

THE MOROCCO COUNTRY CASE STUDY: Positive Practice Environments



The Global Health Workforce Alliance is the PPE supporting partner



Morocco Case Study: Health Care Environments in Morocco



Positive Practice Environments in Morocco:

Developed by

Dr Hassan Semlali

For the Positive Practice Environments Campaign

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ACRONYMS

| | |
|--------|---|
| AGR | Annual Growth Ratio |
| BHC | Basic Health care Centres |
| DEFI | Directorate of Epidemiology and Combating Illnesses |
| DPFR | Directorate of Planning and Financial Resources |
| DMD | Diploma, Masters, Doctorate |
| DRL | Directorate of Regulation and Litigation |
| GDP | Gross Domestic Product |
| HCP | High Commission for Planning |
| HDI | Human Development Index |
| HR | Human Resources |
| ICN | International Council of Nurses |
| IUD | Intra-Uterine Device |
| MANSST | Moroccan Association of Nursing Sciences and Health Techniques |
| MARED | Medical Assistance Regime for the Economically Disadvantaged |
| MDG | Millennium Development Goal |
| MFT | Managed Full Time |
| MoH | Ministry of Health |
| MLA | Moroccans Living Abroad |
| MRC | Moroccan Red Crescent |
| MRI | Magnetic Resonance Imaging |
| MV | Measles Vaccine |
| NAHI | National Agency for Health Insurance |
| NHS | National Health System |
| NGO | Non-Governmental Organisations |
| NFSS | National Fund for Social Security |
| NFSWB | National Fund of Social Welfare Bodies |
| OMI | Obligatory Medical Insurance |
| PFMHS | Programme of Financing and Management of the Health care Sector |
| PPE | Positive Practice Environments |
| RSO | Regional Scheme of Offer of Care |
| SAP | Structural Adjustment Plan |
| SSHI | Service of Studies and Health Information |
| TB | Tuberculosis Bacillae |
| TICH | Training Institutes for Careers in Health |
| UMC | University Medical Centres |
| WHO | World Health Organization |

ABOUT THE REPORT

The report was initiated by the Moroccan Association of Nursing Sciences and Health Techniques on behalf of the Positive Practice Environments (PPE) Campaign core partners. The PPE Campaign core partners include the International Council of Nurses, International Hospital Federation, International Pharmaceutical Federation, World Confederation for Physical Therapy, FDI World Dental Federation and the World Medical Association in addition to the supporting partner the Global Health Workforce Alliance.

This report was written within the context of the PPE Campaign and aimed at examining the main problems faced by health care professionals in Morocco. In particular the report focuses on working environments, recruitment and staff retention. Positive practice environments are settings that ensure the health, safety and personal well-being of staff. They support the provision of quality patient care and improve the motivation, productivity and performance of individuals and organisations. This report is an essential tool and resource to guide the participants of the positive practice environments workshop to respond to the needs and concerns of health care professionals and develop sustainable projects for the future. This report makes recommendations to inform and drive improvements within working environments in the future.

ACKNOWLEDGEMENTS

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INTRODUCTION

The concept of Positive Practice Environments (PPE) for health care professionals does not exist as a structured programme or strategy within Morocco. It is not part of basic education nor of ongoing continuous professional development. It is a new health care concept and priority in Morocco, influenced by epidemiological and demographic transitions, expectations and needs of the population which increasingly demand quality services. In addition, a number of reforms have impacted significantly on the health care sector in Morocco which is driving a change agenda including:

- the reform of the financing in the health sector with the introduction of Obligatory Medical Insurance (OMI) in November 2002;
- the Medical Insurance Regime for the Economically Disadvantaged (MIREDA) which came into effect in one region of the Kingdom in November 2008; and
- hospital and institutional reforms implemented since 1995.

PPEs depend to a large extent on human resources, which must correspond in quantity, quality and distribution to a certain number of criteria essential for the provision of services and health care. Unfortunately, as is the case in many countries, the shortage of human resources in health care is a major obstacle to the delivery of primary health care which is the first step in attaining the Millennium Development Goals (MDGs), as well as supporting curative care, health promotion and rehabilitation services. The implementation of any health care policy or strategy requires an appropriately qualified and motivated health workforce able to respond to the needs of the population by providing health care services that are in line with internationally-recognised norms and standards.

In its 2006 World Health Report, the World Health Organization (WHO) estimates that 59 million health care professionals are required globally, with a further 4.5 million urgently required. Morocco is included in a list of the 57 countries of the world unable to provide vital care due to a grave lack of health care staff. In addition, Morocco is included among the countries that remain extremely vulnerable to the exodus of health care professionals to other countries (WHO, 2006). In 2007, for example, the numbers of medical, nursing and paramedical staff providing direct care to patients was well below the critical threshold of 2.3 health care providers for every 1,000 inhabitants, a threshold judged necessary to assure essential care, in particular those linked to the attainment of the MDGs (WHO, 2006).

Therefore the debate regarding the efficiency and effectiveness of the health care system in Morocco must be informed by robust workforce planning based on population needs, be relevant to the evolution of the health care system, and oriented towards results that would be enjoyed equally by the patient and the health care professional.

CHAPTER 1: COUNTRY OVERVIEW

1.1 Geography, languages and climate

Morocco, officially the “Kingdom of Morocco”, in North Africa, is part of the Greater Arab Maghreb and is situated to the northwest of Africa, bordered on the north by the Mediterranean and the Straits 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. Its population numbers 31,478,000 inhabitants, of which more than half live in urban areas, with the country covering 706,550 km². Morocco has the largest plains and the highest mountains of North Africa. The country bears four great mountain ranges: the Rif, the Middle Atlas, the High Atlas, and the Anti Atlas. Figure 1 highlights the location on the African continent.

Morocco is a country of the Maghreb, a sovereign Muslim State, where the official language is Arabic. These languages include: dialect Arabic or “Darija” (commonly spoken language); Berber or Tamazight; and French and Spanish in the Northern zone of the country.

To the north, the climate is Mediterranean, Atlantic to the west, and Saharan to the south, and is generally temperate due to the sea (more than 3,500 km of coast, 3,000km on the Atlantic Ocean and 500km on the Mediterranean). Globally speaking, the climate is damp on the coast and dry within the country’s interior. The climate is characterised by its unpredictability, seasonal drought and unforeseen floods are phenomena impacting considerably on development strategies.

1.2 Socio-political data

System of governance

The Kingdom of Morocco is an ex-French colony, having gained its independence in 1956. The capital of Morocco is Rabat. The north of Morocco and the Western Sahara were colonised by Spain. Morocco is a constitutional monarchy, and is one of the oldest monarchies in the world. The King is the Chief of State, Supreme Leader of the Army and the Commander of the Faithful. He appoints the Prime Minister who advises on appointing the members of the Government, presides over the Council of Ministers, and promulgates legislative texts.

