

**PROGRAM-FOR-RESULTS INFORMATION DOCUMENT (PID)  
CONCEPT STAGE**

Report No.:PID0003464

<b>Program Name</b>	<i>Health Sector Support Program-For-Results Project</i>
<b>Region</b>	<i>Middle East and North Africa</i>
<b>Country</b>	<i>Kingdom of Morocco</i>
<b>Sector</b>	<i>Health Nutrition and Population</i>
<b>Lending Instrument</b>	<i>Program for Results</i>
<b>Program ID</b>	<i>P 148017</i>
<b>Borrower(s)</b>	<i>Government of Morocco</i>
<b>Implementing Agency</b>	<i>Ministry of Health (MoH)</i>
<b>Date PID Prepared</b>	<i>January 25, 2014</i>
<b>Estimated Date of Appraisal Completion</b>	<i>May 5, 2014</i>
<b>Estimated Date of Board Approval</b>	<i>September 15,2014</i>
<b>Concept Review Decision</b>	The team can proceed with project preparation

## I. Introduction and Context

### *Country Context*

1. **Morocco is experiencing significant political change.** The wave of democratization that has swept the Middle East and North Africa (MENA) region since the start of the Arab Spring has also enveloped Morocco, although its experience has been relatively peaceful, with social demonstrations taking place regularly across the country during 2011 and only sporadic outbursts of violence noted. The response of the Head of State was to propose, in March 2011, a comprehensive package of political reforms that garnered the support of the population through a constitutional referendum held on July 1, 2011.<sup>1</sup> The new constitution sets the basis for a more open and democratic society, lays the foundation for extended regionalization, and explicitly states that health care is a right of the Moroccan people.

2. **There is demand for improved public services in the health sector and a high-level commitment to respond to these expectations.** While the people may be willing to support the Government and its mandate, they are demanding that it break with the past and usher in more credible and faster reforms, notably in the area of improved quality of public services, including health services. Inspired by the new constitution, building on a first-ever national consultation in health called *Intidarat*, and with support from King Mohamed VI, Morocco held during July 1-3, 2013 the second National Conference on Health (the first having been held in 1959) to build consensus on the diagnosis of problems in the health sector and set of planned reforms.<sup>2</sup> The conference was anchored by a Royal Letter for action, a recent 2012-2016 health sector strategy, and a Health Sector White Paper.<sup>3</sup>

<sup>1</sup> The vote in favor of the proposed reforms was 98.5 percent with a participation rate of 73 percent.

<sup>2</sup> Attendees included line ministries, insurers, medical and nursing associations, private sector, academics, civil society, NGOs, donors, and all other major stakeholders.

3. **The proposed program aims to support Morocco’s key objective to increase equity and accountability in the health sector.** The Royal Letter released during the second National Conference on Health states that “*access to healthcare services (...) is crucially important for a dignified life and for the achievement of comprehensive, sustainable human development*” and recognizes that the “*constraints...are mainly due to the limited resources available on one hand and the ever-growing, yet legitimate expectations of the citizens*”. Given its current macroeconomic constraints and a long-standing under-investment in the health sector, the country is primarily focusing on increasing the performance of the health system. The need to respond to the demand for improved access to, and quality of, healthcare services (including through the emblematic pro-poor non-contributory health coverage scheme called RAMED) places the questions of equity and accountability at the center of the reforms. The country is expecting the donor community to support the planned or ongoing reforms within a short- to medium- term period and to help demonstrate, through the monitoring of specific results indicators, that Morocco is putting in place a more patient-centered, equitable and accountable health system.

#### *Sectoral and Institutional Context of the Program*

4. **Morocco spends less on healthcare compared with countries of similar socio-economic development.** The main reason for low expenditures is lower-than-expected public spending as a share of total government expenditures. Though the share of government budget allocated to the health sector has increased by 25 percent since 2007 to reach 3.5 percent in 2013, it remains well below the levels observed in other comparable countries. In collaboration with the Ministry of Health, the Ministry of Finance has prepared a Medium Term Expenditure Framework covering the period 2014-2016, which plans for a 13.6 percent increase in the overall budget allocation to the Ministry of Health, compared to 2013.

