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RESEARCH ARTICLE

PROSPECTS FOR REFORM OF MEDICAL COVERAGE IN MOROCCO

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Abstract

For equal access to health care and to allow citizens greater access to the health system, Law 65-00 relating to Basic Health Insurance (BHI) was created in Morocco in 2005. The development of this law marks the starting point for all optimized actions with measurable objectives in the "health" sector. Even if this law has evolved gradually to try to generalize medical coverage, but it currently remains obsolete, because fifteen years after its implementation, it has not allowed the universalization of medical coverage to all citizens. However, further reform is called for. Government, institutions and society are under increasing pressure to ensure further reform. The constraints of implementing solid governance, financing, equal access to healthcare services are challenges to be taken up in order to reform the regulations relating to medical coverage in Morocco.

Introduction:-

The right to health is the right to benefit from the best medical services whatever the condition, the race, the social environment ... The European charter of health of 1982 specifies that "The right to health, is the right to be treated when one is sick, the right to benefit from the best medical services whatever one's condition : it is equality in access to care and to health institutions ". The Declaration of Human Rights adds that the Right to Health is the right of everyone to the best possible state of health and that this right derives from the inherent dignity of the human person.

It is up to the State to provide the means to ensure the Right to Health as a collective right. An obligation which can be legal if laws are adopted to this effect. In this regard, Morocco formally recognizes, through its constitution, the Right to Health. The consecration of the right to health in the new constitution of 2011, as stipulated in article 31 : "The State, public establishments and local authorities work to mobilize all available means to facilitate equal access for women and men under the conditions, allowing them to enjoy the right to :

1. Health care ;
2. Social protection, medical coverage and mutual aid or solidarity organized by the State ;

It appears that the 2011 constitutional recognition opens the way to a new dimension of law or to the renewal of an existing dimension, wich is the protection and development of rights.

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The international debate concerns the Universal Health Insurance (UHI) and the search for greater equity in access to care. It also relates to the search for greater efficiency of systems, both in terms of the supply of quality care and in terms of financing demand, and cost control.

Numerous health system reforms have been undertaken in most countries of the world. Some of these reforms took on a radical character, others consisted of marginal changes, but all tended towards the extension or even the universality of social protection in matters of health and towards a better balance of responsibilities between Public and Private sectors.

As part of this international movement for reform and change in health systems, Morocco is committed to developing its health system to keep pace with what is happening elsewhere in the world while taking into account the specificity of its challenges he would face. These are linked to the new problems that will be faced in the years to come, such as the aging of the population, the dual demographic and epidemiological transition and the appearance of new diseases ...

Health insurance is of great importance to countries which are in search of development. Morocco has set up a health system composed of a set of resources intended to ensure the promotion, protection, restoration and rehabilitation of the health of the population.

For equal access to health care and to allow citizens greater access to the health system, Law 65-00 relating to Basic Health Insurance (BHI) was created in Morocco in 2005. The development of this law marks the starting point for all optimized actions with measurable objectives in the "health" sector. Even if this law has evolved gradually to try to generalize medical coverage, but it currently remains obsolete, because fifteen years after its implementation, it has not allowed the universalization of medical coverage to all citizens. However, further reform is called for.

Government, institutions and society are under increasing pressure to ensure further reform. The constraints of implementing solid governance, financing, equal access to healthcare services are challenges to be taken up in order to reform the regulations relating to medical coverage in Morocco.

How to converge the management of Compulsory Health Care Insurance (CHCI) by a consubstantial establishment (knowing that it is not the same contribution, same health insurance basket of services, same insurance coverage, ...) ? What are the challenges for the state to manage two schemes, one based on contributions (CHCI) and the other based on rates and taxes, the Medical Assistance Scheme for Poor People (MASPP) ? What role should complementary insurance to improve access to healthcare and reduce healthcare costs for managing bodies ?

The aim of this article is to propose an adequate scenario for reforming medical coverage. We will have to draw a general perspective for the universalization of health coverage, which finds a favorable response from the partners of the ecosystem (Government, fund organims « National of Social Provident Institutions Fund » (NSPIF), « National of social security Fund » (NSSF), regulators « National Agency for Health Care Insurance » (NAHCI), « Control of Insurance and Social Provident Authority » (CISPA), directly supervising concerned "Ministry of Health, Ministry of Labor, and Economy and Finance" and healthcare providers).

In this article, we will first present the foundations of social protection systems, then we will present the state of play of the medical coverage system in Morocco, while examining the factors that hamper the generalization of medical coverage, and finally we will propose,some fans for the reform, based on a qualitative study expressed by the expert method or what is called the DELPHI method, , whether in terms of governance, financing and healthcare services.

Foundations of social protection systems :

Social protection policies play an essential role in the realization of the right to social security for all, the reduction of poverty and inequalities, and the promotion of inclusive growth. Indeed, they strengthen human capital and stimulate productivity, promote domestic demand and facilitate structural changes in national economies.

