



**SOCIAL PROTECTION SERIES**

# **UNIVERSAL HEALTH COVERAGE IN MOROCCO: FROM RIGHT TO TREATMENT TO HEALTH INEQUALITY**

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Arab  
Reform  
Initiative



Arab Region Hub  
for Social Protection

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Cover photo: The social health compound building, Fnideq - July 2023

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## Executive Summary

This paper seeks to analyze the social protection system in Morocco as a whole, with a focus on its main pillar related to the policy of extending compulsory health coverage to vulnerable and disadvantaged groups. Our focus on these groups is intended to highlight their representation and social and cultural attitudes toward the universal health coverage (UHC) programs that aim to guarantee the right to treatment and prevent health risks for more than 22 million additional beneficiaries of compulsory sickness insurance. On 23 March 2021, the king of Morocco issued Royal Dahir No. 1.21.30 to implement Framework Law No. 09.21 on Social Protection, which is based on the provisions of Article 31 of the Moroccan Constitution providing for the right to social protection and health coverage; these goals are also evident in international legislation on the same subject and the 2030 Sustainable Development Goals (specifically the third goal related to health and well-being) to which Morocco is committed.

After analyzing the objectives of the UHC project and its effects on the social reality, the Moroccan medical system, the country's economic structure, and its productive system, the limitations of these programs emerged, as well as the fact that their results on the target groups are not expected or clearly defined. It will have repercussions on the two-thirds of Morocco's population who are poor, indigent, and poorly paid after they are transferred from the Medical Assistance System (Régime d'Assistance Médicale, or RAMED) to the compulsory sickness coverage system and subjected to program targeting. As much as this project reveals important ambitions in the field of assistance and reducing socioeconomic disparities in the right to treatment and protection against health risks, it also reveals some of its technical objectives, the ambiguity of its components on the one hand (targeting and taxation), and the extent of the difficulties and structural obstacles that stand in front of it, as well as the inequality and health injustice that it will perpetuate. Thus, the sustainability of health risk protection comes into question.

### Objective and Methodology

Thinking about social protection in Morocco from the perspective of the sustainability of services, compensation for health risks, and ensuring equitable access to treatment, especially for groups that have never had health coverage, means thinking about a complex reality that does not present itself as politicians and decision-makers envision it. Questions of protection are deeply rooted in individual and collective livelihoods, risk management, and coping. In other words, the social representations that regulate actors' behavior are a key determinant for the effectiveness and sustainability of the various development programs undertaken by the state. In the same vein, it is difficult to implement a public policy in the field of health and social protection without changing the meta-perspective that characterizes the construction of public policies as a whole.

This study adopts a qualitative approach by employing a semi-structured interview technique, focusing on the meaning that social actors produce about themselves, health institutions, and the social protection system led by the Moroccan state in terms of UHC. The same approach also focuses on the actors' different modes of interpretation (whether they are beneficiaries or not) of the forms of inequality they see, potentially or realized, as a result of the social protection system's targeting given the social characteristics of the target group and the nature of the therapeutic and hospital supply in Morocco.

This research is based on a field study employing the semi-structured interview technique with various target groups, experts, opposition politicians, and journalists specializing in the topics of protection and health in Morocco. It will work with two categories of interviewees: the first category includes 40 plan beneficiaries; the second includes six actors who are experts, politicians, and journalists specializing in protection and health, none of which are directly targeted by compulsory health coverage. The interviews conducted with the beneficiaries included two main

subcategories: indigent individuals of both sexes and vulnerable non-wage earners. The following criteria were taken into account in selecting the participants: equal participation by both men and women; age group; geographical area; types of disease(s); nature of work or lack thereof; and type of health coverage. The second group consisted of a female parliamentarian from the opposition party, two experts in the field of health and social protection, an official at the National Social Security Fund (CNSS), and a journalist specializing in public policy. We relied on the analysis of various reports, publications, official documents, laws, regulatory texts, other documents issued by NGOs, and some studies and articles with an academic or journalistic analytical dimension.

## Key Findings and Recommendations

The study showed us the emergence of a new policy intervention context for the state toward the issue of social security within the societal context by trying to institutionalize it – especially for the benefit of the uninsured – producing a dynamic of social action by the official actor or within uninsured groups of small traders, peasants, the indigent, and the poor. As a result, some of the targeted groups now find their way to health treatments or services and seek compensation for damage or treatment costs from the social reserve funds. This presents an important shift in the social security system in Morocco, as the idea of health security had been reserved for the elite from Morocco's independence until the new system's activation. The economic and social status of individuals now determines the possibility of compensation and full or partial coverage. The study also revealed several gaps that will stand in the way of the effectiveness of the right to treatment and UHC in Morocco:

- Excluding some groups from the right to insurance by being categorized as beyond the threshold, contradicts the perspective of health protection as a human right, rather than an unconditional guarantee for indigent or vulnerable groups.
- Access to healthcare is linked to the social targeting system, which is ineffective especially due to the fragility of the selection criteria, the unclear status of workers in the informal sector, widespread unemployment, and the large number of marginalized people. Thus, Morocco's social targeting system can help reduce inequality by providing greater support to disadvantaged households, but it can also produce other exclusions, such as removing eligible beneficiaries or producing new stigmatization of target groups through the publication of lists of beneficiaries.
- There is a lack of clarity on how UHC is financed due to the state being the primary contributor for many of the targeted population; it is also difficult for other groups to sustain their contributions due to their precarious social and professional status, or because they refuse to subscribe to state social security, perhaps preferring to go with a private agency.
- Healthcare services are absent for mothers working in the informal sector, despite being the largest demographic in Morocco.
- There's limited recognition of people with disabilities in healthcare, especially in light of the heterogeneity of this social segment due to their varied physical characteristics and needs vis-à-vis the healthcare system.
- There is a complete exclusion of migrants and refugees, which also contradicts the human rights approach.
- The digital divide prevents many of the targeted and disadvantaged from accessing healthcare. This gap increases for the elderly and those who are geographically isolated; the compulsory health coverage programs did not offer any alternatives or guarantees to help these groups benefit from support and health care, not to mention the administrative difficulties and specific procedures for registration and utilization.

## Introduction

This study falls within the framework of the Non-Resident Fellows Program of the Arab Reform Initiative for 2022-2023. It seeks to analyze the social protection system in Morocco as a whole, with a focus on its main pillar: the expansion of compulsory health coverage to vulnerable and disadvantaged groups. Our focus on these groups is intended to highlight their representation and social and cultural attitudes toward the UHC initiative which aspires to guarantee the right to treatment and prevention of health risks for more than 22 million beneficiaries of compulsory sickness insurance. This study was motivated after the king of Morocco issued a royal Dahir on 23 March 2021 – No. 1.21.30 to implement Law-Framework No. 09.21 on Social Protection based on Article 31 of the Moroccan Constitution – providing for the right to social protection and health coverage; the study was further motivated by international legislation on the same subject, as well as on the third goal (related to health and well-being) in the UN’s Sustainable Development Goals 2023, to which Morocco is committed.