5. **Despite recent progress, health indicators remain low, well below the levels of comparable countries in the region, and are highly inequitable.** The under-five mortality is 29 per 1,000 live births (2011); the infant mortality rate is 30 per 1,000 live births (2010); and the maternal mortality ratio is 112 per 100,000 live births (2011). Child mortality is 40 percent higher in rural areas compared to urban areas and children from the poorest quintiles are three times more likely to die as a result of an often easily treatable childhood illnesses or preventable injuries. These inequities in health outcomes reflect inequities in access to health care providers and inequities in the allocation of resources to public healthcare providers. While the burden of communicable diseases has decreased since 1990, Morocco faces a rise in non-communicable diseases and injuries. In 2011, 18.2 percent of Moroccans, in particular the elderly, suffered from a chronic condition, compared with 13.8 percent in 2004. Despite establishing compulsory health insurance and free of charge access to primary healthcare for all and free hospital care for the poorest through the

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<sup>3</sup> Royaume du Maroc, Ministère de la santé, Livre Blanc: Pour une nouvelle gouvernance du secteur de la santé, Marrakesh, 1-3 juillet 2013.

RAMED, out-of-pocket payments in Morocco still represent 53.6 percent of total health expenditure, the majority due to out-of-pocket expenditures for pharmaceuticals

6. **The organization of healthcare is fragmented and faces major resource constraints.** There is no continuum of care between ambulatory and hospital care, which complicates effective patient follow-up and generates unnecessary costs. Primary health services suffer from a shortage of inputs, in particular drugs and health personnel. There are regional disparities in the distribution of health care personnel and there are also regional imbalances in the distribution of private health care providers.<sup>4</sup> While the public sector continues to provide the bulk of healthcare services, the private sector is expanding rapidly, with little regulation and data related to its activities. In addition, the system faces a critical shortage of human resources in health (HRH) throughout all categories of health personnel as well as issues of absenteeism, dual practice and inadequate skills. The lack of an integrated, reliable and accessible health information system makes it difficult for the MoH to address these problems and to improve accountability amongst health actors. The promises of regionalization are not fulfilled; the regional districts still do not benefit from the legal or regulatory conditions, and do not have sufficient capacity to improve the management and delivery of healthcare at the regional level.

7. **The government has recently engaged in a reform agenda which creates a new window of opportunity for positive change.** In addition to the 2011 Constitution, the Royal Letter that opened the National Conference on Health, the sectoral White Paper, the 2012-2016 Health Sector Strategy and the proceeding of the National Conference on Health are guiding the sector reforms. The following eight priorities of the Government Program emerge from these various documents:

1. Strengthening the essential public health functions of the system;
2. Putting health in all policies;
3. Taking actions on the determinants of health;
4. Promoting universal health coverage;
5. Improving equitable access to quality health services;
6. Improving the governance of the system;
7. Strengthening the Health Management Information System (HMIS); and
8. Strengthening Human Resources for Health.

8. **During the proposed operation preparation, the World Bank team will support the MoH to further define programs under the eight sectoral priorities.** The new strategic orientations for the sector have only been partially translated into an expenditure program. During preparation, the Bank will help the MoH develop such a program in areas jointly identified by the MoH, the World Bank, and the European Union (EU). Criteria proposed by the MoH for selecting these areas were that they be cross-cutting and/or multi-

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<sup>4</sup> Approximately 50 percent of all private physicians are located in the Rabat – Casablanca axis, while there are fewer private physicians in the Southern provinces. (Ministry of Health, 2009)

sectoral, and/or present technical challenges. The areas conforming to these criteria are as follows:

- Sector priority 1.ii) on non-communicable diseases prevention and control;
- Sector priority 1.iii) Strengthening mother and child health;
- Sector priority 5.iii) on reorganization of the referral system;
- Sector priority 5.iv) on development of family health;
- Sector priority 6) on governance;
- Sector priority 7) on HMIS; and
- Sector priority 8) on Human Resources.

9. These areas will be supported jointly by the proposed Program-for-Results (PforR) Project and the EU Budget Support Health II Project under preparation, through a common set of Indicators and Disbursement-Linked Indicators (DLIs). This support seeks to address the following issues:

- Access to primary healthcare is inequitable and of low quality;
- Health human resources are scarce, inequitably distributed, and poorly trained;
- The health sector is suffering from governance challenges undermining the equal access to quality public services; and
- Morocco lacks an integrated, computerized, and accessible HMIS.

