Program Information Documents (PID)

Appraisal Stage | Date Prepared/Updated: 10-Apr-2023 | Report No: PIDA277067

BASIC INFORMATION

A. Basic Program Data

Country	Project ID	Program Name	Parent Project ID (if any)
Morocco	P179014	Morocco Health Reform Program	
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
MIDDLE EAST AND NORTH AFRICA	10-Apr-2023	15-Jun-2023	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Program-for-Results Financing	Ministry of Economy and Finance	Ministry of Health and Social Protection	

Proposed Program Development Objective(s)

To strengthen institutional capacity and governance for improved provision of quality public health services in Program areas

COST & FINANCING

SUMMARY (USD Millions)

Government program Cost	3,053.84
Total Operation Cost	3,053.84
Total Program Cost	3,053.84
Total Financing	3,053.84
Financing Gap	0.00

FINANCING (USD Millions)

Total World Bank Group Financing	300.00
World Bank Lending	300.00
Total Government Contribution	2,753.84

Decision

The review did authorize the team to appraise and negotiate

B. Introduction and Context

Country Context

1. **After a strong post-COVID rebound, a series of domestic and international supply shocks resulted in comparatively abrupt reduction of economic growth.** On the domestic front, Morocco has undergone another severe drought, leading to a collapse of agriculture production that explains almost half of the 2022 deceleration. On the international front, Morocco has confronted an abrupt slowdown in its main trading partners and a surge in commodity prices - fueled by Russia's war on Ukraine. This triggered supply-driven inflationary pressures that have broadened, pushing core inflation to 8.5 percent in February 2023 and disproportionately affecting poorer households. Real Gross Domestic Product (GDP) growth plummeted from 7.9 to an estimated 1.2 percent between 2021 and 2022. The commodity shock, Morocco's reliance on imported energy and food, and a stronger dollar increased the dirham-value of imports by 39.6 percent. Despite the solid performance of exports and workers' remittances, the current account deficit widened from 2.3 to 3.4 percent of GDP, a substantial part of which was financed with Foreign Direct Investment inflows.

2. **The government has responded to ongoing supply shocks with a costly policy package.** The response was focused on preserving households' purchasing power through price subsidies, shielding almost one quarter of the consumption basket from the inflationary surge, and requiring the mobilization of additional public spending for an amount of almost 2 percent of GDP. This approach cushioned what would have otherwise been a more pronounced increase in poverty and vulnerability (although there are more cost-effective approaches). Economic growth is expected to accelerate to 3.1 percent in 2023, but risks are tilted to the downside. [1]

3. **The Government of Morocco (GOM) recognizes weak human capital as a binding constraint to economic growth, and the New Development Model (NDM), seeks to accelerate progress.** Morocco's Human Capital Index (HCI) in 2020[2] was 0.50, indicating that a child born today would only be 50 percent as productive as if they had access to full education and full health, by age 18. This is lower than the average for the Middle East & North Africa (MENA) region, but higher than the average for low-middle income countries (LMIC). On May 2021, the government announced the ambitious and comprehensive NDM charting a path towards sustainable growth, the four top priorities of which include: i) a productive and diversified economy; ii) enhanced human capital that is better prepared for the future; iii) opportunities for inclusion for all; and iv) resilient territories. Under pillar ii), health reform is a priority, and the NDM sets ambitious targets of improving the HCI from 0.50 to 0.75, reaching universal health coverage through the universalization of health insurance, reducing out-of-pocket expenditures from 47 percent to 30 percent of current health expenditures, and improving the density of health professionals

[1] Morocco Economic Update, Winter 2022/23 https://www.worldbank.org/en/country/morocco/publication/morocco-economic-monitor-winter-2022-2023

[2] World Bank, Human Capital Project, October 2020
https://databankfiles.worldbank.org/public/ddpext_download/hci/HCI_2pager_MAR.pdf

from 1.65 per 1,000 to 4.50, by the end of 2035.[3]

