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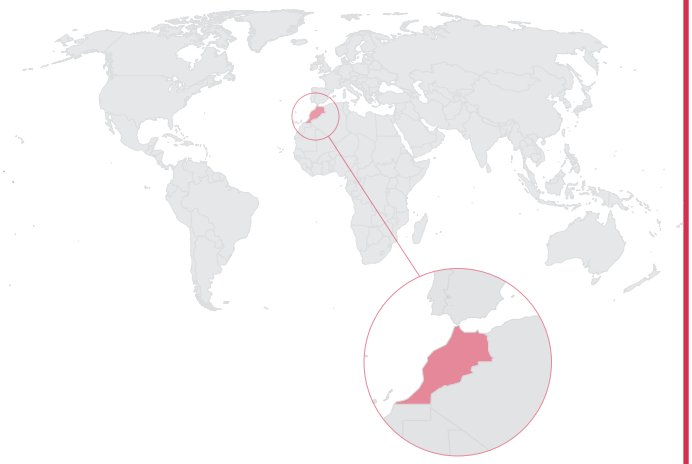

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The Health Care System in Morocco

Global Dynamics of Social Policy CRC 1342

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Content

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1. Country overview (latest data available)

Source: https://ontheworldmap.com/morocco/ (Accessed June 12, 2025)

- Sub-Region: Northern Africa
- Capital: Rabat
- Official Language: Arabic and French
- Population size: 37,712,505 in 2023 (World Bank 2025)
- Share of rural population: 13,153,745 in 2023 (World Bank 2025)
- GDP: 144.42 billion in 2023 (World Bank 2025)
- Income group: Lower middle income (World Bank 2025)
- Gini Index: 45.5 (World Bank 2021; 2004 value) 39.5 in 2013 (World Bank 2025)
- Colonial period: Morocco was colonized by France in 1912. It gained its independence in 1956 (Salem 2021).

2. Selected health indicators

Indicator	Country	Global Average
Male life expectancy in 2023	73	71
Female life expectancy in 2023	78	76
Under-5 mortality rate in 2023	17	37
Maternal mortality rate modeled estimates per 100,000 live births in 2023	70	197
HIV prevalence (total% of population ages 15-49 in 2022	0.1	0.7
Tuberculosis prevalence per 100,000 population in 2023	92	134

Source: World Bank (2025)

3. Legal beginning of the system

Name and type of legal act	National health policy
Date the law was passed	1959 (WHO 2006)
Date of *de jure* implementation	Unknown
Brief summary of content	This policy emerged from the first National Health Conference, held in April 1959 under the presidency of the late His Majesty Mohamed V (Ministère de la Santé, 2013). The conference marked a pivotal moment, laying the foundation for the establishment of Morocco's national health system (Zahidi et al., 2022). The guiding principles that arose from this event steered the country's healthcare system for the next five decades (Ministère de la Santé, 2013). During this period, the state maintained control over the three core functions of the healthcare system: financing, regulation, and service delivery. As a result, Morocco's healthcare system became highly centralized (WHO, 2006). The main focus was on increasing the sanitary facilities especially in rural areas; preventive and promotive programs for the health of mothers and infants as well as prevention and the promotion of the overall health of the population through combating endemic and epidemic diseases (WHO 2006). This policy was intended to cover the whole population and provide free healthcare services within the public sector (El Bayane 2013; WHO 2006).
Socio-political context of introduction	In 1955, Sultan Mohammed V successfully negotiated Morocco's path to independence from French colonial rule. He endorsed the nation's transition to a constitutional monarchy grounded in democratic principles. Full independence was formally achieved with the signing of the Moroccan-French Agreement on March 2, 1956. In the post-independence period, Mohammed V assumed an active political role and was pivotal in laying the foundations of a modern state administration (U.S. National Archives 1950–1959). In 1955, as Morocco approached independence, national efforts were initiated to foster economic and social development, including the reform of the health sector. By the time full independence was achieved in 1956, the country had inherited a severely underdeveloped healthcare system from the French protectorate. This was evidenced by a critical shortage of medical personnel—only 33 physicians were available nationwide—an alarmingly high infant mortality rate of 161 per 1,000 live births, and a low life expectancy of just 47 years (Kirat 2018). Following the first National Health Conference in 1959, Morocco began formulating strategic plans aimed at realizing the right to health as a fundamental human right. These strategies sought to ensure universal health coverage and improve accessibility to healthcare services across the country. This initiative culminated in the formulation of Morocco's first national health policy (El Bayane 2013).