### *C. Relationship to Country Partnership Strategy*

10. **The proposed project is in line with the Country Partnership Strategy (CPS) 2014-2017 under preparation.** The proposed Project fits into the strategic direction anticipated under the new CPS 2014-2017 under preparation, which is set to continue to promote a competitive yet inclusive growth and improvement in the quality and the governance of service delivery, while setting a greater emphasis on youth and gender.

### *D. Rationale for Bank Engagement and Choice of Financing Instrument*

11. **The Bank is well positioned to support health reforms in Morocco.** As outlined in the MENA Health Strategy<sup>5</sup>, the Bank is uniquely positioned to work with countries on health system reforms in the MENA region. As a result of a long history with and an active engagement in Morocco's health sector, the Bank has in-depth knowledge and strong relationships in the sector. In FY13 and 14, the World Bank has been providing substantial technical assistance on several themes: support to the Second National health Conference, universal health coverage roadmap, development of a methodology to prepare a National Health Charter. In addition, the World Bank has produced sector studies including a Health Users' Survey (2009), a health Public Expenditure Tracking Survey (forthcoming) and a Health Public Expenditure Review (forthcoming) These analytical pieces have contributed to increase the awareness by the country of the need to focus on key management reforms in

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<sup>5</sup> The World Bank: Fairness and Accountability: Engaging in Health Systems in the Middle East and North Africa (The World Bank health Nutrition and Population Sector Strategy for MENA 2013-2018), Washington D.C. 2013

order to improve efficiency, equity and-accountability of the overall system and to respond to the increasing demand from the population for better services.

## II. Program Development Objective

12. The Program Development Objective is to expand access of rural population to quality primary health care service.

13. The key results for the proposed operation will be:

- Increased primary health care coverage in under-served areas;
- Improved technical and inter-personal skills in primary health care professionals;
- Improved geographic distribution of primary health care professionals; and
- Improved accountability *vis-à-vis* the population.

## III. Program Description

### A. Description

14. **The proposed PforR operation will contribute to finance an expenditure program for a sub-set of the MoH strategic priorities focusing on:** (i) improving equitable access to primary health care; (ii) improving management and skills of health personnel; (iii) improving health system governance; and (iv) developing an integrated, computerized, and accessible HMIS. Each of these areas of focus is considered in turn below.

15. *Improving equitable access to primary health care.* The proposed operation will help the MoH improve its programs to ensure a more equitable access to primary healthcare. Under this program area, the PforR would support the MoH's programs linked to strengthening primary health care. Several programs are already in place on maternal and child health, rural health, nutrition, and non-communicable diseases which includes strengthening prevention and developing integrated care at the primary level. The MoH is also developing a new primary health care strategy which should be completed in a couple of months. The PforR would concentrate on actions related to developing family health, non-communicable disease prevention at the primary level, and strengthening the referral system.

16. **Possible DLIs under the primary health pillar could be:**

- **Utilization rate of basic health centers, in rural areas; and**
- **Number of health centers in rural areas that have been accredited.**

17. Other possible indicators could include:

- Percentage of pregnant women who have received at least one prenatal/ at least one post-natal visit (routinely monitored), or percentage of pregnant

women who have received four prenatal and one post-natal visits, in rural areas (not routinely monitored);

- Number of diabetics and/or hypertensive patients diagnosed and treated in primary health care centers, in rural areas (routinely monitored), or proportion of diabetics and/or hypertensive patients who adhere to treatment protocol (not routinely monitored);
- Percentage of assisted child-birth, in rural areas;
- Percentage of children vaccinated, in rural areas; and
- Acute respiratory infection rate, in rural areas.

18. *Improving management and skills of health personnel.* The proposed operation will help the MoH improve its program for managing and improving the competencies of the health workforce, thus contributing to increase the performance of the existing and future workforce and to making its deployment among levels of services and geographic areas more equitable. Improved management will require strengthening capacities at institutional, organizational and technical levels.

