



JLN PRIMARY HEALTH CARE INITIATIVE
PRIVATE SECTOR ENGAGEMENT COLLABORATIVE



REGULATION OF PRIVATE PRIMARY HEALTH CARE IN MOROCCO

A COUNTRY ASSESSMENT REPORT

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This assessment report is part of a series of country regulatory assessment reports that are contributing to the body of evidence and practical knowledge synthesized in Regulation of Private Primary Health Care: Lessons from JLN Country Experiences.

This report was produced by the Joint Learning Network for Universal Health Coverage (JLN), a community of policymakers and practitioners from around the world who jointly create practical guidance to accelerate country progress toward universal health coverage.

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ABBREVIATIONS AND ACRONYMS

ANAM	Agence Nationale d'Assurance Maladie (National Health Insurance Agency)
CNOM	Conseil National de l'Ordre des Médecins (National Council of the Medical Association)
CNOPS	Caisse Nationale d'Organismes de Prévoyance Sociale (National Fund of Social Security Bodies)
CNS	Comptes Nationaux de la Santé (National Health Accounts)
CNSS	Caisse Nationale de Sécurité Sociale (National Social Security Fund)
DPRF	Direction de la planification et des ressources financières (Department of Planning and Financial Resources)
DRC	Direction de la Réglementation et du Contentieux (Department of Regulations and Disputes)
ENPSF	Enquête Nationale sur la Population et la Santé Familiale (National Survey on Population and Family Health)
GDP	gross domestic product
HCP	Haut-Commissariat au Plan (High Commission on Planning)
MAD	Unité Monétaire Dirham (Dirham Monetary Unit)
NGO	nongovernmental organization
PHC	primary health care
PHCN	Primary Health Care Network
RAMED	Régime d'Assistance Médicale (Medical Assistance Plan)
THE	total health expenditure
UHC	universal health coverage
WHO	World Health Organization

PREFACE

In 2016, the JLN Private Sector Engagement (PSE) Collaborative completed the first two modules of a five-part practical guide on private-sector engagement, titled [*Engaging the Private Sector in Primary Health Care to Achieve Universal Health Coverage: Advice from Implementers to Implementers*](#). These first two modules cover initial communications and partnership around primary health care (PHC) and provider mapping. To inform the third module, and to help fill gaps in guidance on the regulation of private PHC in low- and middle-income countries, six JLN countries—Ghana, Indonesia, Kenya, Malaysia, Mongolia, and Morocco—conducted assessments of their regulation of the private health sector. The assessments addressed the following research questions:

- What types of regulations are in place?
- How are the regulations implemented?
- What outcomes are achieved by those regulations?
- What resources are available for developing and implementing such regulations?

The assessments focused only on regulation of PHC service delivery (the process of providing PHC services and treatments). They did not cover other types of regulation, such as for human resources, training institutions, pharmaceuticals, or medical equipment.

Regulation is broadly defined as the imposition of rules backed by penalties or incentives to ensure compliance with standards—in this case, standards for the safety and quality of health services and providers. Regulations may govern activities such as licensing to open a facility, certification and accreditation, and offering incentives to promote better service quality. In outlining the scope of the assessments, the PSE Collaborative chose to look at regulation of both public and private-sector providers. They also agreed to focus on PHC service delivery, while recognizing that in describing the regulatory system they would inevitably touch on secondary and tertiary care.

The countries each conducted a document review using secondary data sources and collected primary data through in-depth interviews and focus groups involving national and subnational government entities (ministries of health, health financing agencies, regional health directors), regulatory boards and medical councils, professional associations and

representatives of provider groups and unions (for both public and private providers), members of the media, academics, and civil society organizations (representing consumers).

Each country assessment report describes the country's regulatory context, health sector objectives and strategy, and demographic and health indicators; the regulatory mechanisms currently in use; insights on implementation and performance based on primary and secondary data collection; and conclusions and recommendations for improvement.

This report documents Morocco's experience in regulating private PHC.

Methodology

This assessment of Morocco's regulatory system examines the development and implementation of primary health care (PHC) regulations in Morocco's public and private health sectors, based on key stakeholder perspectives.

Information and views from the following groups and individuals were collected as part of the assessment:

- Ministry of Health
- Regional director of health
- Chief physician of the Care Facilities Network Service (Service de Réseau des Etablissements de Soins)
- Health center chief physicians
- Health center chief officers
- General practice physicians in the public and private sectors
- Mandatory health insurance managerial body
- Basic medical coverage regulatory body
- National Council of the Medical Association

Before launching the assessment, the assessment team conducted a pre-test with two doctors (one in the public sector and one in the private sector) to test the interview guide for comprehensibility. Based on the pre-test, the team reworded and reformulated some questions.

Throughout the assessment process, the team respected the ethical principles of scientific research. They obtained the consent of all persons participating in the assessment and

guaranteed them the right to refuse to participate in or to withdraw from the assessment. They also guaranteed anonymity, data confidentiality, and data protection.

Secondary data collection consisted of a survey of legal documents that regulate the practice of medicine and the organization of care offerings, including (in order of importance) laws, decrees, ministerial orders, and circulars.

Primary data was collected in two regions, using semi-structured interviews for key interviewees and a questionnaire for other participants. The assessment team distributed 24 questionnaires—a number that the team estimated was significant enough to provide adequate representation. The questionnaire (reproduced in Annex D) had 15 questions and ranged from questions about the interviewee’s level of knowledge about PHC to open-ended questions and questions relating to each of the four areas of assessment. The assessment team devised an analysis grid (shown in Annex F) to evaluate the relevance of the various responses.

INTRODUCTION

The assessment team set the following research goals:

- Document the regulatory documents that govern PHC in both the public and private sectors
- Identify the available resources to implement current regulations
- Identify barriers to regulation of the private health sector
- Study and analyze the existing regulatory mechanisms and the extent to which they meet the requirements of practice in both the public and private sectors
- Analyze financing mechanisms for the PHC package in both the public and private sectors
- Analyze challenges that must be met in order to better implement PHC reforms
- Analyze the connection between PHC and other levels of care in achieving universal health coverage

The assessment focused on regulation in its entirety, including:

- The practice of health professionals (including doctors, pharmacists, dental surgeons, nurses, and opticians)
- The geographical organization of care offerings in both the public and private sectors
- The process of providing care

REGULATORY CONTEXT

Health Sector Objectives and Strategy

Morocco is committed to intensifying its support for the transition to universal health coverage (UHC). In striving toward that goal, it faces the need to mobilize more resources for health, use them effectively, and reduce inequities in access to quality health care.

These challenges, combined with resource constraints in the public sector, make it imperative for the government to engage with the private sector in ensuring access to necessary health services for the entire population. To that end, it is important to regulate the private health sector and effectively engage with the public sector to cover the population responsibly and transparently.

The Ministry of Health has embarked on a major effort to reform regulation of the health care system. This project aims to update existing legal mechanisms as well as support new reform measures.

The reforms that affect regulations include:

- Framework Law 34-09 regarding the health care system and care offerings, which describes implementing regulatory oversight and planning for care offerings
- Law No. 131-13 regarding the practice of medicine, which resulted from the reworking of Law 10-94 regarding the legislation of health professions
- Decree No. 1299.13 of 1-8-2013 regarding the creation of health regions and certain structures of the central administration of the Ministry of Health

To strengthen health coverage and ensure fair access to integrated, high-quality maternal, child/youth, and sexual and reproductive health services, the government has developed a national health strategy that aims to improve access to care and coverage for mothers and children and increase access to general medicine services at PHC facilities from 60% to 100% by 2021.¹

¹ 2017–2021 Ministry of Health Strategy

Demographic and Health Outcome Indicators

Table 1 presents selected demographic and health outcome indicators for Morocco.

Table 1. Demographic and Health Outcome Indicators

Indicator	Measure	Year	Source(s)
Total population	34.3 million	2014	Recensement Général de la Population et de l'Habitat Haut-Commissariat au Plan (HCP)
Population age distribution	Age 0–5: 9.3% Age 6–15: 1.8% Age 16–64: 62% Age 65+: N/A	2014	HCP
Urban and rural population	Urban: 61% Rural: 39%	2015	HCP
Poverty rate	4.7%	2014	HCP
Infant mortality rate	28.8 per 1,000 live births	2015	Santé en Chiffres
Under-5 mortality rate	30.5 per 1,000 live births	2015	Santé en Chiffres
Maternal mortality ratio	72.6 per 100,000 live births	2015	ENPSF (DPRF) ²
Top three illnesses that create demand for health services	Cardiovascular diseases Cancer Endocrine and metabolic diseases	2015	Rapport sur les Fonctions Essentielles de la Santé
HIV prevalence	0.1%	2017	Ministère de la Santé

² ENPSF is Enquête Nationale sur la Population et la Santé Familiale (National Survey on Population and Family Health); DPRF is the Department of Planning and Financial Resources.

Indicator	Measure	Year	Source(s)
Diabetes prevalence	5.92%	2015	Rapport sur les Fonctions Essentielles de la Santé
Total fertility rate	2.19%	2014	HCP
Proportion of 1-year-olds who have received DTP3	95.2%	2014	Santé en Chiffres
Prenatal care coverage (4+ visits)	71%	2017	Ministère de la Santé

Health System Indicators

Morocco is facing two transitions that have had a direct impact on the public's needs and their right to health. First, the population is aging; the number of people over age 65 is increasing rapidly and will account for 14.5% of the population by 2027.³ This will have consequences for the health care system, which will face more chronic and degenerative diseases. Life expectancy at birth has increased to 75.8 years⁴ due to the decline in the gross mortality rate from 5.6 per thousand in 2010 to 5.4 per thousand in 2015.⁵ Second, Morocco is experiencing an epidemiological transition with a transfer of morbidity, due to the decline in communicable diseases and increase in noncommunicable diseases.

The dual demographic and epidemiologic transition is the result of efforts to reduce child/youth and maternal mortality. Child/youth mortality declined from 70 deaths per 1,000 live births in 2004 to 30.5 in 2011, and maternal mortality declined from 112 deaths per 100,000 live births in 2004 to 72.6 in 2011.⁶ The epidemiologic transition has affected the leading causes of death; 75% of deaths are now due to noncommunicable diseases, cancer and metabolic diseases, and cardiovascular diseases.

³ Haut-Commissariat au Plan (HCP), 2014

⁴ Santé en Chiffres 2015

⁵ Santé en Chiffres 2015

⁶ ENPSF (National Survey on Population and Family Health) 2016

Table 2 provides a snapshot of health system indicators, including the mix of public and private resources that go toward PHC and diagnostic services.

