Program Information Document (PID)

Concept Stage | Date Prepared/Updated: 01-Nov-2022 | Report No: PIDC269128

Public Disclosure Authorized

BASIC INFORMATION

A. Basic Program Data

Country	Project ID	Parent Project ID (if any)	Program Name
Morocco	P179014		Morocco Health Reform Program
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Does this operation have an IPF component?**
MIDDLE EAST AND NORTH AFRICA	04-May-2023	15-Jun-2023	No
Financing Instrument	**Borrower(s)**	**Implementing Agency**	**Practice Area (Lead)**
Program-for-Results Financing	Ministry of Economy and Finance	Ministry of Health and Social Protection	Health, Nutrition & Population

Proposed Program Development Objective(s)

To improve the quality and availability of public health services in Morocco.

COST & FINANCING

SUMMARY (USD Millions)

Government program Cost	1,800.00
Total Operation Cost	1,800.00
Total Program Cost	1,800.00
Total Financing	1,800.00
Financing Gap	0.00

FINANCING (USD Millions)

Total World Bank Group Financing	100.00
World Bank Lending	100.00
Total Government Contribution	1700.00

Concept Review Decision

B. Introduction and Context

Country Context

1. **While the COVID-19 pandemic and a climate-related agricultural shock pushed the Moroccan economy into a deep recession in 2020, the government's response has been swift**. Real GDP contracted by 6.3 percent in 2020 and rebounded in 2021 with a 7.4 percent growth rate. A slower growth in 2022 is expected (1.1 percent) due to the drought reducing agricultural output by 17 percent.[1] After several years of declines, national poverty rate (at US$3.2 purchasing power parity line) is estimated to have increased from 5.4 percent in 2019 to 6.6 percent in 2020, an increase that could have been larger if not for the government's cash transfer programs. According to the High Commission of Planning (Haut-Commissariat au Plan, HCP), during the lockdown period in 2020, 74 percent of workers belonging to the bottom quintile experienced a reduction in income against 44 percent in the top quintile. The most significantly impacted households were those in urban areas, working in the informal, non-salaried sector, and are engaged in precarious jobs in services and crafts.[2]

2. **The Government of Morocco 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 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. This is lower than the average for the Middle East & North Africa (MENA) region, but higher than the average for lower-middle income countries. 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 coverage of the entire population under health insurance, reducing out-of-pocket expenditures to 30 percent of current health expenditures, and improving the density of health workers from 1.65 per 1,000 to 4.50, by the end of 2035.[3]

Sectoral (or multi-sectoral) and Institutional Context of the Program

3. **Health outcomes in Morocco continue to remain poor and inequitably distributed.** Despite a continuous decline since 2007, maternal and infant mortality continues to be higher in Morocco than regional peers and other middle-income countries, with significant inequalities. Between 2010 and 2017, maternal mortality declined by over one-third, from 112 to 73 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, inequalities continue to 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. A contributing factor to the discrepancy is low rates

[1] Morocco Economic Update, April 2022 https://www.worldbank.org/en/country/morocco/publication/economic-update-april-2022
[2] World Bank. Morocco Macro and Poverty Outlook, April 2021.
[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

of service coverage in rural areas. This is reflected in Morocco's low level of universal health coverage effective coverage index score at 58 percent, which is lower than that of other Maghreb countries or most countries in the MENA region.[5]

4. **While Morocco's epidemiological transition has accelerated, diagnosis, treatment, and control rates for key non-communicable diseases (NCD) remain low.** High blood pressure, high body mass index, and high blood sugar constituted the top three health risk factors in 2019.[6] In 2018, 38 percent of overall mortality was due to cardiovascular diseases, 18 percent due to cancers, and 6 percent due to diabetes.[7] 39 percent of adults above age 15 have never had their blood pressure measured, and 63 percent of adults above age 15 never had their blood sugar measured, indicating low levels of population-level testing despite high prevalence. Effective coverage of both hypertension and diabetes remain low.

