Constraints and obstacles to social health protection in the Maghreb: the cases of Algeria and Morocco

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Introduction

Economic variables must be taken into account in any attempt to develop social health protection systems. However, such variables should not blind us to the importance of social protection as a civic right and as an effective way to improve the well-being of the population, with a resulting positive effect on the economy. Building or reforming social health protection systems involves a complex combination of political, social and technical factors and strategies. Reforms often call for major changes in resource allocation and in the distribution of power and thus evoke fear and resistance among small but powerful segments of society. This paper briefly describes attempts made by Morocco and Algeria to reform their social health protection systems.

Evolution of social health protection systems

The measures taken in Morocco to reform social health protection spanned the period from 2002 to 2006. Before 2002, several coexisting optional health insurance schemes covered only 17% of the population. A system of "certificates of indigence" was operating in parallel and still exists today. Individuals who consider themselves indigent may submit a request to local authorities to receive a certificate granting them access to subsidized hospital care in public facilities. Such a system is universally criticized for being plagued by serious malfunction.[1]

In 2002, after several abortive attempts at reform, the Youssoufi government (1997–2002) pushed through a framework law (No. 65–00) on "basic medical coverage" aimed at phasing in universal coverage for the Moroccan population. This law has two components: compulsory health insurance (*Assurance maladie obligatoire*, AMO) and medical care (*Régime d'assistance médicale*, RAMED) for persons in need.

While the initial decrees on AMO, which were passed in 2005, only concerned the formal sector, in 2007 the Jettou government (2002–2007) extended coverage to self-employed professionals outside the AMO, through a plan known as "Inaya". The RAMED, under pilot-testing in one province, had not yet come into being.

With independence in 1962, Algeria inherited a fragmented social protection system with disparities in the population and services covered.

Beginning in 1970, the government implemented a series of measures to harmonize and unify social protection schemes. Major health programmes were launched, and the decision to provide public sector health care for free was made in 1974. By 1983 this trend had been consolidated through the unification of social security plans. The nationalization of natural resources, the growth of oil revenues and the launch of a vast movement to industrialize the economy and pay fair salaries to the economically active population provided the foundations for the extension of social protection.

This "top-down" way of building a broadened social protection system and health insurance plan was relatively successful for as long as the central government had substantial financial resources and continued to rapidly develop salaried employment in the public sector. The system covered almost all risks (disease, maternity, disability, death, retirement, work injuries, unemployment, etc.) for more than 85% of the population. In 1988, however, oil revenues slumped, marking the end of the social consensus based on the redistribution of income. This ushered in a protracted and exceptionally violent political, economic and social crisis.

Economic constraints for Morocco

Despite an annual increase of more than 4% in its per capita gross domestic product over the last decade, Morocco's economic status remains modest, with an annual per capita income still less than 2000 US dollars. Moreover, this economic growth has not significantly reduced the unemployment rate, which is 16% in urban areas, or the poverty level, with 15% of the population being poor and 23% economically vulnerable. The magnitude of the problem is compounded by inequity. The Gini coefficient for household income has risen progressively: from 0.39 in 1990–91 to 0.4 in 1998–99 to 0.41 in 2000–01. In addition, the informal sector defies tax and social security institutions. More than 20% of the Moroccan population in urban and rural areas lives on gainful, informal labour in non-agricultural sectors.[2] In the approach to social security adopted by Morocco, which is broadly based on Bismarck's model, this singular macroeconomy and labour market situation poses a major challenge for the extension of social health protection.

Vested interests in action

In Morocco, changes and reforms remain entangled in the web of institutional power plays. Yet, in the absence of a true representation of citizens' interests by vectors of influence (political parties, for example), the balance of power

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among all stakeholders in the health system – the central administration, political parties, trade unions, employers and professional associations – results in decisions that do not always reflect the main concerns of the population. When the reform of health funding in Morocco was implemented through the AMO and the RAMED, the power struggle between these different vectors of influence impeded the delivery of the expected product. The initial project, prepared by a group of national experts, ultimately emerged so diluted as to be ineffectual. Health insurance coverage rose from 17% in 2004 to nearly 35% in 2007, but there were many observable flaws in its functioning.

Popular representation was conspicuously absent from the institutional structure of the reform, with neither trade unions nor political parties truly representing citizens. Vested interests prevailed, as exemplified by the indecision that surrounded the implementation of the RAMED, which came to a grinding halt. Furthermore, the Ministry of Finance's narrow, short-term budgetary vision brought the project to a dead end.