Table 2. Health System Indicators

Indicator	Measure	Year	Source(s)
Number of hospital beds per 100,000 population	Total: 38,500 Public: 77% Private: 23%	2015	Santé en chiffres
Bed utilization rate	Public: 5.8% Private: N/A (not available)	2015	Santé en chiffres
Number of outpatient facilities by type	Total: N/A Public: 2,792 Private: N/A	2015	Santé en chiffres
Number of laboratory facilities	Total: N/A Public: 326 Private: N/A	2015	Ministère de la Santé
Number of imaging services	Total: N/A Scanners—public: 83 Scanners—private: 181 MRIs—public: 19 MRIs—private: 54 Public: 32% Private: 68%	2015	Santé en chiffres
Number of pharmacies	Total: N/A Public: 15% Private: 85%	2015	Santé en chiffres
Number of health workers (e.g., doctors, nurses, midwives, technicians, pharmacists, health extension agents)	Total: N/A Public: 57% Private: 43%	2015	Santé en chiffres

Indicator	Measure	Year	Source(s)
Percentage of population covered by a public health insurance plan	63%	2017	Déclaration du Gouvernement 2017
Percentage of population covered by a private health insurance plan	1.1%	2015	ANAM ⁷
Per capita income	US\$3,077	2015	HCP
GDP growth rate (past 5 years for which data are available)	1.1%	2016	HCP
	4.51%	2015	
	2.55%	2014	
	4.54%	2013	
	3.01%	2012	
Total health expenditure (THE) per capita	US\$: 188 Local currency: 1,578 MAD	2013	CNS (DPRF) ⁸
THE as a share of GDP	6.2% of GDP	2016	Loi de Finance 2016
General government health expenditure (GGHE)	US\$5.38 billion	2013	CNS (DPRF)
Private health expenditure	Public: 27.3% Private: 62.7%	2013	CNS (DPRF)
External health expenditure (ambulatory expenditure) per capita	US\$58	2013	CNS (DPRF)
Out-of-pocket expenditure on health per capita	US\$81	2013	CNS (DPRF)
Degree of government decentralization	New division of 12 regions	2015	Décret n°2.15.10 du 20 Février 2015

⁷ Agence Nationale d'Assurance Maladie (National Health Insurance Agency)

⁸ CNS: National Health Accounts; DPRF: Department of Planning and Financial Resources

Overview of the Moroccan Health Care System

From Morocco's independence in 1956 until the late 1990s, the country's health care system was organized around the public sector. It was characterized by free health services and centralized management. The government acted simultaneously as a financial source, administrator, and provider of health care. Over the years, the private sector has grown rapidly, functioning independently in most cases.

Public Health Sector

The public health sector encompasses the medical resources of the Ministry of Health, the Royal Armed Forces, the territorial authority, and other ministerial departments.

The health resources of the Ministry of Health are organized according to a pyramidal scheme. The first level of care for patients is represented by public PHC facilities—urban and rural health centers and local hospitals in rural districts for the public sector. Those facilities provide preventive and promotive care and outpatient curative care. Medical coverage at this level is provided using a fixed strategy that groups the various urban and rural public hospitals and PHC facilities and a mobile strategy for medical coverage of isolated locations.

The second level of care is at provincial hospitals, prefectural hospitals at the level of the Delegation of the Ministry of Health, and regional hospitals in regional capitals. (The Delegation of the Ministry of Health is in charge of implementing health policy at the province or prefecture level; the Regional Department is in charge within each region.)

The third level of care is at university hospitals, of which there are five, located in Rabat, Casablanca, Fez, Marrakesh, and Oujda. (Two others are under construction.) These hospitals offer state-of-the-art health care technology and expertise.

The public sector has undertaken a modernization effort to upgrade its infrastructure and management methods, specifically for human resources. It is doing so by entering into service agreements with the private sector and partnering with territorial governments in certain provinces to recruit health professionals and by introducing new internal regulations

that have enabled administrative restructuring of hospital facilities around three areas of management: medical affairs, nursing care, and administrative affairs.⁹

Private Not-for-Profit Sector

The private not-for-profit sector includes two levels of care:

- Two university hospitals—Sheik Zaid Hospital in Rabat (with 210 beds) and Sheik Khalifa Hospital in Casablanca (with 205 beds).
- Health care institutions managed by community-based health insurance—the National Social Security Fund (Caisse Nationale de Sécurité Sociale, or CNSS) and the National Fund of Social Security Bodies (Caisse Nationale des Organismes de Prévoyance Sociale, or CNOPS); Moroccan Red Crescent; and other semi-public institutions (including Sharif Office of Phosphates and the National Office of Railroads). These institutions provide outpatient and inpatient curative care to employees of both the private and public sectors.

Private For-Profit Sector

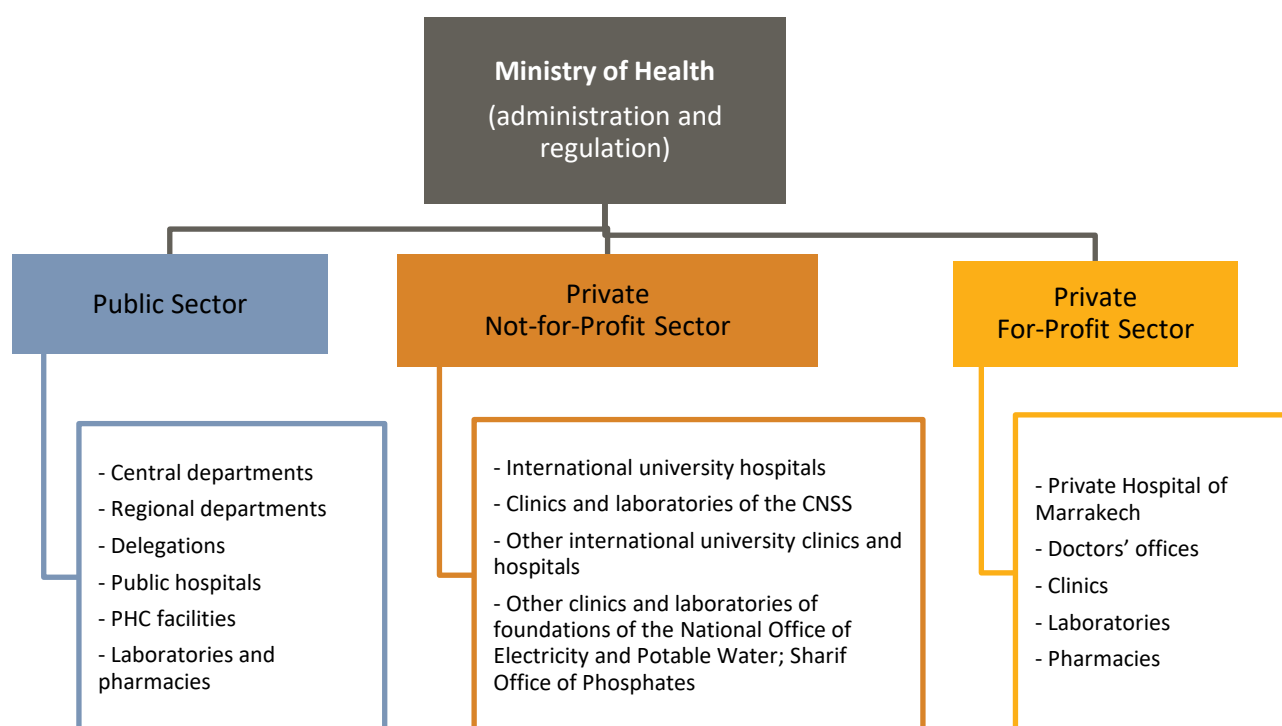
The private for-profit sector includes a private hospital in Marrakesh with 171 beds and more than 400 private facilities across the country with a total of about 7,000 beds. Half of that capacity is located in Casablanca, and the remainder is distributed across Rabat and other large cities. Some facilities are medium-sized, with 50 to 100 beds, and have the most sophisticated equipment, but the vast majority of this sector is made up of small clinics with fewer than 30 beds each and limited resources. The government has varying levels of oversight over the facilities and equipment.

Almost no data on provision of care are provided to the public sector by private practitioners.

Private-sector facilities are managed individually or in groups—such as doctors, dental surgeons, pharmacists, doctors' offices, medical imaging, biology, care and rehabilitation, dental surgery, hospitalization clinics, pharmacies, and drug depots.

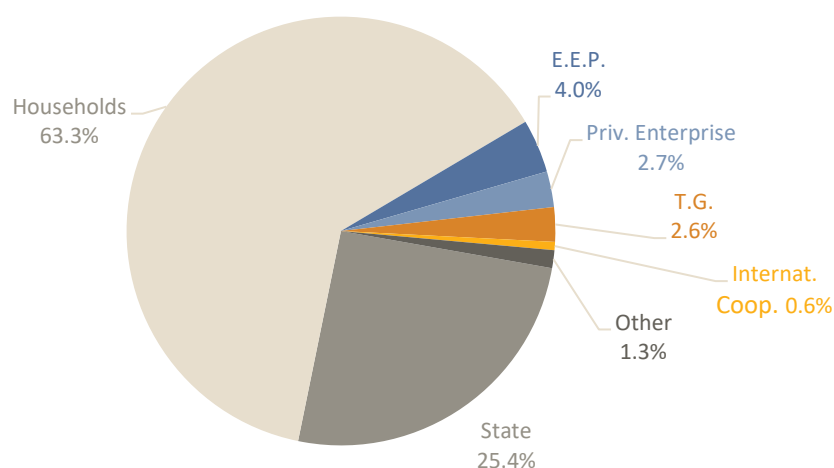
⁹ Order of the Ministry of Health No. 456–11 of July 6, 2010 containing internal regulation of hospitals published in Official Gazette No. 5926, March 17, 2011

Figure 1. The Health Care System



The health care system is financed mainly by direct out-of-pocket payments from households, accounting for 50.7% of total health expenditure. Health insurance accounts for only 22.4%.

Figure 2. Funding Sources by Type of Institution



The population covered by health insurance or a medical assistance plan has increased significantly, from 35% in 2010 to 62% in 2017.

Total health expenditure (THE) reached US\$5.38 billion in 2012, representing 6.2% of GDP.¹⁰ In terms of expenditure per provider, the Ministry of Health (which has 78% of the country's bed capacity) receives only about 27.3% of the financing of the national health system. The Primary Health Care Facilities Network receives only 33% of these funds.¹¹

The number of facilities has grown considerably, with more than 2,770 PHC facilities,¹² 144 public hospitals (with a total of 27,000 beds), and 380 private clinics—nearly 10,800 beds in all. But despite those efforts, access to basic services is lacking in rural areas and for disadvantaged populations and women. In isolated areas, 20% of the population lives more than 10 kilometers from the closest basic health care facility.

Curative services are underutilized, with a contact rate of less than 0.6 per person per year.¹³ That can be explained by the shortage of staff at all levels of the health care system and by the poor quality of services offered. Despite expanded training of doctors and medical support staff, the shortage of health personnel continues to be a major challenge for the Moroccan health system. Despite increases at all levels and in all specialties, Morocco still has only 6.2 doctors (public and private) per 10,000 inhabitants¹⁴; it has fewer than 9.7 nurses per 10,000 inhabitants. Framework Law 34-09 of 2011 on health system and care offerings includes the health charter and the regional plan for care offerings. The goal is to optimize public and private care offerings to meet the public's need for health care and services, achieve fairness in geographic distribution of material and human resources, and correct regional imbalances.

¹⁰ National Health Account (CNS), 2013

¹¹ National Health Account (CNS), 2013

¹² Santé en Chiffres 2015

¹³ Santé en Chiffres 2015

¹⁴ Santé en Chiffres 2015

REGULATORY LANDSCAPE

Regulatory Efforts to Date

In Morocco, regulation of health care is built around a set of documents (including laws, *dahirs*, orders, decrees, ministerial circulars, and agreements) and oversight and supervision of the public and private sectors by the Ministry of Health.