19. **Possible DLIs under the human resource pillar could include:**

- **Number of rural primary health centers with physicians trained in family or community health;**
- **Indicator linked to transferring the recruitment management of physicians from the central to the regional levels; and**
- **Indicator linked to the preparation and implementation of a capacity building action plan for medical, paramedical and administrative staff.**

20. *Improving Governance.* The proposed operation will support increased regulation and control of private providers through the development of an adequate institutional arrangement. Law no. 39-04 on health system and health care services, which was adopted in July 2011, includes dispositions about the preparation and implementation of supply side management tools such as the health map, accreditation systems, and the establishment of institutional prerequisites. However implementation of Law no. 39-04 has not started as no Decree has been adopted yet. The proposed operation will also support increased accountability of health care providers vis-à-vis the population through the establishment of an effective grievance system, including the definition of processes related to grievance registration and management as well as feedback, and the establishment of dedicated services at the facility and central level.

21. **Possible DLIs under the governance pillar could include:**

- **Implementation of Law No. 39-04 on healthcare services (potential annual targets: the publication of specific decrees on institutional prerequisites); and**
- **Development of grievance mechanisms (potential annual targets: number of grievance services at the health care facility level, proportion of complains that received feedback).**

22. *Developing an integrated, computerized, and accessible HMIS.* The objective of the

government program in this area is to foster good governance and accountability of the Moroccan health system through the development of a nationally integrated and transparent HMIS with the ultimate aim of improving quality of and access to health services in Morocco, particularly for disadvantaged populations. The pillar will cover two phases of the Government program, implemented over 2-4 years, laying the strategic, legal, institutional, governance and structural groundwork for putting in place a national, intergraded and computerized HMIS. The third phase, the national scale-up expected to take 3-4 years to implement, is beyond the timeline for the current PforR.

23. Indicators and DLIs for the HMIS pillar will, by nature of the tasks, principally consist of process indicators.

24. **Possible DLIs under the HMIS pillar could include:**

- **Completion of strategic framework (potential targets: completion of a national M&E strategy; updating of the HMIS master plan; completion of the HMIS stocktaking exercise);**
- **Completion of technical work (potential targets: finalization of data dictionary, data model, and chart of statistical accounts);**
- **Development of central and regional systems for primary care (potential targets: software and hardware purchase and integration; establish a NHIC; implementation of regional systems in select areas); and**
- **Adoption of a health card (unique patient identifier) in selected regions.**

#### **IV. Initial Environmental and Social Screening**

25. The program supported by the proposed loan is not likely to have any significant direct effects on environmental and natural resources. However, it may entail increased access to health care facilities, resulting in an increase in hazardous medical waste. Under the closed Health Financing and Management Project, as well as with WHO and European Commission support, the MoH has, among others, developed hospital management plans, established dedicated environment services in hospitals for waste management and developed guidelines to ensure management of manage hospital waste. In addition, a specific decree was promulgated in 2009 on medical waste management, including the disposal of pharmaceuticals. Information on the implementation experience of this new regulation will analyzed during preparation through the Environmental and Social System Assessment.

26. The proposed program is expected to have a positive social impact. Through its sector strategy, the MoH seeks to improve equity in access to quality health services by focusing program activities on rural areas where more than 60 percent of the poor live, by reducing out-of pocket expenditures for the poor, and by strengthening primary health care that tends to benefit the poor disproportionately. The proposed PforR will support programs addressing these issues. The first and second pillars will encourage the development of health services in rural areas by identifying indicators that: (i) promote the prevention of non-communicable diseases in rural zones, and (ii) encourage a more equitable distribution

of human resources. Under the third pillar, the proposed PforR will support programs that contribute to improving the poor’s access to healthcare services by supporting the implementation of the health map which will introduce transparent and equitable criteria for establishing public (& possibly private) healthcare facilities. In addition, this pillar will help the MoH develop programs for the introduction of feedback mechanisms that will allow the poor to voice their needs. Finally, the fourth pillar will support the establishment of an HMIS that will make data available to the population, and ultimately create mechanisms to engender voice and population feedback. Women and children will benefit directly from strengthened healthcare services at the primary health level.

**27. Tentative financing**

Source:	(\$m.)
Borrower/Recipient	Not yet available
IBRD	USD100 million
European Union	USD 68.5million equivalent
<b>Total</b>	<b>Not yet available</b>

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