Social protection : a heterogeneous concept:

Social protection covers all the institutional mechanisms, public or private, taking the form of a collective welfare system and / or implementing a principle of social solidarity, which cover the costs resulting for individuals or households from existence a certain number of identified social risks (health, old age, unemployment, poverty, etc.)

(Caicedo, Koubi and Yanat-Irfane, 2011). According to the definition adopted by the Inter-Agency Social Protection Assessment Initiative (ISPA), "social protection refers to a set of policies and programs designed to prevent and protect all individuals - especially vulnerable groups. - against poverty, vulnerability and social exclusion during the different stages of life."(ISPA, 2016).

Social protection benefits include, on the one hand, social benefits proper, which take the form of transfers allocated personally to households, and, on the other hand, social service benefits, which provide access to free or priced services, reduced, and help cover social risks.

Referring to the social protection accounts, Mireille Elbaum (2011), identified six main categories of risk : health risk, old age-survival risk, maternity-family risk, employment risk, housing risk, poverty risk-social exclusion.

These clarifications on social protection highlight the universality of social protection (to all people) including medical coverage. To this end, CHCIng the conventions on which social protection is based, it is important to discuss that relating to our research framework "universal medical coverage". In fact, ILO Convention No. 102 represents its legal reference framework which has had a considerable impact on international legal systems for social protection. One of the main characteristics of Convention No. 102 is that it contains flexibility clauses allowing members ratifying it to progressively achieve universal coverage, of which Morocco is a part.

After having analyzed the concept of social protection, it is then appropriate to present its generic models of social protection

Generic models of social protection:
When we study social protection systems, their mode of operation and financing, we see that they are structured around two archetypes : the Bismarckian model (based on the conception of Chancellor Bismarck) and the Beveridgian model (based on the ideas of the economist Beveridge), Philippe Mossé (2017).

The first refers to support methods favoring the insurance logic (benefits are paid to individuals who are insured against such risk) ;

The second has an assistance logic (benefits are paid to individuals who need them).
However, the establishment of one model or another generally requires a gradual process, fast in developed countries and sometimes slow in developing countries.

The three waves of development of solidarity health insurance in developing countries :
Alain Letourmy (2008), indicated that the development of Health care insurance passes through three successive waves and are still prolonged with varying intensity :

The first wave : health insurance for the formal economy sector:
corresponds to the establishment of public compulsory insurance institutions on the one hand, and private organizations with voluntary membership on the other. These two categories of organizations were set up within the sole sector of the formal economy, but according to different logics.

The common idea, however, was that employees of private companies and civil servants should be able to access good quality care, obviously at a cost, especially if it was provided in the private sector.

To these public institutions, we can attach the establishment of civil servants' Mutuals insurance, with automatic or voluntary membership, with a shared contribution, but their management relates them more to commercial insurance companies than to health insurance institutions of solidarity.

Finally, some private insurance organizations have emerged in response to a lack of the public system.
If we want to characterize the development of health care insurance that corresponds to this first wave, we can say :

That it is part of a fairly fragmented process, directed mainly towards the formal sector where people have well-codified jobs ;

That the state's involvement varies with regard to health risk coverage, despite the desire to set up a comprehensive social security system ;

That the state does not always follow through and that it may not even respect it's commitments ;

That there is no real control of the institutions whose management can be entrusted to the social partners or to private actors.

The second wave :the rise of microinsurance and mutual health care insurancefor the informal sector :
The second wave health care insurancedevelopment and solidarity is marked by the emphasis placed on micro health care insurance. The approach followed then favors the informal sector and promotes voluntary membership options for mutual societies or microinsurance organizations.

Generally speaking, the creation of mutual health organizations and health microinsurance organizations cannot be attributed to the State. The initiatives are more of private origin (local actors) or external (foreign actors, NGOs). However, in some countries, the State very quickly took an interest in the development of mutual health organizations, even posting a policy of promoting voluntary insurance, this desire was confirmed in several States by legislating for the benefit of mutual health care insurance, health regulations relating to mutuality. This wave of development of microinsurance has continued, led by the State, which aims at universal coverage.

The third wave : solidarity health care insurance as a vehicle for universal health coverage :
The third wave of development is considered the operationalization phase of reforms. It is characterized by the official involvement of the State and the definition of a specific health coverage policy which must concern all categories of the population. While the goal can be considered the same in all countries, which is, "universal coverage", each follows its own path and the content of policies varies widely.

To fix ideas, we can identify two major trends. Either the state is considering a major reform that sets up an innovative institutional architecture, in which each category of populations can find some form of protection. Either, the State considers a more pragmatic approach, which starts from a breakdown of the population and tries to give each category specific coverage, implemented as and when available, according to the means available.

However, Morocco like developing countries has experienced almost the same trajectory of the above three waves.

The inventory, methodology and results of the research:
Despite the reform of the health risk management system in Morocco, it is considered to be the fruit of hard work and a long wait. Waiting which began in 1992, to end with the adoption of a law 65-00 voted in November 2002 then of decrees of application taken in August 2005. Health coverage in Morocco is characterized by a heavy fragmentation of its plans, with heterogeneous services, funding methods and governance.