5. **Morocco's population health is vulnerable to climate variability and projected climate change trends, necessitating strengthening the health system.** Agriculture is endangered by decreases in annual rainfall, increasing the risk of crop failures, food insecurity, and malnutrition. The country is also likely to face an increased incidence of dengue fever, malaria, and schistosomiasis. Climate change is expected to increase mean annual temperature and the intensity and frequency of heat waves, resulting in a greater number of people at risk of heat-related medical conditions. The elderly, children, the chronically ill, the socially isolated and at-risk occupational groups are particularly vulnerable to heat-related conditions.

6. **Further improvements in health outcomes are constrained by persistent health system challenges.** Morocco has been experiencing constraints across each of the four functions of its health system. Limited health financing by the government has constrained investments to expanding health system capacity, even as expenditures have been increasing recently to support the implementation of reforms. Low levels of human resources for health per capita, coupled with inequitable distribution, prohibits the delivery of quality services. Finally, an overly centralized governance system with limited use of health information systems prohibits responsiveness at local levels, and the lack of a performance-based management system provides a binding constraint to expanding the availability and quality of health services.

7. **Over the past decade, there have been efforts to measure and improve quality of care, pointing to areas for improvement.** The Ministry of Health and Social Protection (MHSP) conducted six rounds of a quality competition (*concours qualité*) between 2007-2015, ranking health centers and hospitals across domains including accessibility, competency, management, and patient satisfaction. The last round of the competition demonstrated substantial variation in performance, as well as substantial inequalities within and across regions. Hospitals, on average, scored lowest on patient satisfaction (38 percent) and health worker technical competency (44 percent), whereas health centers scored lowest on community engagement (33 percent).[8] The results of the assessment have been utilized for regional quality improvement strategies; however, in the absence of autonomy at the regional, territorial, and facility levels, the ability of decision-makers and providers to respond to these results has been limited. An assessment in 2018 of maternal health service delivery quality in 12 regional hospitals demonstrated similar constraints, notably with 91 percent of hospitals not

[5] 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
[6] Institute for Health Metrics, 2022 (data from 2019) https://www.healthdata.org/morocco
[7] STEPwise survey, 2017-18
[8] Results of the quality competition are summarized in an internal World Bank policy note from 2021, "Towards a high-quality health system in Morocco"

complying with structural and organizational norms, 50 percent of facilities not implementing clinical audits, and 80 percent of facilities not implementing targeted in-service training.[9]

8. **Morocco responded effectively to COVID-19, even as population satisfaction with the quality of the health system remains low.** Despite the aforementioned baseline 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. Effective response has also been reflected in population satisfaction, with 86 percent of the population being satisfied with the country's performance in responding to the pandemic in April 2021.[10] Half of the population during the same period reported dissatisfaction with the quality of health services, a rate which has historically been low (82 percent dissatisfaction in 2018).[11]

9. **Building on this momentum and responding to the dissatisfaction of the population with the health system, the government launched a comprehensive health sector reform process in July 2020.** The health sector reform was announced three months into the COVID-19 pandemic during the King's annual speech, and was integrated into the New Development Model and the current government's program in 2021. The reform seeks to improve the quality, equity, and resiliency of the health system. On the demand side, the reform aims to extend health insurance coverage to 11 million uninsured people, increasing the health coverage from 70 to 100 percent through gradually enrolling individuals based on occupation groups as well as expanding eligibility for the poor and vulnerable within an integrated insurance scheme (AMO) through 2025. As described in more detail in the section on the Program-for-Results Financing (PforR) Program Boundary, Framework Law 06-22, which was adopted by the Council of Ministers on July 13, 2022, and by the House of Councilors at the Parliament on October 11, 2022, engenders a substantial redesign of the health system.