Sectoral and Institutional Context

4. **Morocco has made substantial progress in health outcomes over the past decade, but geographic inequalities persist.** Between 2010 and 2018, maternal mortality declined by over one-third, from 112 to 72,6 maternal deaths per 100,000 live births.[4] Rural maternal mortality also declined significantly, from 148 to 111 maternal deaths per 100,000 live births. Yet, regional disparities persist across maternal and child health indicators: in 1992, rural maternal mortality was 1.27 times that of the urban maternal mortality rate; in 2018, rural maternal mortality was 2.47 times that of the urban maternal mortality rate. Coverage of key health interventions differs by region: while 94 percent of deliveries in Casablanca and Rabat regions were attended by skilled personnel, the same figure was only 67 percent in Draa-Tafilalet. The same inequalities across regions are seen for other key maternal, neonatal, and child health indicators, as well as across urban and rural areas.[5]

5. **While most of the disease burden in Morocco is due to non-communicable diseases (NCD), their diagnosis, treatment, and control rates remain low.** High blood pressure, high body mass index, and high blood sugar constituted the top three health risk factors in 2019.[6] 39 percent of adults above age 18 have never had their blood pressure measured, and 63 percent of adults above age 18 never had their blood sugar measured, indicating low levels of population-level testing despite high prevalence. Effective coverage of both hypertension and diabetes remains low. Coverage of key NCD interventions is higher for females, and for those in urban areas.

6. **Substantial improvements have been achieved in the context of limited resources, yet the health system faces substantial challenges.** Morocco has lower government health expenditures, as well as lower levels of physical and human resources capacity, than middle-income countries or MENA averages, even as its average outcomes are similar to comparator countries, implying that the health sector is performing near its efficiency frontier. At the same time, Morocco's effective coverage index score at 58 percent, which is lower than other Maghreb countries and the average for the MENA region.[7]

7. **There is substantial regional variation in disease burden, health needs, and health system performance, yet the governance of the health system remains centralized, with constraints regarding the production and use of data.** A centralized governance system with limited use of health information systems limits responsiveness at local levels, and the absence of a performance-based management system provides a binding constraint to expanding the availability and quality of health services. Despite

[3] La commission spéciale sur le modèle de développement, 2021. « Le nouveau modèle de développement : libérer les énergies et restaurer la confiance pour accélérer la marche vers le progrès et la prospérité pour tous »
[4] All data in this paragraph is from the Population and Family Health Survey (ENPSF), 2018
[5] A detailed assessment of health outcomes across regions, urban, and rural areas is presented in the technical assessment on the basis of latest available data.
[6] Institute for Health Metrics, 2022 (data from 2019) https://www.healthdata.org/morocco
[7] Effective coverage is defined as intervention coverage adjusted by need, use, and quality, capturing the proportion of health gain that could be potentially received from the intervention relative to what is experienced. Data here comes from the Institute for Health Metrics and Evaluation, 2019 https://www.healthdata.org/morocco

the adoption of regionalization and deconcentration[8] reforms since 2011[9], the health sector has remained largely centralized.

8. **An effective response to COVID-19 limited the impact of the pandemic.** Despite health system constraints, Morocco implemented effective and consistent public health measures, and communicated them effectively to the public to garner trust and reduce the spread. With significant increases to the health budget and a focus on service continuity, impact on essential health services was reduced and the system responded to surges in severe cases. An early commitment to vaccine procurement gave Morocco one of the highest vaccination rates across low- and middle-income countries, putting it on a path to reopen safely and quickly. This has resulted in lower per capita case and death rates compared to other countries in the MENA region.

9. **Over the past three years, Morocco has embarked on a comprehensive health financing reform process, strengthening revenue raising, harmonizing pooling, and rationalizing purchasing arrangements.** Prior to the launch of the health financing reform process, the Moroccan health financing system was characterized by low levels of government health spending; fragmented across three purchasers and with low levels of financial risk protection, with a third of the population lacking any form of financial risk protection; and passive purchasing systems prohibiting the utilization of financial incentives to leverage desired quantity or quality of health services. There is currently limited budgetary autonomy and financial management capacity within secondary hospitals managed by Autonomously Managed State Service (SEGMA), which are mostly subsidized by the Ministry of Health and Social Protection (MHSP), whereas Central University Hospitals (CHUs) are paid through a mix of global budgets, fee-for-service, and case-based payments. Government health expenditure has been increasing by almost 10 percent[10] annually since the launch of the reform, and the government has universalized health insurance to enroll previously ineligible population groups, with the aim of reaching 100 percent coverage by 2023.