There is no disagreement regarding the importance of this UHC project, the philosophy behind implementing its framework law, or its noble objectives, however, after analyzing the objectives of this project and its effects on the social reality, the Moroccan medical system, and the country’s economic structure and production system, the limitations of the UHC initiative emerged, including its uncertain results and unforeseen impacts on two-thirds of the Moroccan population – the poor, indigent, and those with medium and low incomes – after their transfer from the Medical Assistance Scheme (RAMED) into Compulsory Health Insurance System (AMO) and are subjected to the principle of targeting while the project reflects significant ambitions in the realm of assistance and aims to reduce social and economic disparities by ensuring the right to treatment and protection from health risks, it also reveals certain technical objectives and ambiguities in its components, particularly regarding targeting and taxation. Furthermore, it highlights the significant structural challenges and obstacles it faces, alongside the inequalities and health injustices it risks perpetuating. These factors call into question the sustainability of health risk protection. These are the main conclusions that led us into the field to conduct this qualitative study using a semi-structured interview technique with target groups, experts, politicians from the opposition faction, and journalists specializing in the topic of social protection and health in Morocco.

This paper is divided into five sections. The first

includes the context and objectives of the study, in which we highlight the various justifications for conducting it and its objective justifications within the Moroccan context. The second section summarizes the basis of the UHC project in Morocco and includes a brief historical overview. The third section covers previous studies and the theoretical and conceptual premises governing the question of social protection and UHC in Morocco. The fourth section describes the methodology adopted in the study, explaining the reasons and justifications for this choice and its field techniques. This section also includes a discussion of research ethics, which we added to the field study with the participants. The final section of the paper presents our findings and is followed by a conclusion presenting a general discussion of these findings and recommendations.

## Study Context and Objectives

This study comes more than three years after the official launch of the social protection project in Morocco when the framework law was published in the Kingdom’s Official Gazette.<sup>1</sup> This social protection project is part of an international and local context characterized by the question of expanding social protection for groups living with various social and health risks. In Morocco, the question of UHC has become the subject of societal debate since the project was launched by the head of state in March 2020. For the first time in Morocco’s contemporary history, such a debate is being raised among political and economic actors, and the groups concerned, and has even extended to the general public, which we consider evidence of the birth of a new kind of “security awareness” regarding the issues of health insurance, unemployment or job loss, and the role of the state and health insurance among others. Reading the text of the framework law, its regulatory texts, and following its set agenda reveals several milestones that require

1 General Secretariat of the Moroccan Government, Framework Law No. 09.21 on Social Protection in Morocco, published in the Official Gazette, No. 6975, April 5, 2021, available at [http://www.sgg.gov.ma/Portals/1/lois/Loi\\_09.21.pdf](http://www.sgg.gov.ma/Portals/1/lois/Loi_09.21.pdf) (General Secretariat, Framework Law No. 09.21)

attention, especially related to health and preventative health care.<sup>2</sup> Therefore, the ongoing implementation of this project is not without challenges or questions and methodological difficulties, particularly regarding the idea of conducting a study on a project that is still in progress. This raises questions that may occur to every reader, regardless of their perspective or area of interest. To address this dual dilemma – both epistemological and methodological – we relied on our three-year observation of the project.

We found that while the project's foundations for compulsory health coverage are ambitious, they are counterbalanced by complex constraints inherent in the realities it seeks to address. These constraints are reflected in various social indicators related to development, health, poverty, spatial disparities, the unclear engagement of stakeholders, and the cultural frameworks of the targeted groups themselves. These factors collectively motivated our decision to undertake this study.

This study does not evaluate the social protection project as a protection against the risks of illness in light of the difference between a project evaluation and a research study, which has its own objectives, conditions, and constraints (although some objectives overlap, on the one hand highlighting the paths that the UHC project should take and the stakes before it, and generating practical recommendations for official actors in order to draw attention to what could be a social policy in the field of UHC). Instead, this study seeks to shed light on the system of compulsory health coverage in Morocco as a form of social protection; to outline its objectives in order to publicize it and monitor its potential effects, whether in reducing social disparities affecting access to treatment or deepening some existing inequalities; and to highlight the form of social resistance that has emerged in its ruins.

In this regard, this study seeks to monitor new manifestations of inequality by examining the imposition of contributions to social security funds for certain vulnerable groups in exchange for their access to compulsory health coverage in accordance with the principle of solidarity between groups that the state seeks to implement in Morocco. This study also seeks to create a space in the social protection project for other voices – such as experts, politicians, and journalists – alongside a space for the targets themselves, not only discussing the founding idea and principles, but also in

the construction of its premises and pillars, especially with regard to the area of demographic targeting and linking health care insurance or protections to major structural reforms stipulated in the framework law on social protection (which also covers the reform of pension funds, family allowances, the clearing system, rehabilitation of health institutions, and building a national database through the adoption of the national register).<sup>3</sup> The sustainability of UHC is a real question in this ambitious project for social protection in healthcare.

Our comprehensive review of various literature and reports on the subject of social protection in third-world countries or emerging economies led us to consider it a complex issue that goes beyond the logic of development architects and their schemes. These often isolate social protection as either a standalone issue or a technical matter, focusing on aspects such as targeting beneficiaries, redirecting social support, or registering individuals in social security funds. However, social protection goes beyond such a limited framework, embodying a broader social horizon in which the state seeks to engage as a public policy. This perspective closely aligns with the question of UHC in Morocco, where social, health, and economic indicators point to the interconnectedness of these issues within the broader scope of development.

This study also evokes the need to think about the issue of protection against the risks of disease and guaranteeing the right to treatment within the basket of programs that Morocco has worked to build over two decades. We can consider the general context around the state's perception of social protection and its role within these programs and development plans during the last two decades (which have been dominated by discourse on improving the social status of individuals and groups). Since the turn of the millennium, the head of state has been aware of the magnitude of the difficulties that two-thirds of Moroccans face, and this was one of the justifications for the creation of the National Initiative for Human Development in 2005 and other social programs through which the king wanted to fight social disparities and all forms of inequality, especially with regard to access to treatment and hospitalization. The total number of development programs is estimated at 140. However, their results have not met the expectations of officials or citizens; governance, effectiveness, and coordination have been absent according to official reports from the state

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2 General Secretariat, Framework Law No. 09.21.

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3 General Secretariat, Framework Law No. 09.21.

and international partner organizations in the field of development and social intervention.<sup>4</sup>

At the same time, we can consider the transformation of the question of development from the right to income and livelihood by fighting poverty and regional disparities to the right to health as a political agenda and a developmental horizon that finds its objective justification first in the social protection floors stipulated by the International Labour Organization (first in 2012<sup>5</sup> and reaffirmed at its 109th conference in 2021)<sup>6</sup> and in the 2015 Sustainable Development Goals report. The right to treatment is organically linked to the right to genuine social security and access to real health care, and is accompanied by the availability of four minimum guarantees:

1. Access to basic health care, including maternity care.
2. Basic income security for children.
3. Basic income security for people of working age who are unable to earn sufficient income.
4. Basic income security for the elderly.