The Moroccan system of governance is characterised by maintaining the equilibrium between institutional stability and opposition dynamism, between security and liberty, between power-sharing and the long life of the fundamental State institutions. Since its independence, the country has founded its institutions on the multiparty system. Today, approximately 30 political parties freely exercise their activities in the Kingdom. Legislative elections are held every five years to elect the members of the two Chambers: the Chamber of Deputies, and the Chamber of Councillors or second chamber of which the latter renews one third of its members every three years.

Regional structure

Morocco is made up of 16 regions, each headed by a Wali, equivalent to a Préfet in France, as well as a Regional Council representing the main interests and bodies of the region. These Regional Councils have the status of local communities, which elect assemblies in charge of

managing affairs democratically within the conditions determined by law. Since the 1997 reform decentralising the Moroccan administration, Morocco is subdivided into three levels:

- Sixteen economic regions (created by law 47- 96) representing the active bodies in the region. These regions have the status of local communities (article 101 of the Constitution).
- These regions include the 45 provinces and 26 prefectures managed by a Governor. These are the urban equivalent of the above economic regions, making up the second link of the local organisation of the country, and are managed by a Governor.
- Finally, the country is also divided into 1,547 communes of which 249 are urban and 1,298 rural.

Regionalisation is increasingly relevant to the political debate in Morocco, being one of the priorities launched by the King, aiming to set up strong, democratically elected, regional institutions, enjoying fiscal autonomy and allowing them to ensure sustainable development.

The regionalisation of the Moroccan health system is an opportunity to improve the financing of health, the management of human resources, access to care, organisation of services and the overall governing of the system. Regionalisation is also a lever for State action to implement strategies and reforms, for the reinforcement of intersectoral collaboration, for the accountability of external services and local communities, as well as being a means for regulation and redistribution of resources, of negotiation and development of partnerships between the public and private sectors, and with civil society.

In addition the number of non-governmental organisations is estimated to be 20,000 and remarkably continues to grow.

Poverty rate

In Morocco, poverty and social inequalities have always been a constant characteristic of the country's social fabric. This phenomenon has grown significantly since the application of the Structural Adjustment Plans (SAPs) in the 1980s.¹ A study carried out by the High Commission for Planning (HCP) for Morocco in 2007 showed that the national poverty rate was 9.0% (14.5% in rural areas, and 4.8% in urban areas) (HCP, 2008, p.45).

Illiteracy rate

The Mohammed Bin Rachid Al Maktoum Foundation, in a report on knowledge in the Arab world for 2008, estimated illiteracy in Morocco to be 43%. This figure is reported to be higher among women at 54.7 %.

Unemployment rate

According to the HCP, unemployment reached 9.8% in 2009, however, employment differs radically according to gender . Women, particularly those with diplomas, are the more vulnerable to unemployment. The unemployment rate among women is 27.5% generally, but 50.1% for those with higher education diplomas (HCP, 2008. p.20).

¹ The Structural Adjustment Plans (SAPs) are an economic reform programme that the International Monetary Fund (IMF) or the World Bank put in place to allow countries suffering from great economic difficulties to lift themselves out of their economic crisis.

Unionisation

Approximately 20 trade unions represent a variety of professions and workers, however, only 7% of workers are unionised, health care professionals are served by nine syndicates. Employers are grouped in a confederation.

1.3 Economic data

The monetary unit is the dirham (MAD). On average, 1 United States Dollar (USD) is equivalent to 8.5 MAD. The economy, like society, is undergoing change in Morocco. In this process, there are advances, but also many challenges. The macro-economic environment remained stagnant for a long time, offering few opportunities for advancement and development.

The agricultural sector remains largely at a stand-still, due to a number of elements including:

- lack of water;
- tenancy issues;
- small farms; and
- ancient cultural practices.

In relation to industry, the textile industry played a positive role during the 1970s with regard to exports. However, the growth of Asian exports has drastically impacted on the Morocco export market. The impact of this increased the national debt, leading to a macroeconomic imbalance with a growing budgetary deficit, and a rate of inflation varying year to year. Nevertheless, the proximity of Morocco to the European continent has proved beneficial to the national economy with many European companies relocating for economic reasons.

Morocco's Gross Domestic Product (GDP) is relatively high, compared to the African average. The former, in 2008, was about 85.2 billion USD, about 9% of the global GDP of the continent.

Table 1 - Evolution of some economic indicators between 2006 and 2009

| Indicators | 2006 | 2007 | 2008 | 2009 |
|---|--------|-------------------|-------------------|-------|
| Gross Domestic Product in billions of USD | 65.64 | 74.4 ¹ | 85.2 ¹ | 91.7 |
| GDP growth (constant prices) | 7.8 % | 2.7 % | 6.5 %* | 5 %* |
| GDP per inhabitant in USD | 2,151* | 2,422* | 2,901* | 2,868 |
| Rate of inflation | 3.3 % | 2 % | 3.9 %* | 2 %* |

Source: (IMF & World Bank, 2006-2009)

(*) Estimated figure

(1) World Bank figures

The rate of economic growth was 5.6% in 2008 whilst in 2007 it was only 2.7%. This was due to a 16.3% increase in volume of agricultural production (not including fishing). Economic growth was primarily influenced by internal demand as household consumption contributed 5.5 points to the growth of the GDP.

The decrease of exports of goods and services by 1.1% and the increase of imports by 10.9% has contributed to accentuating the negative contribution of external debt. Furthermore, fewer remittances from Moroccans Living Abroad (MLA) has accelerated the decrease of available national income.

In general, progress has been made in recent years in Morocco demonstrated by an increase in the global quality of living of the population, revenue, buying power, consumption and energy.

1.4 Demographics and main health indicators

During the 40 years following independence Morocco has experienced a high demographic growth. Today the situation is stabilising particularly with the change in Moroccan society specifically in relation to education and social changes including, for example, family planning programmes, which have made a significant difference to the quality of life of the female population.

The change in the age profile of the population is one of the greatest consequences of the demographic transition. Youth are the main segment of the population making up about one third of the population. Unfortunately political structures have not actively integrated them into the global development equation due to both a lack of governmental programmes focusing on this age-group, and a lack of a framework within political parties. Furthermore, 10% of Morocco population is 60 years or above and there is almost no infrastructure for this age group, including health care structures specialising in care of the elderly.

Women have played an important role in the growth of Morocco's human potential. Historically they were largely not considered within the human resource development process, but, following a long struggle to achieve recognition, they have made considerable progress. Examples of progress include the reform of the *Family Code* in 2003, and the *Code of Nationality* in January 2007 (Ministry of Justice, 2004 & 2007).

As in other countries, the rural and remote areas of Morocco have generally remained behind the dynamism of the larger cities, on the level of economic development as well as that of human development and social change. Disparities between town and country require additional social and economic solutions in terms of infrastructure, investment, and communal programmes for rural areas.

