital and pre-conceptional health are new areas of concern (Ministry of Health of Morocco 2018).

Breast and cervical cancers are the most common cancers among women in Morocco, with a standardized incidence of 45 and 14 new cases per 100,000 women, respectively. Since 2012, early detection of breast cancer has been generalized at the national level, and early detection of cervical cancer is effective in some territories. While early detection of breast cancer has been very successful, early detection of cervical cancer is being expanded (Ministry of Health of Morocco 2018).

To combat violence against women and children, the Ministry of Health has instituted a national program to care for women and children who are victims of violence. However, several challenges need to be met, particularly the strengthening of inter-sectoral coordination and the development of the necessary resources, particularly human resources, including forensic doctors, psychiatrists, psychologists, and social workers (Ministry of Health of Morocco 2018).

NON-COMMUNICABLE DISEASES

In Morocco, the epidemiological and demographic transition is reflected in an increase in the morbidity and mortality burden of non-communicable diseases such as cancers, diabetes, cardiovascular diseases, and chronic renal failure. Adults over 18 years show a prevalence of diabetes of 11%, a prevalence of hypertension of 30%, a prevalence of obesity of 20%, and hypercholesterolemia of 11% (Ministry of Health of Morocco 2016). The prevalence of tobacco use is around 13% (men 30% and women 1%) compared to 18% (men 31% and women 3%) in 2006.

The incidence of cancer is estimated at 40,000 new cases per

year (Ministry of Health of Morocco 2012). Kidney failure shows a prevalence of chronic kidney disease of around 3% or about 1 million people affected (Ministry of Health of Morocco 2011). Chronic respiratory diseases, notably asthma (about 4%) and chronic obstructive pulmonary disease (also about 4%), are real public health problems in Morocco (Ministry of Health of Morocco 2016).

COMMUNICABLE DISEASES

The burden of communicable diseases in Morocco has been reduced since the 1980s, and they are currently responsible for only 18% of deaths. Some diseases have been eliminated. We now distinguish three groups of communicable diseases: diseases that have been eliminated or are in the process of being eliminated: malaria, blinding trachoma, schistosomiasis, leprosy, and poliomyelitis; diseases that are still public health problems: tuberculosis, HIV infection, viral hepatitis, meningitis and certain diseases, including rabies, leishmaniasis, and anthrax; and emerging diseases and/or those that constitute threats of public health emergencies: hemorrhagic fevers, respiratory infections with new infectious agents, vector-borne diseases, etc. Leishmaniasis, collective food poisoning, the scourge of envenomation by ophidian bite, and scorpion sting are still major public health problems (Ministry of Health of Morocco 2016).

Morocco has strengthened some of its capacities (surveillance and response plans) to consolidate national health security, including for some global health crises such as the AH1N1 influenza pandemic and the Ebola virus disease epidemic. Nevertheless, this system needs to be strengthened and modernized by establishing public health emergency operational centers and using new communication techniques (Ministry of Health of Morocco 2016).

MENTAL HEALTH

Mental disorders represent a significant burden of morbidity in Morocco. Almost one individual in two declares at least one mental disorder, ranging from simple insomnia or a nervous tic to more serious disorders such as depressive, anxiety/psychotic disorders, or those disorders linked to the consumption and/or abuse of alcohol or drugs (Ministry of Health of Morocco 2016).

Regarding health infrastructure, we only observe 34 psychiatric and addictology care structures spread across the different networks of health facilities (hospital care, primary care, and sociomedical care). The total bed capacity is 2,209 beds,

i.e., a density of 0.65 beds per 10,000 inhabitants (below the EMRO region average of one bed per 10,000 inhabitants). There is also an inequity in the territorial distribution of these facilities. Indeed, two regions do not yet have any psychiatric or addictology facilities (Ministry of Health of Morocco 2016).