When the AMO was set up, different pressure groups played a negative role in several ways as a result of the management structure chosen for the AMO. Instead of opting for a single body to avoid fragmentation, trade unions, which had a stranglehold on mutual funds and on the national social security fund (*Caisse nationale de Sécurité Sociale*, CNSS), enforced the creation of a host of funds and of a regulatory agency that was also responsible for managing the RAMED's financial resources. Today this is a major obstacle to the successful integration of new groups of beneficiaries and to the RAMED's effective implementation.

Employers, who enjoyed close relations with government circles and brandished the trump card of "defending the competitiveness of Moroccan business faced with the challenge of globalization", successfully exerted pressure to reduce contribution rates (currently 5% to 5.5%) and private sector employee benefits. In 2007, through the network of private insurance companies, it gained control of the management of the Inaya health insurance scheme for self-employed professionals, arguing that it was not part of the AMO. This is diametrically opposed to the spirit and letter of mandatory health insurance law No. 65–00.

The administration rubber-stamped decisions that have been detrimental to the efficiency of the AMO. The Department of Finance, acting as an employer, enforced maximum and minimum contributions for public sector employees, thereby engendering regressive contributions. As for the Department of Social Security, it backed the interests of the trade unions and existing funds and imposed its restrictive vision of social health insurance (towing the line of the employers) by favouring a package of benefits under the private sector employee scheme that excluded ambulatory care (except for mothers, children and persons with chronic diseases). As for nongovernmental organizations (NGOs) and the media, their weight was insignificant in counterbalancing the absence of popular representation in the health funding reform process.

Algeria: a system in crisis

The 1990s were marked by an economic crisis and a rapid transformation guided by structural adjustment principles.[3] As a result, the public industrial sector was gradually dismantled, while the private sector and informal economy were rapidly expanded. Since 2000, the leap in oil prices has helped to improve the country's financial situation but Algeria still remains dependent on oil exports for more than 90% of its external income. Its economy is largely dominated by the formal and informal private sectors. These trends are destroying the foundations on which the Algerian social protection system was built, namely public industrial and administrative sectors providing employment to a growing salaried population.[4]

Several factors aggravate the crisis. The government monopoly on the pharmaceutical sector was abolished, and Algeria witnessed a rapid growth of the private sector in the health care and medical product retail segments. This implies that users and the social security system now carry a greater financial burden and that free health care is being increasingly challenged by both budgetary constraints in the public sector and the tendency to increase user and patient responsibility. Consequently, households' out-of-pocket payments for heath care services and drugs are rising steadily: less than 20% of total health expenditure in 1979, as opposed to nearly 30% in 2005–2007.

Moreover, a lack of adequate regulation tools and capacity renders health insurance institutions incapable of controlling escalating health expenditure or of quickening the slow growth of social contributions. Three key factors explain this: (i) many public enterprises have been dissolved or downsized; (ii) a significant portion of private employers under-declare their actual workforce; and (iii) the informal employment sector is growing steadily. This carries an inevitable penalty: health insurance is currently being strangled at the institutional and financial levels.

The current blocking of the institutional system prevents any real reform of the health and social protection systems. The government increases the supply of medical care with no genuine strategic vision, and health professionals defend their immediate interests. The response to the social needs of an economy and a society that have faced enormous transformations during the last 30 years has been far from adequate.

Conclusion

The population of Morocco, especially the most vulnerable sectors, has pressing and legitimate demands in the area of social health protection. The intractability of the administration and of certain segments of civil society, compounded by the use of economic constraints to maintain the status quo, should be challenged and reviewed. There is also a fundamental need to improve the capacity of the administration to combat the growth of the informal sector, increase tax collection and attenuate the prevailing narrow, short-term budgetary vision, particularly in terms of funding for non-contributory health protection systems. Moreover, NGOs should be involved in the reform process and steps should be taken to prevent collusion between the government and the profit-oriented private sector, whose unjustified interference in the management of public affairs is detrimental to the population.

In Algeria, various reform measures have either been planned or already set in motion in a number of areas: a contracting process between social security and public health care facilities;

a hospital management reform; a revision of the list of reimbursable medical products and services, etc.[5,6] While all these measures are legitimate and can produce some positive effects, they are not currently part of a coherent overall strategy and policy. They fail to address the structural causes of the spurious and inefficient nature of the existing social and health protection system. The latter is often reduced to a mere cash pot and no longer based on the principle of solidarity or aimed at the efficient purchasing of quality health products and services for as many members of the community as possible. Genuine reforms are still to come. ■

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