Table 3. Regulatory Mechanisms

Type of Regulation	Practice of Medicine	Practice of Nurses and Opticians	Laboratories
Law	<ul style="list-style-type: none"> Private medicine practice No. 10–94 of 21–11–1996 Practice of professions of pharmacist, dental surgeon No. 1–59–367 of 7–11–2002 Private pharmacy practice No. 17–04 of 7–12–2006 Private medicine practice No. 131–13 of February 19, 2015 		<ul style="list-style-type: none"> Private medical biology testing laboratories No. 1–02–252 of October 3, 2002
<i>Dahir</i>	<ul style="list-style-type: none"> Practice of professions of dental surgeon No. 1–59–367 of February 19, 1960 Authorization to practice the profession of pharmacist in a private capacity No. 2–07–1064 of 17–7–2008 	<ul style="list-style-type: none"> Profession of retail optician No. 2193 of October 4, 1954 Use of title and practice of profession of nurse No. 1–57–008 of 1–09–1960 	

Type of Regulation	Practice of Medicine	Practice of Nurses and Opticians	Laboratories
Decree	<ul style="list-style-type: none"> • Application of law No. 10–94 practice of medicine No. 2–97–421 of 6–11–1996 • Application of law No. 131–13 regarding the practice of medicine No. 2–15–447 of 2016 	<ul style="list-style-type: none"> • State Diploma of nurse No. 2–57–1094 of June 6, 1958 	<ul style="list-style-type: none"> • Private medical biology testing laboratories No. 1–02–252 of 2005
Order		<ul style="list-style-type: none"> • Prices of acts performed by midwives and nurses in the private sector No. 368–79 of 11–07–1979 	<ul style="list-style-type: none"> • Minimal technical standards of private medical biology analysis laboratories No. 2008–05 of 19–10–2005

Table 3.1. Spatial Organization of Health Care Provision and Pathways

Nature of regulation	Care pathways	Care Packages and Health Care Offers	Region
Law		Health system and the care offer n ° 34-09 of 2-7-2011	
Decrees		Health system and healthcare offer, health card n ° 2-14-562 of 20-8-2015	
Orders			Creation of certain structures of the central administration n ° 1299.13 of 1-8-2013
Circulars	Care pathways and coordinated medical follow-up n ° 129 of 9-10-2015		

There are two general texts on the regulation of primary health care in Morocco: (1) Professional practice and supply and (2) the care pathways.

Apart from the legal texts setting the technical standards for the construction, installation and safety of clinics, laboratories and private practices, there are also specific texts on the subject of public and private sectors.

Regulatory Actors

Table 4 describes the regulatory actors that are responsible for developing and implementing health care regulations and developing standards for PHC. The Ministry of Health drafts regulations that require legislative approval and updates and amends other legal documents based on stakeholder input. Implementation is the responsibility of the Ministry of Health, General Secretariat of Government, territorial governments, and other government departments, and it can involve assigning specific roles or mandates to representatives of government departments or civil society organizations. Interactions among the various regulatory actors are complex, especially when it comes to seeking common ground.

After analyzing secondary sources on the role of regulatory actors, the assessment team decided to look closely at the following items during primary data collection:

- The types of stakeholders involved in drafting regulations
- The roles of various stakeholders in drafting and implementing regulations that govern the PHC network
- The interdependencies and interactions among the various stakeholders

Table 4. Roles of Regulatory Actors

Regulatory Actor	Regulatory Role		Interaction with Other Actors (Collaborations or Conflicts)
	Development	Implementation	
Ministry of Health	<p>Has a legislative and regulatory program for each ministerial mandate.</p> <p>Is in charge of drafting and adoption of legislative and regulatory documents.</p> <p>Has a central department in charge of health regulation.</p> <p>Suggests legislative bills and drafts government decrees.</p>	<p>Calls on various central departments to propose regulatory documents.</p> <p>After consulting with various parties and stakeholders, the department of regulation and disputes handles the finalization of legislative bills, decrees, and ministerial orders.</p>	<p>Negotiates with all potential partners to reach consensus; if consensus is not reached, it adapts the regulation in question to serve the public interest.</p> <p>The interaction depends on the sensitivity of the subject.</p>
Territorial authorities	<p>Exercise a central role, particularly regarding environmental hygiene and environmental factors that are likely to affect health. Local governments thereby assist the administrative police. They also have full membership on regional commissions that determine care offerings.</p> <p>Develop public-private partnerships for health.</p>	<p>Publish unilateral enforcement acts with respect to any violations affecting environmental hygiene and public health within the township.</p> <p>Propose or advocate for regulation of care offerings within the territory.</p> <p>Enter into agreements or contracts with the Ministry of Health and/or private providers.</p>	<p>Local governments play a considerable collaborative role, especially in connection with regionalization.</p> <p>However, in some areas of activity the Ministry of Health and local governments do not get along.</p>

Regulatory Actor	Regulatory Role		Interaction with Other Actors (Collaborations or Conflicts)
	Development	Implementation	
National Health Insurance Agency (regulator of basic medical coverage)	<p>Develops regulation governing interaction between care providers and managerial bodies that reimburse them.</p> <p>Develops practice guidelines and revises and determines the nomenclature of referral fees.</p>	<p>Provides technical opinions through the board of directors of ANAM on regulatory documents.</p> <p>Oversee the balance between resources and expenses for each plan.</p> <p>Regulates the Mandatory Health Insurance system.</p>	<p>Negotiations with care providers and health insurance administrative bodies.</p>
National Council of the Medical Association (CNOM)	<p>Creates or provides input on the code of medical ethics.</p> <p>Oversees morality, probity, competence, and commitment in the practice of medicine and the observance of professional duties by all members.</p> <p>Helps draft regulatory and legal documents.</p>	<p>Requires providers to register with the Council in order to be able to practice medicine.</p> <p>Intervenes in the process of qualifying specialists.</p> <p>Can refer certain professionals to the disciplinary committee or penalize them.</p>	<p>Collaboration with the Ministry of Health to conduct these functions as needed.</p> <p>Has a quasi-conflicted relationship with certain professionals, especially with the labor union body.</p>

Regulatory Actor	Regulatory Role		Interaction with Other Actors (Collaborations or Conflicts)
	Development	Implementation	
Care users	<p>Defend their interests through their representatives (associations of consumers).</p> <p>Have a presence on the board of directors of ANAM.</p>	<p>Intervene in certain services (sponsorship, benefactors).</p> <p>Advocate to the media.</p>	<p>Increasingly in confrontation with the Ministry of Health and care providers.</p>
Academics	<p>Write practice guidelines under the aegis of the regulatory body.</p> <p>Issue recommendations and standards.</p> <p>Guide professionals and the public on adopting certain approaches.</p>	<p>Research and provide oversight of practitioners.</p> <p>Provide initial and continuing education.</p> <p>Organize scientific events (conferences, colloquia, symposiums, etc.).</p> <p>Publish studies and reports and disseminate them widely.</p>	<p>In partial harmony with the goals of the Ministry of Health.</p> <p>Collaborate with the Council and most professionals.</p>

Resources for Regulation

The resources available to regulatory actors—financial, human, and material—are described in Table 5. Some questions regarding resources will require more in-depth primary data collection, including:

- Types of resources available for devising and implementing regulations regarding PHC
- Staff size, staff technical qualifications, and budget allocations

Table 5. Resources for Regulation

Regulatory Actor	Technical and Support Staff	Budget
General Secretary of Government	Executives who issue administrative authorization to practice medicine in the private sector, following the opinion of the oversight ministry (Ministry of Health).	State Budget
Ministry of Health: Department of Regulation and Disputes (DRC)	A central department at the Ministry of Health that drafts legal documents. This department includes attorneys and 70 executives and has three divisions: <ul style="list-style-type: none"> • Division of Regulation (two units) • Division of Disputes and Professional Affairs (three units) • Division of Partnership (three units) 	State Budget
Ministry of Health: Department of General Inspection	A multi-disciplinary team in charge of inspections and oversight in the public and private sectors and internal auditing and evaluation in the public sector. It has 18 executives. Inspection and oversight team include two to three inspectors and sometimes representatives from other technical departments such as the Department of Regulation and Disputes or the Department of Hospitals and Outpatient Care, depending on the nature of the inspection.	State Budget

Regulatory Actor	Technical and Support Staff	Budget
Territorial authorities	Executives mandated for this purpose in 12 regions, 75 provinces and prefectures, and 1,538 townships. A technical commission oversees compliance opening of private offices and clinics in terms of location and adherence to norms.	State Budget
Regional Department of Health	Regional inspector coordinates with the Department of General Inspection	State Budget
National Council of the Medical Association (CNOM)	Elected by doctors; has several commissions, including one that authorizes providers to practice medicine in the public and private sectors.	Autonomous budget and State subsidy
Mandatory Health Insurance managerial body (CNOPS and CNSS)	Medical oversight is entrusted to professional practitioners who are hired as employees or contractors by each managerial body, with no possibility of combining that function with the function of providing care.	Budget of the managing body
National Health Insurance Agency (ANAM)	ANAM is administered by a council chaired by the Minister of Health. It also consists of representatives of the administration; employers; insured people in the public and private sectors; mandatory health insurance managerial bodies; and of care providers. The director of the agency carries out the decisions of the board of directors.	ANAM budget

Tracking and Reporting Regulatory Efforts and Performance

Table 6 provides data about tracking and reporting on regulation of PHC. It documents performance indicators for each regulatory activity—specifically, the number of inspection missions conducted per year, the number of complaints and grievances received, and the penalties imposed on facilities and health workers. It also provides information on whether and how frequently reports have been published, whether information is collected according to a plan devised by the regulatory authority or at the request of the authority with jurisdiction (including the minister of health).

Table 6. Regulatory Activities and Performance

Regulatory Activity	Performance Indicator	Period	Source(s)
Investigations of providers that have requested authorization to practice	Implementation of the decree of law concerning accreditation	Under development	Department of Regulation and Disputes (Ministry of Health)
Facility inspections conducted	More than 550 clinics 172 public health facilities	From 2012 to 2015, inspections were conducted at the request of the minister of health and in emergencies.	Ministry of Health Media
Penalties imposed on facilities after inspections have revealed violations	Figures not available	Year-round	Ministry of Health Media

Regulatory Activity	Performance Indicator	Period	Source(s)
Complaints received	Complaints received at all levels (central, regional, and provincial), such as using Chikaya, a method of receiving feedback via mobile phone.	Year-round	Ministry of Health
Complaints reviewed	3,549 (from citizens)	Year-round	Ministry of Health
Penalties imposed on facilities following complaints	Example: Closing an analysis laboratory that did not comply with pricing in 2017 Warnings, suspensions Termination of service agreements Press release to service users Advice from CNOM	Year-round	Ministry of Health CNOM Media
Penalties imposed on providers following complaints	Disciplinary committee proceedings Layoffs Legal proceedings Notice to CNOM Fines (according to degree of offense)	Year-round	Ministry of Health CNOM Media
Incentives (both financial and nonfinancial)	Quality aid Review of performance-based financing	Year-round	Ministry of Health CNOM

The health system has evolved to align with the strategic organizations of the government and the epidemiological and medical profile of the country. By analyzing large projects that have been launched in the health field, the assessment team concluded that regulation follows the same logic as that of the goals of the health care system. In other words, the current legal and regulatory mechanisms represent the sovereign powers of the government to organize and regulate the health sector. Moreover, the health sector is growing steadily, with the private sector experiencing exponential growth in all areas (technological, economic, coverage of the population, nature and volume of the services provided, and so on).

Several factors have spurred the legislature to amend and develop health regulations, including public health needs and the need for greater efficacy, quality, and efficiency in the system. Morocco has also instituted regulations in response to advances in technology and medical practices and to address disparities in the distribution of health resources across geographic regions and social categories. In addition, regulations help Morocco honor its global health commitments and align with international health regulations.

Regulations have evolved over time to support various health and hospital reforms, with regulations initially focused on establishing various professional bodies and setting milestones for dividing up health and hospital institutions. Subsequent regulations served to support large country projects, such as regionalization, private-public partnerships, resource mobilization, and ensuring the right to health under the new constitution. Overall, health regulations address human and material resources, services, and care offerings, as well as the process of care delivery, health surveillance and monitoring (in both outpatient and hospital settings), and the role of professional bodies (including those for doctors, pharmacists, dentists, and nurses).