NON-DISCRIMINATION

In recent years, the population with special needs has received much attention from public authorities and health policies (Ministry of Health of Morocco 2020). This population is made up of four groups:

- People with disabilities represent nearly 7% of the population of Morocco, of whom 34% are aged 60 and over. The prevalence of disability, which is increasing worldwide, is a real challenge for Morocco today, given the aging of the population and the diseases associated with this group (Ministry of Health of Morocco 2018).
- The elderly, the majority of whom have at least one chronic disease. The prevalence of diabetes and high blood pressure are respectively 20% in 2018 (23% in urban areas and 15% in rural areas) against 15% in 2011 and 34% in 2018 (36% in urban areas and 30% in rural areas) against 28% in 2011 (Ministry of Health of Morocco 2018).
- The carceral population, estimated at 83,203 in 2018, is predominantly male and under 40 years old (Ministry of Health of Morocco 2018). This population is more vulnerable due to the accumulation of many risk factors, including socioeconomic and health precariousness, poor access to care, etc., and sometimes inadequate detention conditions (overcrowding and promiscuity).
- The immigrant population benefits from Morocco's new strategy (2014), responding to one of the major problems facing Africa and the Euro-Mediterranean area. The measures taken in its favor are based on the values of solidarity and integration. Immigrants legally have the same access rights to care in the public health sector as nationals.

The right to health is theoretically ensured for vulnerable populations, as it is for the entire population in Morocco. However, in practice, these special populations may have difficulty accessing healthcare.

HEALTH FINANCING

According to the latest estimates, total health expenditure in Morocco reached approximately 61 billion dirhams in 2018 against 52 billion dirhams in 2013, an overall increase of approximately 17% and an average annual increase of approximately 3% (Ministry of Health of Morocco 2013; 2018). Moreover, current health expenditure represents 97% of total health expenditure; the rest is devoted to investment-related expenditure. Between 2013 and 2018, total health expenditure evolved at a slower pace than the evolution of GDP. Indeed, in 2018, total health expenditure represented 5.5% of GDP against 5.8% in 2013, i.e., a drop of 0.3 points during 2013-2018 (Ministry of Health of Morocco 2013; 2018).

Health expenditure per capita amounts to 1,730 dirhams (approximately 180 USD), with a relative evolution of approximately 10% in 5 years. Households are still the first health funder in Morocco, with a share of 46%, higher than the internationally recommended standards (less than 25%). The second funder is health insurance. In 2018, it covered approximately 41% of the Moroccan population and financed 30% of total health expenditure, with an increase of 7 points compared to 2013 (Ministry of Health of Morocco 2013; 2018). The share of the state in health financing via national and local tax resources remained almost constant between 2013 and 2018, recording a proportion of around 24% in 2018. The contribution of international cooperation to health financing represented only 0.2% in 2018 (Ministry of Health of Morocco 2018). Indeed, the support of partners is more qualitative than quantitative and is concerned with mobilizing the necessary expertise and capacity building (Ministry of Health of Morocco 2020).

Of the total current health expenditure, pharmacies and suppliers of medical goods are the primary beneficiaries, with a share of 23%. They are followed by public health establishments, which mainly include hospitals under the Ministry of Health and primary healthcare establishments, with a proportion of 22%. Private clinics and mutualist clinics represent approximately 19% of current health expenditure. Private outpatient providers, including but not limited to medical practices, dental practices, dialysis centers, and other centers offering outpatient services, receive only 15%. The remaining share of current health expenditure goes to laboratories and radiology centers, including national public institutes and laboratories, with a share of 12%, and to other

care providers (for example, NGOs, traditional care providers, etc.), with a proportion of 8% (Ministry of Health of Morocco 2018).

The resources mobilized by the national health system during 2018 are devoted first and foremost to expenditure on hospital care, comprising almost 30% of current health expenditure. This item includes all expenditures related to full and day hospitalization (including drugs and medical goods, analyses, radiology, etc., consumed during the hospital stay). Also, expenditure on ambulatory care (curative and preventive) and the purchase of drugs and medical goods represented respectively 29% (of which 5% for preventive care) and 23% of current health expenditure, whereas biological analyses and radiology only received 12% of this expenditure (Ministry of Health of Morocco, 2018).