4. Characteristics of the system at introduction

a. Organisational structure

The first National Health Conference, held in 1959, firmly established the state's responsibility for the healthcare system. Two key declarations from the conference articulated the foundational principles of Morocco's health policy: "The health of the nation is incumbent on the State," and "The Ministry of Public Health must ensure its design and implementation" (El Bayane, 2013). These statements underscored the central role of the state in both the formulation and execution of public health policy. In alignment with these principles, five successive development plans were implemented, prioritizing the organization of healthcare delivery and the control of epidemics (Ministère de la Santé 2013).

The centralized nature of Morocco's initial healthcare system can be attributed to the enduring administrative legacy of French colonial rule, which emphasized strong central authority in policy-making and governance (Ministère de la Santé 2013).

b. Coverage

In principle, all citizens were entitled to healthcare under the national health policy, which aimed to achieve equitable access to services for the entire population. The 1959 National Health Conference emphasized equity as a core objective, seeking to ensure nationwide accessibility to healthcare (El Bayane 2013). To support this goal, coverage strategies such as the deployment of mobile health units were introduced (Ministère de la Santé 2013). However, the specific functions and operational details of these strategies are not clearly outlined in the existing literature.

Coverage (principal health insurance)

Percentage of population covered by government schemes	100%
Percentage of population covered by social insurance schemes	Unknown
Percentage of population covered by private schemes	Unknown
Percentage of population not covered	N/A

Source: El Bayane, 2013

c. Provision

Indicator	Value
Physicians (per 1,000 inhabitants) in 1960	0.1
Beds in public hospitals (per 1,000 inhabitants) in 1960	1.6

Source: World Bank 2025

In the early stages of Morocco's health system, the range of services offered was limited. By 1960, there were approximately 394 public basic healthcare establishments (Ministère de la Santé 2013). These facilities primarily served rural areas, focusing on preventive and promotive health programs, particularly maternal and infant health, as well as general population health (WHO 2006). This initial phase of the healthcare system spanned from 1959 to 1980. A second phase followed the 1978 Alma-Ata Conference, lasting from 1981 to 1995, and marked a shift in focus toward primary healthcare (El Bayane 2013).

Throughout these phases, the Ministry of Health served as the principal provider of healthcare services. It was responsible for delivering care and managing public health interventions, including epidemic control. The Ministry operated the hospital network, the Basic Care Health Network, and various national institutes and laboratories (WHO 2006). As the system evolved through subsequent reforms, healthcare delivery became organized around two primary structures: the ambulatory care network and the hospital network. The ambulatory care network encompassed primary healthcare facilities serving both rural and urban populations, while the hospital

network was composed of general hospitals offering basic services and specialized hospitals delivering more advanced care at provincial and regional levels (Zahidi et al. 2022; Espace Associatif 2019).

d. Financing

The budget allocated to the Ministry of Health was relatively limited when compared to other middle-income countries. From the 1960s to the 1990s, there was a noticeable decline in the Ministry's share of national expenditure. In the 1960s, health spending accounted for approximately 1.7% of Morocco's GDP (Dmytraczenko 2001). Additionally, the 1959 Municipal Charter assigned local authorities the responsibility for covering the costs of healthcare services provided to the population (Ministère de la Santé 2013). Despite these decentralized financial responsibilities, the state remained the primary funder of the national health system, with healthcare services largely provided free of charge to the public (WHO 2006).

e. Regulation

The state exercised control over the three core functions of the healthcare system, including regulation (WHO 2006). In accordance with the resolutions of the 1959 National Health Conference, the Ministry of Health was entrusted with the responsibility for both the design and implementation of national health policy. This regulatory role was operationalized through strategic planning initiatives led by the Ministry (WHO 2006).