Most regulations apply to the public sector, which means the government is responsible for applying them. In some cases, that responsibility is shared with other parties. For example, the oversight and supervision of the private health sector increasingly falls to the Ministry of Health in coordination with CNOM. Regulation, oversight, and supervision of private PHC delivery is limited.

The General Secretariat of Government and the Ministry of Health (through the Department of Regulations and Disputes, the Department of General Inspection, and the General Secretariat), play crucial roles in drafting and implementing PHC regulations. But compliance

and implementation challenges remain, especially in regard to the private sector, given the lack of financial, material, and staffing capacity for drafting and implementing laws and for monitoring and enforcement. The Department of General Inspection, which has only 18 permanent staff, is responsible for investigating and inspecting health facilities and regularly reporting to the minister; it acts at the instruction of the minister and cannot take initiative to conduct surveys or studies.

A lack of technical skills, along with financial constraints at the central and regional levels, delays the publication of implementing documents and support mechanisms for enforcement and monitoring. The inspection reports that do get written are intended only for the minister and usually remain confidential. Information that is made public often comes from the news media or through CNOM. In addition, most laws define penalties and sanctions for noncompliance but offer few incentives for compliance. The assessment team did not note any evaluation of regulatory documents that can explain their amendment or reworking.

Based on the review of secondary sources, the assessment team decided to collect primary data through a self-reported questionnaire and semi-structured interviews with officials at the central and provincial levels and with practitioners in both the public and private sectors.

IMPLEMENTATION AND PERFORMANCE OF REGULATORY ACTIVITIES

The assessment team faced a number of challenges in collecting qualitative data, including difficulty enlisting respondents due to the length of the questionnaire and the time needed to conduct each interview. The self-reporting nature of the questionnaire also calls into question the reliability of the responses. The nonresponse rate was about 6%, mostly due to chief officers of health centers and some general practice physicians in both the public and private sectors declining to participate.

The research team used an analysis grid to analyze the data collected from fielding the questionnaire. Deliberately, a number of questions were added to the questionnaire introduction, the goals of which were to evaluate the interviewees' level of knowledge about primary health care, to determine the state of regulation of primary health care in practice and the experience of its implementation, and to evaluate its performance. The research team decided to classify responses in five levels:

- 1) Very relevant (VR): answers the question directly
- 2) Relevant (R): answers the question without substantiating that answer
- 3) Moderately relevant (MR): partly answers the question but stays on topic
- 4) Not relevant (NR): a confused response that does not answer the question
- 5) No response (NonR): the interviewee has no response to give and/or prefers not to respond

The assessment team used an analysis grid to classify the responses by level of relevance. (See Annex F.)

The analytical framework is rooted in the history of regulation of primary health care in Morocco which developed in 1960s. To apprehend this analysis the researchers were inspired by the Donabedian "structure-process-result" model. The structure refers to the legal texts, the material and human resources used to develop and implement this regulation. The process refers to the procedures and mechanisms used for implementation and compliance. The result is a reference to the effect of this regulation on health services.

Recap of Expected Goals of the Questionnaire

The questionnaire is intended to determine:

- The level of general knowledge of primary health care
- The type of regulations that govern primary health care for the private and public sectors
- The implementation of those regulations
- The available resources to develop and implement regulations countrywide
- The results achieved by instituting those regulations.

Analysis of Questionnaire Responses

General Knowledge of PHC

Among the 24 interviewees, only five (22%) named and described the PHCN in both the public and private sectors, including the participants in that organization and their roles in the development and regulation of PHC in Morocco. The five interviewees were two representatives of the mandatory health insurance managerial bodies, two officials in the central administration of the Ministry of Health, and one representative of the basic medical coverage regulatory body.

Regulations Governing PHC in the Private Sector

More than half of the interviewees were unable to cite the documents and authorities governing PHC regulation in the private sector. One respondent said, “There is no regulation that governs private-sector practice for primary care. Regulation oversees only the practice of medicine and the place where it is practiced. Each practitioner preserves his medical autonomy and the acts that he may perform, so long as those acts are within his specialty.” Only 8% of the respondents—officials in the central administration of the Ministry of Health—answered this question accurately, barely citing Framework Law No. 34-09 of 2-7-2011 on the health care system and care offerings and the private practice of medicine No. 131-13 of February 19, 2015.

Implementation of Regulations

Among the interviewees, 45% were unable to describe how regulations are implemented or how they facilitate quality care delivery. The other respondents said the regulations are not entirely effective and do not regulate the private sector. One interviewee in the private sector said the regulations are ineffective because poor patients are unable to choose their attending physician. The respondent said, “In my everyday practice as a private doctor, when I send my patients who have a RAMED¹⁵ card, I tell them you have to go see a doctor at the health center, which prevents the patients from getting care wherever they want.” One official at the central level said, “The current regulations remain ineffective and do not make it possible to oversee and regulate the private sector because most regulatory documents are out of date, considering the evolution and the field of activity of this sector.”

Resources Available to Develop and Implement Regulations

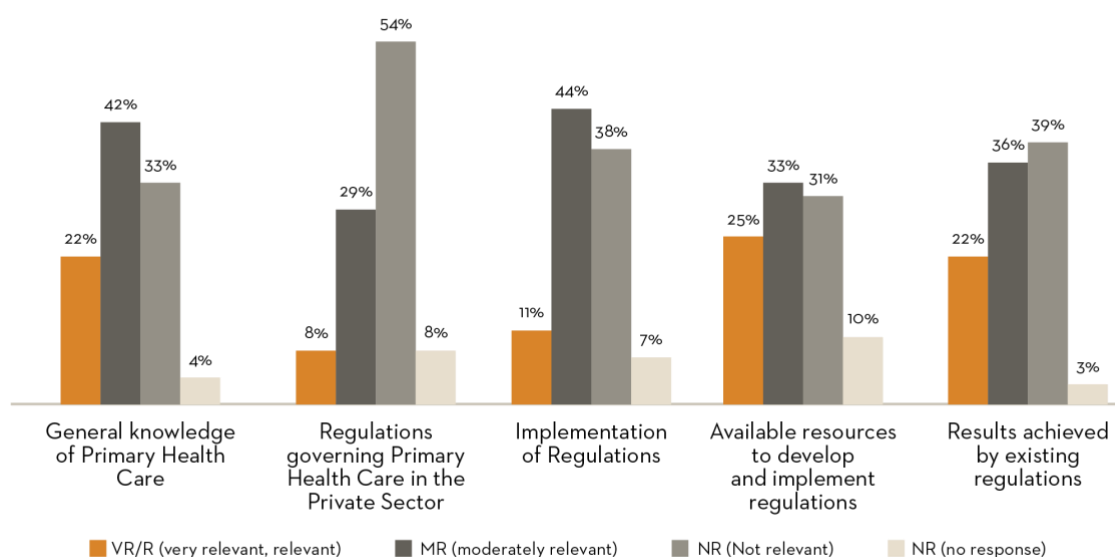
Among the interviewees, 10% were unable to name any legal documents or material or human resources for developing and applying PHCN regulations. Only six interviewees (25%) identified difficulties in implementing regulations—including ignorance of the regulations, lack of implementing or supporting documents to make certain laws enforceable, and lack of updates to basic and continuing education programs that would help providers understand the regulations. Those interviewees included two officials in the central administration of the Ministry of Health, two representatives of the mandatory health insurance managerial bodies, one CNOM representative, and one representative of the basic medical coverage regulatory body.

Results Achieved by the Regulations

Nearly 40% of the interviewees were unable to give a clear answer about the effects of current regulations on the health care system and especially on quality of care and patient safety, continuity of access to care, integration of care, and reduction in copayments for patients with medical coverage.

¹⁵ Régime d’Assistance Médicale (Medical Assistance Plan)

Figure 3: Graph of interviewee perception on the questionnaire by objective



Data Analysis and Summary

Statutory and regulatory mechanisms in Morocco are built around a set of documents, including laws, *dahirs*, orders, decrees, circulars, and agreements. The assessment revealed a lack of knowledge about regulations as well as implementation challenges and problems with compliance. This can be partly explained by the lack of an evaluation framework for public-sector laws.

The Ministry of Health has attorneys that write legal documents, and it coordinates with the Department of General Inspection at the regional level, but only a limited number of officials within the ministry have the expertise to develop and implement regulations. This prevents the health care system from taking full advantage of the legal tools in place, especially for regulating the private sector.

Certain provisions in the legal documents are not correctly applied, which limits their effectiveness. Accountability is also lacking. Regulators do not take responsibility and do not have incentives to take full responsibility for implementing regulations, particularly in the

private sector. For example, law 131–13, which was intended to regulate care offerings, is difficult to enforce among private-sector providers that serve isolated regions.

The regulations that govern PHC in the private sector cover authorization of doctor's offices, laboratories, dispensaries, and so forth, as well as standards, services provided, disease reporting, and service agreements between providers and the Ministry of Health.

This assessment shows that the organization of the private sector as it is conceived currently by regulatory documents does not meet the expectations of the population or of the managers of public care offerings, specifically as it relates to equity of access for isolated areas. Consequently, the regulations in force in the public sector (on the health charter and the regional plan of care offerings) do not enable regulation of care provided in the private sector.

Regulation of the private sector is distributed among various levels: the Ministry of Health, the regulatory agency, managerial bodies, and the National Council of Professional Associations. However, resistance to change and problems with implementation and enforcement are found in both the public and private sectors. This kind of dysfunction was described by general practice physicians in the private sector, who cited certain regulatory documents that have not been updated to keep up with changes in the private sector.

The relationship between the public sector, the private sector, and the oversight ministry remains limited and focuses mostly on the epidemiological monitoring or mandatory disease reporting (which is regulated by Order of the Minister of Public Health No. 683-95 of March 31, 1995, with terms of enforcement set by Royal Decree No. 554-65 of June 26, 1967, which contains the law making it mandatory to report certain diseases and prescribe prophylactic measures to help eradicate those diseases).

Apart from the implementation of some regulatory documents, specifically inspection and sanctions, it is mandatory to make the private sector comply with current regulations to regulate care offerings, their fair distribution, and the quality of care provided in the private sector.

Despite of the diversity of participants involved in the drafting and implementation of health care regulations (including the technical departments of the central administration of the Ministry of Health, sectoral partners, territorial governments, the National Council of

Professional Associations, basic medical coverage managerial bodies, academics, elected officials of both chambers of Parliament, representatives of care users, and labor unions), interviewees cited gaps in the law and insufficient human and material resources to enforce these regulations. The Ministry of Health performs its mission of supervising the private sector timidly, and the private sector is increasingly resistant to change and the implementation of existing regulations.

The roles and responsibilities of the various parties in writing and implementing laws are not always clearly defined, and the number of attorneys for drafting the legal documents is insufficient. The regions do not have a lot of room for decision-making, specifically to strengthen the integration and complementarity between the public and private sectors. Respondents also note a lack of communication about new regulations and delays in drafting documents for implementing or supporting certain laws.

As decentralization is implemented, it is necessary to rethink coordination mechanisms among those parties for more and better engagement. This would reduce the gaps in care offerings and have a positive impact on public health.

CONCLUSIONS

In working toward UHC, Morocco considers regulation essential to balancing inputs and outcomes to achieve that goal. The regulations adopted in recent years are applied at national, regional and local level. Their implementation is the prerogative of the Ministry of Health, as well as other departments depending on the specific tasks to each department.

