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DELEGATION OF THE COMMISSION
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THE IMPACT OF PUBLIC SOCIAL SPENDING
ON LOW-INCOME HOUSEHOLDS

HEALTH CARE

(Draft Report N° 2)

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SUMMARY OF REPORT

I. POPULATION AND HEALTH

In a developing country, national health care policies try to maintain or improve the population's standard of health care by focusing on the primary needs of households. These health care needs are affected by various demographic, economic and social factors.

In the past 32 years, Morocco's population has multiplied by 2.3, increasing from 11 million inhabitants in 1960 to over 25.4 million today. Its structure has also changed, in that the number of economically active people has increased, while the percentage of people younger than 15 has dropped, and the number of people over 65 has increased only slightly. At the same time, nearly 50% of the Moroccan population lives in urban areas, mainly in the big cities, while the rest inhabit low-density rural zones. The consequences of such demographic changes on the public health care system can easily be imagined.

Population Health Indicators

In association with improvements in nutrition, the standard of living, sanitation, education and other such factors, Morocco's national health care policies have brought about:

- An increase in life expectancy from 47 in 1960 to 67 years in 1992;
- Improvements in maternal and child health care monitoring, although maternal mortality remains rather high;
- A decrease in the frequency of the major infectious diseases, although their levels of incidence remains high, especially for diseases associated with food or water contamination;
- A change in the population's morbidity profile due to the increased frequency of diseases that tend to characterize developed countries.

Household Health Utilization

Looking at the data gathered and analyzed by the National Study on the Standard of Living of Households (N.S.S.L.H.), it is possible to draw certain conclusions about the attitude of the people interviewed towards illness and the type of medical care used.

1. The higher their income level, the more sensitive to their state of health the interviewees are.

As a national average, the morbidity rate declared by the people interviewed was 15.2%. This rate climbed to 22.8% for people with high incomes, whereas it dropped down to 9.7% for those with lower incomes. The morbidity rates declared were higher in cities than in rural areas. This is probably due more to social and cultural factors than clinical ones.

2. For economic and perhaps also for cultural reasons, medical prevention does not seem to be a common practice.

In general, the people interviewed consulted a doctor only when they were ill; only 2.6% of the interviewees consulted a doctor regularly. This rate varied proportionally to the income, 1.3% for the poorest 10% of the population, and 7.2% for the richest 10%.

3. The higher the income, the more often people consult a health practitioner when ill.

As a national average, the population's attended morbidity is 53.4%. However, it reaches 64.4% for the richest 20% of the population, and drops to only 31.6% for the poorest 20%. Here again, a discrepancy exists between the urban zones (62.5%) and the rural areas (41.3%).

4. The differences in attitude and behavior towards illness are due mainly to economic factors and the availability of medical care - both public and private - which is highly concentrated in urban regions.

For example, the average distance covered by a patient to consult a doctor is 7.6 Km in the city and 24.1 Km in the country. The trip requires 28 minutes in the first case, and 64 minutes in the latter.

5. Most ill people (98.6%) use modern medicine, either private or public. The rate is slightly higher in cities (99%) than in rural zones (87.7%).
6. The majority of sick people consult medical doctors (86.1%).

This proportion is more or less the same for all income classes, both in rural and urban areas. Alternately, ill people consult a pharmacist: a national average of 7.8% in close proportions in both urban and rural areas. Finally, 4% of the sick consult a nurse.

7. 51.8% of consultations are made by private doctors in their offices. The rest are made by doctors in the public sector, representing 36.7% of all consultations.

8. The public sector is predominantly used by the poorest households.

65.9% of the sick from the first quintile consult only the public sector, compared to only 26% in the last quintile. In terms of deciles, this translates as 78.6% for the first decile and 19% for the last one.

9. 59.3% of all patients are satisfied with the medical care provided by public health services.

This rate is higher in rural sectors (68.5%) than in urban sectors (54.3%). The rate of dissatisfied people, although lower than 50%, nevertheless remains high.