10. **Constraints in the availability, distribution, and performance management of the human resources for health pose one of the most substantial bottlenecks to the delivery of quality health services in Morocco.** There are currently about 27,881 doctors in Morocco[11] (13,682 and 14,199 respectively in the public and private sectors) and a total of 35,789 paramedic resources (including 15,772 general nurses and 5,757 midwives). The number of physicians per 1,000 population in Morocco stands at 0.7, a measure below the LMIC average of 0.9 physician per 1,000 population.[12] Similarly, the number of nurses and midwives per 1,000 population in Morocco stands at 0.9; below the LMIC average of 2.3 per 1,000 population. The government estimates a need for an additional 32,000 doctors and 65,000 nurses, which is substantially above the current available capacity.

[8] Deconcentration in the Moroccan context refers to the devolution of various limited responsibility and decision-making roles to territorial entities. Decentralization refers to the complete or near-complete transfer of power, responsibilities and competencies to local collectivities which have moral personality and an autonomous budget. There are three dimensions of decentralization in this context: political, fiscal, and administrative. The deployment of GST fit the definition of decentralization across each of the three dimensions.
[9] 2015 Organic Law on Regionalization, 2018 Charter on Deconcentration.
[10] World Bank analysis of Government of Morocco documents
[11] http://cartesanitaire.sante.gov.ma/dashboard/pages2/index_2021.html
[12] World Bank. (2021). *World Development Indicators – Based on latest available year data*.

11. **Building on this momentum and responding to the limitation of the health system, the government launched a comprehensive health sector reform process in July 2020, with substantial political will, commitment and engagement for its effective implementation.** The health sector reform was announced three months into the COVID-19 pandemic during King Mohammed VI's annual speech and was integrated into the NDM and the current government's program in 2021. The reform seeks to improve the quality, equity, and resiliency of the health system. Through four pillars, the supply-side health system redesign program seeks to strengthen organizational and institutional capacity for health system governance; improved availability and competence of human resources for health; reorganized health service delivery; and strengthened pharmaceutical regulatory and production capacity.

12. **The World Bank Program for Results (PforR) supports the achievement of results in Program areas within the supply-side health system redesign program which are going to be implemented in the next five years by the MHSP.** Given the fact that the PforR will be implemented in the early stages of the reform, interventions will focus on the establishment of building blocks for successful implementation. This will enable the reform to improve the availability of high-quality health services, deliver competent care, and strengthen the health system through interventions to improve governance, health workforce, and service delivery capacity. While the legislative framework and the strategic vision for the reform are established through the promulgation of Framework Law 06-22 in December 2022, there remains a degree of uncertainty with regard to the timeline for adoption of other laws. As such, interventions pertaining to the scope of these institutions are out of the Program scope, which includes the Establishment of the High Authority for Health , Moroccan Agency for Pharmaceuticals, and the Moroccan Agency for Blood and Blood Products. Further certainty on the implementation of the reform will be ascertained through the publication of implementation decrees for each of the laws, as well as the promulgation of Laws 08-22 (on Territorial Health Groups, GST) and 09-22 (on Human Resources for Health).

13. **Through three results areas, the Program incentivizes results aligned with international evidence to improve quality of care.** The government's health system redesign program seeks to introduce a high quality health system; one that "optimizes health in a given context by consistently delivering care that improves or maintains health outcomes, by being valued and trusted by all people, and responding to changing population needs."[13]

Result Area #1: Strengthened organizational and institutional capacity for health system governance

14. **Given the essential role of strengthened governance in improving the quality and availability of health services, the Program supports aspects of the health system redesign program which are going to be implemented in the next five years, as outlined in Framework Law 06-22 and Law 08-22 as well as the Triennial Budget Programming.** The Program supports the achievement of results pertaining to each of the dimensions of this approach, and will enable a transition towards governing for quality, through supporting the achievement of the following results: strengthened institutional capacity through the new decentralized governance system, including to mitigate climate risks; updating of provider payment methods particularly for hospitals to improve quality of care; improving the content, quality, accessibility and utilization of health data, and organization of exchange and coordination platforms between regions

[13] Kruk, M.E., et al, 2018. High-quality health systems in the Sustainable Development Goals era: time for a revolution. The Lancet Global Health 6, e1196–e1252. https://doi.org/10.1016/S2214-109X(18)30386-3

and the central level.