The assessment yielded a number of conclusions:

- Health regulation is not just the responsibility of the health sector; it is the concern of all sectors and all members of society. The entire government is responsible for its implementation.
- Contributions to legislation by other actors and partners in the health field are inadequate.
- Although the private health sector is an important provider of services and care, its role as a partner is not entirely defined and it is hardly regulated. The partnership between the public and private sectors merits better organization.
- The responsiveness of a health care system can be measured by its ability to produce regulations that enable it to react promptly to changing needs.
- Technical support is needed to produce legal documents that can mobilize the private sector and engage them in the effort to achieve UHC.

The overall conclusion based on primary and secondary data is that Morocco does not make optimal use of existing health regulations to achieve the objectives of those regulations.

RECOMMENDATIONS

The limited oversight of medical practice in Morocco poses a serious challenge to the growth of the health care system, which cannot keep pace with advances in health practices and technology. Good regulations must help improve public health and must anticipate threats to public health and establish a good balance between the response to health needs and the response to the public's expectations.

Regulations are often considered a potential response meant to solve the many problems that arise in the provision, financing, and performance of health services. However, the nature of medical practice and the characteristics of health require that other arguments be taken into consideration by the government before drafting regulatory documents.

Recommendations from the respondents are described in Table 7.

Table 7. Recommendations

Recommendation	Rationale	Impact on the Private Health Sector	Priority Level
Define a suitable strategy for regulation that encompasses Morocco's health policy, priorities, statutes, and the various resources for its drafting and implementation.	To address areas that need improvement—rules that need to be followed, specific statutes that are needed for better accountability and monitoring, etc.	Will strengthen health sector regulation and oversight.	1
Adopt a regulatory framework for the private health sector.	To ensure integration, efficacy, and accountability in the private health sector.	Contracts and partnerships are potential mechanisms for engaging the private sector in addressing gaps in care offerings across regions.	2
Implement a participatory approach to ensure that the legislative system is more in tune with reality.	To enable commitment and involvement by responsible stakeholders.	Make administrative procedures fluid so they serve citizens and practitioners at the same time.	2

Recommendation	Rationale	Impact on the Private Health Sector	Priority Level
Produce a country manual that includes all regulations governing the health care system and how to implement those regulations.	To guide health care practice and processes.	Health professionals can use the manual as needed to help them improve the quality of patient care.	3
Set up mechanisms for tracking, oversight, and evaluation of existing regulations.	To evaluate and amend ineffective regulations.	The new and amended regulations will be enforceable in both the public and private sectors.	3

The assessment team recommends that the following additional measures be implemented:

- Clarify and simplify the regulatory documents while issuing new decrees for implementing the regulations.
- Streamline administrative procedures to better serve citizens and health professionals.
- Set up a structure (such as a department) within the Ministry of Health that is dedicated to the private health sector in order to boost the sector's involvement in the country's health policy.
- Set up a national committee of evaluation and accreditation to conduct periodic outside evaluations of regulations and regulatory activities using tools such as a guide of good practices or a reference framework for rules of professional ethics.
- Support regionalization through accountability methods to avoid replication of the challenges facing the central level.
- Establish suitable accountability mechanisms to make new services available—such as reproductive health, family medicine, community health, health of young people, and certain biological tests and drugs.
- Implement guides to good practices and management manuals, and encourage a culture of support for care providers.
- Improve communication about regulations so they can be better implemented.
- Penalized failure to obey the regulations.
- Improve training of public and private health professionals and create channels of communication for a true public-private partnership.

Without any doubt, this assessment is of major importance for filling the gap in popularizing health care regulations in general, and is also a good way to encourage decision-makers to involve themselves more in monitoring their implementation and communicating with the various parties in the health care system to make it more efficient, better quality, and provide more accountability to users.

REFERENCES

ANAM (National Health Insurance Agency): www.anam.ma

CNOM (National Council of the Medical Association): www.cnom.ma

CNOPS (National Fund of Social Security Bodies): www.cnops.org.ma

CNSS (National Social Security Fund): www.cnss.ma

Dahir No. 1–57–008 of February 19, 1960 regulating use of the title and practice of the profession of nurse.

Dahir No. 1–59–367 of February 19, 1960 regulating the practice of the professions of doctor, pharmacist, dental surgeon, herbalist, and midwife.

Dahir No. 1–60–160 of September 1, 1960 amending dahir No. 1–57–008 of February 19, 1960 regulating use of the title and practice of the profession of nurse.

Dahir of October 4, 1954 regulating the practice of the profession of retail optician.

Decree 2–14–562 of July 24, 2015 issued for implementing the framework law 34–09.

Decree No. 2–07–1064 of July 9, 2008 regarding the practice of pharmacy, and the creation and opening of dispensaries and pharmaceutical facilities.

Decree No. 2–15–447 issued for implementing law No. 131–13 on the practice of medicine.

Decree No. 2–57–1094 of June 6, 1958 instituting a State Diploma of nurse.

Decree No. 2–93–308 of October 29, 1993 bearing special status of the association of nurses and medical assistants.

Decree No. 2–97–421 of October 28, 1997 issued for implementing law No. 10–94 on the practice of medicine.

Framework law 34–09 of July 2, 2011 regarding the health care system and care offerings.

Implementing decree No. 1–02–252 of 21–7–2005.

Implementing decree regarding marketing authorization of drugs for human use.

Law No. 01–03 of March 24, 2003 amending law No. 78–00 containing municipal charter.

Law No. 12–01 of October 3, 2002 regarding private medical biology analysis laboratories.

Law No. 131–13 of February 19, 2015 on the practice of medicine.

Law No. 17–04 containing the code of drugs and pharmacy of November 22, 2006.

Law No. 17–08 of February 18, 2009 amending and supplementing law No. 78–00 containing municipal charter, as amended and supplemented.

Law No. 34–99 of November 7, 2002 amending and supplementing dahir No. 1–59–367 of February 19, 1960 regulating the practice of the professions of doctor, pharmacist, dental surgeon, herbalist, and midwife.

Ministerial Order No. 2008–05 of 19–10–2005.

Order of the Minister of Health No. 902–08 of July 21, 2008 that sets the technical standards of installation, salubrity, and area of the space that is to accommodate a pharmacy dispensary and the technical standards regarding pharmaceutical facilities.

Order of the Minister of Public Health No. 368–79 of July 10, 1979 setting the prices of acts performed by midwives and nurses in the private sector.

Order of the Minister of Public Health No. 683–95 of March 31, 1995 setting the terms of enforcement of royal decree No. 554–65 of June 26, 1967 containing the law making it mandatory to report certain diseases and prescribing prophylactic measures to eradicate diseases.

Site of the Ministry of Health in Morocco: www.sante.gov.ma

ANNEX A: BACKGROUND DATA ON MOROCCO

Geographic Data

Morocco—officially the Kingdom of Morocco—is located in the northwest of Africa, bordered to the north by the Mediterranean Sea and the Strait of Gibraltar, and to the west by the Atlantic Ocean. To the south, Morocco shares a border with Mauritania and to the east with Algeria. According to the 2014 General Census of Population and Habitat, the population is 34.32 million people, more than half of whom live in urban areas, and the area covers 710,850 square kilometers. The official language is Arabic, but other languages spoken include Moroccan Arabic (Darija), Berber (Tamazight), French, and Spanish (in the northern part of the country). Over the past decade, English has been increasingly taught in Moroccan schools.

The climate is Mediterranean in the north, Atlantic in the west, and Saharan in the south; it is generally moderate thanks to the sea—the country has more than 3,500 kilometers of coastline.

Sociopolitical Data

The Kingdom of Morocco is a former French colony; its capital is Rabat. It achieved independence in 1956. Northern Morocco and the western Sahara were colonized by Spain. Morocco has a constitutional monarchy and is one of the oldest monarchies in the world. The king presides over the Council of Ministers and promulgates legislative documents.

About 30 political parties operate freely. Legislative elections are held every 5 years to elect the members of the two chambers: the Chamber of Deputies and the Chamber of Counsellors, which renews a third of its members every three years.

Morocco has 12 regions, each having a wali as its head, and a regional council representing the “living forces” of the region. Those regional councils have the status of local governments, which elect assemblies that are in charge of democratically managing their affairs under the law.

The country has about 20 labor unions, but only 7% of workers are unionized. Employers are gathered in a confederation.

The monetary unit is the dirham (MAD); US\$1 is equivalent to about MAD 10.

Economic Data

Overall, the Moroccan economy has made notable progress, with a rising overall standard of living in terms of income, purchasing power, consumption, and savings. The economic outlook over the medium and long term is good. According to the World Bank, Morocco has made many economic reforms in recent years and has invested heavily in modernizing its economy, which fosters new investment opportunities in new sectors, and has successfully established value chains.

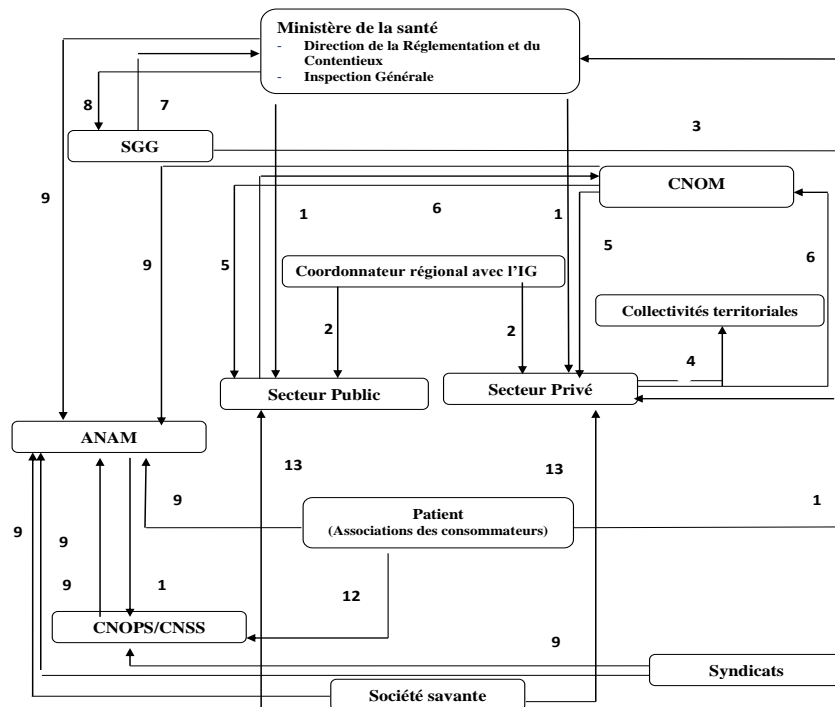
However, the country remains heavily agricultural. That sector is hampered by lack of water and by obsolescent technologies, the landscape, the meagerness of most farms, and antiquated farming practices.

Nevertheless, Morocco's proximity to Europe has benefited the economy through outsourcing by European companies, specifically in the automotive and aeronautical sectors.

Economic growth increased from 1.2% in 2016 to 4% in 2017, thanks to 15.1% growth in agricultural value in 2017.