Governance :
Indeed, irregularity is the key word to describe the governance of the different regimes that make up the BHI. Indeed, several organizations intervene, sometimes financial manager of one regime, sometimes regulator of another. The legal statutes of these bodies are far from homogeneous with a view to unified long-term management. However, the NSPIF, manager of the CHCI in the public sector, which gives it a hybrid status, firstly because it manages significant public funds has an almost private establishment status "federation of mutual societies" on the other hand the NSSF has a status of public establishment although it manages private funds.

The observation is thus made that there does not exist, at the level of the bodies of the BHI system, a normative and regulatory framework in terms of governance.

In terms of governance, the law admittedly grants NAHCI the management of the resources allocated to MASPP. But in the current state of affairs, NAHCI only manages registration operations. This regulatory mismatch has resulted in the lack of a third party payer in accordance with the rules of good governance of social assistance schemes.

The mission of the NAHCI is clear within the framework of article 59 of the law 65-00 "to ensure the technical supervision and to ensure the implementation of the regulatory tools of the CHCI and to ensure the implementation system regulation tools ", but there is a lack of texts describing the sanctioning modalities to enforce the legal and regulatory provisions of medical coverage, apart from the deconventing of healthcare providers.

At the institutional level, the establishments that intervene in the BHI system are characterized by the plurality of institutional actors in a context of overlapping responsibilities and lack of coordination. This hinders the design of clear and effective policies and the conduct of coordinated and efficient programs.

Funding:
The multiplicity of CHCI schemes, affirmed by Law 65-00 on the code of basic medical coverage, does not promote long-term financial viability of medical coverage as a whole.

Indeed, the public sector CHCI managed by the NSPIF and the private sector managed by the NSSF have divergent financing parameters through inequitable contribution rates and divergent coverage rates.

In addition to these elements of divergence, the environment of the organizations managing the CHCI is characterized by a triple demographic transition (12 active / one retiree in 1986 and 2.32 active / one retiree in 2016), epidemiological (18.2 % of the Moroccan population with LTD) and technological (sophistication of medical technologies linked in particular to technical progress and better accessibility to care), which results in an exponential increase in expenditure on services over the past ten years.

We thus note the insufficiency of funding sources for the assistance component. Noting that the generalization of MASPP has led to compulsory interventionism of patients covered by this plan to the public hospital to benefit from sometimes heavy and expensive procedures.

This situation did not necessarily translate into an increase in the investment budgets allocated to hospitals, which can lead to a drop in the quality of care provided, especially in the event of aging of hospital equipment and the inability of health services to provide maintain them, according to the ONDH report (2017). The same report explains that the own revenues of public hospitals have decreased, which is explained by an increase in the share of free patients (mainly MASPP) and by the fall in that of paying patients, which represents a substantial shortfall.

Differences in care benefits:
The CHCI scheme is characterized by a dissimilarity of the Health insurance basket of servicess, as the MASPP scheme. The difference is clear : disparate baskets of care and different coverage rates which results from these elements that the loss rate is 22% for the NSSF, while it is 47% for the NSPIF for the year. 2017.

	NSPIFInsurance coverage	**NSSFInsurance coverage**
Medicines	70% SPP[1]	70% SPP
Medicines for LTD[2]/ HED[3]	100% SPP	Between 90 and 100% SPP
Private sector Hospitalizations	90% NRP[4]	70% NRP
Public sector Hospitalizations	100% NRP	90% NRP
Ambulatory care	80% NRP	70% NRP
Loss experience rate	47%	22%

Table 1 :- Comparison of service coverage rates between public and private sector CHCIs.
The MASPPHealth insurance basket of services is characterized by its insufficiency, however, it is limited to medically required services available in public hospitals.

Indeed, stabilizing the Health insurance basket of services and establishing consistency in coverage levels between the public and private sector CHCIs represents a major challenge, harmonizing that of MASPP remains more

[1] Sale Public Price.
[2] Long-Term Diseases.
[3] Heavy and Expensive Diseases.
[4] National Reference Pricing

complex but it should guarantee the universalization of the BHI within a framework of the equity of access to services.

In fact, we summarize the state of play of the establishment of medical coverage in Morocco in the table below.

	Compulsory scheme				**Special scheme**				**Failed scheme**		**Incovred scheme**			
	Public sector CHCI	**Students CHCI**	**Article 114 law 65-00**	**Privatesector CHCI**	**Authority Auxiliaries**	**Imams**	**Former resistance fighters and members of the Liberation Army**	**Human rights violations victims**	**INAYA**	**MASPP**	**Independants CHCI**	**Parents**	**Informal sector**	**Without income**
Population	Public sector Officials and retirees « Public Health Insurance »	Students pursuing training in public or private education or vocational training establishments	Public or private sector, Officials, employees and retirees eligible but not affiliated or registered on compulsory schemmanaged by	Private sector employees and retirees	M²oqqaddems et Chioukhs	Imams	Former resistance fighters and members of the Liberation Army	Human rights violations victims	Craftsmen, traders and liberal professions	Poor and vulnerable population	Professionals, independants workers and self-employed workers (law 98.15)	Policyholders CHCI parents uninsured	Informal sector Workers	Without income
Implementation Year	2005	2016		2005	2007	2007	2007	2007	From 2006	2008 pilote expe	Unpublished impl	not approved low	planned on	planned on