These four guarantees must be met to achieve effective health care; in light of the various development indicators in Morocco and the nature of its healthcare system, it is somewhat difficult to achieve these metrics by international standards given the types of support that the Moroccan state has provided to these groups.<sup>7</sup> Care and protection from the risks of disease are more related to the economy and culture than to health.<sup>8</sup> At a time when

the Moroccan healthcare system aims to create a climate and space to protect vulnerable and poor groups from health risks and ensure their access to medical institutions – whether public or private – without any selectivity or social discrimination, Morocco has the lowest rate of the active population that benefits from legal coverage for work-related accidents.<sup>9</sup> Unemployment remains high, with the national rate reaching 13% in 2023 (17% in urban areas and 7% in rural areas).<sup>10</sup> There is poverty and inequality in the geographic distribution of services and goods, and most elderly do not benefit from the right to a pension; even for those who do benefit, their monthly pension does not exceed the minimum wage in Morocco, and most health-related expenses are borne by families. This burden is further compounded by the inclusion of people with disabilities.<sup>11</sup> Among the difficulties facing the four requirements for a health care guarantee are the governance of social coverage funds; the instability of the labor market; the proliferation and opacity of the informal labor sector; and the lack of labor market control, regulation, and inventory. For example, a study by the High Commission for Planning shows that the share of workers in the informal sector reached 28.7% of the total labor force in 2021, most of whom are males, heads of households, or youth under the age of 35.<sup>12</sup> At the same time, work in Morocco is characterized by low productivity,

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allocated only 2% of the wealth generated annually to public expenditures on the health sector, the lowest percentage compared to countries in the MENA region (2.83%). This explains, to some extent, why the proportion of the population with health coverage compared to the total population in Morocco does not exceed 54.6% as of 2016. World Health Organization, *Global Report on Health Data Systems and Capabilities 2020*, p. 44, available at <https://iris.who.int/bitstream/handle/10665/358070/9789240048874-ara.pdf>

4 Banque Africaine de Développement, “Maroc programme d’appui à la gouvernance de la protection sociale (PAGPS)”, 2016, <https://bit.ly/36lxqFg>, p. 15.

5<sup>5</sup> International Labour Organization, Fourth Report (2B) “Social Protection Floors; for Social Justice and Fair Globalization”, 2012, p. 5, available at <https://www.ilo.org/ar/media/164416/download>

6 International Labour Organization, Report of the International Labour Conference, 109th Session, “Towards building the future of social protection; for a people-centred world of work”, p. 55, available at <https://www.ilo.org/publns>

7 For the types and amounts of direct support in Morocco, see Direct Support System Platform, available at <https://www.asd.ma/ar>

8 According to the World Health Organization, in 2011 Morocco

9 Economic, Environmental and Social Council, “Social protection in Morocco, the state of affairs and ways to strengthen security and social assistance systems”, Self-referral no. 34/2018, p. 15, available at <https://www.cese.ma/docs/la-protection-sociale-au-maroc/>

10 High Commission for Planning, “News note on the status of the labor market during the first quarter of 2022”, available at [https://www.hcp.ma/La-situation-du-marche-du-travail-au-premier-trimestre-de-2022\\_a3110.html](https://www.hcp.ma/La-situation-du-marche-du-travail-au-premier-trimestre-de-2022_a3110.html)

11 Economic, Environmental and Social Council, “Older Persons in Morocco”, Self-referral No. 20/2015, available at <https://www.cese.ma/docs/les-personnes-agees-au-maroc/>

12 High Commission for Planning, “Les Brefs du Plan”, No. 16, 2021, available at [https://www.hcp.ma/Les-Brefs-du-Plan-N-16-02-Mars-2021\\_a2668.html](https://www.hcp.ma/Les-Brefs-du-Plan-N-16-02-Mars-2021_a2668.html)

a dominance of unpaid or underpaid work, and undignified work (i.e., absence of a contract or any health, occupational, or safety insurance).<sup>13</sup>

These and other difficulties put the National Human Development Index (IDHN) in a very mediocre or even low ranking if viewed from the perspective of health and health insurance. According to the 2017 report of the National Observatory for Human Development, which considers health to be the most important of the 17 dimensions of the Human Development Index, the difficulties in accessing treatment and medicine continue to increase with the growing disparities between rural and urban areas, between regions with the highest rates of poverty and isolation (such as Beni-Mellal or Khenifra), and in gender, with women being the most affected by the inequality.<sup>14</sup>

The consideration of some social indicators when discussing social protection in Morocco in terms of illness and health care is due to their importance in every social policy and targeting rubric for these issues.<sup>15</sup> The experience of the RAMED program<sup>16</sup> – adopted by Morocco in 2012 to achieve social protection in health care and reduce inequality in access to treatment – shows the limitations of the targeting logic.<sup>17</sup> RAMED confronted a complex reality

that limited the possibility of achieving the various objectives on which it was based<sup>18</sup>: a fragile health system with weak or limited public funding; lack of medical staff, especially specialists, regional imbalances; poor governance; and targeting issues. One confounding factor was that RAMED holders' access to health services is limited to public hospitals that are often not large enough to meet their health needs.<sup>19</sup>

Similarly, the COVID-19 pandemic and the 2023 earthquake in the al-Haouz region have exposed the aforementioned shortcomings and challenges that continue to affect access to comprehensive health care for vulnerable and disadvantaged groups, making the measures taken by the state to combat the effects of disasters on these groups unable to guarantee a sustainable right to treatment and protection from health risks. New forms of social exclusion have also emerged: difficult or limited access to treatment, lack of access to medicine, and geographically isolated impacted areas.<sup>20</sup>

It is clear from the above that social protection programs, including UHC, face major obstacles despite the political and societal ambitions that accompany them or the changes they bring about in people's livelihoods – especially for those with chronic diseases such as renal insufficiency and cardiovascular disease. This is our conclusion, as well as that of other researchers who have worked on the same question.<sup>21</sup>

This study aims to highlight the idea that sociological thinking about how the state manages social issues in Morocco is characterized

13 Fouad Abdel Moumni, "The Social State is conditional on development and development is conditional on the employment of idle productive forces and a break with the cost, organization and culture of the makhzen", pp. 31-18, *Spring Magazine*, Issue 15, "The Social State; Concept and Experiences, Slogan and Reality", Ben Said Ait Yedder Center for Research and Studies, 2023.

14 The National Observatory for Human Development in Morocco (ONDH), "Human Development Report in Morocco, 2017", pp. 65-50, available at <https://www.ondh.ma>

15 By social targeting, we mean the system used by the state to determine who is eligible to receive support and assistance, a system that has revealed its limitations in various international experiences, available, for example, at Laure Pasquier-Doumer, Emmanuelle Lavallée, Anne Olivier and Anne-Sophie Robilliard, "Cibler les politiques de lutte contre la pauvreté dans les pays en développement? Un bilan des expériences", *Revue d'économie du développement*, 17, 5-50/2009, available at <https://doi.org/10.3917/edd.233.0005>

16 Ministry of Health of Morocco, "Report of the International Conference on Health Coverage for Vulnerable Groups", 2015, available at <https://www.sante.gov.ma/Documents/2017/02/rapport%20ramed.pdf>

17 Raphael Cottin, "Le ciblage direct des ménages est-il possible pour les politiques de santé ? Le cas du RAMed au Maroc". *Mondes en développement*, 187, 29-50/2019, available at <https://doi.org/10.3917/med.187.0029>

[org/10.3917/med.187.0029](https://doi.org/10.3917/med.187.0029)

18 Morocco's Ministry of Health (MS), Report of the "International Conference on Health Coverage for Vulnerable Groups", 2015.