ANNEX B: REGULATORY ACTORS

Acteurs et institutions impliqués dans l'élaboration et la mise en œuvre de la réglementation



- 1) Règlements, légifère, contrôle, inspection, supervision
- 2) Contrôle, inspection, supervision
- 3) Autorisation administrative pour l'exercice dans le secteur privé
- 4) Autorisation d'ouverture d'un cabinet, officine, laboratoire et clinique
- 5) Autorisation d'exercice, Appliquer les sanctions disciplinaires
- 6) Inscription et cotisation auprès du conseil
- 7) Valide et approuve les projets de lois et décrets relatifs à la santé

- 8) Donne l'avis en matière de l'autorisation pour l'exercice dans le privé
- 9) Concertation au Conseil d'Administration
- 10) Dépôt des plaintes et des réclamations, avis et enrichissement de la réglementation
- 11) Encadrement technique de l'AMO ainsi que sa régulation
- 12) Adhésion à l'agence de gestion de l'assurance maladie
- 13) Formation continue en matière de la réglementation et établissement des normes et des bonnes pratiques

ANNEX C: REGULATORY MECHANISMS

This section provides an overview of regulatory and oversight mechanisms for health care in Morocco. The mechanisms are listed in a table that include a broad set of mechanisms, such as regulation of professional practice, introduction of standards and rules, regulation and streamlining of care offerings, and the obligation to report certain communicable diseases. They also provide information about regulatory targets, who include health professionals (doctors, pharmacists, dentists, nurses, opticians, etc.), and regulatory actors (elected officials, political decision-makers, local governments, central and regional departments, private investors, etc.).

The assessment team focused on the following aspects of regulation during primary data collection:

- Regulations governing health care practice
- Implementation of regulations, including challenges encountered
- The effects of regulations on the health care system
- Fields of implementation (public sector versus private sector)
- Changes to legal mechanisms governing the health care system

Table A-1. Regulatory Mechanisms

Mechanism	Instrument(s)	Target(s)	Rationale	Implementation Status	Source(s)
<p>Regulating the profession and practice of medicine in both the public and private sectors.</p> <p>Determining the aspects of the partnership between the public and private sectors as to medical benefits.</p>	<p>Required advance registration with the medical association for any practitioner practicing his/her profession in the public sector and in the private sector.</p> <p>Registration and setup of doctors from abroad subject to regulatory provisions in force.</p> <p>Establishes the terms of creation, operation, and oversight of doctors' offices.</p> <p>It subjects the creation of private clinics to compliance with procedures and standards specific to each type of facility.</p> <p>Prohibition for a health insurance entity to create or manage a clinic or a comparable facility.</p> <p>Submitting partnership agreements between doctors or between a doctor and a clinic to the approval of the president of the national council and the rules of the code of ethics.</p>	<p>Doctors practicing in the private sector and the public sector; state services; territorial governments; Public institutions</p>	<p>The requirements of efficacy, quality and efficiency of the health care system require diversification of the forms of practice of medicine and new ways of financing and management of private care structures.</p> <p>The present judicial system responds to the progress of medical practice and profound changes in the health care system while considering the changes in the international medical and economic environment to make the health care system attractive to investment.</p>	<p>Adoption by the Chamber of Representatives and the Chamber of Counsellors in Parliament.</p> <p>Promulgation and publication in the official gazette on February 19, 2015.</p> <p>Abrogation of the provisions of law No. 10-94 regarding the practice of medicine, of August 21, 1996.</p> <p>Opinion of the National Council of the Medical Association (CNOM).</p> <p>Decree implementing law No. 131-13.</p>	<p>Law No. 131-13 of February 19, 2015 regarding the practice of medicine.</p> <p>Decree No. 2-15-447 issued for implementing law No. 131-13 regarding the practice of medicine.</p> <p>Decree No. 2-97-421 of October 28, 1997 adopted for application of law No. 10-94 regarding the practice of medicine.</p>

Mechanism	Instrument(s)	Target(s)	Rationale	implementation Status	Source(s)
Regulation of the practice of professions of doctor, pharmacist, dental surgeon, herbalist and midwife.	<p>Issuance of authorization to practice by the General Secretary of the government.</p> <p>Methods and cases of revocation of authorization to practice.</p> <p>Prohibition on illegal practice and penalties related thereto.</p>	<p>Doctors; Pharmacists; Dental surgeons; Midwives; Herbalists</p>	<p>Safety and public health requirements impose the regulation of the various professions in question (doctors, pharmacists, dental surgeon, herbalists and midwives).</p> <p>Control and regulate the practice of professions in a public capacity.</p>	<p>Promulgation and publication of dahir No. 1–59–367 of February 19, 1960 in the official gazette.</p> <p>Amendment and partial authorization of dahir No. 1–59–367 of February 19, 1960 by law No. 34–99 of November 7, 2002.</p> <p>Authorizations to practice issued by the General Secretary of the Government.</p>	<p>Dahir No. 1–59–367 of February 19, 1960 regulation of the practice of the professions of doctor, pharmacist, dental surgeon, herbalist, and midwife.</p> <p>Law No. 34–99 of November 7, 2002 amending and supplementing dahir No. 1–59–367 of February 19, 1960 regulating the practice of the professions of pharmacists, dental surgeons, herbalists, and midwives.</p>

Mechanism	Instrument(s)	Target(s)	Rationale	Implementation Status	Source(s)
<p>Standardization of the pharmaceutical monopoly and regulation of the necessary requirements as to the manufacture, storage, distribution, and delivery of drugs and pharmaceutical products.</p> <p>Introduction of standards and rules of good practices and pharmacovigilance of drugs.</p> <p>Regulation of the profession of pharmacist and terms of private practice.</p>	<p>Extending the pharmaceutical monopoly to nonmedicinal pharmaceutical products.</p> <p>Defining the status and powers of the chief pharmacist of a pharmaceutical facility.</p> <p>Requiring authorization of drugs before marketing.</p> <p>Provisions regarding gifts of drugs.</p> <p>Defining the dispensary as a place of dispensing (sale).</p> <p>Introducing standards and rules of good practices (setting up of dispensary, equipment of pharmacies for internal use, and pharmaceutical facilities).</p> <p>Organizing the promotion of drugs and medical information.</p> <p>Authorization to practice the profession of pharmacist in a private capability.</p>	<p>Dispensary pharmacists</p> <p>Inspector pharmacists</p> <p>Industrial pharmaceutical facility</p> <p>Wholesalers distributors of drugs and pharmaceutical products</p> <p>Clinics and comparable facilities</p>	<p>Modernization of the pharmaceutical industry and improvement in drug production techniques.</p> <p>The country's strengthening of the concepts of health monitoring and safety.</p> <p>Internationalization of drug manufacturing and influence of global agreements on customs tariffs.</p> <p>The initiative for harmonization of pharmaceutical legislation.</p>	<p>Adoption by the Chamber of Representatives and the Chamber of Counsellors of Parliament.</p> <p>Promulgation and publication in the official gazette, on November 22, 2006.</p> <p>Publication of two implementing decrees.</p> <p>Publication of a ministerial order.</p> <p>Dialogue with the national institutions representing industrial pharmaceutical facilities.</p>	<p>Law No. 17-04 containing code of drugs and pharmacy of November 22, 2006.</p> <p>Implementing decree regarding the authorization to market drugs for human use.</p> <p>Decree No. 2-07-1064 of July 9, 2008 regarding the practice of pharmacy, the creation and opening of dispensaries and pharmaceutical facilities.</p> <p>Minister of Health Decree No. 902-08 of July 21, 2008 setting the technical standards of installation, salubrity, and area for the space that is to accommodate a pharmacy dispensary and the technical standards regarding pharmaceutical facilities.</p>

Mechanism	Instrument(s)	Target(s)	Rationale	implementation Status	Source(s)
Standardization of conditions for setup, operation, and management of private medical biology analysis laboratories.	<p>Submitting private medical biology analysis laboratories to certain conditions of opening and operating.</p> <p>Setting terms of operation of laboratories.</p> <p>Administrative authorizations regarding the operation of private medical biology testing laboratories.</p> <p>Provisions regarding possible penalties in the event of violations.</p>	<p>Biologist doctor;</p> <p>Biologist pharmacist;</p> <p>Biologist veterinarian;</p> <p>Anatomical pathologist doctor</p>	<p>Formal regulation can foster improvement in the quality and safety of care.</p> <p>Respond to the essential role of medical analysis laboratories in the process of patient care.</p> <p>Keep track of technological and IT progress in medical and biological diagnosis.</p>	<p>Promulgation and publication in the official gazette, on October 3, 2002.</p> <p>Drafting and publication of implementing decree No.1-02-252 of 21-7-2005.</p> <p>Publication of minimal technical standards for private medical biology analysis laboratories No. 2008-05 of 19-10-2005.</p>	<p>Law No. 12-01 of October 3, 2002 regarding private medical biology analysis laboratories.</p> <p>Implementing decree No. 1-02-252 of 21-7-2005</p> <p>Ministerial order No. 2008-05 of 19-10-2005.</p>

Mechanism	Instrument(s)	Target(s)	Rationale	implementation Status	Source(s)
<p>Regulation and institutionalization of the profession of nurses and medical assistants.</p> <p>Determination of the field of practice of the profession and the acts to be performed.</p>	<p>Requirement of authorization to practice.</p> <p>Obligation to obtain a diploma.</p> <p>Performance of acts under a medical prescription or close supervision by a doctor.</p> <p>Institutionalization and creation of special status of the association of nurses and medical assistants.</p> <p>Definition and determination of the powers of each professional category.</p> <p>Setting the prices of the acts performed by midwives and nurses in the private sector.</p>	<p>Nurses holding a State diploma</p> <p>Assistant nurses</p> <p>Medical assistants</p> <p>Midwives</p>	<p>To face the acute shortage of nurses, after independence.</p> <p>Nurses are very much in demand, considering the epidemiological situation at this time; the nursing profession follows the same trend as medical and technological sciences.</p>	<p>Promulgation and publication of the dahir in the official gazette, on February 19, 1960.</p> <p>Amendment of the above mentioned dahir on February 19, 1960.</p> <p>Publication of the implementing decrees.</p> <p>Publication of a ministerial order setting the prices of the acts.</p>	<p>Dahir No. 1-57-008 of February 19, 1960 regulating use of the title and practice of the profession of nurse.</p> <p>Dahir No. 1-60-160 of September 1, 1960 amending dahir No. 1-57-008 of February 19, 1960 regulating use of the title and practice of the profession of nurse.</p> <p>Decree No. 2-57-1094 of June 6, 1958 instituting a State Diploma of nurse.</p> <p>Decree 2-93-308 of October 29, 1993 containing special status of the association of nurses and medical assistants.</p> <p>Order of the Minister of Public Health No. 368-79 of July 10, 1979 setting the prices of the acts performed by the midwives and nurses in the private sector.</p>

Mechanism	Instrument(s)	Target(s)	Rationale	Implementation Status	Source(s)
Regulation and creation of the profession of optician.	Requirement of authorization to practice. Obligation to obtain a diploma. Performance of acts under a medical prescription.	Optician	Progress of medical techniques, especially in relation to correction of vision.	Promulgation and publication of the dahir of October 4, 1954.	Dahir of October 4, 1954 regulating the practice of the profession of retail optician
<p>Institutes a tool for regulation and planning of care offerings.</p> <p>Streamlining of investment in care offerings.</p>	<p>Health charter as a tool of regulation of care offerings, which can enable judicious distribution of infrastructures, teams, and human resources over the entire national territory.</p> <p>Regional plans of care offerings (SROS) tool of planning and regulation of offerings at the regional level.</p> <p>Institutionalization of the National Commission and regional commissions on care offerings.</p> <p>Judicial apparatus that acts as a uniform reference framework that defines the health care system, and clarifies the rights and duties of the population and patients as to health.</p>	<p>Political decision-makers</p> <p>Territorial governments</p> <p>Regional departments</p> <p>Central departments</p> <p>Associations working in the health field</p> <p>Private investor</p>	<p>Inclusion in the constitution of the right to health with the advent of the new constitution of 2011.</p> <p>Honor the health commitments assumed by Morocco under international agreements.</p> <p>Remedy disparities of geographical distribution of medical resources.</p> <p>Reduce disparities between regions and social categories, to correct dysfunctions of the health care system.</p> <p>Commitment of the State to guarantee Moroccan citizens equal access to health care and services.</p> <p>Encourage investments in the health field and develop a partnership between the private sector and the public sector.</p>	<p>Promulgation and publication of the law in the official gazette, on July 2, 2011.</p> <p>Development and publication of implementing decree 2-14-562 of July 24, 2015.</p> <p>Creation of regional commissions on care offerings.</p> <p>Development and validation of certain regional plans of care offerings.</p>	<p>Framework law 34-09 of July 2, 2011 regarding the health care system and care offerings.</p> <p>Decree 2-14-562 of July 24, 2015 issued for application of Framework law 34-09.</p>