The pricing of medical procedures in Morocco is still based to a large extent on negotiations between representatives of the Ministry of Health and associations of doctors and other health professionals. Also, the method of financing hospitals and liberal health professionals does not yet integrate the notion of financing based on performance or incentive financing for the quality of care. Informal payment, directly at the patient's expense, is still practiced in the public sector and is heavily used in the private sector.

Despite an increase in recent years, the budget allocated to health in Morocco remains limited. Also, OOP expenditure continues to be the main source of financing at the expense of social insurance mechanisms. The pricing system for healthcare professionals does not fully integrate the logic of cost analysis and financing based on performance and quality of care. Finally, informal payment is still an existing practice.

HEALTH SERVICES AND MEDICINES

Undeniable progress has been recorded in Morocco since independence regarding healthcare supply. This progress concerns, in particular, the extension of the network of primary healthcare facilities, medical practices, pharmacies and dental practices, hospitals, and private clinics, and the development of university hospitals.

In terms of population coverage, the overall public service provision has gone from one primary healthcare facility per 14,600 inhabitants in 1990 to one primary healthcare facility per 12,238 inhabitants in 2018 (Ministry of Health of Morocco

2021). Despite this favorable evolution, several constraints and dysfunctions are to be reported, notably, the inequitable distribution of the various health facilities between urban and rural areas and between regions; the service which remains insufficient to meet the needs of the population; the delays in the implementation of the health map; the obsolescence and lack of maintenance of the real estate and medical and technical equipment; and the poor complementarity between the public service and the private sector.

Concerning the drug sector, since the 1960s, Morocco has implemented a national pharmaceutical policy to improve access to medicines and health products and to regulate the pharmaceutical sector. This strategy has enabled the gradual establishment of a strong national pharmaceutical industry and a structured, codified, and demanding distribution and dispensing circuit, allowing the accessibility and availability of medicines at the level of health structures and pharmacies. It has also promoted the rational use of medicines by regulating the professional methods of prescription and delivery.

In addition, the sector has developed according to the socioeconomic evolution of Morocco and the technological and therapeutic progress. Thus, the new Pharmacy Code was published in 2005, followed by a legal arsenal comprising different legislative and regulatory texts specific to medicines and pharmacy (Ministry of Health of Morocco 2018). Despite all these efforts, several constraints still characterize the drug sector and have an impact on the right to health, including the prices of medicines which remain high in relation to the purchasing power of Moroccans and compared to similar countries; the therapeutic protocols that are not generalized; the system of supply and management of medicines in the public sector which is deficient; and the low penetration of generics.

ACCESS TO DATA AND HEALTH INFORMATION

The constitutionalizing of the right of access to information occurred with the promulgation of the 2011 constitution (General Secretariat of the Government of Morocco 2011). Article 27 of the constitution establishes the principle and refers to the law for the terms and conditions of implementation. The organization of access to the information within the national health system takes three forms which are made available to decision-makers and managers at all levels of the health system. This is useful for planning and budgeting, improving

quality, and responding effectively to consumer needs.

INFORMATION FOR HEALTH ACTORS

The task of information, education, and communication in relation to the various health programs was not clearly defined until 1994 by the Ministry of Health. Subsequently, the Internal Regulations of Hospitals of 2010 (Ministry of Health of Morocco 2011) entrust the hospital director with developing a hospital's internal and external communication strategy and supporting the various departments in drawing up their specific communication plans. Finally, the Framework Law of 2011 (Official Bulletin of Morocco 2011) attributes to the state the mission to "develop information, education and communication actions" one of the tools of prevention in health matters (article 4).

The publication of information by the Ministry of Health uses the Ministry's website and the sub-sites to which it links. The Ministry's website also links to general government websites that compile cross-sectoral information. Other tools, such as information, communication, and awareness campaigns, are also used.

INFORMATION FOR PATIENTS AND USERS

Moroccan law does not define in a detailed manner the patient's right to be informed, prior to any medical act or intervention, about his or her state of health, treatments or preventive actions, their usefulness, their possible urgency, their consequences, the frequent or serious risks that are normally predictable, the possible alternatives, and the possible consequences if the patient refuses the treatment.