10. In both cities and rural regions, the lack of medicine is the leading reason for dissatisfaction (37.4%).

The other reasons include the waiting time (26.3%) and the poor reception of patients (27.7%). Paradoxically, the remoteness of health care facilities constituted a reason for dissatisfaction more in cities than in rural regions: 11.4% vs 3.6%, respectively.

II. THE NATIONAL HEALTH SYSTEM: POLICY AND PARTICIPANTS

To meet the demand for health care, the national medical care system is distributed between outpatient services and hospitals, both private or public.

New Trends in Health Policy

An assessment of Morocco's health situation and policy at the beginning of the eighties revealed poor medical conditions, especially in rural and suburban zones. It also revealed the limitations of the system designed to meet the needs of a growing population. Public health expenditures were diverted more towards the building of hospital facilities, mainly in urban zones (79%), than towards the outpatient system (only 21%).

In order to correct imbalances in the national health care system and strengthen its efficiency and equity, priorities were shifted during the mid-eighties in favor of developing basic health care and finishing projects already initiated. Also given priority were appropriate management and financing policies, improvements in staff training, and infrastructure maintenance.

..Production and utilization of health care

Morocco's national health care system, which has expanded appreciably over the last thirty years, is divided into three sectors: public, semi-public and private. The state is the

principal care supplier and financial agent. It also monopolizes training in the health fields.

The primary responsibility for implementing those various functions lies with the Ministry of Public Health (M.P.H.). It organizes the networks of basic care and hospitals, which are the foundation of the national health coverage.

Considerable progress has been made in the development of the infrastructure, yet this did not prevent it from deteriorating at various levels.

While the number of Primary Health Care (P.H.C.) units amounted to 1,653 in 1991, the distribution of medical care is drastically uneven first at the regional level and then between rural and urban zones. P.H.C. units are not easily accessible to the whole population, particularly in rural areas.

The second component of the state's health operations is the hospital network of the M.P.H.. The network was composed of 52 units in 1960, vs. 98 in 1991 (+85%), and during the same period the number of beds went from 15,523 to 28,034. However, it should be noted that the distribution of those beds is unequal between the various specialties in the hospitals, and that the hospital buildings and equipment are considerably outdated.

Medical supervision has improved remarkably since the total number of public sector doctors went up from 431 in 1960 to 3,359 in 1991. However the relative distribution of these doctors between regions remains very unequal: 0.56 per 10,000 inhabitants in the Tensift region, and 1.03 in the southern central region.

In 1991 the public health care divisions of the M.P.H. provided more than 5 million hospital bed days, more than 7.5 million medical consultations, and about 30 million medical examinations. Added to that are some 3.5 million laboratory tests. But, between 1980 and 1991, this production has dropped in terms of relative quantity.

We also know that the eighties were marked by a clear drop in quality, partly resulting from a relative reduction of the budgetary resources allocated to this ministry. These resources are the major source of funds for financing the medical care which is granted almost totally free of charge.

The N.S.S.L.H. provides a verification of these observations through data provided on the use of public health services by households: "

1. 37% of the sick population consults the public sector.

This proportion is higher in poor households, where it peaks at 79%.

2. Somewhat paradoxically, high-income households are clearly the first beneficiaries of public health services, while the low-income households are the least served.

This is true for all services offered by public health facilities.

3. Public hospitals receive 69.6% of all hospitalized people. All of the low-income urban dwellers use public hospitals, whereas only 44% of the people belonging to the last decile use them. In the last decile, 32% consult private doctors and 26% go to cooperative clinics.

Public hospitals remain the only recourse for poor people who don't have the resources to pay for the same care in the private sector. However, although few high-income households use public hospitals, they are the ones who draw most benefit from them. In fact, although they received 27.7% of all hospitalizations provided by public hospitals, they represented 41.3% of the total number of hospital bed days. This is still more flagrant for the last decile, which used 12.9% of the hospitalizations and 31.7% of the bed days.