Relationship to CAS/CPF

10. **The proposed Program is aligned with the overall objective of the Country Partnership Framework (CPF, 2019-2024, Report No. 131039-MA) to help Morocco promote social cohesion by improving the conditions for job creation and reducing social and territorial disparities.** The CPF pursues three strategic focus areas: (i) Promoting Job Creation by the Private Sector; (ii) Transforming and Protecting Human Capital; and (iii) Promoting Inclusive and Resilient Territorial Development. Governance and Citizen Engagement form a foundation of the CPF. The proposed Program directly supports the second and third focus areas of the CPF and will contribute to the Objective 6 "Improve the quality and efficiency of health service delivery systems", and the Objective 7 "Strengthen social protection for the poor and vulnerable" by strengthening the quality and efficiency of the health system delivery to meet the Moroccan population's expectations through equitable access and quality of care.

[9] Ministere de la santé, 2018. Rapport de l'enquete nationale d'evaluation de la qualite des soins et des services des maternites hospitalieres et des unités de neonatologie au niveau des hôpitaux régionaux au Maroc
[10] Latest available Arab Barometer report for Morocco, 2021 https://www.arabbarometer.org/wp-content/uploads/Morocco_ArabBarometer_Public-Opinion_2021_En-1.pdf
[11] Arab Barometer surveys, 2021 and 2018

11. **The Program is also in line with the MENA Strategy.** With a focus on improved access to quality of public services and on enhanced governance mechanisms, the Program is aligned with Pillar II of the 2015 MENA Strategy "Renewing the Social Contract". It also contributes to the expanded MENA Strategy (March 2019) pillar on "Building Human Capital", which places a greater focus on harnessing human capital and the World Bank Group Gender Strategy (FY16-23) by contributing to increasing women's access to health.

Rationale for Bank Engagement and Choice of Financing Instrument

12. **The proposed Program supports the implementation of the government's health sector supply reform.** As described in detail on the PforR Program Boundary section, the Moroccan government has codified a comprehensive reform of the health supply in the Framework Law 06-22, with the goal of improving the quality and availability of public health services through focusing on equity, continuity, and accountability. The government summarizes the program across four pillars which are further unpacked in the next section, the first three of which form the results areas for the proposed PforR: i) strengthening governance and digitizing the health information system; ii) improving human resources for health; iii) redesigning health service delivery; and iv) strengthening pharmaceutical regulatory and production capacity. The Framework Law includes the ten overarching objectives below, which form the objectives of the government program that will be supported by this PforR:

- Facilitating the access of citizens to health services and improving their quality;
- Ensuring an equal and equitable distribution of the offer of treatments over the entire territory;
- Territorial planning of the health supply in the public sector and improvement of its governance through the creation of territorial health groupings;
- Ensuring pharmaceutical sovereignty, availability and safety of medicines and health products and its quality;
- Development of means of monitoring and prevention of threats to health;
- Reorganizing clinical care pathways and digitizing the health system;
- Strengthening health surveillance in order to reach the standards approved by the World Health Organization;
- Improving the compensation of the human resources working in the health sector by establishing a civil health service that takes into account the specifics of jobs and professions in the sector;
- Activating the mechanisms of partnership, cooperation and integration between the public and private sectors;
- Encouraging scientific research and innovation in the health field.

13. **The Program builds on the World Bank's deepening engagement in the Moroccan health sector since 2015, complementing the Development Policy Financing (DPF) series which focus on social protection reform.** The World Bank has engaged actively in the Moroccan health sector since 2015, which is when the Improving Primary Health in Rural Areas Program-for-Results (PforR) (US$135 million, P148017) operation became effective. The PforR strengthened primary health service delivery in rural areas by enabling a shift in the focus of the system toward NCDs. It also supported (i) expansions in the coverage of maternal and child health services, (ii) strengthened health information systems, (iii) measurement of different dimensions of quality of care, and (iv) expansion of surge capacity for COVID-19 response. Complementing the PforR, the World Bank has also engaged in a substantial policy dialogue to inform the design of transformational health sector reforms. In close collaboration with the government, a comprehensive health financing diagnostic has been conducted, a roadmap has been developed regarding the integration of different financial risk protection schemes, and costs of service delivery at primary health facilities have been analyzed to inform contracting.