The initial phase of implementing the national health system began with the establishment of the first faculties of medicine and professional training institutions, aimed at building human resource capacity. This was followed by the development of coverage strategies intended to expand access to health services. In a later development, the 1976 Municipal Charter delegated specific responsibilities to local authorities, particularly in the areas of hygiene and sanitation (Ministère de la Santé 2013).

5. Subsequent historical development of public policy on health care

a. Major reform I

Name and type of legal act	Dahir n° 1-02-296 du 25 rejeb 1423 (3 octobre 2002) portant promulgation de la loi n° 65-00 relatif à l'assurance maladie (Dahir 1-02-296/2002 promulgating law 65-00 on the basic medical coverage)
Date the law was passed	3 October 2002
Date of *de jure* implementation	2005-2012
Brief summary of content	The enactment of the law establishing Basic Medical Coverage (CMB) represents a pivotal milestone in the reform of health financing in Morocco. Its primary objective was to achieve universal health coverage through a dual approach combining subsidized and non-subsidized health insurance schemes. The CMB framework comprises two key components: Assurance Maladie Obligatoire (AMO – Mandatory Medical Insurance) and the Régime d'Assistance Médicale (RAMED – Medical Assistance Scheme). AMO is a non-subsidized insurance scheme designed to protect salaried workers in both the public and private sectors from financial risk associated with healthcare costs. RAMED, by contrast, is a state-subsidized program aimed at covering the most vulnerable and low-income populations. Under this scheme, individuals classified as poor are exempted from contributions, while those deemed vulnerable are required to make minimal payments (Chen 2018; Zahidi et al. 2022). The AMO was piloted in 2008, while RAMED was rolled out nationally in 2012 (Boukhalfa 2022).

Population coverage	The AMO provides coverage for employees in both the public and private sectors. Public sector employees are insured through the National Fund for Social Welfare Organizations and National Social Security Fund *Caisse Nationale des Organismes de Prévoyance Sociale (CNOPS*), while private sector employees are covered by the Caisse Nationale de Sécurité Sociale (CNSS) (Chen, 2018). The RAMED, on the other hand, is designed to cover individuals from low-income households. According to Article 2 of Dahir n° 1-02-296, CMB extends to a broad range of beneficiaries, including civil servants, agents of the State, employees of local authorities, public institutions, and legal entities governed by public law. It also includes pensioners from both the public and private sectors, former resistance fighters, members of the liberation army, and students enrolled in public or private higher education institutions—provided they are not already covered under Section 5 of the same law. According to Article 5 of the law, coverage under the CMB also extends to the family members of the insured. This includes the spouse and children up to the age of 21, as well as children with disabilities regardless of age. Additionally, unmarried children up to the age of 26 who are pursuing higher education are eligible for coverage, provided they are not already beneficiaries of the same insurance scheme.
Type of benefits	According to Article 7 of Dahir n° 1-02-296, the range of healthcare services covered under both AMO and the RAMED includes a comprehensive set of medical and paramedical services. These services encompass: » Preventive and curative care; » General medical services as well as medical and surgical specialties; » Maternal care, including prenatal monitoring, childbirth, and postnatal care; » Hospitalization and surgical interventions, including reconstructive surgery; » Medical biology analyses; » Radiology and medical imaging (e.g., x-rays); » Pharmaceuticals eligible for reimbursement; » Human blood donations and blood derivatives; » Medical devices and implants required for various medical and surgical procedures, tailored to the type of illness or injury; » Reimbursable medical prosthetic and orthotic devices; » Medical eyewear; » Dental care; » Orthodontic services for children; » Functional rehabilitation and physiotherapy; » Paramedical services.
Socio-political context of introduction	Amid the economic liberalization of the 1970s, social inequalities in Morocco deepened, particularly in access to healthcare. Existing insurance schemes such as CNSS and the Caisse Mutualiste Interprofessionnelle Marocaine (CMIM) were largely inadequate in covering low-income and vulnerable populations. These schemes primarily benefited formal sector employees, leaving significant portions of the population without financial protection for health services. In response to these disparities, the health financing reform—through the introduction of the CMB—was designed to expand coverage both to formally employed workers not previously insured and to those unable to afford contributions under the CNSS system (Kirat 2018).