Such a discrepancy may be explained by the mean length of the hospital stay, which amounts to 53.1 days for urban dwellers of the last decile (the most privileged), vs 9.1 for rural inhabitants of the first decile (the least privileged). This can lead to the supposition that the first category stays longer and probably has hospitalizations whose the mean daily cost is higher.

Urban dwellers of the last decile paid for only 16.8% of the hospitalizations provided to them by public hospitals, with a mean cost amounting to 16.75 Dh per day. The national mean is 32% for hospitalizations at 22.70 Dh per day.

4. The discrepancy regarding hospitalizations also appears at the level of paramedical care.

As for the number of treatments, the last decile uses 19.5% of the public sector's services, although the total number of treatments reaches 64.5%. The mean number of health care services used per treatment is 27 for this group, whereas it is 8 as a national mean. About 70% of public paramedical care is provided to the wealthiest 20% of the population, vs 21% for the middle 40%, and 9% for the poorest 40%.

5. In contrast to hospitalization and paramedical care, the use of public-sector medical consultations is more evenly distributed between the various socio-economic classes.

26.3% of all public sector consultations go to the population's wealthiest 20%, 48.1% of the visits to the middle 40%, and 25.6% to the poorest 40%.

Only 7.3% of all public consultations are paid for. This percentage is still lower in public dispensaries, where 98.3% of the consultations are free of charge. Hospitals demand payment for 12.5% of the visits. The average fee for consultations seems to be high: 101.15 Dh as national average, with 32 Dhs in dispensaries and 121 Dhs in hospitals.

6. 48% of the analyses and X-rays made in the public sector were done for the wealthiest 20% of the population, while the middle class received 40%, and the poorest 40% received 12%.

37.3% of the analyses and X rays made in public hospitals were paid for by the patients. The average fee paid in the public sector was 92.26 Dhs.

7. 39% of the dental care services offered by the public sector were provided for the wealthiest 20%, vs 40% for the middle-class patients and 21% for the poorest 40% of the population.

At the national level, 30% of the dental care services offered by the public sector were paid for by the patients. The average fee was 31.86 Dh.

8. With regards to pharmacies, 3.7% of the patients reported that they received free medicine from public sector services.

23.5% of the medicine was given to the wealthiest 20%, vs 33.5% to middle-class patients, and 43% to the poorest 40%.

Although the state's role in health care is vital, the private sector role is significant and increasing.

In 1991, Morocco had 3,032 private doctors: 1,929 of them were generalists or general practitioners, and 1,103 of them were specialists. The first group tripled in 10 years. In 1991, more than 69% of the generalists were working in the northwestern and central regions, where 48% of the population lives. Similarly, more than two thirds (74.3%) of the private specialists are concentrated in the two regions. However, in the course of the last 10 years there has been a slight devolution of private medical practices.

The number of private clinics was estimated at 83, half of which were concentrated in Casablanca and Rabat, and more than two-thirds of which were concentrated in the central and northwestern regions.

The network of private pharmacies has also increased. The number of pharmacies multiplied by 2.3 in 10 years, and amounted to 1,802 units in 1991. 64% of the private pharmacies are located in the northwestern and central regions; nevertheless, its devolution is more pronounced than in the other medical or paramedical activities.

In 1991, barely 782 nurses and midwives were working in the private sector, vs more than 23,000 in the public sector. More than 80% of the total number are located in the central and northwestern regions.

Most household medical expenditures go to the private medical and pharmaceutical sectors. According to the N.S.S.L.H. study, the private health care sector receives 92% of the expenditures, the public sector gets 6%, and insurance companies get 2%. However, the private sector - not including the National Agency for Social Security (C.N.S.S.) - seemed to have contributed only 60 to 65% of the 1991 medical care coverage.

There are other interesting trends to note:

1. 56% of the medical expenditures were made by the wealthiest 20% of the population, whereas 36% of it was made by the middle class, and 8% by the poorest 40%.
2. One-third of the expenditures were made by rural people, whereas two-thirds were made by urban dwellers.