In the current state of the law, this question is implicitly addressed through the provisions relating to the patient's prior consent to care, which is the subject of two main texts: the 1953 Code of Ethics for Doctors and the 2010 Internal Regulations for Hospitals (Ministry of Health of Morocco 2011). However, prior consent to care is better organized by the Internal Regulations of Hospitals of 2010 (Ministry of Health of Morocco 2011), which concerns the public sector. Nevertheless, these internal regulations devote only a single article to patient information.

The right to access health information is legally guaranteed in Morocco but may be difficult. A national health information system exists; however, researchers and policymakers may have limited access to some health data.

HEALTH WORKERS

Human capital is the most important asset and the primary resource that the health system must develop to create the conditions necessary to improve population health continuously. Despite the efforts made, the human resources situation in Morocco still shows a quantitative and qualitative deficit, which is increasingly significant, even worrying.

The WHO places Morocco among the countries with an acute shortage of healthcare personnel. The current number of medical and nursing staff remains below the minimum requirements to guarantee the entire population quality healthcare access. The public sector data indicate that the national health workforce represents a ratio of about seven doctors per 10,000 inhabitants and about nine nurses per 10,000 inhabitants (Ministry of Health of Morocco 2018).

The regional distribution of health professionals largely favors metropolitan regions and urban areas. About 60% of health professionals in both public and private sectors are concentrated in the Casablanca and Rabat regions, where only 34% of the population lives. The distribution between general practitioners and specialists in the public sector is abnormally reversed. The age pyramid of human resources in the public sector shows a higher number of staff in the 40-60 age group, with a greater risk of retirement in the years to come (Ministry of Health of Morocco 2016).

RECRUITMENT CAPACITY BELOW MINIMUM REQUIREMENTS

The recruitment rate, particularly in the public sector in recent years, has not been able to improve coverage or compensate for accumulated retirements. The same applies to the private sector, which increasingly requires qualified health professionals for its development.

Indeed, compared to the needs expressed by the Ministry of Health, i.e., more than 51,000 budgetary posts between 2008 and 2018, only 23,600 budgetary posts have been created, and during the same period, 10,450 retirements have not been compensated (Ministry of Health of Morocco 2018).

These departures will increase over the next fifteen years to reach an annual average of over 1,400. Moreover, staff instability and endemic absenteeism sometimes aggravate the shortage of human resources (Ministry of Health of Morocco 2016).

AN EVOLVING SYSTEM FOR TRAINING HEALTH PROFESSIONALS

Over the last few decades, the public authorities have invested heavily and continue to do so in medical and paramedical training to provide the population with a sufficient number of qualified health personnel.

Concerning medical training, and despite all the efforts through the national initiative for the training of 3,300 doctors per year by 2020, Morocco still suffers from an acute shortage of medical personnel, both in terms of quantity and quality (Ministry of Health of Morocco, 2018).

Currently, Morocco has seven public medical faculties whose geographical location aims to improve accessibility to medical studies and university hospital infrastructures in all the regions. Three private universities in the health sciences have been added to the national capacity to train doctors, two of which are non-profit.

Regarding continuing education, there is no clear strategic plan for skills development. In a context characterized by rapid developments in the health sciences and new biomedical and therapeutic technologies, it is now necessary to develop a concerted policy of compulsory continuing education and put a continuous system for evaluating knowledge and skills in place. This policy could be facilitated by the new distance learning tools.

The health workforce suffers from a significant deficit in Morocco. This quantitative and qualitative shortage in human resources is structural and is aggravated by an unbalanced regional distribution.

GLOBAL FACTORS AND COVID-19

The year 2020 was marked by the COVID-19 pandemic, a major health crisis, calling on all governments to prioritize measures likely to limit its spread and mitigate its consequences.

This health crisis resulted in significant changes responsible for social, economic, and political crises, requiring large-scale, collective, and united responses. Morocco prioritized the health security of the population by working to prevent the spread of the COVID-19 pandemic (containment) and by taking proactive initiatives and measures to reduce its impact (prevention, information, vaccination, etc.).