19 Raphael Cottin, "Le ciblage direct des ménages est-il possible pour les politiques de santé ?"

20 High Commission for Planning, "The Second Phase of the Research on the Impact of the Coronavirus on the Economic, Social and Psychological Situation of Households", June 2020, available at [https://www.hcp.ma/Rapports-sociaux-dans-le-contexte-de-la-pandemie-COVID-19\\_a2577.html](https://www.hcp.ma/Rapports-sociaux-dans-le-contexte-de-la-pandemie-COVID-19_a2577.html)

21 Othman Makhon, "Morocco's Social Protection Programs: Can the Country Overcome the Odds?", Arab Reform Initiative, September 2023, available at <https://www.arab-reform.net/publication/moroccos-social-protection-programs-can-the-country-overcome-the-odds/>

by two main positions: the position of the technocratic actor in engineering medium- and long-term projects for society, and the position of the researcher who observes these social policies. Development has its internal logic that may or may not be partially or completely in line with the political actor. This paper's reference point remains the reality targeted by development, its specificities, and the rooting of cultural and social characteristics in the structure targeted by the social engineer. Protection against the risks of illness and UHC in Morocco does not deviate from this sphere, as the reality is made up of structural issues – governance, poverty, spatial inequality – and issues related to the culture of protection and care and the representation of the future among the target groups. Resistance to the taxation system, to targeting, and enrollment in social security funds emerge, sometimes referred to as hidden or silent resistance; these resistances appear to the scientific observer in the behaviors of those targeted, such as the strategy of dropping out of one category and joining another,<sup>22</sup> or abandoning payments due to financial difficulties after being placed in a category, following the logic of targeting, taxation, and subterfuge, on the principle of targeting to prevent classification in the positive performance indicator. Illiteracy remains a real obstacle to the culture of social protection in Morocco, obstructing most public policies of this kind as there are multiple procedures and enrollment paths that must be navigated, preparation of documents, and deadlines to be aware of and adhere to.

This study seeks also to highlight the hidden elements and interconnections, with an anthropological dimension, that surround the idea of operationalizing social protection and UHC in Morocco. This revelation is supported by the most prominent research and conclusions already reached by development anthropologists in developing and emerging countries (e.g., Jean-Pierre Olivier de Sardan, Didier Fassin, and Marc Augé), the most important of which is the gap between what political actors aspire to in the field of development and social change and the sociological and anthropological reality; this gap leads the development plan to fail in achieving its goals or deviate from them. The success of UHC in Morocco is contingent on bridging this

divide so as not to limit the possibility of achieving its goal of creating the right to treatment as a gateway to a stronger bond of belonging to society and its institutions. This sense of belonging leads the individual to another sense of self-recognition, as envisioned by Serge Baugham.<sup>23</sup>

Based on the above, we can formulate research questions as follows: What are the social and cultural determinants of the operationalization of compulsory health coverage in Morocco? What is the nature of the social knowledge that target groups possess about the UHC project? What strategies have these groups produced in the face of the idea of payment in exchange for the right to health? How do political and civil actors perceive the ability of UHC to enshrine the right to health in Morocco?

As a major premise of this study, we argue that the reality targeted by the social protection system of compulsory health coverage is complex and socially and culturally constructed, which reduces the chances of its operationalization and the creation of therapeutic justice. Its unforeseen consequences, especially for the target groups, are not sufficiently clear – namely, the two-thirds of Morocco's poor population that will be transferred from the RAMEC medical assistance system to the compulsory health coverage system, as well as the vulnerable middle- and low-wage groups whose mobility and contribution to social security funds are still uncertain.

## **A Brief History of Morocco's Social Protection System: From Assistance to Protection**

Morocco's first social security fund, for wage earners only, was established in 1959. The system was modernized in 1972 to include family benefits, short-term benefits (e.g., illness, accidents, and mourning), and long-term benefits (e.g., total or partial paralysis, death, retirement, and compensation for the family of the deceased). However, these benefits completely

22 Unified Social Register, Finishing Procedures, available at <https://www.rsu.ma/ar/web/guest/proc%C3%A9dures>

23 Serge Paugam, *Du lien social aux liens sociaux*, Paris, PUF, 2009, p.50-59.

lacked health coverage until the year 2000, with the introduction of Regulatory Law 65.00 on basic health coverage, known as AMO (Assurance Maladie Obligatoire). According to this law, wage earners, retirees, and students became eligible to benefit from health services provided by both public and private institutions, along with reimbursement for expenses they incurred. For their expenses. RAMED was introduced in 2005, funded by the state and local communities.<sup>24</sup> The health coverage system will change with Law 65.00, as wage earners became entitled to benefit from health coverage from the CNSS, while non-independent workers and the self-employed were retained until the promulgation of the Social Protection Law 2021 (Article 4), which constitutes a major basis for this study.

However, data from the National Health Insurance Agency (ANAM) highlights the imbalance between the number of enrollees by social security funds.<sup>25</sup> The National Fund for Social Security Organizations (CNOPS) had 1,350,090 public sector wage earners in 2021, while the private sector had 3,765,226 male and female enrollees. Despite the notable improvement in the number of enrollees, especially in the private sector, the same ANAM report indicates that this number does not cover the resources needed to ensure the sustainability of health protection and insurance. Only 36.26% of enrollees benefit from compulsory sickness insurance, and the rest – 63.04%, divided between 10.09 million indigent and poor Moroccans and 11 million self-employed Moroccans – do not benefit from any coverage. This data shows the demographic weight of these groups and their needs for health services and coverage. The transition to a comprehensive social protection program, which began in 2017, was reinforced by the emergence of two legal texts that clarify the status of self-employed and non-wage earners within the Social Security Fund and their access to compulsory sickness insurance. Then, in 2019, another regulatory text emerged providing a precise map of the categories and their technical distribution, indicating that the matter is subject to constant institutional and legislative review and update likely due to the social protection

programs and the structural difficulties (including governance and sustainability) that the CNOPS has accumulated over decades.

## UHC in Morocco: From Choice to Compulsion

Morocco did not have a previous system that forced non-employees and some private sector workers to “automatically and sometimes compulsorily enroll in social reserve funds”. It started with the 2021 Finance Law, after which Morocco moved at the legislative level to require pre-registration in these funds – especially for wage earners and freelancers – in exchange for compulsory health coverage. This context can be viewed differently in terms of the premises and principles governing the behavior of individuals and institutions that have not enrolled, as there is a clear link between the tax rate imposed on the self-employed and the size of their contribution to the social security fund. For example, the Finance Law established a 10% tax on which this contribution is determined. In this context, the National Population Registry and the Unified Social Registry were created, both managed by the National Registry Agency. Based on the national digital identifier, an individual is assigned points and a poverty and indigence index is constructed; both of these metrics lead to a state contribution to the CNSS.<sup>26</sup> If a family’s entitlement index changes (+/- 749), the family must pay a predetermined amount.<sup>27</sup> This moved contributions to the fund from a matter of choice to a compulsory act for practitioners of liberal professions (e.g., doctors, lawyers, merchants). While we do not argue that this form is the most effective, we would like to point out that the state’s vision to push the self-employed to join the fund is now realized through a system of taxation and cumulative fines for those who are late in paying contributions (see more details below).