Result Area #2: Improved availability and motivation of human resources for health

15. **To rectify the challenges in the availability, distribution, and performance of the HRH workforce in Morocco, the health system redesign program seeks to improve the availability and quality of the health workforce.** Framework Laws 06-22 and Law 09-22 seek to improve the availability, motivation, and performance of the health workforce through five actions: (i) improving the availability and distribution of the health workforce, through improved training capacity and the recruitment of foreign doctors or Moroccan doctors residing abroad; (ii) tasking GST with recruiting and managing the performance of the health workforce in their respective catchment areas; (iii) improving the compensation of the human resources working in the health sector by establishing a special status for the health workforce and introducing a performance payment on top of a base salary; (iv) enhancing public-private partnerships; and; (v) updating pre-service and in-service training curricula.

Result Area #3: Upgrading health infrastructure and reorganization of service delivery

16. **This result area of the Program supports the third pillar of the health system redesign program, upgrading health infrastructure and reorganizing health service delivery.** To rectify the insufficient physical resource capacity, to improve spatial and gender equity of health outcomes, and to improve the quality of health services, a substantial reorganization of the health service delivery system is needed. Framework Law 06-22 and Law 08-22 address this through several components, including the reorganization of care pathways to introduce gatekeeping (primary health care institutions for public sector); institutionalizing of quality evaluation and improvement modalities; and the rehabilitation and upgrading of public primary health facilities and public hospitals to improve their structural quality.

C. Proposed Program Development Objective(s)

Program Development Objective(s)

17. To strengthen institutional capacity and governance for improved provision of quality public health services in Program areas.

18. The following indicators will be used to measure progress towards achievement of the Program Development Objectives:

PDO-Level Results Indicators	Strengthened institutional capacity and governance	Improved provision of public health services	Improved quality of public health services
Implementation of new decentralized governance system, including to mitigate climate risks	x		

Special status for health professionals established to improve the quality of health service delivery	x	x	x
Quality of care at hospitals and primary health care evaluated and improved		x	x
Availability of essential health service package at primary healthcare centers[14]		x	

D. Environmental and Social Effects

19. **An Environmental and Social Systems Assessment (ESSA) has been conducted to inform the preparation of the Program.** The ESSA examines the Environmental and Social (E&S) systems applicable to the Program to evaluate compliance with the provisions of the World Bank Policy and Directive on PforR financing and ensure that the E&S risks of the Program are well managed. Overall, environmental and social benefits of the Program stem from addressing bottlenecks in health sector development; the Program will enable a transition through strengthening all aspects of the health system, with a focus on governance, human resources for health, and service delivery. Social benefits of the Program come from the inclusion of women and youth, potential job and skills creation, the promotion of sustainable livelihoods, and citizen and community participation.

[14] This indicator captures the improvements to service delivery capacity at the primary care level: through the introduction of a gatekeeping modality, ESSP will be the first point of contact between the population and the health system.

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CONTACT POINT

World Bank

Name :	Denizhan Duran		
Designation :	Economist, Health	Role :	Team Leader(ADM Responsible)
Telephone No :	5220+35509	Email :	dduran1@worldbank.org

Borrower/Client/Recipient

Borrower :	Ministry of Economy and Finance		
Contact :	Abdelmajid Mellouki	Title :	World Bank Group Coordinator
Telephone No :	212537677385	Email :	m.mellouki@tresor.finances.gov.ma

Implementing Agencies

Implementing Agency :	Ministry of Health and Social Protection		
Contact :	Abdelouahab Belmadani	Title :	Director of Planification and Financial Resources
Telephone No :	212537761675	Email :	belabdou23@gmail.com

FOR MORE INFORMATION CONTACT

The World Bank
1818 H Street, NW
Washington, D.C. 20433
Telephone: (202) 473-1000
Web: http://www.worldbank.org/projects