These efforts have informed the design of the health financing reform, which is currently being implemented to cover 11 million Moroccans who lack health insurance, and to integrate the medical assistance program (RAMED) into the mandatory health insurance scheme (AMO) to improve equity and efficiency. The implementation of the comprehensive health financing and social protection reform is being supported by a series of World Bank DPF operations, the first of which was approved on June 16, 2022 (US$500 million, P176937) and the second of which is under preparation. A stronger health supply is a prerequisite for the success of the health financing and social protection reform, which is addressed through the DPF series. In addition to the current engagement around the DPF, the World Bank is supporting a comprehensive study on defining the financial and operational model for Territorial Health Groups, which is one of the key tenets of the proposed PforR. The World Bank is also providing support to the MHSP for the assessment of climate resilience and environmental sustainability of health care facilities, as well as the development of an action plan on the basis of this assessment for the climatic and environmental upgrading of health facilities.

C. Program Development Objective(s) (PDO) and PDO Level Results Indicators

Program Development Objective(s)

To improve the quality and availability of public health services in Morocco.

PDO Level Results Indicators

14. Table 1 below shows the preliminary PDO indicators and DLIs, which will be further discussed and finalized during Program preparation. Where applicable and relevant, each of the indicators will be disaggregated to allow for measuring progress towards spatial and gender equity.

Table 1 Preliminary PDO-level results indicators, intermediate outcomes, and DLIs

PDO	Indicators
To improve the quality and availability of public health services	• Effective coverage of hypertension: percentage of hypertensive population with controlled high blood pressure • Effective coverage of diabetes: percentage of diabetic population with low blood sugar • Effective coverage for maternal health: percentage of pregnant women receiving timely antenatal care, delivering at a health facility, and receiving timely postnatal care
Intermediate outcomes	**Disbursement-linked indicators**
Strengthened organizational and institutional capacity for health system governance	• Number of Territorial Health Groups (GST) established, contracted, and implementing costed, prioritized regional health plans, including a focus on health promotion and climate change adaptation • Improved integrated disease surveillance capacity at national and territorial levels • Design and implementation of national guidelines for accreditation, contracting, and quality management • Percentage of population with an electronic health record
Improved availability and competence of human resources for health	• Established and operationalized public health function, including links of health worker competence to compensation • Number of new physician/nurse graduates per year • Percentage of training institutions implementing an updated pre-service curriculum, including a focus on climate change's impacts on health

	• Percentage of university hospitals implementing an updated in-service curriculum, including a focus on climate change's impacts on health
Redesigned health service delivery	• Number of primary care centers (ESSP) rehabilitated and upgraded to reduce emissions • Percentage of the population accessing care through the primary level • Finalization of the updated integrated national and regional health maps • Percentage of the population living 5 kilometers outside the catchment area of a primary care center in areas with the lowest access

D. Program Description

PforR Program Boundary

15. **The proposed PforR will focus on the first three of the four pillars of the government program, with further exclusions to be specified during preparation.** Given the cross-cutting, interlinked, and exhaustive nature of the first three pillars of the government's health system reform program as stipulated in Framework Law 06-22, the PforR is expected to support a substantial part of the government program within these pillars, excluding investments with potential to cause significant adverse impact on the environment and/or affected people as defined in the World Bank Policy and Directive on PforR financing, or if they involve works, goods, and consultancy contracts above the Operations Procurement Review Committee (OPRC) thresholds. The fourth pillar of pharmaceutical capacity is excluded, given its relatively indirect impact on achieving the PDO. During preparation, the Program boundary would be fully defined within the three pillars, with a focus on areas where the PforR can catalyze impact to improve the quality and availability of public health services, including an emphasis on equity. Program interventions across the three pillars (results areas) are further defined below:

- Strengthening organizational and institutional capacity for health system governance: In order to improve responsiveness and enable improving quality of care, the Framework Law introduces radical changes to the governance of the health system at all levels. The establishment of Territorial Health Groups (*Groupements Sanitaires Territoriaux* – GST), which are going to serve as institutional and operational structures responsible for ensuring the provision of public health services. As deconcentrated entities with decision space across health system functions, GST will ensure the complementarity and coordination of health facilities and services and will allow to tailor the supply of services to the specificities of the region. The GST aim to create integrated health services based on a Regional Medical Program that meets the specific needs of the population while maximizing quality and efficiency. There will be one GST for each of the 12 regions of Morocco, and they will be set up as a single institutional and operational structure responsible for ensuring the provision of health services, acting as the backbone of health service delivery. Coordination of health services across levels of care will be ensured within each GST, with the primary health center within a GST forming the entry point to care-seeking, and primary and secondary services being organized around regional hospitals through a referral system. As such, GST will integrate service delivery while taking on functions across governance (i.e. developing the epidemiological regional health profile and managing service delivery capacity for both public and private sectors) and financing (i.e. defining financing needs and revenue collection particularly for investment and infrastructure budget). GST will also contract health facilities within their region, and purchase health services. This comprehensive deconcentration of service delivery and decision-making is expected to contribute to improved health outcomes in Morocco, particularly for conditions which require sustained engagement and follow-up such as maternal, newborn, and child health, as well as non-communicable diseases. This transition implies a substantial shift in a traditionally centralized health system context. Improvements in governance

will be accelerated by the digitalization of the health system, with the launch of an integrated health information system (across public and private sectors, as well as across service delivery and billing for insurance purposes), and patient-level electronic medical records.

- Improved availability and competence of human resources for health: In order to reduce the shortage of human resources for health, alleviate territorial disparities, and improve clinical quality, Framework Law 06-22 would operationalize the special status accorded to health workers which would allow for them to be paid on the basis of performance, as well as incentivize the recruitment of foreign doctors. In addition to these financial incentives, the Law also stipulates for the expansion of training capacity, particularly for priority cadres that face substantial shortages, as well as the opening of new training programs for specialists. In order to improve clinical competency, the Law includes measures to update training curricula, scale up continuous in-service training, and improve inequalities in the distribution of health workers within and across regions.

- Redesigned health service delivery: In order 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 does so through two levers. First, it stipulates care pathways such that patients can only seek services at the hospital level if they first refer to the primary care level, either through an attending physician at public health centers or a private generalist physician. In order to do so, it also launches a family medicine system, and substantially emphasizes preventive activities. It also includes an update to national and regional health maps to ensure an up-to-date inventory of health infrastructure and in order to inform future investments to reduce the territorial disparity of health facilities. Second, it stipulates the rehabilitation and upgrading of both public primary health centers and public hospitals for the improvement of their structural quality.

E. Initial Environmental and Social Screening

16. **Environmental and Social (E&S) Assessments.** To inform the preparation of this PforR, an Environmental and Social System Assessment (ESSA) will be conducted by the Bank to identify potential environmental and social impacts of the Program. The ESSA will examine the risks entailed by the Program activities and assess all parties' (involved in the implementation of the Program) environmental and social management systems with a view to determining compliance with the provisions of the PforR Bank Policy and Bank Directive and suggesting risk mitigation measures to include within the Program. The results of the ESSA will inform program design and key measures to improve E&S risk management will be included in the Program Action Plan and/or in the results framework. The development of the ESSA will additionally provide a platform to engage stakeholders in consultations regarding E&S aspects. National consultations will be organized, and the final version of the ESSA document will be made public before appraisal.

17. **Based on a preliminary assessment and available information during identification, the proposed operation is compliant with the PforR Bank Policy and Bank Directive and is not expected to have significant adverse impacts on the environment and/or affected people.** The Program does not include any activities that are judged to be likely to have significant adverse impacts that are sensitive, diverse, or unprecedented on the environment and/or affected people in accordance with the requirements of the PforR policy. The Program's PDO is to "*improve the quality and availability of public health services in Morocco*" which means that the Program will support and finance positive E&S impacts. Through three key pathways that the PforR would focus on, the Program aims at: i) Strengthening organizational and institutional capacity for health system governance; ii) Improving availability and competence of human resources for health and: iii)

Redesigning health service delivery. Potential negative, individual or cumulative environmental and social impacts associated with the Program activities are considered moderate to substantial.

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