									with Private health insurance company	rience 2012 generalization	ementing decree		2021	2021
Fund Organisms	NSPIF (delegated management to 9 Mutual insurance)	NSPIF (delegated management : NSCUWO[5] et VTWPO[6])	*Internal funds ; * Mutual insurance ; *Private health insurance company	NSSF	*Private health insurance company	* Private health insurance company	* Private health insurance company	*NSPIF (State behalf management)	* Private health insurance company	*NAHCI (financial management) : *Interior Ministry (Registration)	NSSF	NSPIF (public sector Policyholders CHCI parents uninsured "law bill 63.16")		
Funding	*5% for assets distributed as follows: **2,5% Subsidised by the employee; **2,5% Subsidised by	*Annual fee-for-services plan 400 DH : **State subsidized for public education establishments	*Subsidies from employer organizations and employee ; *Variable group insurance contract.	*6,37% for assets distributed as follows : **2,26% Subsidised by the employee ; **4,11% Subs	*Interior Ministry Subsidies	*HABOUS MinistrySubsidies	*High Commission of Former resistance fighters and members of the Liberation Arm	*National Council for Human Rights Subsidies	Depending on the specific contributions of the three products offered : Assassi, Moutaka	Assistance scheme : * State and local authorities ; * Beneficiaries annual partial contribution	Specific to each profession.	Depending on the fund organisms equilibrium rate (Subsidised by the insured)		

[5] National for social and cultural university works office.
[6] Vocational Training and Work Promotion Office.

	the employer ; *2,5 % for Pensioners ; *Payment limit : 400 DH ; *Minimum threshold : 70 DH.	students ; **private education institutions students contt ributions.		idised by the employer. *4,52% for Pensioners . *Without payment limit.			y Subsidies		mil or Chamil.					
Covered benefits	Care services avilables on hospitals linked to the public and private system	Same Care services of CHCI schem managed by NSPIF	Care services specific to each organization or group insurance contract	Care services avilables on hospitals linked to the public and private system	Same Care services of CHCI schem managed by NSPIF	Same Care services of CHCI schemmanaged by NSPIF	Same Care services of CHCI schem managed by NSPIF	Same Care services of CHCI schem managed by NSPIF	Depending on the three products offered : Assassi, Moutakamil or Chamil.	Care services avilables only on hospitals linked to the public system	Same Care services of CHCI schem managed by NSPIF	Same Care services of CHCI schem managed by NSPIF		
Insured Number	1 268 479	227 950		2 795 643	16 000	41 755	7 869		10 000 000	14 400 000	11 000 000	260 000		
Beneficiaries Number	3 093 421	227 950		6 378 316	40 000	100 000	30 500							
Gouvernance	Board of directors of 24 members divid	Board of directors of 10 members : 8		Board of directors of 24 members divid						Board of directors of 24 members divid				

	ed equally between the representatives of the State and the Mutuals insurance with the unions, chaired by a president of the Mutuals insurance elected from among themselves.	representatives of the State and Directors NSCUWO et VTWPO, chaired by the president of the public sector CHCI.		ed equally between representatives of the State, representatives of employers and representatives of workers, chaired by the head of government or by the government authority delegated by him for this purpose.						ed equally between 9 representatives of the State and the directors of UHCs[7], chaired by the head of government or by the government authority delegated by him for this purpose.				

Table 1:- inventory of the various medical coverage schemes set up in Morocco.

Indeed, defining a scenario for reforming medical coverage in order to guarantee its universalization is proving to be very complex. In fact, we have made sure that the appropriate research methodology is chosen.

[7] University hospital center.

Research Methodology:-

Our research object aims to show under a suitable scenario how the medical coverage system should be reformed with a view to its universalization. Our research was carried out using an inductive approach by consulting several players in the medical coverage environment. To structure and organize our field study, we will rely on the DELPHI method which is increasingly known to specialists in medium and long-term strategy development, Booto, and al.,(2011). It is a participatory approach characterized by the anonymity of the data, of the participating experts and by the independence of opinions, which makes it possible to gather summaries of opinions and to reach a common conclusion.

Several points led us to use the Delphi method :

First, the problem of identifying the legal limits of Law 65-00 does not lend itself to precise analytical techniques but can benefit from subjective judgments and assessments on a collective basis ;

Then the convincing profiles sought in the context of our research are those who have a more strategic vision, able to interpret situations, make recommendations, able to assess situations, observe developments, give an objective and congruent assessment and to develop a well-founded analysis or judgment (expert population);

Thus the high number of people seems difficult to interact effectively, something which is not always required in a Delphi, and the heterogeneity of the participants is important to guarantee the validity of the results;

And finally the deadlines, the costs and the availability of the expert population do not allow frequent meetings.
It adapts to our needs by its orientation to the collection of data through experts. In short, an approach that uses the lived experience of experts.