Mechanism	Instrument(s)	Target(s)	Rationale	Implementation Status	Source(s)
Obligations to report certain diseases.	<p>Develop and define a list of diseases subject to international health regulation.</p> <p>Develop and define a list of diseases that can cause epidemic outbreaks.</p> <p>Develop and define a list of diseases that give rise to mandatory disinfection and/or insect control.</p> <p>Approach and procedure to be followed for reporting so-called mandatory diseases to the ministry of health.</p>	<p>Doctors in the private sector and public sector</p> <p>Medical support staff</p>	<p>Align with international health regulation.</p> <p>Reinforce prophylactic measures that can stop certain epidemic diseases.</p>	<p>Publication of royal decree No. 554–65 of June 26, 1967 containing a law making it compulsory to report certain diseases.</p> <p>Order of the Minister of Public Health No. 683–95 of March 31, 1995 that lays down the terms of enforcement.</p> <p>Collection and analysis of mandatory disease-reporting sheets.</p>	<p>Order of the Minister of Public Health No. 683–95 of March 31, 1995 setting the terms of enforcement of royal decree No. 554–65 of June 26, 1967 making it compulsory to report certain diseases and prescribing prophylactic measures able to stop diseases.</p>

Mechanism	Instrument(s)	Target(s)	Rationale	Implementation Status	Source(s)
<p>Urban hygiene and sanitation regulations.</p> <p>Health regulation to improve the health conditions of the city or township.</p>	<p>Set up municipal /township hygiene offices of the municipality of the city or the township.</p> <p>A technical commission that inspects facilities that harm the environment and public health; responsible for watching over the cleanliness and sanitation of the public's environment.</p>	<p>Doctors, hygiene technicians, laboratory assistants, administrative staff of the municipality or township</p> <p>Commercial and industrial facilities</p> <p>Elected officials</p> <p>Provincial health delegations</p>	<p>Combat all forms of pollution and degradation of the environment and natural equilibrium.</p> <p>Ensure public safety and combat vermin of any nature.</p> <p>The town charter has put the president of the town council in charge of managing the sanitation and cleanliness of the public environment.</p>	<p>Promulgation and publication of the municipal charter.</p> <p>Amendment of the charter on several occasions.</p> <p>In January 2001 an interdepartmental circular set the powers of the hygiene office doctor.</p> <p>The circular of the Minister of the Interior No. 133 of October 18, 2004.</p>	<p>Law No. 17-08 of February 18, 2009 amending and supplementing law No. 78-00 containing municipal charter, as amended and supplemented.</p> <p>Law No. 01-03 of March 24, 2003 amending law No. 78-00 containing municipal charter.</p>

ANNEX D: ASSESSMENT QUESTIONNAIRE

This is the questionnaire administered for the assessment, including the list of people to be interviewed, the consent form, and the questions.

People to be Interviewed

- Officials in the central administration of the Ministry of Health
- Regional director of health
- Deputy minister of health
- Chief physicians of SIAAP (Service Public de L'Assainissement Francilien)
- Chief physicians of health centers
- Chief officers of health centers
- General practice physicians in the public and private sectors
- Others (from the mandatory health insurance managerial body, basic medical coverage regulatory body, CNOM, etc.)

IDENTIFICATION

Region Province/Prefecture

Position Sector (public or private)

Profile Seniority

INTRODUCTION/CONSENT

Hello, I am (specify capacity, responsibilities, purpose of the interview, what primary health care means, etc.) and, considering your professional experience and your expertise, I would like to discuss with you and get information and collect data about regulations and practice in primary health care: knowledge of regulations and the consequences of their implementation in practice, the package of activities, effects on public health, constraints encountered while practicing your profession and the areas of improvement.

The information that you share with us is confidential, and your identity will not be disclosed in any way. The results of this study will be used for managerial research for development of the health care system in the country.

Note: The Ministry of Health is using the WHO definition of primary health care as defined by the Declaration of Alma-Ata, which it subscribed to in 1978. This care comprises:

- Education for health
- Maternal and child protection, including family planning
- The promotion of good food and nutritional conditions
- Vaccination against the major infectious diseases
- Prevention and control of local endemic diseases
- Treatment of common diseases and injuries
- Supply of essential drugs

DISCUSSION TOPICS

The questions will relate to primary health care (PHC) regulations in the public and private sectors:

- Statutory and regulatory documents (their drafting and implementation)
- Resources available to the public and private sectors for implementing regulations
- Impact of regulations on PHC practice
- Proposals to improve the implementation of regulations and the quality of PHC

The individual interviews and the focus groups will be semi-structured and focus on the following questions:

- 1) Could you describe for us how the Primary Health Care Network (PHCN) is organized in the public and private sectors in your region (public) / your practice (private)?
- 2) In your view, what types of stakeholders are targeted when regulations are written? What are the challenges (if any) of that process? Do you have any suggestions for improving them?
- 3) How do you judge the role of partners in the drafting and implementation of regulations of the PHCN?

- Territorial governments

- Civil society organizations and nongovernmental organizations (NGOs)
- The mandatory health insurance managerial body
- The basic medical coverage regulatory body
- The National Council of the Medical Association (CNOM)
- Users of care
- Academia

4) How can the role of those partners be improved?

5) How do you evaluate the relationship between the private sector and the public PHCN and the Ministry of Health?

6) Could you describe the regulations that govern private PHC in your context?

7) How are those regulations implemented? In your view, are they effective and do they actually regulate the private sector? Why?

8) How do PHC regulations meet your needs for better patient care in your practice in terms of the following?

- Package of care
- Performance
- Continuity of care

9) How are the service-purchasing commissions connected with regulating the Primary Health Care Network (PHCN) organized for the two sectors?

- For prescribing diagnostic tests
- For choosing the list of drugs
- For compliance with standards and protocols
- For other services

10) What resources are available for devising and implementing PHC regulations?

11) How do the resources made available to the PHCN (by the Ministry of Health, CNOM, etc.) affect health services in terms of the following?

- Quality of care and patient safety
- Continuity of access to care
- Integration of care

- Reducing copayments for patients who have medical coverage

12) In your opinion, what are the difficulties in implementing PHC regulations?

13) What are the effects of current regulations on the health care system?

14) What do you hope to change or introduce as part of regulation to improve the following?

- Fairness in access to care at the primary level
- The quality of PHC
- The direct expenditure of households in accessing care

15) Any conclusions or comments you wish to share?

ANNEX E: QUESTIONNAIRE RESPONSES

Responses to the interviews and focus groups are summarized below.

- 1) Could you describe for us how the Primary Health Care Network (PHCN) is organized in the public and private sectors in your region (public) / your practice (private)?

Primary organization of health care

- The public sector is predominant; it is structured hierarchically and partitioned.
- Pyramidal hierarchy where the Basic Health Care structures (urban and rural health centers/level 1 and 2) constitute the first level of orientation-recourse for patients
- PHC facilities are managed by chief physicians and chief nurses, in charge of administrative management, organization and dispensing of care at those facilities
- The private for-profit sector, made up of general and specialized doctors' offices and dental medicine offices and dispensaries
- The private not-for-profit sector, which is ill understood, made up of offices (specifically dental) and clinics managed by the CNOPS, the CNSS, associations or foundations
- The community-based health insurance sector, which is not very developed, centered on dental care, optician centers and certain specialized consultations

- 2) In your view, what types of stakeholders are targeted when regulations are written? What are the challenges (if any) of that process? Do you have any suggestions for improving them?

Stakeholders:

- Technical departments of the central administration of the Ministry of Health
- Sectoral Partners
- Territorial governments
- CNOM
- Basic medical coverage managerial bodies
- ANAM
- Elected officials of the two chambers of Parliament
- Labor unions

Regulatory challenges and obstacles:

- Not enough attorneys who specialize in drafting legal documents
- How to make regulations applicable for the private health sector
- Resistance to change and to implementing regulations
- Lack of reliable information for the private sector as to oversight of implementing regulation
- Shortage of human and financial resources (cost of conducting inspections and audits of regulations)
- Insufficient capabilities of decentralized external services (regions) to be truly responsible for their decisions
- Lack of integration and complementarity of the public and private sectors
- Insufficient communication regarding all new regulations

Suggestions:

- Political commitment to make regulations enforceable
- Commitment of the administration so that it fully plays its role in regulatory compliance
- Strengthening inter-sector collaboration for regulatory compliance
- Strengthening monitoring and evaluation of regulatory performance
- Give more decision-making power to local actors and enable them to more effectively and rapidly meet the expectations and needs of the population as to health regulation compliance
- Benchmark of best practices in other countries for drafting and implementation of regulations

3) How do you judge the role of partners in the drafting and implementation of regulations of the PHCN?

Territorial governments:

- Paramount in setting up regionalization
- Recruitment of human resources
- Transportation and medical evacuation and assistance
- Decision-making power: validation of the regional health charter, regional plans of care offerings

Civil society organizations and NGOs:

- Essential role for promoting health
- Essential role for mobilizing actors and the public
- Opinion and enrichment of regulatory documents
- Some care provided based on volunteerism (specifically for medical campaigns)

Mandatory health insurance managerial body:

- Supervise the implementation of good practices in the private sector
- Watch over financial balances
- Coverage of the insureds
- Medical oversight and disputes

Basic medical coverage regulatory body:

- Establish national agreements
- Regulate the basic mandatory health insurance system
- Overall balance between resources and expenditure for each basic mandatory health insurance system
- Revise the reference pricing
- Produce guides of good practices

National Council of the Medical Association (CNOM):

- Opinion on the opening of doctors' offices and laboratories
- Contribute to the drafting of regulatory documents
- Partners for compliance with existing regulations

Users of care:

- Their representatives (associations of consumers) defend their interests
- Involvement in certain services (sponsorship)

Academics:

- Develop therapy protocols under the aegis of the regulatory body
- Research and oversight of practitioners (seminars, conferences)
- Initial and continuing education

4) How can the role of those partners be improved?