This distribution between the rural and urban areas of the total medical expenditure is reflected in almost every category.

3. 62% of all medical consultations were made by private doctors. Rural people with incomes equivalent to urban dwellers were more likely to use the private sector.

However, when taking into account the total number of private sector consultations, one finds that nearly two-thirds of them were made for urban inhabitants.

In terms of the overall population, the wealthiest 20% account for 44% of the private consultations, the middle-class households used 43%, and the poorest 40% used just 13%. As for payments, those 3 groups disburse 54%, 36% and 10%, respectively.

4. The private sector provides only 5% of hospital stays, but it receives 81% of the disbursements made by households in this category.

The wealthiest 20% of the population accounts for 36% of the total bed days in private clinics, the middle 40% uses 57%, and rural inhabitants belonging to the poorest 40% use 7%.

High-income urban inhabitants are the biggest consumers: 33.5% of the total number of hospital bed days at an average rate of 1,000 Dh per day. At the national level, the average fee for a day spent in a private clinic amounts to 565 Dh. It is interesting to compare those figures to the average cost of a day spent in a public hospital, and to the prices paid by the different socio-economic groups.

5. Almost 88% of all dental care was provided by the private sector.

71% of the disbursements in this category were made by the wealthiest 20% of the population, 21% of it by the middle 40%, and 8% of it by the poorest 40%.

6. 58% of the analyses and X-rays were made by the private sector, which received 91% of all the disbursements made in this category.

More than three-fourths of these services were utilized by urban dwellers, especially by those in the high-income group (47%).

In total, 53% of those services were provided to the wealthiest 20%, whereas 37% went to the middle 40%, and the remaining 10% was used by the poorest 40%.

70% of the disbursements in this category are made by the wealthiest 20%, whereas 25% are made by the middle 40%, and the remaining 5% by the poorest 40% of the population.

III. PUBLIC HEALTH CARE BUDGETARY TRENDS

An analysis of budgetary allocations over the period 1980-92 shows that the budget of the M.P.H. leaped from 760 million dirhams (MDh) in 1980 to 2,161 MDh in 1991. This means that the budget was multiplied by 2.8, an increase with a yearly average of 10%.

The budget proportion of the M.P.H. in the GIP (Gross Internal Product) has decreased slightly, from 1.03% in 1980 down to 0.90% in 1991. Compared to the growth of the state budget, it passed from 3.6% in 1980 to 4.7% in 1991, following a progressive increase initiated in the mid-eighties.

The development of the health budget per capita shows that the resources allotted by the M.P.H. to each citizen was 86 Dhs in 1991, 69 Dhs of which were operating costs, and 18 Dhs of which were equipment costs. In real terms expressed in 1980 dirhams, the per capita public expenditure was about 41 Dhs, all expenses included. It did undergo an average yearly increase of 0.5% in relation to 1980, but its real value has remained unchanged since 1988.

Assessments made by the M.P.H. of the distribution of funds show that, in real terms, the stagnation of the M.P.H.'s resources from 1980 to 1987 was followed by a net buildup of its finances from 1987 to 1990.

The allocation of resources between the various levels of the health care system has undergone changes in favor of non-University Hospital Centers (U.H.C.'s) and outpatient service networks. In spite of this, 72.5% of those expenses were absorbed by hospitals, vs only 27.5% for health centers and dispensaries.

In terms of equity and efficiency, there was a significant reduction of regional disparities in medical care expenditures. There was also an improvement in the use of available resources, as shown by indicators of the average productivity and activity of personnel in SEGMA hospitals.

However, in terms of hospitals, the U.H.C.'s in Rabat and Casablanca currently receive about one-third of the total health care resources and 44% of all hospital funds. It can also be noted that, in terms of national distribution, the northwestern region receives 34% of the M.P.H.'s resources, although it contains less than 22% of the total population.