The Delphi method can be carried out by following four steps, Crochemore, (2005) :
1. Rigorously define the subject to be treated and its perimeter;
2. Research and training of the expert panel ;
3. Design and write an interview guide ;
4. Collect information either by mail, telephone interview or face to face then process the results.

The choice of experts to consult depends on several criteria, in fact the probative profiles sought are those who have a more strategic vision, able to make an assessment, able to interpret situations, make recommendations and define expectations.

We present below the details of the profile of the experts :

	Experts	Department heads	Division heads	General Managers	Others	Total
Organizations	NSSF	2	2	1		5
	NSPIF	2	3			5
	NAHCI		4	1		5
	CIPSA				1	1
	ISCRSP Members[8]				4	4
	Total	4	9	2	5	20

Table 2:- The experts solicited and their origins.

A total of 20 people were interviewed over a twenty-four month period (May 2017 to April 2019), with an average interview duration of one hour and thirty-five minutes. Almost all of the interviews were recorded with the interviewee's permission, and transcribed. They were then analyzed using a content coding method.

The content of the interview guide is shown in the following table.

[8]Established in 2018, it is chaired by the Head of Government, it is the Interministerial Steering Committee for the reform of Social Protection.

Themes and sub-themes covered	Underlying questions
The interviewee and his place in the organization	- Organizational chart - Activities
Environmental actors	- Evolutions observed - Perception of the environment
Governance	- Legal status, - Field of intervention (managing body, regulator, financial manager, etc.), - Composition of management bodies, - Legitimacy of the representativeness of management bodies, - The presidency of the boards of directors, - Active committees emanating from the board of directors.
Funding	- Resources, - Contribution rate and CHCIunt, - Contribution limit and threshold, - Influence of the financial ecosystem.
Health insurance basket of services	- Covered benefits, - Reimbursement and coverage rate.

Table 3:- Summary of the interview guide.

We were able to use "content analysis" to process this qualitative data as systematically as possible. The results presented below come from a codification of the data favoring the crossing of these.

Results and discussions:-

The BHI is a social building site, its establishment has aroused political commitment at the highest level of the State. The implications of this commitment are justified by :

The combination of the socio-economic development of the Kingdom and social justice ;

The catching up of the delay in human development and social coverage compared to countries with similar economic development.

In the register of basic medical coverage (BHI), Morocco has taken important steps by gradually putting in place all the schemes in place: compulsory health care insurance (CHCI) for public and private sector employees in 2005, medical assistance scheme (MASPP) in 2012, CHCI for students in 2016, CHCI for the self-employed and liberal professions in 2018 and special schemes.

These plans[9] should materialize Morocco's evolution towards universal[10] medical coverage which is part of the 2030 human development agenda and the priorities of the World Health Organization (WHO) for the period 2014-2019[11].

Governance component reform scenario :

The BHI system in Morocco is fragmented in its management (CHCI, MASPP regime, special regimes, internal funds, private insurance, etc.). Indeed, structural reform is required, since in a complex and evolving environment, and in view of the importance of the missions and the financial challenges represented by medical coverage. We can thus observe reforms of a general nature and those of a specific nature.

[9]Residual regimes were put in place from 2007 : former victims of human rights violations, mosque imams, preachers, auxiliaries of authority, veterans and members of the liberation army and artists.

[10]According to the ESEC, the coverage rate of the Moroccan population was 54% in 2017.

[11] For the period 2014-2019, the World Health Organization (WHO) has specified its priorities in several areas of action, "in particular the progress towards universal health coverage (UHC), the challenge of non-communicable diseases (NCDs)), especially mental health, the application of the provisions of the international health regulations (IHR 2005), the improvement of access to quality, effective, safe and affordable medical products, and action on social determinants , economic and environmental health ".

General reforms:

Reduction and strengthening of the role of board members :

As we have seen, there is an over-representation of board members of organizations in the BHI ecosystem. However, these boards of directors must ensure that its size and composition are adequate, since the Moroccan code of good governance practices includes CHCIng its rules for the proper functioning of the governance[12] body, which should not include more than 12 members while the boards of directors of the managing bodies and the regulatory agency greatly exceed this number of members.

According to the experts consulted, it is proposed to set up Specialized Committees by introducing new operating methods from the Board as provided for by the BHIPG-EEP (Audit Committee, Governance Committee, etc.), which should be made up of people who are independent from the management of the institution and include people with extensive experience. They must be free from political interference and their reports must be made public, in order to guarantee independence and transparency.

CHCIng the proposals, the experts also demand to appoint the representatives of the boards of directors "intuitu personae" on the basis of criteria favoring professional competence, in particular in the technical, economic and financial fields. To this end, it would be wise to organize adequate training for Council members in order to facilitate their integration and participation in the work. These training courses must cover the general characteristics of establishments, their businesses, strategies, policies, challenges and the risks they face. It should ultimately lead to certified directors.