Indeed, from the start of this health crisis, Morocco was able to

secure the acquisition of biomedical and laboratory equipment and the tests and reagents necessary for COVID-19 detection, vaccination, and treatment and ensure their delivery to the population. These efforts at the national level also focused on mobilizing partners towards support for crisis management and sharing expertise for developing innovative solutions and new technologies for the resilience of the national health system.

In addition, several budgetary supports (grants, loans, etc.) from different multilateral partners were mobilized to support the financing of health activities in the context of the COVID-19 crisis, helping to make the health sector more resilient to public health emergencies.

Indeed, the health crisis linked to COVID-19 has been relatively well managed in Morocco. It is necessary to transform the threats imposed by the pandemic into opportunities to strengthen the health system's resilience in the face of possible future crises. Strategies must then be put in place to ensure self-sufficiency in health.

ROAD MAP AND RECOMMENDATIONS FOR ACHIEVING THE RIGHT TO HEALTH IN MOROCCO

Several recommendations can be proposed for strengthening effective access to the right to health in Morocco. Indeed, it is important to continue and strengthen the structural reform of the health sector in Morocco, to address structural healthcare issues, and to seize the historic opportunities offered by the COVID-19 health crisis to bring about qualitative changes in the understanding of health as a public service placed at the center of the protection of national security and sovereignty.

The mission of the state to ensure the enjoyment of rights does not only rest on its sovereign functions of governing and protecting society but also on its legal responsibility, based on its international and national obligations, to promote and protect the rights of its citizens and to prevent violations of those rights. The right to health must be seen as one of the main responses to the challenges of development in general and the right to development in particular. This is because of the close relationship between the determinants of health on the one hand and the conditions for sustainable development and human security on the other.

Based on the barriers and dysfunctions identified above and considering the position of the national reference administrations (Economic, Social and Environmental Council, 2018; National Council for Human Rights of Morocco, 2022), efforts to improve access to the right to health for all the population may incorporate the following fundamental actions.

STRENGTHENING THE COORDINATED CARE PATHWAY AND THE PREVENTION APPROACH

- Strengthen prevention, early diagnosis, and primary care programs based on right to health principles of equity.
- Create, operationalize, and develop surveillance and epidemiological observation mechanisms and early warning centers.
- Adapt health facilities to be safe and adequate in normal and crisis situations.
- Consider the human rights-based approach and the need for

a progressive improvement of the enjoyment of the right to health for all and/or groups of people in developing health policies and strategies, not only the efficiency aspect.

- Consider all the social determinants of health, such as providing safe drinking water, nutrition, adequate housing, the environment, and other determinants that impact the enjoyment of the right to health.
- Overhaul the national health system by placing primary healthcare at the heart of the system as the best qualified and most effective means of achieving universal health coverage in general and the social protection agenda in particular.
- Rely on an adapted care pathway that allows each citizen the right to choose his or her doctor, who will follow, receive, orientate, and accompany him or her and coordinate his or her pathway through the health system in order to save time in diagnosis and treatment, and to rationalize the use of the efforts of health professionals, health expenditure, the use of basic infrastructures and the improvement of the quality of care.
- Adapt doctors' training to the population's basic needs, and accommodate the particularities of community medicine.
- Consider mental health in its broadest sense as "the ability of each person to feel, think and act in a way that enables him or her to enjoy life and meet its challenges." This will be done within the framework of the principles of equity and dignity of persons in all its dimensions.
- Promote mental and psychological health by restructuring hospitals at national and regional levels to follow the changes and dynamics induced by societal, demographic, and epidemiological transformations.
- Develop the community approach and give associations and civil society an important place in promoting health education, urban health, and youth health.

PROMOTING GOOD GOVERNANCE AND REDUCING GEOGRAPHICAL SOCIAL DISPARITIES

- Develop and implement advanced regionalization in the health sector to meet citizens' expectations and involve them in the reflection, management, and implementation of

health policies adapted to their territorial, cultural, health, and economic specificities.