Moroccans Living Abroad (MLA) have continued to increase over the last 50 years, and have today become one of the largest foreign communities in some host countries. They are seen as an important group that will influence the future potential of the country. Table 2 provides examples of some demographic indicators.

Table 2 - Demographic indicators

| Indicators | Source | Value |
|---|-----------------|---------------------|
| Demographic growth ratio (2008) | HCP | 1.4% |
| Density (habitants per km ²) | DPFR, MoH, SSHI | 70 |
| Infant mortality rate / 1000 births | DPFR, MoH, SSHI | 40 |
| Urban population | DPFR, MoH, SSHI | 56.1% |
| Life expectancy at birth (2008) | DPFR, MoH, SSHI | 72.6 years |
| Rural households with electricity (2008) | HCP | 80% |
| Urban households living in homes connected to a source of drinking water (2008) | SSHI, DPFR, MoH | 89.8% |
| Rural households with access to a source of drinking water (2008) | HCP | 43.2% |
| Rural households throwing their refuse into nature (2007) | HCP | 95.2% |
| HDI, Human Development Index (2009) | UNDP | 130th/181 countries |

Key of terms:

DPFR: Directorate of Planning and Financial Resources

HCP: High Commission for Planning

MoH: Ministry of Health

SSHI: Service of Studies and Health Information

CHAPTER 2: THE HEALTH SYSTEM AT A GLANCE

The Moroccan health system includes a public sector, a private not-for-profit sector, and a private for profit sector, and is currently undergoing a number of reforms, including a financing reform, hospital reform and institutional reforms.

The health system is generally characterised by new health priorities, imposed by the epidemiological and demographic changes. Based on these trends the Moroccan health strategy identifies and combats certain illnesses and aims to eliminate others. In addition to lengthening life expectancy, enhancing quality of life of those additional years is essential. The World Health Organization states that without quality of life, an increased longevity is of no interest, the hope for good health is as important as life expectancy (WHO, 1998).

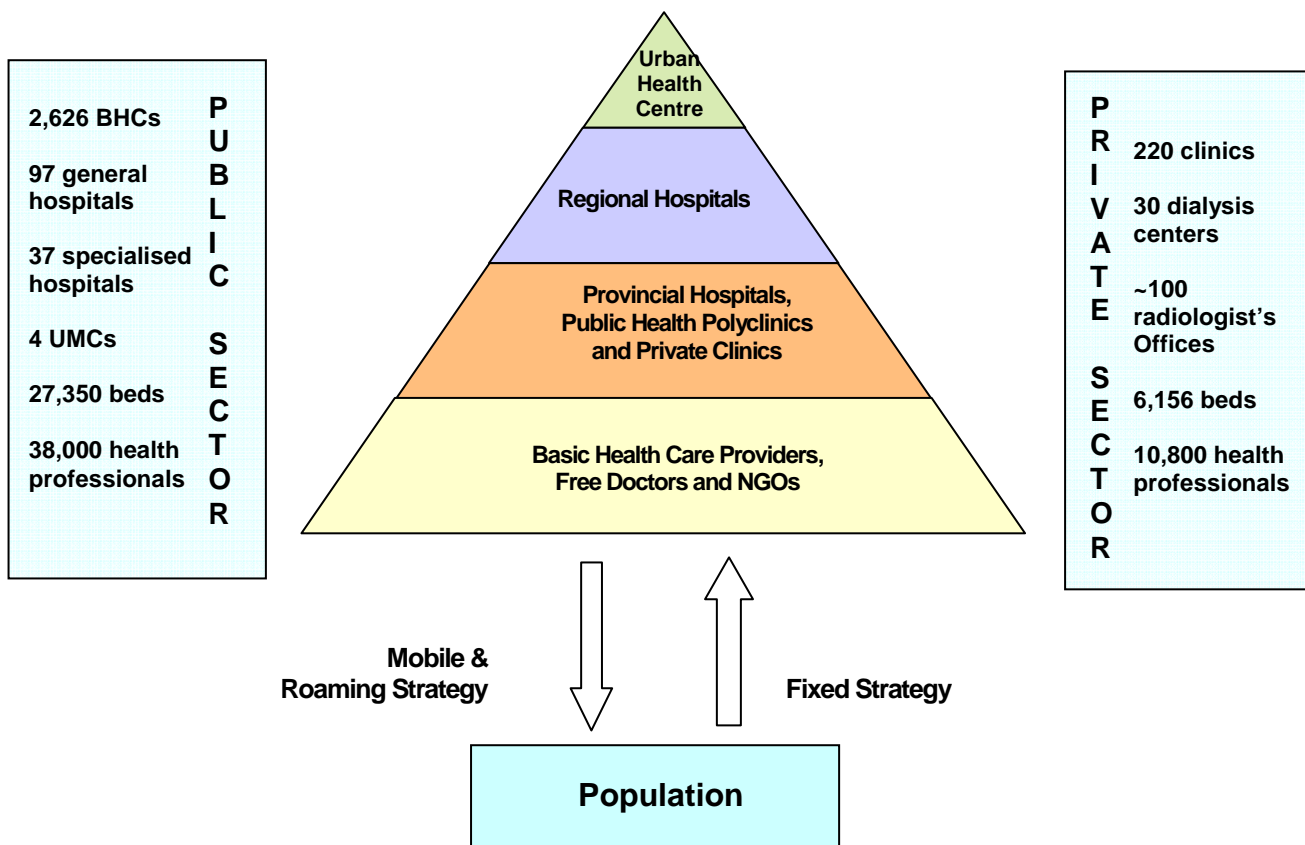
2.1 Organisation of the health system

The Moroccan health system is currently organised around two sectors:

The public sector includes the health care resources of the Ministry of Health, the Royal Armed Forces, Local Communities and other Ministerial Departments. Medical coverage is guaranteed by three strategies: fixed, mobile and roaming, with the aim of adapting health care coverage to the needs of the population and the constraints of the environment. Through the fixed strategy, a person requiring services and care goes to a basic health care provider. The mobile and roaming strategies cover, the rural environment. A mobile medical team goes periodically to those areas located far from health centres. The roaming strategy is a non-medical activity where a nurse takes a motorbike or even a donkey to distribute certain medicines (oral rehydration, contraceptive pills, eye cream, etc.), and to promote health care procedures in particular for pregnant women, diabetics and other chronic diseases. The public sector has some 2,626 Basic Health care Centres (BHCs), 138 hospitals including 97 general hospitals and 37 specialised hospitals, and four University Medical Centres (UMCs). The whole public service totals 27,350 beds and 38,000 care professionals. See Figure 2.