In addition to the representation of unions, a proposal for the representation of civil society remains important. Since in the context of third-party payment, the asymmetry of information prevents policyholders from knowing what type of act they are going to undergo or that they have undergone and are surprised by the CHCIunt of the co-payment and the additional benefits, this which may have to incur significant care expenses. A non-deliberative representation that directly defends the interests of the insured is essential to preserve their rights.

Finally Make the boards of directors accountable in terms of overseeing management acts while ensuring rigorously preventing the interference of boards and their members in the management acts of organizations.

Transparency and dissemination of information:

The insured, a weak loop in the system, does not have access to information about the organisms that make up the ecosystem. This involves studying the possibility of disseminating certain information to policyholders such as : good governance practices and the way in which these bodies apply them ; the composition and organization of the board ; regulated agreements ; some elements on the summary statements ; Council resolutions ; Etc.

Specific reforms :

NSPIF :

The NSPIF which finds itself in a legal imbroglio characterized by the management duality of CHCI-Employee and CHCI-Student with separate budgets and diversified governance. This is a heavy task to achieve efficient management.

Despite its private legal status, the NSPIF remains governed by the Code of Mutuality (article 81 of law 65- 00), but by virtue of its role as manager of a public service, it is considered a public establishment. However, under Decree-Law No. 2.18.781 (October 10, 2018) ratified by Law No. 94.18 - the creation of the Moroccan Health care insurance Fund (CMAM) as a strategic public establishment subrogating the NSPIF in the management of health care insurance schemes is an important step in the reform of the governance of the compulsory health care insurance system managed by the NSPIF.

The representation of Mutuals insurance raises certain issues related to the possibility of a conflict of interest between the status of the 8 Mutuals insurance as members of the NSPIF board of directors and their status as

[12] Best practices governance Moroccan code for companies and public establishments, and the circular of the head of government of March 19, 2012.

healthcare producers. They become both judge and party in the making of strategic decisions relating to the CHCI regime. The reduction was recorded in the framework of Decree-Law No. 2.18.781 to 4 representatives instead of 8.

Make coherent the composition of the board of directors of the student CHCI chaired by a Chairman of the Mutual who has no role in the management process of this health care insurance.

And recently the chairman of the board of directors of the NSPIF is a chairman of one of the 8 Mutuals insurance, while the NSPIF, which has all the attributes of public establishments, should be chaired by the Head of Government. However, this provision has been implemented since Legislative Decree No. 2.18.781 Placed the presidency of the CMAM board of directors under the dome of the Head of Government.

The classification of CMAM as a strategic establishment under organic law 17.19 amending and supplementing organic law No. 02.12 Relating to the appointment to higher functions in application of the provisions of articles 49 and 92 of the Constitution, constitutes a premise and a path to legal reform of the BHI sector.

NSSF :
Harmonization of the governance of the NSSF with that of the NSPIF is essential for a unified management of health care insurance over time.

NAHCI :
Referring to the recommendations of the CESE, (2018), “Restore and respect the prerogatives of the National Agency for Health care insurance (NAHCI) whose mission (article 59 of law 65-00) is to ensure the technical and oversee the implementation of CHCI regulatory tools and oversee the implementation of system regulation tools ”.

The experts consulted insisted on regulatory reform in order to endow the NAHCI with legal means or the power to impose sanctions to enforce the legal and regulatory provisions of medical coverage (impose financial penalties without recourse to justice "restitution of undue payments", protection of policyholders).

Thus, they demand the renewal of regulation, through the creation of a health authority independent of the supervision of health to avoid defending the interests of healthcare providers. The creation of a High Authority for Health, competent to rule in complete independence on the criteria for reimbursement of drugs and medical devices, their admission to the standards, the development of therapeutic protocols, guides to good practice, the text on acts transferable abroad, the extension of the basket of care, etc. This authority will coordinate prevention and medical control policies within the framework of a national vision.

The dual mission of NAHCI as regulator of CHCI and financial manager of MASPP with different boards of directors is almost difficult to achieve, indeed a new organization is needed within the framework of medical coverage. Subsequently, the experts plead for the separation of the roles of regulator of CHCI and financial manager of MASPP. They point out thatNAHCI must focus on its role as a regulator, and entrust MASPP to the NSPIF, the NSSF or other organizations, as part of national solidarity.

CIPSA :
The NSSF and the NSPIF are subject to technical control by the Authority, whose mission is to ensure that these bodies comply with the provisions of Law No. 65-00 and the texts adopted for its application.

However, the experts ask the CIPSA to be mandated to monitor compliance with procedures, consolidate statistics, actuarial studies, etc. for in extremis to make proposals in terms of legal texts aimed at reforming the medical coverage system.

Financing component reform scenario :
The multiplicity of CHCI schemes, contrary to the principle of solidarity, risk pooling and unification affirmed by law 65-00 on the code of basic medical coverage, does not promote the long-term financial viability of the health coverage as a whole harmonization of financing parameters.