In the same framework, Law 98.15 was also issued compelling every economic, social, or cultural sector to provide the CNSS with any information it has regarding its practitioners. For example, the

24 Ministère de la santé et de la protection sociale, “Analyse des Iniquités en santé”, 2022.

25 Agence Nationale de l’Assurance Maladie, “Rapport annuel global de l’assurance maladie obligatoire”, 2021, p. 16, available at <https://anam.ma/anam>

26 Ministère d’Economie et de finance Marocaine, “site officiel”, <https://www.finances.gov.ma/ar/>

27 Unified Social Register, “Site officiel”, <https://www.rsu.ma/ar/web/guest/proc%C3%A9dures>

transportation sector sends a list of taxi drivers within a specific area, or the regional health delegation sends information on private sector doctors who own private clinics. In this way, the CNSS knows the identity of the contributor and the amount of the contribution to be paid. This can push many who have not contributed and beneficiaries of social protection services to join the circle of contribution, broadening the base of non-wage earners and ensuring balance and financial sustainability for the CNSS, according to the state. The state has also announced that it will be responsible for paying the contributions of the indigent and the poor to the social security funds.

## Study Core Concepts

In this study, we start from a number of concepts. The first group is made up of the concepts of social protection: comprehensive social protection, social health protection, the right to health, social inequality in health and treatment, and the concept of social targeting. Together, these concepts form a conceptual network that helps us build the general questions of the study, deconstruct their components, and monitor their intersections. Many of these concepts have been defined in the Arab Monitor report – such as the concept of social and comprehensive social protection and the right to health and its protection – which we adopt in this study.<sup>28</sup>

We also believe that the concept of social inequality requires going beyond any simple or technical approach to this inequality. For Didier Fassin, social inequality is part of the general structure of the body and society; he criticizes the idea expressed by French philosopher Jean-Jacques Rousseau two and a half centuries ago, according to which the inequalities engraved in the body are natural. Not only are the physical differences between individuals not based on nature or some kind of biological essence, but their determination stems from the inequalities created by society.<sup>29</sup> We also employ the concept of social targeting as a transcendence of the technical logic, which assumes the control and

monitoring of social and economic boundaries between individuals, to another logic that takes into account the invisibility of many groups that live in fragility or destitution; this invisibility becomes an obstacle to building comprehensive social protection.<sup>30</sup>

## Study Methodology and Techniques

Thinking about social protection from the perspective of sustaining services, compensating for health risks, and ensuring equal access to treatment – especially for groups without previous health coverage – means thinking about a complex reality that does not present itself as politicians or decision-makers envision it. Questions of protection are deeply rooted in individual and collective livelihoods, risk management, and coping systems. In other words, the range of social representations into which actors' behaviors can be organized determines the effectiveness and sustainability of the various development programs implemented by the state. In the same vein, anthropological study, particularly in relation to development, shows how difficult it is to implement a public policy in the field of health and social protection without changing the meta-perspective that characterizes the creation of public policies and their operationalization at the level they target.<sup>31</sup> Trends have emerged with a group of anthropologists who have studied and observed the implementation of health development programs in developing or emerging countries. For example, Jean-Pierre Olivier de Sardan, who is considered a model for ethnographic orientation in the construction and implementation of development projects, refuted technical or development-oriented approaches that are devoid of all forms of anthropological or sociological knowledge of the reality targeted by such programs.<sup>32</sup>

28 Arab Non-Governmental Organizations Network, "The Arab Monitor for Economic and Social Rights in Arab Countries, the Right to Health", pp. 96-137, 2023, available at <https://www.annd.org/ar/publications/> - 9.

29 Didier Fassin, et al, *Les inégalités sociales de santé*, La Découverte, 2000, pp. 20-25.

30 Olivier de Sardan, Jean-Pierre, *La revanche des contextes, des mésaventures en ingénierie sociale en Afrique et au-delà*, Karthala, 2021, pp.15-25.

31 Jean-Noël Ferrié and Jean-Claude Vérez, "Introduction. Mondes en développement", 187, 7-13/2019, available at <https://doi.org/10.3917/med.187.0007>

32 Olivier de Sardan and Jean-Pierre, *La revanche des contextes, des mésaventures en ingénierie sociale en Afrique et au-delà*, Karthala.

From this perspective, this study aims to adopt a qualitative approach through the use of the semi-structured interview technique, focusing on the importance of the meaning produced by social actors about themselves, health institutions, and the social protection system led by the Moroccan state with regard to UHC. The same approach also seeks to focus on the beneficiary and non-beneficiary actors' different modes of interpretation of the forms of potential or realized inequality resulting from the system's targeting, taking into account the social characteristics of the target group: indigent, low-income, poor, vulnerable, or unstable employment. The therapeutic and hospitalization options in Morocco are often characterized by deficiencies and disparities in access to and utilization of health services.<sup>33</sup>

We followed a content analysis approach to analyze the data obtained from the individual interviews with different actors after building networks for horizontal and vertical coding of the data, which allowed us to identify the main themes on which we built axes for analysis and synthesis. The stages of qualitative analysis, according to the deductive approach, are generally summarized as follows: condensing the raw textual data into a concise and summarized form; establishing clear links between the research objectives and the summarized findings from the raw data; and developing a framework for the underlying structure of the experiences or processes that appear in the raw data.<sup>34</sup> However, recognizing the ability of the entire method to work analytically with data does not mean that the researcher's own ability to explore the general themes, semantics, and language employed by the study participant should be overlooked. Here, it is necessary to use some kind of content analysis or to invoke what is called grounded theory, as they are generally complementary mechanisms of qualitative analysis.<sup>35</sup>

33 Ministère de la santé et de la protection sociale, "Analyse des Iniquités en santé", pp. 9-14/2022, available at [https://www.sante.gov.ma/Publications/Etudes\\_enquete/Documents/2022/Rapport%20Analyse%20iniquit%C3%A9s%20en%20sant%C3%A9%20au%20Maroc%20\(1\).pdf](https://www.sante.gov.ma/Publications/Etudes_enquete/Documents/2022/Rapport%20Analyse%20iniquit%C3%A9s%20en%20sant%C3%A9%20au%20Maroc%20(1).pdf)

34 David R. Thomas, "A General Inductive Approach for Analyzing Qualitative Evaluation Data", *American Journal of Evaluation* 27 (2): 237-46/2006, available at <https://doi.org/10.1177/1098214005283748>

35 Paillé, Pierre, "L'analyse par théorisation ancrée", *Cahiers de recherche sociologique*, 147-81, 23/1994, available at

Within the same framework, we conducted a field study through the semi-structured interview technique with two groups. The first group is made up of 40 beneficiaries, male and female, of the compulsory health coverage program, while the second group included interviews with six actors who are not directly targeted by this coverage: a parliamentarian from the opposition Socialist Union Party; a parliamentarian in the government majority; two experts in the field of health and social protection; an official from the CNSS; and a journalist specializing in Moroccan public policy. The study's target population is divided into two main categories: indigent individuals of both sexes and vulnerable non-wage earners. We used the following criteria in selecting the interviewees: equal representation from each gender; elderly and non-elderly; residents in urban and non-urban areas; varying types of diseases; people who are wage earners, self-employed, or unemployed; and people who are involved in AMO or RAMED.