The private sector is made up of two sub-sectors, one non-profit, grouping the health resources of the National Fund for Social Security (NFSS), the Mutuels and the National Fund of Social Welfare Bodies (NFSWB), the Moroccan Red Crescent (MRC), and NGOs. The non-profit private sector has 1,874 beds. The second, for-profit, sub-sector is made up of the health care structures of the free market sector, organised individually or grouped together, by doctors, dental surgeons, pharmacists or other health professionals (consulting rooms, medical scanning, pathology, care and rehabilitation, dental surgery, hospital clinics, pharmacies, and medical warehouses). In relation to infrastructure, this sector consists of 220 clinics, 30 dialysis centres, and about 100 radiologist's offices (with or without scanners, and some Magnetic Resonance Imaging offices), in addition to other specialisations, and a significant number of general medicine practitioners with sonogram facilities. This sector has a total of 6,156 beds and 10,800 care professionals.

Figure 1 - Pyramid of health care services in Morocco



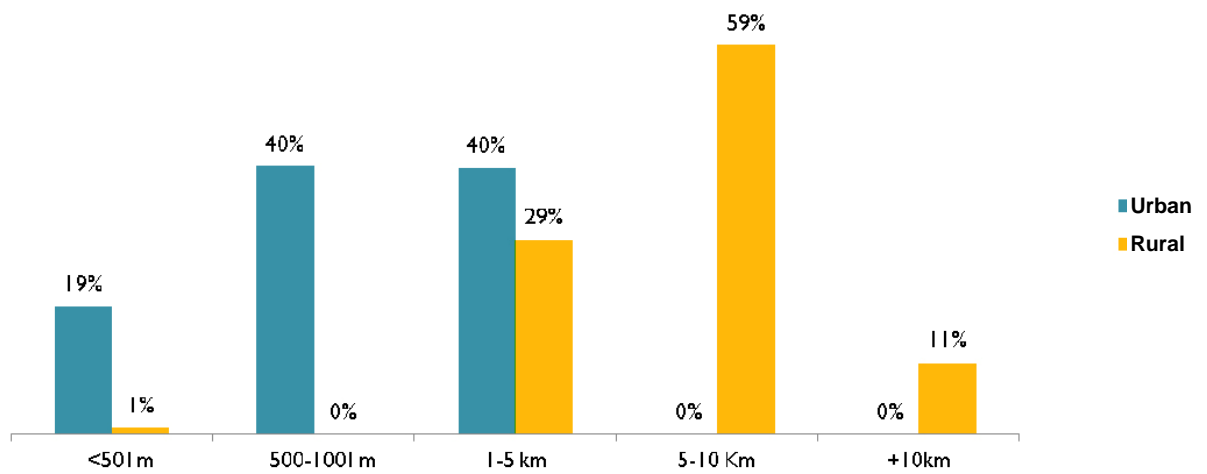
Source: MoH 2005

The Basic Health care Centres (BHCs), in particular those providing care to the population, namely Rural Dispensary (RD), Community Health Centre (CHC), CHCB with birth module, Urban Health Centre (UHC) and UHCA with birth module, have curative and preventive activities, as well as targeting and promoting priority health targets (MoH 2007). The different activities or services that can be provided in these centres include:

- birth
- dental consultations and dental care
- emergency care
- general medical consultations
- hospitalisation
- laboratory examinations
- mental health
- radiological examinations
- school hygiene
- specialised medical consultations
- testing and water treatment.

These activities and services are run through a network of 2,626 health care bodies, of which 1,731 are in rural locations. The human resources working in a BHC vary in number from one region to another as well as between the rural and urban milieus. In urban areas, 100% of the population live less than 5 km from a providing health care facility, whereas in rural areas, only 30% of the population are less than 5 km from a providing health care facility, 59% live between 5 and 10 km, and 11% more than 8 km (MoH 2010). Graph 1 demonstrates the distance between urban and rural health care services with the majority of rural areas located furthest from access to health care.

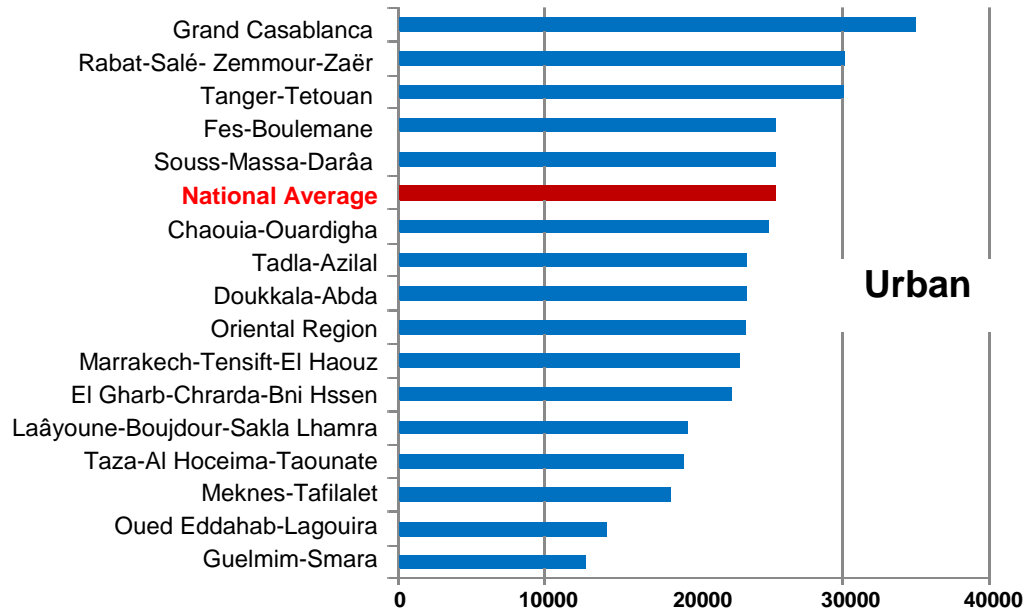
Graph 1 – Distance in meters and kilometres from health care facilities