Indeed, the public sector CHCI managed by the NSPIF (5% distributed equally between employee and employer ; 2.5% for retirees with a ceiling : 400 DH) and private sector managed by the NSSF (6.37% for the assets distributed

2.26% salary, 4.11% employer's share ; 4.52% for retirees without a ceiling) have divergent financing parameters through unfair contribution rates.

NSSF contributions were revised for the second time in 2016 following inclusion in their dental Health insurance basket of services. The result of these elements is that the loss rate is 22% for the NSSF, while it is 47% for the NSPIF for the year 2017. This threatens the sustainability of the compulsory scheme.

Experts plead for a unified global equilibrium rate (public and private sector) on the basis of a new actuarial study, taking into account the specificity of the population as a whole, and removing the ceiling on contributions with a view to harmonize them in the long term to broaden the parameters of solidarity.

Involvement of the Ministry of the Economy and Finance:
The incessant demand from healthcare producers to revise tariff agreements can weigh heavily on the balance of management bodies. Likewise, the decisions taken at the level of the NAHCI (National Health care insurance Insurance) commissions remain without visibility in the work methodology and without prior financial evaluation, therefore the amendment of Law 65.00 and its implementing decrees are essential by involving the Ministry of Finance, particularly in making decisions that may impact the financial balance of the system. This is particularly the case for the expansion of the basket of care, the revision of reference prices, the inclusion of new categories, etc.

To this end, the experts propose the creation of a strategic health-finance commission and the parties concerned to monitor decisions with a financial impact on health care insurance schemes (agreement, financing, basket of care, etc.).

Creation of a drug purchasing center:
More than half of the expenditure on healthcare services of the managing bodies is allocated to drugs. However, the price of drugs in Morocco is much more expensive than in developed countries[13].

The experts propose the creation of a virtual drug purchasing center (public hospitals, military hospitals, CHCI management bodies) under the aegis of the Ministry of Health, which will use competition to obtain low prices between laboratories based on calls for tenders from the Ministry of Health as a starting point to spare the community from aberrations of laboratories and speculators. The prize will become national and no one will deviate from it.

Promotion of the prevention and fight against fraud:
The promotion of prevention is an important vector for changing the behavior of policyholders and healthcare providers. The weak promotion of prevention against chronic diseases makes investment in prevention in its three dimensions (primary, secondary and tertiary) necessary, as well as the promotion of healthy living, within the framework of a national vision, led by the Ministry of Health.

The experts propose strengthening the legal arsenal relating to prevention within the framework of Law 65-00 in terms of budgeting, actions, consultations and pooling with the actors concerned. They thus suggest orienting part of the percentage of participation of the organizations managing basic compulsory health care insurance schemes, which is a uniform levy of 0.6% of the contributions and contributions of GOs provided for in article 68 of law 65-00 to promote healthy living. They also suggest the pooling of efforts through the establishment of a national commission to fight against fraud like France (interministerial commission for the fight against social fraud).

Positive and inclusive interpretation of the provisions of article 44 of law 65-00:
The CESE (2018) recommends a positive and inclusive interpretation of the provisions of article 44 of law 65-00 in order to give the organizations of basic compulsory health care insurance schemes the full latitude to contribute, in kind, to non-profit and solidarity purposes, the development and management of equipment and health care offers, in the service of the general health policy and social protection of Morocco;

[13] Currently, there is no structure in charge of ensuring the balance of the BHI as a whole, it is shared between several actors.

Reformulate Article 44 of Law 65-00 on the Code of Basic Medical Coverage in order to clarify its provisions so as to explicitly state that mutual societies and the NSSF have full legitimacy and vocation to create, develop and manage care units.

Note that the NSPIF had a central pharmacy that was supplied with expensive drugs for the benefit of its policyholders, which was closed in 2016 to comply with article 44 of law 65-00, which constitutes an estimated loss of 700,000 DH per day.

Downward revision of service fees:
Some acts are over-quoted, for this purpose the experts recommend :

Revise downward the prices of acts of biology, medical devices, dental and exploration which are characterized by over-quoting ;

Continue the series of price reductions for drugs, whether originator, generics and biosimilar by the Ministry of Health, as part of the implementation of the national pharmaceutical policy ;

Apply the tax exemption to drugs related to all LTD / HED (and medical devices of these LTD) ;

Coherent CHCI / CHI[14]organization:
In addition to the compulsory plan, which bears the major part of the costs incurred, some organizations have recourse to additional cover (mutual funds, private insurance, social work foundations, etc.).

For better funding, the experts are proposing the definition of a national vision for medical coverage based on an CHCI-AMC joint to better manage the high risk. It makes it possible to strengthen the health care coverage of insured persons articulated around the reorientation of CHCI towards high risk, thus sparing the insured from bearing catastrophic health care expenses.

Insufficient funding sources for the assistance component:
The 2017 ONDH report highlighted the lack of funding for MASPP. The reduction in investment budgets allocated to hospitals, which can lead to a drop in the quality of care provided, especially in the event of aging hospital equipment and the inability of health services to maintain them. The same report explains that the own revenues of public hospitals have decreased, which is explained by an increase in the share of free patients (mainly MASPP) and by the fall in that of paying patients, which represents a substantial shortfall.