We directed the same interview guide to all members of the first category, with a slight adaptation of the questions based on individual circumstances (such as those who are paid, unpaid, or permanently unemployed). The interview guide included the following topics: knowledge of the social protection program in Morocco and representation of health services; public or private healthcare; circumstances before and after obtaining basic health coverage; paying for health coverage; exemptions; the health system; and protection against health risks.

We relied on a different guide for the second category of interviewees, which included the following topics: their perception of the social protection project; the marketing methodology; the targeting and taxation methodologies (i.e., poor and indigent, effective or ineffective); governance, financial resources, and management effectiveness; and human resources and health infrastructure.

Instead of analyzing individual interviews, we analyzed various reports, publications, official documents, laws, and regulatory texts that dealt with the topic of social protection and health

<https://doi.org/10.7202/1002253ar>

coverage in Morocco, with the aim of identifying the objectives, premises, and difficulties that still surround the current project, its horizon, and its extensions. These documents are distributed among official institutions such as the High Commission for Planning, the Economic, Social and Environmental Council, the National Observatory for Human Development, and other documents produced by NGOs and other entities, in addition to studies and articles with an academic or journalistic analytical dimension.

## Research Ethics

This study is based on the research ethics guide included in the frame of reference of three Canadian institutions – the Social Sciences and Humanities Research Council, the Natural Sciences and Engineering Research Council of Canada, and the Canadian Institutes for Health Research – on responsible research behavior, and the “La conduite responsable en recherche” (responsible conduct of research) document on research ethics in the social sciences issued by the Arab Council for the Social Sciences, especially its guiding principle: “Respect for persons, good treatment, and justice”.<sup>36</sup>

Accordingly, we believe that the principle of informed consent and autonomy is a prerequisite for conducting field research. We informed the research participants about the basic elements of the study: its topic and objectives, the duration and nature of participation, the possibility of withdrawal, and the way the data will be used. We will use pseudonyms for the participants rather than their real names, and we will not use their data except in the process of scientifically constructing the data. Ethical considerations in this study will not only apply to fieldwork and direct relationships with research participants but also to the process of analyzing and interpreting the data. In our research, we will make sure that the voices of the participants, and not the voice of the researcher, are the most important.

## Results

### *Health coverage as a daily discussion:*

#### *Signs of a culture in the making*

The study revealed a social change concerning the relationship between the targeted groups and the concept of insurance and protection from health risks. This change follows over half a century of these groups experiencing a lack of security. Society has remained divided into two categories: the *secured* and the *unsecured* (*sécurisés et non sécurisés*). This division, introduced by the social security system, has led to a new way individuals perceive the social hierarchy, shaped by this categorization.

The topic of social protection, how to benefit from it, and the stories of others came up in every meeting we had with our respondents. We spent more than a year conducting field research in the areas of study, during which we examined the emergence of new narratives on the subject of security and healthcare under the new system. We looked at this issue throughout the implementation of the field study, during the interviews we conducted with those who are targeted by compulsory health coverage, such as small traders or sellers in the informal sector (known as “farasha”), or small and medium-sized farmers in rural areas. We recorded how access to health coverage has become an obsession in the minds of all social groups. Their discussions were dominated by two main elements. The first element was access and procedures. It became clear that knowledge of these procedures is not shared by all, despite the state’s allocation of registration units at the provincial level. The second element was concerns surrounding taxation on these groups and their ability to sustainably meet the requirements for participation, especially those who were categorized by the targeting principle as individuals outside AMO-Tadamon. Mr. Hamid, 41, a farmer who specializes in seasonal crops like wheat, said: “We are in favor of health coverage. We consider it important, but we are afraid of the requirements that we will not be able to meet. As a simple farmer, working in his small field that is not even enough to meet his needs, how will 120 dirhams [about US\$12.13] per month be enough?” Another young man, a 35-year-old grocer, adds: “We are for health coverage. In any case, it is important for us and our children.” These quotes illustrate the extent of the collective feeling that has begun to take root in the minds of the targeted individuals regarding the importance of compulsory health coverage, despite the concerns about meeting

36 Arab Council for the Social Sciences, “Guide to Research Ethics in the Social Sciences”, available at [http://www.theacss.org/uploads/cke\\_documents/RE-guidelinesAr.pdf](http://www.theacss.org/uploads/cke_documents/RE-guidelinesAr.pdf)

the requirements for those whom the Unified Digital Identifier (UDI) has categorized as obligated to contribute.

### ***Social protection as a political stake***

The field study reveals how the issue of social protection has become a regulator for political debates among actors in the field and even affects their electoral stakes. There is no disagreement among actors about the position that social protection has come to occupy in their political agendas, which are primarily electoral. It is enough to read the electoral drafts or visit the websites of political parties – whether those leading the government or those in the opposition – to see the presence of the social protection issue as an agenda item that reflects the party’s position in terms of construction or implementation, or in terms of defending a party’s legitimacy and relevance in a society where two-thirds of its members live in conditions of poverty, compound vulnerability, spatial and social inequality, and insecure access to basic treatment or hospitalization. Through our interviews with parliamentarians from the opposition and the majority, we reached a significant conclusion on how the issue of health coverage and the right to treatment has become the first political card that dominates the discussion of actors inside and outside the legislative institution: holding this card is considered a political gain. However, we do not consider this feature to be specific to Moroccan society, but rather to all political experiments that are driving reforms related to health and healthcare.

### ***Treatment from charity to protection***

The field study we conducted in Beni-Mellal, Khenifra, Rabat, and Kenitra showed a positive attitude among the target groups about the importance of compulsory health coverage. It allowed indigent beneficiaries to access health services in public and private medical institutions. Positive narratives emerged, such as a story from an interviewee about someone they knew who had received surgery without paying anything, to which they credited the coverage. One participant in our study, Mrs. Halima, a 71-year-old widow living in a neighborhood with affordable housing, underwent catheterization in a private clinic after benefiting from the AMO-Tadamon social security card. A second case is that of Mr. Omar,

from the same social group, who benefits from free dialysis at a private clinic in the city of Temara. We conducted an in-depth interview with Mr. Omar that lasted an hour and a half, during which he talked about the difficulties he faced in managing his health after suffering from acute kidney failure due to the high costs of dialysis sessions; that changed when he obtained the AMO-Tadamon card, which gave him the right to health coverage and to receive dialysis sessions without any financial difficulty.