2.2 Care provision

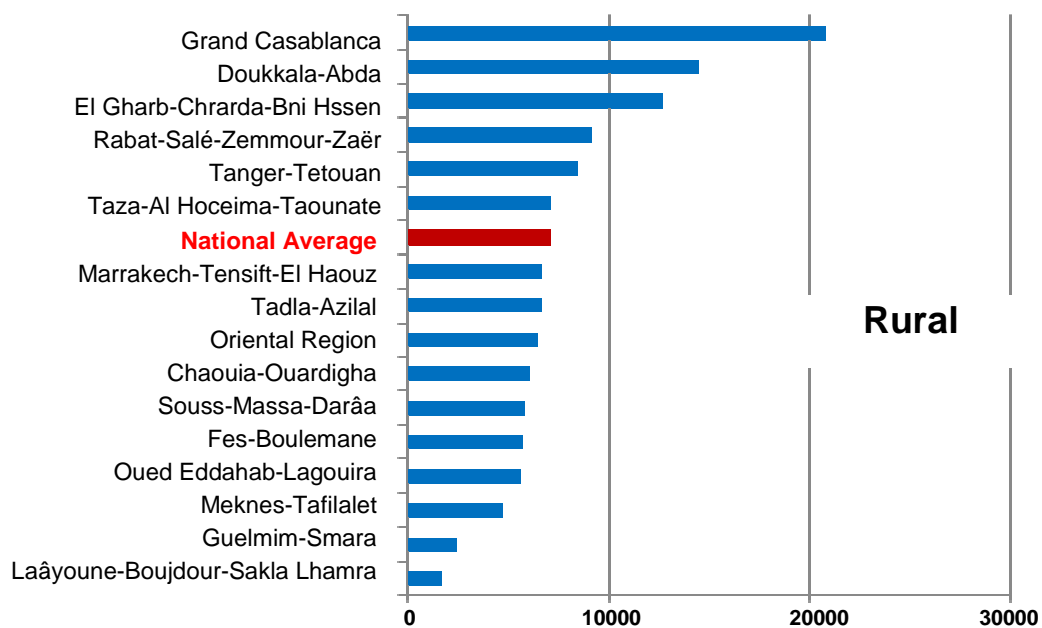
Graph 2 demonstrates the number of inhabitants per BHC in urban areas.

Graph 2 - Ratio of inhabitants per Basic Health care Centre (urban) by regions

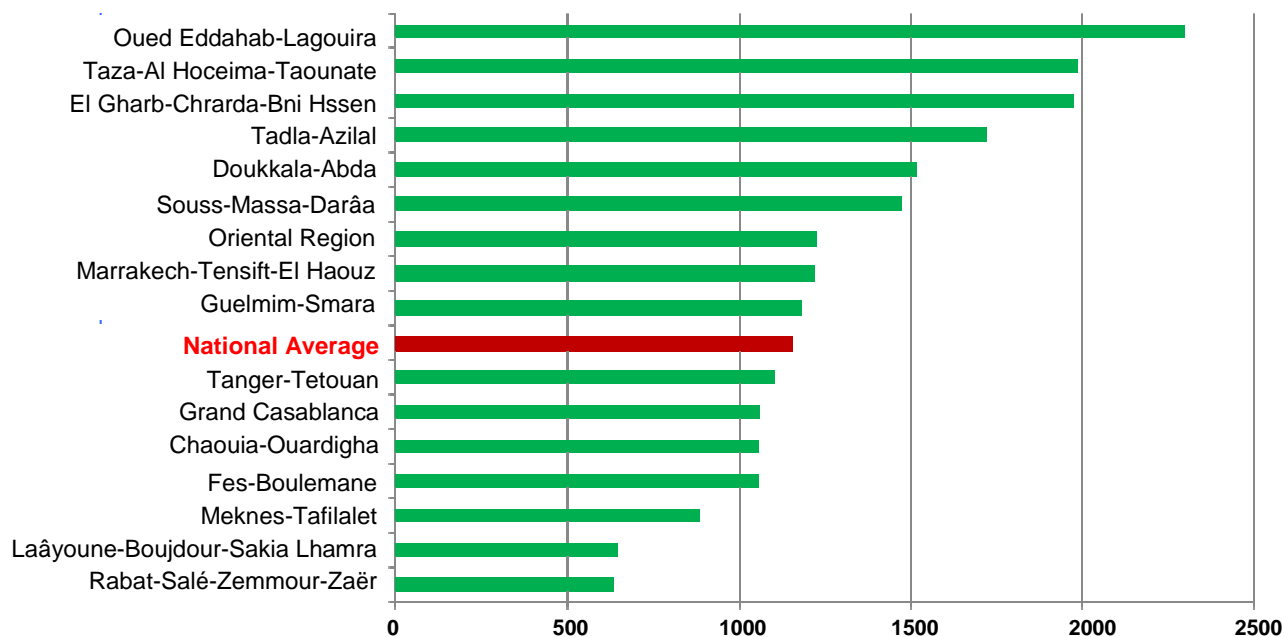


The average number of inhabitants per BHC is over the national average in five urban regions and six rural regions. There is a great disparity between rural regions: the inhabitant/BHC ratio varies between 1,700 and 21,000 inhabitants per centre. Graph 3 demonstrates the disparity in the ratio of inhabitants to the various health care centres in rural areas.

Graph 3 - Inhabitant per BHC ratio (rural) by regions



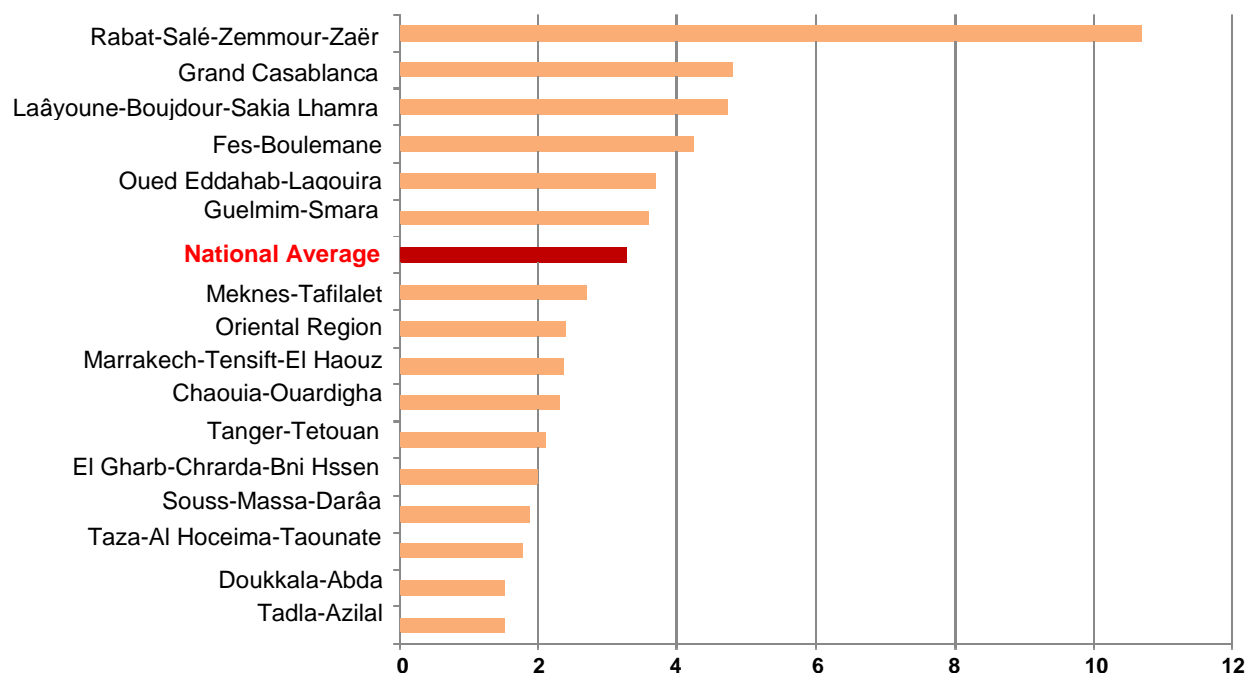
Graph 4 – Ratio inhabitants per hospital bed by regions