The switch to MASPP was therefore accompanied by a drop in the contribution of paying users to the own resources of public hospitals. Two categories of financial resources are potentially able to compensate for it. These are the operating subsidy and reimbursements linked to MASPP.

However, the experts consulted foresee the reimbursements linked to MASPP to be covered by an external fund, financed by tax revenues (Internal consumption tax on tobacco, HEDohol, sugary drinks), OECD report[15] (2020), as well as taxes based on the turnover of pharmaceutical laboratories, dispensing pharmacies, private health establishments, and finally taxes on the various forms of gambling "betting or lottery" (practiced in a private context " Casino,… "Or within the regulated framework" Moroccan Games and Sport, Royal company for horse heartening,… etc. "), corresponding to a classic pre-financing mechanism as in the case of health care insurance.

Putting public hospitals back at the heart of national health care insurance policy:
Ensure fair competition between the public and private healthcare supply by improving quality and efficiency requirements at the level of public and private healthcare structures. Hence the need to provide the public hospital with the human and material resources necessary to enable it to play the role of a locomotive in the health sector.

[14] Complementary health insurancere.
[15] OECD report "Mobilization of tax revenues for health financing in Morocco", 2020.

Reform scenario for the harmonization of healthcare services component:
The healthcare coverage environment is characterized by disparate baskets of care and a MASPP basket for improvement. The prospect of the unification of regimes is conditioned by a homogeneous and stable basket. Harmonization involves alignment with the best levels of benefits, of compulsory basic health care insurance schemes, in particular at the level of Health insurance basket of servicess. In fact, within the framework of maintenance of acquired skills, the experts suggest alignment with the best basket of care, however they retain the basket of care from the NSPIF which is considered to be the best in terms of covered benefits and reimbursement rate.

Stabilizing the basket of care and establishing consistency in coverage levels between the public and private sector CHCIs represents a major challenge, harmonizing that of MASPP remains more complex but it should guarantee the universalization of the BHI within a framework of equity access to services.

Based on the high concentration of the healthcare supply on the Rabat-Casablanca axis, as well as the delay recorded in the publication of the implementing texts of framework law 34-09 relating to the health system and the supply care, as well as the absence of a health card for the private care sector. Experts demand fluidity in the publication of regulatory texts allowing fair access to community care for all citizens. They insist on the definition of a health policy oriented towards the development of a major chapter within a future "health charter" and a contribution to human development.

Moreover, the Ministry of the Economy, Finance and the Reform of the Administration during its intervention before the finance committee (2020), opted for "a unified and universal basket of care CHCI", independently of contributory powers of beneficiaries.

The ultimate objective is to provide Moroccan citizens with a universal and solidarity basket of care and a service that meets their expectations in terms of protection of their rights, financial and physical accessibility and quality and modern services.

Conclusion:-

Morocco is experiencing a constant increase in the health needs of its population, and consequently in the resulting financing needs. Demographic changes, the increase in life expectancy, the new demands of citizens in terms of well-being and health, the development of CHCI, lead to a continuous increase in health expenditure.

In addition, the proliferation of schemes, the high degree of direct payments, and the absence of an integrated information system to manage medical coverage remain weaknesses from which the governance of the BHI in general suffers.

All the more so since the proliferation of schemes leads to differences in the treatment of beneficiaries (contribution and ceiling levels, Health insurance basket of servicess, reimbursement levels, types of eligible establishments) which risks reinforcing the existing inequalities in terms of 'access to quality care. In addition, this proliferation limits the possibilities of rationalizing the management of resources, does not allow transfers and cross-subsidies between funds and the sharing of risks between categories of the population of very different socioeconomic levels. These inequalities could be reinforced by the fact that the most solvent populations participate little in the CHCI (they continue to subscribe to specific insurance systems).

The preceding elements provide a nuanced assessment of the development of solidarity medical coverage in Morocco. However, other perspectives are about to emerge. Indeed, in October 2020, His Majesty the King sets, before Parliament, the agenda for the generalization of social coverage for the benefit of all Moroccans set for 2022, considering that it is a “Major national project, of an unprecedented nature”.

It is obvious that the CSU is the major project which will constitute, alongside the Unified Social Register[16] (USR), the two pillars of national social policy over the coming years and the two bases of solidarity on which Morocco will

[16] Established by Law 72-18 relating to the targeting mechanism for beneficiaries of social support programs.

build its development model and its policy of social cohesion and inclusion. However, the RSU represents the essential link for the reform of social programs. It is a State response both to the problem of targeting low-income households that must benefit from public social programs and to that of the fragmentation of the social protection system, characterized by overlaps and dysfunctions that affect it. efficiency and effectiveness.

Finally, the development and universalization of medical coverage must be carried out far from political debates relating to its practical organization.

The final objective is to walk, together, towards Universal Health Coverage which is surrounded by royal high solicitude, preserving the achievements and building a lasting system for our future generations.

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