6. Description of current health care system

a. Organizational structure

As previously outlined, two distinct schemes were introduced under Reform 65-00 of 2002 (Dahir No. 1-02-296): the AMO and the RAMED. Later, in 2021, individuals previously covered by RAMED—primarily low-income populations—were transitioned into the AMO system, pursuant to Decree No. 2-22-*797*, adopted in November 2021. This decree was enacted as part of the broader implementation of the Social Protection Law No. 09-21, which had been adopted in March 2021. The primary objective of Law No. 09-21 is to safeguard citizens against economic and social vulnerabilities. Decree No. 2-22-*797* specifically aims to extend health insurance coverage to all individuals, irrespective of their socio-economic status. One of the key intentions behind this reform was the centralization and unification of all health insurance schemes within a single framework (Mansour & Benmouro 2023).

According to Article 21 of Decree No. 2-22-797, the responsibility for implementing the decree is shared among several government bodies, including the Ministry of the Interior, the Ministry of Economy and Finance, and the Ministry of Health and Social Protection. Although the decree does not explicitly clarify whether the new system is fully centralized, it is established that Morocco's healthcare system was highly centralized prior to the reform (Belabbes 2020; Chen 2018).

Coverage

Percentage of population covered by government schemes	Unknown
Percentage of population covered by social insurance schemes in 2022	74.6%
Percentage of population covered by private schemes	Unknown
Percentage of population not covered in 2022	20%

Source: Boukhalfa 2022; own calculations of percentage shares based on Boukhalfa's estimates and the total population size in 2022.

b. Coverage

The AMO scheme initially covered two primary groups: salaried public sector employees, whose coverage was funded by the CNOPS and salaried private sector employees, insured through the Caisse Nationale de Sécurité Sociale (CNSS). Prior to the reform, eligibility for the AMO required a minimum of 54 days of contributions within the preceding six calendar months (Social Security Administration 2019).

Following the 2021 reform, individuals who were previously beneficiaries of the RAMED program were automatically integrated into the AMO scheme. For new applicants, registration must be completed through the Unified Social Register, after which a formal request to join the AMO is submitted to the Ministry of Interior. Eligibility is determined based on a socio-economic index; if the applicant and their dependents fall below the established threshold, they are automatically enrolled in the AMO scheme (Mansour & Benmouro 2023).

Therefore, the coverage of the Moroccan population expanded significantly, rising from 16% in 2005 to 70.2% in 2021. Under the new reform, 11.17 million individuals were covered by the AMO scheme, while 11 million were covered by RAMED. As a result, approximately 25.2 million beneficiaries are now included under the AMO (Boukhalfa 2022). Moreover, the reform extended coverage to an additional 2.74 million self-employed individuals, including doctors, nurses, tourist guides, and other professions, bringing the total number of newly included groups to 13.74 million (Mansour and Benmouro 2023). Consequently, the total coverage under the new system reaches 27.94 million people. This is approximately 74.59% of the total population (37,457,971), demonstrating a substantial increase in national healthcare coverage under the reform.

c. Provision

Indicator	Value
Physicians per 10,000 inhabitants in 2021 (Zahidi et al. 2022)	7.3
Nurses/midwives per 10,000 inhabitants in 2017 (World Bank 2025)	14
Beds in public hospitals per 10,000 inhabitants in 2021 (Zahidi et al. 2022)	10.0

Sources: World Bank 2025; Zahidi et al. 2022

Healthcare services are provided by both public and private sectors, with the public system having a broader infrastructure. As of 2021, the public sector includes 2,124 rural health centers, 165 hospitals with 23,786 functional beds, and 10 psychiatric hospitals with 1,374 beds. The private sector operates 84 clinics with 12,534 beds and 234 hemodialysis centers.