The distribution of 1991's total health care budget (2 million Dh, 98% of which is managed by the M.P.H.) reveals that personnel costs accounted for 57.6%, operational costs and debt reimbursements for 16.9%, fixed assets for 13.3%, and purchases of consumables for 8.1%.

The 1991 approved budget amounted to 2,150 MDh, of which 302 MDh was for fixed assets and 1,848 MDh was for recurrent expenditures. The total cost of the M.P.H. services was estimated at 1,866 MDh, not including administrative costs. Depending on the kind of expense, this total cost breaks down into 1,596 MDh for operating costs and 270 MDh for capital investments. Depending on the kind of medical care provided, the same total cost divides into 1,177 MDh for hospital services and 690 MDh for outpatient services. "

IV. PUBLIC FUNDING OF MEDICAL CARE CONSUMPTION AND ITS IMPACT ON LOW-INCOME HOUSEHOLDS

Households are the first source of funds for health care in Morocco (50%), followed by the State (20 to 25%) and Social Protection (18%).

The Household Health Care Expense (HHCE) was evaluated through payments made by households for health care goods and services. The Total Medical Consumption (TMC) can be estimated within the interval limited by the following estimates:

	HHCE per capita	HHCE TOTAL (in millions)	TMC (in millions)
Lower hypothesis	139 Dh	3,666	7,133 Dh
Medium hypothesis	147 Dh	3,761	7,522 Dh
Higher hypothesis	178 Dh	4,563	9,126 Dh

The total HHCE is thus between:

- 2.1 and 2.6% of the total household consumption,

and the TMC rests between:

- 4.1 and 5.3% of the total household consumption,
- 3.0 and 3.8% of the G.I.P.

The distribution of the household health care expenditure is highly uneven at various levels:

- at the socio-economic level, the richest 20% spent 56% of the HHCE in 1991, vs only 3.2% for the poorest 20%;
- Nearly 70% of the HHCE was made by urban inhabitants, vs 30% for the rural population (a ratio of 1 to 2.3);
- 76% of the needy live in the countryside. Although they numbered about 8 million people, they spent only 6.4% of the HHCE;
- The per capita expenditure of the richest 20% was 17 times more than that of the poorest 20%. This gap is less acute in cities (1 to 14) than in rural areas (1 to 18).

As previously noted, M.P.H. services are mainly utilized by the middle and higher-income layers of the urban population. Nearly three-fourths of those who use public health services are urban inhabitants.

At the national level, the richest 20% of the population used more than two-thirds of all paramedical health care, 40% of the hospital bed nights, and one-fourth of all external medical consultations. In contrast, low-income households - 40% of the population - used less than one-fifth of the M.P.H.'s medical care services.

The transfer analysis of health care expenditures leads to the following conclusions:

1. The richest 20% benefit from more than 40% of the M.P.H.'s budget, whereas the poorest 40% benefit from less than 20% of it.

This imbalance is still more flagrant when one looks at the health care expenditures per capita. The richest 20% receive 6.8 times more than the poorest 20%; urban inhabitants belonging to the wealthiest 20% receive 7.7 times more than rural dwellers belonging to the poorest 20%.

2. This inequity is compounded by the health insurance situation.

The last quintile of the population receives 52% of the expenditure, whereas the poorest 20% get only 4.5%. In general, low-income households, representing 40% of the population, benefit from only 12% of those transfers.

3. The utilization of medical care by low-income households is highly dependent on public funding.

The M.P.H. funds almost one-fourth of the total household medical care consumption in relative terms. However, the magnitude of this contribution is higher for low-income households, for whom the M.P.H. funds 40% of the consumption.

The burden of public funding is in reverse relation with the income: The higher the income, the lower the relative magnitude of public financing.

4. The rural areas remain the least privileged

We have already seen that the per capita average medical consumption is 3 times lower in rural areas. In general, urban inhabitants benefit from 3 times more transfers per capita than their rural counterparts. The M.P.H. pays for half the medical consumption of low-income urban dwellers, vs a little more than one-third for rural inhabitants of the same group.