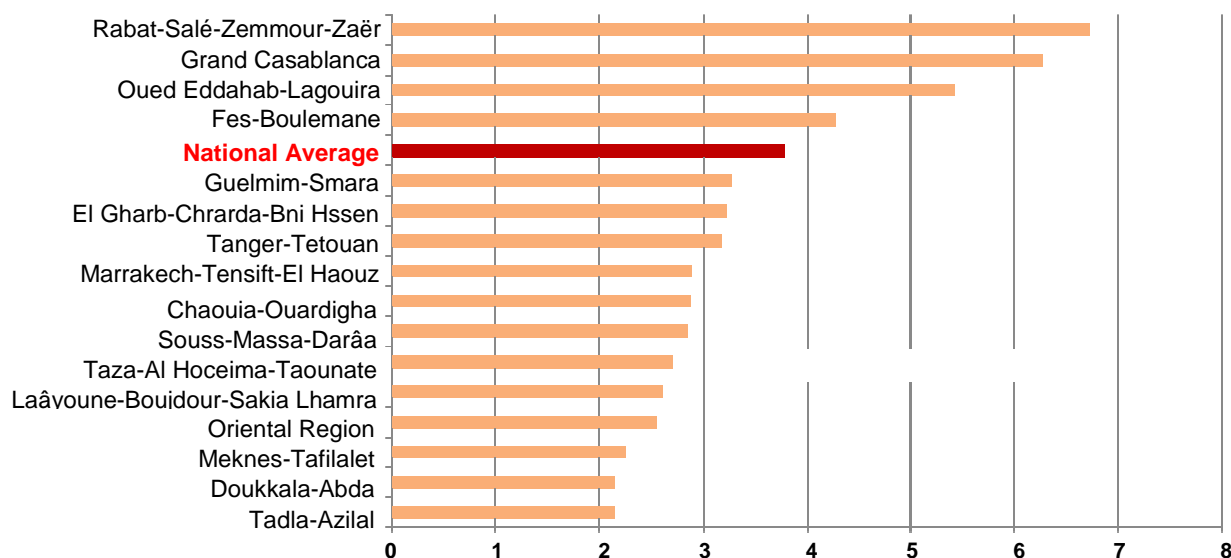
As shown in Graph 4, the average number of inhabitants per hospital bed varies between 600 inhabitants per bed in the region of the capital (Rabat-Salé-Zemmour-Zaër), and more than 2,000 in a region of the Moroccan Sahara.

Graph 5 shows that the average number of doctors per 10,000 inhabitants is below the national average of 3.3 in 12 regions. Whereas Graph 6 shows the national average of doctors to paramedics is 1:4.

Graph 5 – Ratio of medical personnel to population (doctor/inhabitant x 10'000) by regions



Graph 6 – Ratio of paramedics to doctors by regions



Furthermore, a health care analysis shows that there is a disparity between urban and rural locations, and between regions, for example, six regions have rural birth centres with no qualified midwives. Only two regions have two midwives per rural birth centre. In total, 500 hospital centres have 35,380 beds, of which 75% are in public health care, with a concentration over two regions which benefit from 42% of private clinics, and 22% of public hospitals.

There are also health care facilities that are not equipped or only partially functional, and there is an under-use of almost the entire health care system (average occupation rate of 56%). The average

number of medical consultations is 0.6 contacts per person in urban areas and 0.4 contacts in rural areas with the average number of paramedical consultations being one per year in urban areas and 0.9 in rural areas. Recourse to health care is strongly linked to the distance that must be covered to reach the health care centre with the closer the centre, the greater the average number of consultations per inhabitant.

2.3 Main challenges within the Moroccan health system

An analysis of the Moroccan health system identifies the following problems:

- Difficulties in accessing health care for the poorest and for rural populations with a disparity between access and demand of care for certain illnesses, in particular chronic illnesses. The level of use of health care services is, in half the cases, linked to financial support. (MoH 2007).
- Non-satisfactory management of public hospitals, which suffer from a range of inefficiencies, making them unable to compete with private hospitals. These hospitals have a certain number of problems linked to:
 - centralised management;
 - lack of autonomy;
 - lack of coordination with BHCs;
 - deficiency in managerial competence;
 - traditional management of medicines which encourages their depletion;
 - poor quality of reception and care; and
 - a mismatch between technical facilities and the human resources required to make them work.
- Lack of a policy to manage and develop human resources. At this level, the following issues are of note including:
 - lack of staff to tackle the increase in demand of care, voluntary departures and retirements as well as the extension in hospital infrastructure, in particular with regard to the creation of new UHCs;
 - non-transparent management approaches which cause internal social conflict linked to posting and staff movement;
 - scarce number of programmes for continuous education and training;
 - lack of fiscal advantages linked to grade, constraints, responsibility and working in certain areas;
 - employment of public sector staff by the private sector (consequence of the managed full time system (MFT)² which permits specific health care professionals to practice medicine freely);
 - problem of absenteeism and corruption, as well as a lack of a feeling of responsibility among some health care professionals; and
 - lack of social programmes as a means to motivate staff.
- The absence of medicine policies in general particularly in regard to:
 - insufficient use of generic medicines; and
 - no benchmark for care therefore no clarity in the policy for fixing prices, charging for surgery, reimbursement of certain medicines and no freedom given to pharmacists to substitute some medicines for others.
- Lack of a partnership policy with local communities and civil society, vital factors for human development.
- Lack of a partnership policy with the private sector, which works at the fringes of the health care system without sharing in professional training and ethical training.

² MFT: Law no. 10.94 linked to the medical profession, in particular article 56, authorises research and teaching doctors, surgeons, biologists, pharmacists and surgeon dentists in hospitals to practice medicine freely in clinics described as "university clinics".

- The centralised management system allows for direct intervention by the State through the Ministry of Health in the entire health care chain, going from health care provider to financial provider as well as regulator and planner.
- Deficiencies in specialised structures for geriatrics and lack of retirement homes.

The following statistics provide an overview of some key ratios within the health system (SSHI, DPFR & MoH 2010):

- Inhabitant per nurse (public sector): 1,134
- Inhabitant per doctor (BHC): 9,510
- Inhabitant per public sector doctor: 2,900
- Inhabitant per private sector doctor: 3,693
- Percentage of doctor specialists (public sector): 56%
- Beds per nurse (public sector): 1.0
- Beds per doctor: 4.9
- Inhabitant per hospital bed (public sector): 1,150
- Inhabitant per BHC: 1,200
- Inhabitant per dental surgeon: 8,525
- Inhabitant per pharmacist: 3,626.