In total, there are 27,881 physicians across both sectors. However, the physician-to-population ratio is only 7.3 per 10,000 inhabitants—well below the World Health Organization recommendation of 17.5 per 10,000 to meet Sustainable Development Goals (Zahidi et al. 2022).

The original service package provided by the AMO included hospitalization, outpatient care, and prescribed medications (Ruger & Kress2007). Recent reforms have expanded this package for newly enrolled beneficiaries,

granting them access to the full range of medical services previously reserved for private-sector employees. These include free treatment and hospitalization in public facilities, as well as partial reimbursement for care received in the private sector (Mansour & Benmouro 2023; Boukhalfa 2022).

However, the persistent issue of poor quality in public health services must be acknowledged. Long waiting times, inadequate infrastructure, and staff shortages often induce patients to seek care in the private sector. Consequently, despite formal coverage, many beneficiaries continue to pay out-of-pocket expenses to access timely and reliable healthcare.

d. Financing

Although public healthcare spending as a percentage of GDP has increased in recent years, it remains modest by international standards. In 2022, healthcare expenditure accounted for approximately 5.68% of GDP, which is comparable to other middle-income countries (World Bank 2025). However, the Ministry of Health and Social Welfare allocated only 5.8% of the national budget to healthcare—a figure significantly below global benchmarks. According to the Abuja Declaration and World Health Organization guidelines, governments should allocate between 12% and 15% of their total budget to the health sector (Boukhalfa 2022). This funding gap continues to limit the expansion and improvement of healthcare infrastructure, services, and workforce capacity.

The CMB is currently funded through a mix of worker and employer contributions, supplemented by allocations from the state budget. Employees continue to contribute regularly, with the breakdown of contributions to the AMO distributed as follows: households account for approximately 14.1%, private enterprises contribute 10.9%, the state adds 3.3%, public enterprises and institutions contribute 0.7%, and territorial communities provide 0.4% (Zahidi et al. 2022). Recent reforms have expanded coverage to include groups that are unable to contribute financially, with the state assuming full responsibility for their coverage (Decree 2-22-797, 2022; Mansour & Benmouro 2023).

These reforms have significantly broadened access to medical services. Beneficiaries now have free access to all healthcare services offered by public institutions. Additionally, they are eligible for reimbursements of up to 70% for expenses incurred in the private sector. In the case of chronic diseases, the compensation rate ranges from 70% to 100%, and for treatments unavailable locally, reimbursement rates can reach 100%. The overall cost of the reform, including the integration of newly covered populations, is estimated at 51 billion Moroccan dirhams (MAD), of which approximately 23 billion MAD are financed directly by the state (Mansour & Benmouro 2023).

e. Regulation of dominant system

The AMO scheme is managed by the CNSS, which is responsible for reimbursing medical expenses to both public and private healthcare providers, including university hospitals. This process is coordinated in partnership with the Ministry of Health and the Ministry of Finance to ensure alignment with national health and financial strategies. In addition to its financial role, CNSS is also tasked with overseeing medical supervision and enhancing the quality of services provided to insured groups (CNSS, 2023; Article 14, Decree No. 2-22-797 2022). Furthermore, CNSS plays a central role in the enrollment process. According to Article 3 of the same decree, it is responsible for registering newly eligible groups into the system and determining eligibility criteria. The successful implementation of the newly expanded, generalized health insurance system involves the coordinated efforts of several key ministries, including the Ministry of the Interior, the Ministry of Economy and Finance, and the Ministry of Health and Social Protection, all of which are jointly responsible for operationalizing the reform and ensuring its long-term sustainability (Decree No. 2-22-797 2022).

From its inception, the AMO scheme was regulated through a structured policy-making process that prioritized expert consultation and government oversight. A committee of experts, chaired by the Prime Minister, was established to define the benefits package under the scheme. After reviewing several options, including (A) catastrophic coverage limited to urgent surgeries and chronic illnesses, (B) catastrophic plus ambulatory coverage, and (C) comprehensive coverage including hospitalization, ambulatory care, and drugs, the committee opted for the third option. This choice was based on the need to standardize coverage and provide a more holistic package of essential healthcare services to insured individuals (Ruger & Kress 2007).