Territorial governments:

- Strengthen the partnership with the department in terms of human and logistic resources (ambulances, equipment, and housing of health professionals)
- Decision-making power: validation of the regional health charter, regional plans of care offerings
- Improvement in medical outcomes (National Initiative for Human Development)
- Communication system and sharing of information among legislators, health professionals and users

Civil society organizations and NGOs:

- Participative democracy by strengthening their role for promoting patient rights and health
- Active involvement in the enrichment of regulatory documents
- Information, campaign to raise public awareness of existing regulations
- Education of patients, families and professionals
- Strengthen public involvement capabilities for consciousness-raising, support, training and education
- Regulation of care offerings

Mandatory health insurance managerial body:

- Help improve care services for insureds and invest in care offerings
- Coordinate community-based health insurance companies concerned, medical oversight
- Technical opinion and supervision of protocols in the private sector
- Watch over financial balances
- Review collection of services for insureds

Basic medical coverage regulatory body:

- Establish national agreements among managerial bodies, care providers and suppliers of medical goods and services
- Regulate the basic mandatory health insurance system (control of costs and observance of pricing)

- Opinion on draft legislative and regulatory documents regarding basic mandatory health insurance
- Total balance between the funds and expenses for each basic mandatory health insurance plan
- Technical support for managerial bodies
- Arbitration in the event of disputes between the various parties involved in health insurance
- Supportive role by facilitating negotiations for revising the reference pricing

National Council of the Medical Association (CNOM):

- Decide on applications for admission to the membership of the Medical Association
- Issue opinions on laws and regulations regarding the practice of the profession
- Coordinate any health promotion action with the proper authorities
- Watch over efforts to combat the illegal practice of medicine
- Defend the moral and professional interests of the medical profession
- Opinion on the opening of doctors' offices and laboratories
- Watch over compliance with ethics and deontology

Users of care:

- Act with patient associations and undertake a citizen approach for participating and taking collective responsibility in health policy
- Relations between patients and doctors
- Defend interests by means of their representatives (associations of consumers)
- Involvement in certain services (sponsorship)

Academics:

- Develop therapy protocols
- Support certain scientific research actions
- Research and oversight of practitioners (seminars, conferences)

5) How do you evaluate the relationship between the private sector and the public PHCN and the Ministry of Health?

- Limited relationship
- Complementary relationship (sending patients from public to private / biological, radiological tests and specialty)

- Epidemiological monitoring (reporting of diseases, etc.)
 - Continuing education (associations of private doctors and public sector)
- 6) Could you describe the regulations that govern the private PHC in your context?
- 7) How are those regulations implemented? In your view, are they effective and do they actually regulate the private sector? Why?
- Limited oversight of medical practice (e.g. dental surgery, etc.)
 - Regular inspection compromised (quality of care, pricing, etc.)
 - Verification of opening authorizations
 - Drafting of law on care offerings in the private sector
 - Implementing regulatory documents and evaluating them
 - Standardizing and implementing therapy protocols for the private sector
 - Except for implementing some regulatory documents, specifically the inspection and the inherent penalties, it is mandatory to induce private sector compliance with existing regulations in order to assure regulation of care offerings, their fair distribution and quality of care
- 8) How do PHC regulations meet your needs for better care of patients in your practice in terms of the following?

Package of care:

- Standards of availability of doctors and nurses especially in rural environments to offer this package of care
- Reference framework for patient circuit
- Type of services offered
- Reference frameworks of prevention
- Availability of drugs
- Method of delivery of care

Performance of care:

- Efficiency in access to care
- Reporting package and conceptual framework of health program indicators
- Reactivity of health professionals for high-quality services
- Achieving the goals assigned to PHC
- Adaptation of resources dedicated to PHC

- Producing care volume, high-quality services and optimizing the production process (productivity)
- Certification and accreditation

Continuity of care:

- Attending physician identified
- Accessibility outside of business hours
- Complete and coordinated longitudinal services
- Comprehensiveness of services
- Reliable reference cross-reference system

9) How are the service-purchasing commissions connected with regulating the Primary Health Care Network (PHCN) organized for the two sectors?

For prescribing diagnostic tests:

- In the DRS/DMS (purchases of private sector service / specialized consultations)
- Referral of patients to private laboratories and radiology units

For choosing the list of drugs:

- Within provincial commissions based on a list and a budget allocated for each provincial delegation

For compliance with standards and protocols:

- The few therapeutic protocols that exist are generally not applied by practitioners

For other services:

- Just purchasing service for patients with kidney failure receiving dialysis that is effective and has full resources to guarantee its continuity

10) What resources are available for devising and implementing the PHC regulations?

- The existence of a central structure at the Ministry of Health that has attorneys and competencies required for drafting legal documents. An effort must be made in

terms of financial funds for motivation and strengthening their powers and to monitor and evaluate the implementation of legal documents.

11) How do the resources made available to the PHCN (by Ministry of Health, CNOM, etc.) affect health services in terms of the following?

Quality of care and patient safety?

- When the structures have the required standards and a favorable practice environment, we can evaluate the quality and safety of care. Also there is the culture of merit, which will definitely improve quality of care.

Continuity of access to care?

- Here, too, a minimum of resources is required to sustain availability of care

Integration of care?

- Need to set up mechanisms that enable this integration and assemble bring together the parties in overseeing their enforceability

Reducing copayments for patients who have medical coverage?

- Need to apply the pricing of acts, to reduce the price of drugs and medical devices
- Need to reduce direct expenditures of households
- Need to combat corrupt practices
- Reinforce inspection missions
- Recourse to penalties when they are required

12) In your opinion, what are the difficulties in implementing PHC regulations?

- Ignorance of these regulations
- Lack of communication about these regulations
- Insufficient missions for inspection and supervision
- Lack of certain documents to implement or support certain laws to make them enforceable
- Review of basic and continuing education programs for mastery of regulations
- Lack of resources for implementing certain validated laws

13) What are the effects of the current regulations on the health care system?

- The regulatory documents that are implemented have very beneficial repercussions on access to public or private care (reduction in patients' direct expenses, reorganization of access to care, reduction in wait time to receive care, etc.)
- Other documents have the virtue of at least existing and they require promotion and if necessary penalties to make them implementable

14) What do you hope to change or introduce as part of regulation to improve the following?

Fairness in access to care at the primary level?

- Raise the level of financing to improve regional plans for offering care and applying the health charter
- Motivate the human resources who work in isolated areas

The quality of PHC?

- Draft the document of the law on accreditation and certification of public and private care structures
- Institutionalize a quality competition and make it mandatory for all public and private care structures

The direct expenditure of households in accessing care?

- Achieving UHC
- Compliance with National Reference Pricing to reduce patient copayments
- Reduce the price of drugs and medical devices
- Encourage the use of generic drugs

15) Any conclusion or comment that you wish to share?

ANNEX F: ANALYSIS GRID FOR QUESTIONNAIRE RESPONSES

The assessment team used an analysis grid to rank questionnaire responses by their level of relevance:

- Very relevant (VR): answers the question directly
- Relevant (R): answers the question without substantiating that answer
- Moderately relevant (MR): partly answers the question but stays on topic
- Not relevant (NR): a confused response that does not answer the question
- No response (NonR): the interviewee has no response to give and/or prefers not to respond

This helped the assessment team extract the most relevant information from the responses.

Table F-2. Analysis Grid

Goals	Relevance of Response				
	VR	R	MR	NR	NonR
	NR	NR	NR	NR	NR
A. Level of general knowledge of PHC					
1. Could you describe for us how the Primary Health Care Network (PHCN) is organized in the public and private sectors in your region (public) / your practice (private)?					
2. In your view, what types of stakeholders are targeted when regulations are written? What are the challenges (if any) of that process? Do you have any suggestions for improving them?					
3. How do you judge the role of partners in the drafting and implementation of regulations of the PHCN? <ul style="list-style-type: none"> • Territorial governments • Civil society and NGOs • The mandatory health insurance managerial body • The basic medical coverage regulatory body • The National Council of the Medical Association (CNOM) • Users of care • Academia 					
4. How can the role of those partners be improved?					

Goals	Relevance of Response				
	VR NR	R NR	MR NR	NR NR	NonR NR
5. How do you evaluate the relationship between the private sector and the public PHCN and the Ministry of Health?					
B. What types of regulations govern the private health sector?					
6. Could you describe the regulations that govern private PHC in your context?					
C. How are regulations of the private health sector implemented?					
7. How are those regulations implemented? In your view, are they effective and do they actually regulate the private sector? Why?					
8. How do PHC regulations meet your needs for better patient care in your practice in terms of the following? <ul style="list-style-type: none"> • Package of care • Performance of care • Continuity of care 					

Goals	Relevance of Response				
	VR	R	MR	NR	NonR
	NR	NR	NR	NR	NR
<p>9. How are the service-purchasing commissions connected with regulating the Primary Health Care Network (PHCN) organized for the two sectors?</p> <ul style="list-style-type: none"> • For prescribing diagnostic assessments • For choosing the list of drugs • For compliance with standards and protocols in practice • For other services 					
12. In your opinion, what are the difficulties in implementing PHC regulations?					
D. What resources are available to devise and implement regulations?					
10. What are the resources available for devising and implementing PHC regulations?					
12. In your opinion, what are the difficulties in implementing PHC regulations?					

Goals	Relevance of Response				
	VR	R	MR	NR	NonR
	NR	NR	NR	NR	NR
E. What outcomes are achieved by the regulations implemented?					
11. How do the resources made available to the PHCN (by Ministry of Health, CNOM, etc.) affect health services in terms of: <ul style="list-style-type: none"> • quality of care and patient safety? • continuity of access to care? • integration of care? • reducing copayments for patients who have medical coverage? 					
12. In your opinion, what are the difficulties in implementing PHC regulations?					
13. What are the effects of the current regulations on the health care system?					

ANNEX G: IMPLEMENTATION AND PERFORMANCE OF REGULATORY ACTIVITIES

Table G-3. Implementation and Performance of Regulatory Activities

Participant	To what extent are regulations fulfilling their mandate? 1 = strongly disagree 2 = disagree 3 = neutral 4 = agree 5 = strongly agree	Implementation and Performance Strengths	Implementation and Performance Weaknesses	Suggested Changes
Ministry of Health (DRC)	5	Exhaustiveness of regulations.	Delays in implementing regulations. Lack of certain documents implementing or supporting certain laws to make them enforceable.	Dialogue with partners. Benchmark of best practices in other countries for regulatory drafting and compliance.
Territorial governments	3	Important role in advanced regionalization.	Insufficient human and financial resources for implementing the regulations.	Give more decision-making power to local actors and respond more effectively and rapidly to public expectations and needs regarding compliance with health regulations.

Participant	To what extent are regulations fulfilling their mandate? 1 = strongly disagree 2 = disagree 3 = neutral 4 = agree 5 = strongly agree	Implementation and Performance Strengths	Implementation and Performance Weaknesses	Suggested Changes
National Health Insurance Agency	4 (especially as part of basic medical coverage)	Autonomy	Insufficient means to meet its commitments.	The agency should fully play its role according to the missions that are assigned to it. Perform a supporting role by facilitating negotiations to revise the reference pricing.
Mandatory Health Insurance managerial body	4	Involvement in pricing of the package offered by private PHC facilities. Provides medical oversight in coordination with the relevant community-based health insurance companies.	Limited role in drafting and implementing regulations at PHC facilities.	If, in the future, the services provided at public PHC facilities are reimbursable by the Mandatory Health Insurance managerial bodies, it will then play a key role.
Users of care	3	Increasing involvement (with a trend toward institutionalizing that involvement).	Role remains limited despite everything (on certain issues). Improper use of PHC. Lack of information on the services offered.	Consciousness-raising campaign among the relevant population.

Participant	To what extent are regulations fulfilling their mandate? 1 = strongly disagree 2 = disagree 3 = neutral 4 = agree 5 = strongly agree	Implementation and Performance Strengths	Implementation and Performance Weaknesses	Suggested Changes
Academics	4	Producing guides on good practices under the aegis of the regulatory body.	Problem of availability.	The revision of basic and continuing education programs for mastering the regulations.
National Council of Professional Associations	4	Opinion and enrichment of documents.	Some guides on good practices are not widely used by practitioners.	
Media	3	Want to play a role.	Lack of communication about regulations. Insufficient media specialization in the field.	Consciousness raising, training, and support for the media. Dissemination of information.