The main causes of mortality reported in 2007 include (SSHI, DPFR & MoH 2010):

- Illnesses of the circulatory system: 22.14%
- Tumours: 11.04%
- Certain illnesses linked to the perinatal period: 8.84%
- Endocrine, nutritional and metabolic illnesses: 6.3%.

The following are some indicators (SSHI, DPFR & MoH 2010):

- Maternal mortality: 227 per 100,000 live births(2009)
- Child mortality: 3.75% (2009).

Epidemiological indicators (incidence rate per 100,000 inhabitants in 2008):

- Tuberculosis: 81.7
- Malaria: 0.5 (0 indigenous cases)
- Cerebro-spinal meningitis: 3.5
- AIDS: 1.3.

Percentage of women using contraception:

- Pill: 41%
- IUD: 0.6%

Percentage of births in supervised locations (2008):

- Normal 67.3%
- Dystocic 19.5%
- Caesarean 13.2%

Vaccination coverage (in %) of children of 12 to 23 months:

- Tuberculosis: 98.4%
- MMR: 90.4%
- Completely vaccinated children: 89.1%

Death due to road accidents is approximately 4,000 deaths per year.

2.4 Financing model of the health care system

The financing of the health care system in Morocco shows a global expenditure of 4.3 billion USD at the end of 2008, namely 5.6% of the GDP. Compared to other countries at a similar level of development, there is a sizeable gap.

Table 3 - Level of global health care spending compared to countries at a similar level of economic development (2006)

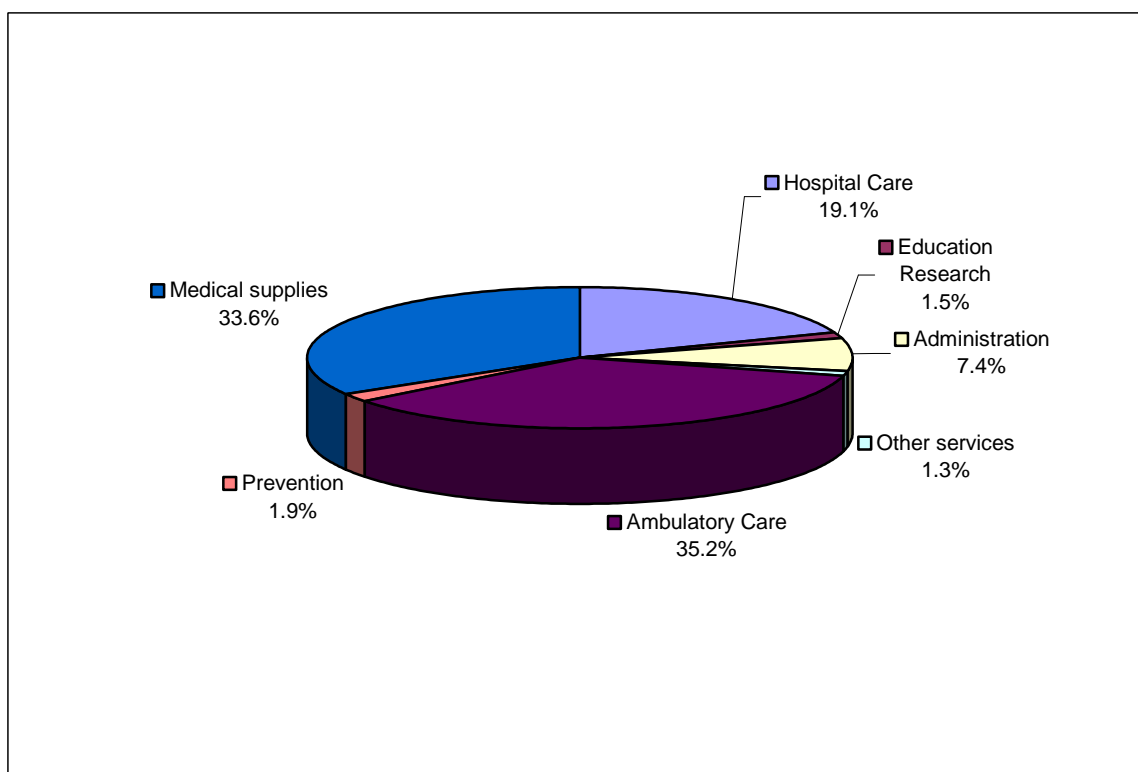
| Country | GDP per capita | | Health care spending per capita | | Health expenditure to GDP ³ | |
|---------|----------------|----------------------------------|---------------------------------|----------------------------------|--|----------------------------------|
| | US\$ | Growth over the 2001-2006 period | US\$ | Growth over the 2001-2006 period | Percentage % | Growth over the 2001-2006 period |
| Morocco | 2,126 | 10.45% | 114 | 14.08% | 5.3 | 1.33% |
| Jordan | 2,458 | 6.16% | 238 | 11.84% | 9.7 | 0.42% |
| Iran | 3,172 | 20.10% | 215 | -9.29% | 6.8 | 1.22% |
| Tunisia | 3,033 | 8.00% | 154 | 2.82% | 5.1 | -4.74% |
| Lebanon | 5,612 | 4.50% | 494 | -0.24% | 8.8 | -6.32% |

Source: Country health information, WHO, www.who.int/nha/country/en

The budget of the Ministry of Health was almost .86 billion USD in 2007, less than 28 USD per inhabitant, 5.5% of the general State budget, and only 1.3% of GDP.

³ Health expenditure to GDP refers to health expenditure per person (the percentage figure is derived by dividing the health care spending per capita by the GDP per capita).

Figure 2 - Functional classification of health care spending (2006)



The national health care system spends more than 33.6% of its monetary resources on buying medicine and medical goods. Ambulatory care, including health promotion check-ups and external consultations, represents 35.2% of spending. This spending is exacerbated by the weakness of funds allocated to collective health prevention (drinking water testing, information, education and communication etc.).

Public hospitals, despite representing more than 80% of national bed capacity, only receive 9.8% of insurance spending in the context of direct payments and 6.6% of the total health insurance spending.

Global health care spending in 2006 in Morocco is financed by (MoH 2006):

- fiscal resources: 22.6%
- direct household spending: 57.4%
- medical insurance: 17%
- employers: 1.8%
- international cooperation: 0.7%
- other: 0.5%.

The financing of health care by households is currently a source of inequality in access to care, in particular among the poorest and those without health insurance. This situation is made worse by the lack of institutionalised solidarity and the pooling of health risks, due to the weakness of health insurance which only covers 37% (17% in 2006) of the total population. As a result, Morocco chose to extend the basic medical coverage. Firstly, through the implementation of Obligatory Medical Insurance for active professionals and retired persons in

the public and private sectors, through two managing bodies: the National Fund of Social Welfare Bodies (NFSWB) for civil servants and public sector workers, and the National Fund for Social Security (NFSS) for workers in the private sector. These managing bodies are overseen by a regulatory body, the National Agency for Health Insurance (NAHI).