Regarding remuneration, the scheme has distinct mechanisms for goods and services. For goods, particularly pharmaceuticals, the prices in private pharmacies are regulated by the Directorate of Medicines and Pharmacy using a benchmarking method that compares prices across sixreference countries—France, Spain, Belgium, Portugal, Saudi Arabia, and Turkey.Reimbursements for medications are generally based on the official purchase price, as agreed upon by the National Health Insurance Agency, the National Fund for Social Welfare Organizations, and the CNSS (Boukhalfa 2022).

For healthcare services, official pricing is established through agreements between private healthcare providers and government entities. For example, the standard cost for a general practitioner visit is set at 80 dirhams (approximately US$8), and a specialist visit at 150 dirhams (US$15). However, in practice, private providers often do not adhere to these agreed tariffs. Patients frequently incur higher out-of-pocket expenses due to official co-payments and the difference between actual provider charges and the regulated fees. In specific cases, such as private hemodialysis services, the Ministry of Health pays providers directly, bypassing patients altogether (Chen 2018).

7. Co-existing systems

In addition to the AMO scheme, several co-existing systems operate to provide health insurance coverage to specific segments of the population. One such mechanism is the Single Professional Contribution (SPC) system, which targets low-income groups earning above the minimum wage. As part of broader efforts to expand health insurance access, the SPC allows individuals—particularly those with irregular or self-declared income—to pay a fixed tax based on a flat-rate income assessment in exchange for health coverage (Mulvihill 2022). In parallel, there are also internal insurance schemes, known as mutuelles internes or régimes internes, which are offered and managed by public, semi-public, or state-affiliated institutions. These schemes serve employees of entities such as Régie des Tabacs, Bank Al-Maghrib, and Banque Populaire, providing them with an independent form of health insurance coverage outside the national system (Kirat 2018).

8. Role of global actors

Global actors play a supportive rather than a direct decision-making role in Moroccan health policy. While the Moroccan government remains the primary decision-maker, it has occasionally proposed health agendas for international debate. For example, in 1999, the government, in collaboration with the World Bank, organized the Symposium on Health Sector Financing in Morocco. This event brought together officials, academics, healthcare providers, insurers, and the media to discuss practical approaches to implementing health reforms, as well as determining which social groups should be covered and the scope of benefits (Ruger & Kress 2007). Additionally, the liberalization of the healthcare sector under Law 131-13 allows foreign commercial groups to invest in Morocco's healthcare system. These commercial entities have been particularly vocal in highlighting regional imbalances in healthcare access and quality (Belabbes 2020).

More recently, following the adoption of the new social protection reform, the Ministry of Economy and Finance requested technical assistance from the International Labour Organization (ILO) on October 31st, 2022. The ILO's involvement is focused on capacity-building for executives and managers responsible for implementing the social protection reforms. This includes providing studies on the fiscal aspects of health insurance, family allowances, and old-age pensions (ILO 2022).

9. List of additional relevant legal acts

Dahir portant loi no 1-76-388 du 15 février 1977 modifiant et complétant le Dahir no 1-57-187 du 12 novembre 1963 portant statut de la mutualité.

Décret n° 2-05-740 du 18 juillet 2005 pris pour l'application des dispositions de la loi n° 65-00 portant Code de la couverture médicale de base relatif à l'organisation financière de l'assurance maladie obligatoire de bas.

Loi n° 03-07 du 30 novembre 2007 relative à l'assurance maladie obligatoire de base pour certaines catégories de professionnels du secteur privé et modifiant et complétant la loi n° 17-99 portant Code des assurances.

Loi n° 116-12 du 4 août 2015 relative au régime de l'assurance maladie obligatoire de base des étudiants.

Loi organique n° 98-15 du 23 juin 2017 relative au régime de l'assurance maladie obligatoire de base pour les catégories des professionnels, des travailleurs indépendants et des personnes non salariées exerçant une activité libérale.

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