Mr. Omar’s case is typical of the reality of more than one million Moroccans who suffer from renal insufficiency and live a life of destitution and subsistence with the accompanying difficulties of accessing dialysis due to its high financial cost, not to mention the social cost. However, Mr. Omar’s transformation occurred once he received the AMO-Tadamon card, which enabled him to attend treatment sessions: “It was impossible for me and people like me to have a session in a private clinic for filtering; we were looking for clinics or benefactors, and having sessions in the public hospital is almost impossible because of the long waiting period.”

### ***The right to treatment based on targeting***

Many social groups within those targeted by compulsory health coverage have expressed their unwillingness to pay for it. They explain that the targeting is unfair and does not take into account the social difficulties experienced by these groups, most of whom end up as members of the informal sector. They also believe that self-employment in Morocco does not constitute a homogeneous unit and is not linked by a set of conditions: a trader is not the same as a taxi driver, a small farmer, or a construction worker. We are faced with a mosaic of professions and trades that have been subjected to a neoliberal bureaucratic perspective that creates categories according to what has been called a “unified digital identifier”. Says Mr. Ahmed, a 41-year-old taxi driver: “I am not protected at all, so how can I be expected to pay a monthly contribution to the fund? The car owner and the holder of the transport permit (*agrément/gréma*) impose the work on me and take a larger share than what I, the driver, earn... I am for this social protection system; I would even like to have a card that would allow me easy access to hospital and retirement, but mostly God is silent.” It is clear from Mr. Ahmed’s account how difficult it is for people like him to contribute to social security funds; an estimated one-third of Moroccans work in “unstructured”

sectors. The reality of taxi drivers is one example of a social group that suffers from inequality in terms of access to treatment and medicine that is expected to be provided by the current social protection system and compulsory health coverage, especially since a number of “free” professional associations in Morocco have not yet organized in a way to keep pace with the state’s expectations regarding monthly financial contributions to UHC. The uncertainty of the conditions of their professional practice may prevent them from accessing health services and benefits, resulting in denial of treatment.

In light of this situation, a number of social practices have emerged in those seeking the right to treatment in order to decode the targeting and turn it in their favor. The puzzle for them was the digital identifier, an obstacle that moved from its techno-mechanical nature to its inequality-producing bureaucratic nature. The field study showed us at different levels how the questionnaire and its indicators became the subject of ridicule by those who were targeted and those who worked at the electronic registration counters for those wishing to obtain compulsory health coverage.

### ***The right to treatment needs sustainable financing***

The field study revealed that the financing of UHC is a point of disagreement among the various stakeholders, although the official rhetoric shows what the sources of funding are and recognizes their sustainability. In this regard, one of the economists participating in the study, a 63-year-old university graduate, believes:

*“Social protection and the universalization of health coverage for Moroccans are contingent on a review of the country’s economic system, the methods of wealth production, and its distribution – specifically, where and how added value is generated and allocated. In other words, it calls for transparency in regulating this added value to enable genuine financing of social protection, as outlined in the provisions of the framework law.”*

This conceptualization is somewhat consistent with the Beirut Forum’s “Principles of Social Protection in the Arab World”. The ninth principle states: “The desired social protection systems should be financed primarily through the internal redistribution of

wealth and public resources, rather than simply relying on sovereign debt as the main source of financing, whether external or domestic.”<sup>37</sup> The same statement also called for the adoption of financing schemes that adhere to the principles of development effectiveness, consistent with a statement by the Addis Ababa Action Agenda’s Financing for Development.

### ***No UHC with a limited public health offer***

UHC cannot be separated from the reality of the health system in terms of its financing, its treatment and organizational structure, and its human resources. This conclusion has been reached by various local and international reports and studies that we reviewed and has been expressed by more than one political official. Public health financing is a fundamental pillar of the constitutional right to health. The general budget of the Ministry of Health still ranges between 6% and 7% of the public budget, instead of the 12% recommended by the World Health Organization.<sup>38</sup> Health spending remains less than 6% of GDP, which is lower than the global average of 10%.<sup>39</sup> Perhaps this is one of many constraints that continue to impede the right to health in the Arab region and Morocco in particular, as concluded in the Arab Monitor’s sixth report on the right to health.<sup>40</sup>

The realization of the right to access medical services for the target group remains more

37 Howaida Adly Roman, “A Guide to Universal Social Protection in the Arab Region: Challenges and Opportunities”, Arab Reform Initiative, September 2023, available at <https://www.arab-reform.net/publication/a-guide-to-universal-social-protection-in-the-arab-region-challenges-and-opportunities/>

38 World Health Organization, “Health Economics and Health Care Financing”, available at <https://www.emro.who.int/ar/health-economics/strategy/>

39 Souad Chteoui and Chaimaâ Chhaima, “L’Extension de la Couverture Sociale Au Maroc Moteur de l’Innovation Sociale: Quels Enjeux pour les Etablissements de Santé?” *Revue de Management et Cultures (REMAC)* ISSN: 2550-6293 N° 10/2023, available at <http://revues.imist.ma/?journal=REMAC>

40 Arab Non-Governmental Organizations Network, “The Arab Monitor for Economic and Social Rights in Arab Countries, The Right to Health”, July 2023, available at <https://www.annd.org/ar/publications/>

related to the public healthcare system in Morocco, which has various difficulties and structural obstacles impeding this right. Public treatment suffers from a clear shortage of human resources and their unequal distribution regionally and nationally. It also suffers from a lack of beds and governance. In contrast, the health sector is witnessing a steady increase in the private medical sector, which raises major questions about the reception of indigent holders of compulsory health coverage. There is still not enough data to answer these questions, only ambiguity and confusion.

The deep-rooted social inequality vis-à-vis health in Morocco is perhaps the most prominent issue in establishing the right to treatment given the aforementioned difficulties, making it difficult to operationalize UHC, especially for those seeking public health services. Mr. Ahmed, 55, one of the participants in the field study and an expert on health policy in Morocco, believes that the right to treatment in its true sense depends first on hospital system reform – referring to other international experiences that ended the question of public hospital reform – before thinking about health protection: “Look at the state of public services—can they ensure the right to healthcare?” (he asks), and then answers: “No.” Ahmed’s statement highlights the major challenge that continues to face Morocco’s efforts to address health inequality, despite various plans and programs aimed at improving the healthcare system and public service delivery.

These efforts have largely remained confined to the legal and structural-institutional framework, such as enacting Framework Law 06.22 on the national healthcare system, establishing regional health agencies, and issuing other regulatory texts. The Supreme Council also noted these issues in its aforementioned report, observing that the implementation of compulsory health insurance is contingent on improving public hospitals, which continue to suffer from numerous deficiencies. These shortcomings risk undermining the right to healthcare, which forms the foundation of the UHC vision.

### ***AMO-Tadamon: Stigmatization to the rhythm of assistance***

A significant portion of the beneficiaries of the Medical Assistance Program “RAMED” was transitioned to the new system, “AMO-Tadamon,” as the new model of “Compulsory Health Insurance” (commonly referred to in Morocco as “AMO”) for the disadvantaged.<sup>41</sup> This aligns with the state’s aim to universalize compulsory health coverage for all citizens, as stipulated in the framework law and its accompanying legislative texts. Additionally, the National Social Security Fund has been entrusted with managing this compulsory health insurance alongside its management of other social security schemes for remaining social categories.