- Adapt and harmonize the legal system relating to the health sector with the requirements of the human rights-based approach. This starts with recognizing access to healthcare as a human right by removing legal obstacles that could prevent citizens or certain groups of citizens from benefiting from this right.
- Take into consideration the multisectoral approach in drafting draft laws and proposals relating to the health sector to overcome certain difficulties that are not directly related to the health sector and hinder access to the right to health. This will help to address some of the complex management difficulties that do not necessarily fall within the government authority responsible for the health sector.
- Reorganize institutional health structures with a rights-based rather than a needs-based logic, and adapt them to the coordinated care pathway in the national health system.
- Find the legal means and institutional mechanisms to integrate the determinants of the right to health (economic, social, cultural, environmental, and cultural dimensions) in designing, implementing, and evaluating public health policies.
- Anticipate health crises to ensure better territorial management of health risks by developing proactive and appropriate health strategies and programs to deal with health hazards.

INCREASING HEALTH FINANCIAL RESOURCES TOWARD UNIVERSAL HEALTH COVERAGE

- Increase the budget allocated to the Ministry of Health in relation to the general state budget to meet the standards of the WHO, which recommends a percentage of 12%, to progressively reach universal health coverage.
- Increase per capita spending on health to 419 US dollars in 2030 while reducing household spending by more than half: from 50% currently to less than 30% as the primary target, to fall below the 25% threshold eventually.
- Free health financing from the constraints of macroeconomic balances and treat the health sector

as an investment sector that would strengthen national sovereignty.

REGULATING THE PRIVATE SECTOR AND ENCOURAGING THE PUBLIC-PRIVATE PARTNERSHIP

- Establish public health policy as a strategic sector that transcends political divides and legislatures.
- Improve the attractiveness of public hospitals through increasing financial investments and enhancing quality of care to create competition for the patient's benefit.
- Better regulate the private sector by controlling its activity and the pricing within private facilities by limiting informal payments and improving the quality of care it provides to patients.
- Clearly define the notions of health services and health establishments, regardless of their legal status. In this regard, it is important to treat the public and private sectors equally in terms of their responsibilities as service providers, whether in terms of prevention, diagnosis, treatment, or rehabilitation.
- Develop the private, not-for-profit sector, a health sector that can collaborate closely with the public sector to promote access to care for all while limiting the costs of care for patients by following national reference pricing.
- Develop the public-private partnership to mobilize the financial, technical, and human resources available to the private sector and place its expertise at the service of the state's public health policy.
- Accelerate the implementation of the national public-private coordination commission, to make it a decision-making and not a consultative body. The ultimate objective of such an initiative is to enable the two sectors to be involved in defining the strategic orientations of the national health system.

CONCLUSION

Morocco has an important legal arsenal allowing the enjoyment of rights and has recently launched several projects to overhaul the national health system, the fruits of which will be reaped in the years to come.

Nevertheless, given the current situation and based on the data available, the fact remains that the right to health still suffers from various barriers, notably geographical and socioeconomic disparities, low health financing and incomplete universal health coverage, shortage and geographic inequality of health professionals, non-integrated private sector and poor public-private partnership, and weak coordinated care pathway and prevention approach

Health sector reform should be seen as an integral part of reducing social and territorial disparities. With the consolidation of decentralization as a method of managing public affairs, health policy becomes one of the components of the strategy for promoting spatial justice. Thus, advanced regionalization can be a lever for promoting spatial justice in the area of access to the right to health and the reduction of territorial disparities. Expanded health coverage should guarantee an adequate financing mechanism, allowing individuals to benefit from sufficient coverage of their healthcare costs. The national health system should fully regulate the private sector and facilitate cooperation with the public sector to establish a coordinated care pathway. The national health system must also be able to attract more health professionals and better distribute them across the country. The preventive approach must be able to target the socioeconomic and environmental determinants of the right to health, the adoption of the primary healthcare strategy, and the promotion of sexual and reproductive health.

Finally, it would be beneficial to assess how the current health sector reforms will improve health rights in Morocco once implemented. For this, high-quality studies are strongly recommended to analyze the effects of these reforms and derive the best benefits for the entire population.

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