We will not talk here about the technical difficulties that accompanied the transition from the RAMED system to the AMO-Tadamon system. Many people found themselves among those who had to pay, despite their inability to do so or without knowing their contribution rate; their limited income, or sometimes the absence or instability of income, contributed to their exclusion from the AMO-Tadamon card benefits.

Our visits to the Social Security Fund offices and healthcare centers, guided by an observation network specifically designed for this purpose and supported by a team of researchers, revealed significant insights. The researchers were strategically positioned in billing departments, where citizens request services from responsible staff, as these areas serve as points of social interaction among service seekers. They were also present in waiting rooms to capture the dynamics and experiences of individuals seeking healthcare services. The purpose was to observe the various practices and relationships that have formed as a result of the division of beneficiaries of compulsory health coverage into two categories. One of the first ethnographic observations in this regard is at the level of language: “Sir/Madam, are you AMO or AMO-Tadamon?”<sup>42</sup> Mrs. Rahma, 56, a participant in the study who previously held a RAMED card and now holds an AMO-Tadamon card, said: “I don’t

41 The beneficiaries of the compulsory sickness insurance program were divided into two categories: AMO, who pay their own enrollment fees, and AMO-Tadamon, for whose contributions the state is responsible for.

42 This comes from direct observation in the field.

know why it's called that; before, we were known as 'RAMED', and in any hospital, I was admitted to, they would ask me: 'Are you a RAMEDist?' and now they are repeating the same naming issue: 'Are you AMO-Tadamon?' Why this distinction? We are one AMO." Deconstructing Mrs. Rahma's statement reveals how a technical bureaucracy becomes both a stigmatizing bureaucracy for individuals seeking the right to treatment and a facade bureaucracy that hides behind a system of social stigmatization that results from the connotations chosen by the technical architect of such a project. To the extent that the categorization of beneficiaries into two distinct categories provides technical ease of management, it nevertheless produces a social reality.

## Conclusions and Recommendations

This study devoted to compulsory health coverage and the right to treatment in Morocco revealed a number of conclusions that we consider preliminary, but in our view, they reflect the nature of the change brought about by the compulsory health coverage system in the lives of individuals and groups it affects and the transformation of the issue of treatment into an issue of social structures and practices managed outside the logic of its technical engineer. This study also highlighted the emergence of a different form of state management of the social security issue through its institutionalization, especially for the benefit of uninsured groups, which produced a continuous dynamic of social action both by official actors and among the uninsured groups of small traders, peasants, the indigent, and the poor. A large number of people are now able to access treatments or health services and seek compensation for damage or treatment costs from the social reserve funds. This creates an important shift in the social security system, as the idea of social security remained elitist and bureaucratized from Morocco's independence until the new system's activation. We are not trying to say that access itself, and compensation for damage, has been fully realized, but we are interested in the social representation that has been formed among those targeted by the possibility of compensation for damage, or full or partial coverage of a medical intervention. AMO is a mechanism to formalize the right to health in Morocco and to help poor and disadvantaged families access the right to health, even though it remains subject to questions

about equitable access to health services and the quality of care in certain areas, especially for those suffering from geographical isolation, poor economic conditions, and the instability of their professional careers.

On the other hand, the study revealed a number of gaps that will stand in the way of the realization of the right to treatment and the implementation of UHC in Morocco:

- The nonprocedural nature of the targeting approach excludes some groups from the right to insurance by categorizing them outside the threshold. This contradicts the perspective of health protection as a universal human right that states must guarantee unconditionally, especially for indigent or vulnerable groups. The expansion of the informal sector, unemployment, and triple-disadvantaged youth (i.e., those without employment, education, or training) also pose major challenges to the targeting system and the operationalization of UHC in Morocco.
- Linking access to healthcare to the social targeting system is ineffective given the lack of rigor in the selection criteria, the unclear status of workers in the informal sector, widespread unemployment and informal employment, and the large number of marginalized people in the labor market, among other issues. Morocco's social targeting system may help reduce inequality by providing greater support to disadvantaged households, but it may also produce other exclusions, such as removing eligible beneficiaries or producing new stigmatization of target groups through the publication of lists of beneficiaries.
- There is still a lack of clarity on how UHC will be financed. This is due to the state being the primary contributor for large groups of the target population; it is also difficult for other groups to sustain their contributions due to their precarious social and professional status, or because they refuse to participate in state social security, preferring to go with private agencies, for example.
- The lack, or even absence, of healthcare services for mothers working in the informal sector, despite being the largest demographic in Morocco.
- There is limited understanding and recognition of people with disabilities in the field of

healthcare, especially in light of the lack of heterogeneity of this social segment due to the multiple and diverse characteristics or types of disability. Consequently, their needs vis-à-vis the healthcare system are multiple.

- Morocco's health protection programs have not devoted any significant attention to migrants and refugees, which is a form of exclusion.
- The digital divide still prevents many of those targeted and disadvantaged from accessing healthcare. This gap increases for the elderly and those who are geographically isolated, and the compulsory health coverage programs have not offered any alternatives or guarantees to support them or help them benefit from healthcare. There are also administrative difficulties and specific procedures for registration and access that remain a challenge for the Moroccan healthcare system.

## About the Arab Region Hub for Social Protection

We are a space in and through which professionals dedicated to exploring, understanding and advocating for better social protection in the Arab region exchange ideas and explore and initiate collaborative action. We envision an Arab region in which all people, regardless of their identities, are guaranteed social protections that secure their access to the essential goods and services needed to ensure their well-being and decent standards of living, which in turn gives them the opportunity to prosper and contribute as active members of society. We aim to facilitate the development of equitable and sustainable social protection systems in the region by: executing, encouraging and facilitating the production, analysis, collation, and dissemination of interdisciplinary knowledge about the topic; facilitating dialogue within professional spheres and awareness raising among the wider public; and enhancing collective action that amplifies advocacy efforts with the different stakeholders and decisionmakers.

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## About the Social Protection Program

The Arab Reform Initiative's Social Protection Program, which gave birth to the Arab Region Hub for Social Protection, aims to place social policy and its impact on the socio-economic rights of citizens and residents in Arab countries center stage in the research and advocacy efforts seeking to achieve social justice and social equality. By mobilizing and coordinating a community of practice and knowledge on social protection, the program aims to create a safe space for regular and systematic dialogue between the different stakeholders, in order to help addressing the problem of fragmented, non-inclusive, ineffective, and unsustainable social protection systems in the region. While doing so, the program adopts different perspectives – from addressing the necessary policy, programmatic, institutional, financial, legal and legislative reforms; to the political economy involved in the feasibility of these reforms; passing by social activism around welfare policies.



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## About the Arab Reform Initiative

The Arab Reform Initiative is an independent Arab think tank working with expert partners in the Middle East and North Africa and beyond to articulate a home-grown agenda for democratic change and social justice. It conducts research and policy analysis and provides a platform for inspirational voices based on the principles of diversity, impartiality, and gender equality.