The Medical Assistance Regime for the Economically Disadvantaged (MARED) makes up the second part of the system of basic medical coverage which is covered by legislation. This is a social net for the poorest, whose economic vulnerability keeps them outside the contributory system. It is based on the principles of social assistance and national solidarity. Its financing is mainly ensured by the State and local communities, as well as by a contribution from eligible beneficiaries.

CHAPTER 3: HUMAN RESOURCES AT A GLANCE

Since the 1960s, the supply and demand of health professionals has known cyclical crises due to a certain number of elements, in particular political and socio-economic factors. The most critical period followed the Structural Adjustment Plan (SAP) in the 1980s. This crisis was harsher due to reforms undertaken by the Ministry of Health over the last two decades. It was exacerbated by the continuing exodus of health professionals who migrated to find better conditions of work elsewhere.

Currently, according to the World Health Report of 2006, Morocco is one of 57 countries suffering from a grave lack of health personnel, and remains extremely vulnerable to their exodus towards other countries. This lack of human health resources is made worse by the inequality of repartition of human resources between rural and urban areas and within the different regions of the Kingdom.

With the current shortage of health care professionals there is virtually no unemployment, in particular with regard to specialists, general practitioners and nursing staff. Dental surgeons and pharmacists are competitively recruited. Unsuccessful candidates can benefit from aid packages to help them set up in the private sector.

3.1 Changes in the workforce

Table 4 - Changes in the numbers of doctors between 1999 and 2007 (MoH 2010)

| Year | Public | | | Private | | | Whole | | |
|------|---------|-------------|--------|---------|-------------|-------|---------|-------------|--------|
| | General | Specialists | Total | General | Specialists | Total | General | Specialists | Total |
| 1999 | 3 338 | 2 878 | 6 216 | 3 407 | 3 024 | 6 431 | 6 745 | 5 902 | 12 647 |
| 2000 | 3 597 | 3 636 | 7 233 | 3 282 | 2 530 | 5 812 | 6 879 | 6 166 | 13 045 |
| 2001 | 3 832 | 3 687 | 7 519 | 3 590 | 3 205 | 6 795 | 7 422 | 6 892 | 14 314 |
| 2002 | 4 625 | 3 484 | 8 109 | 3 485 | 3 376 | 6 861 | 8 110 | 6 860 | 14 970 |
| 2003 | 4 575 | 4 693 | 9 268 | 3 465 | 3 574 | 7 039 | 8 040 | 8 267 | 16 307 |
| 2004 | 4 573 | 5 030 | 9 603 | 3 499 | 3 673 | 7 172 | 8 072 | 8 703 | 16 775 |
| 2005 | 4 605 | 4 939 | 9 544 | 3 663 | 3 981 | 7 644 | 8 268 | 8 920 | 17 188 |
| 2006 | 4 746 | 5 025 | 9 771 | 3 905 | 4 040 | 7 945 | 8 651 | 9 065 | 17 716 |
| 2007 | 4 892 | 5 114 | 10 006 | 4 163 | 4 100 | 8 263 | 9 055 | 9 214 | 18 269 |

Analysing the current availability of medical and paramedical staff, compared to WHO standards, shows that there is a serious shortage, exacerbated every year by staff retiring, and the needs of newly-created health bodies with additional resource requirements, such as the UMCs.

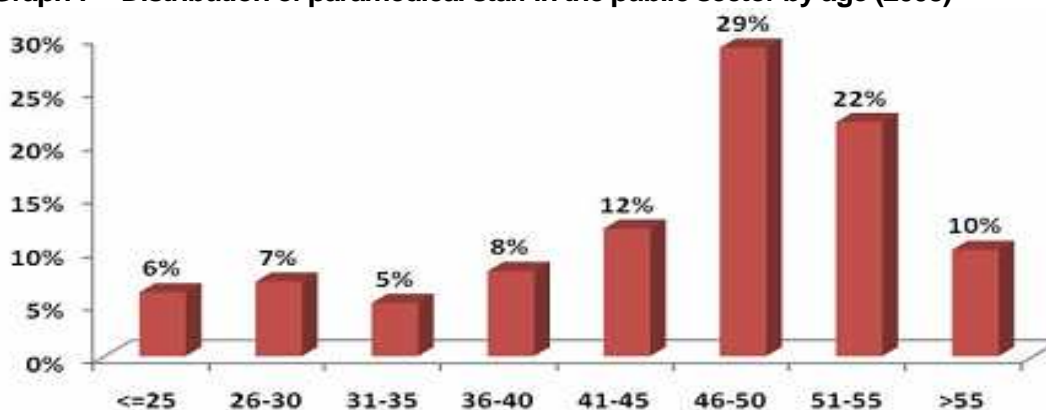
The latest official figures, published by the Ministry of Health in 2007 show 18,269 doctors spread out across the country, with 45% working in the private sector. Among this 49.5% are general practitioners. The numbers of national medical staff has increased on average by 4.7% over the last decade (1999-2007).

Table 5 - Changes in the number of nurses between 1999 and 2007

| Year | Public sector | | | Private sector | | | |
|------|------------------|------------------|--------|----------------|--------|---------|-------|
| | Qualified nurses | Auxiliary nurses | Total | General | T.A.A | General | T.A.A |
| 1999 | 13 512 | 12 727 | 26 239 | 26 239 | - | 2 106 | - |
| 2000 | 13 778 | 12 396 | 26 174 | 26 174 | - 0,2% | 2 152 | 2% |
| 2001 | 14 342 | 12 047 | 26 389 | 26 389 | 0,8% | 2 185 | 2% |
| 2002 | 14 943 | 11 626 | 26 569 | 26 569 | 0,7% | 2 262 | 4% |
| 2003 | 15 419 | 10 858 | 26 277 | 26 277 | -1,1% | 2 431 | 7% |
| 2004 | 16 072 | 10 730 | 26 802 | 26 802 | 2,0% | 2 876 | 18% |
| 2005 | 16 049 | 9 672 | 25 721 | 25 721 | -4,0% | 3 540 | 23% |
| 2006 | 16 704 | 9 405 | 26 109 | 26 109 | 1,5% | 4 569 | 29% |
| 2007 | 17 386 | 9 146 | 26 532 | 26 532 | 1,6% | 6 157 | 35% |

With regard to paramedical staff, there are approximately 32,689 technicians and nurses working on the national level with more than 80% working in the public sector. The latter has increased on average by 2% per year over the same period.

Graph 7 – Distribution of paramedical staff in the public sector by age (2008)

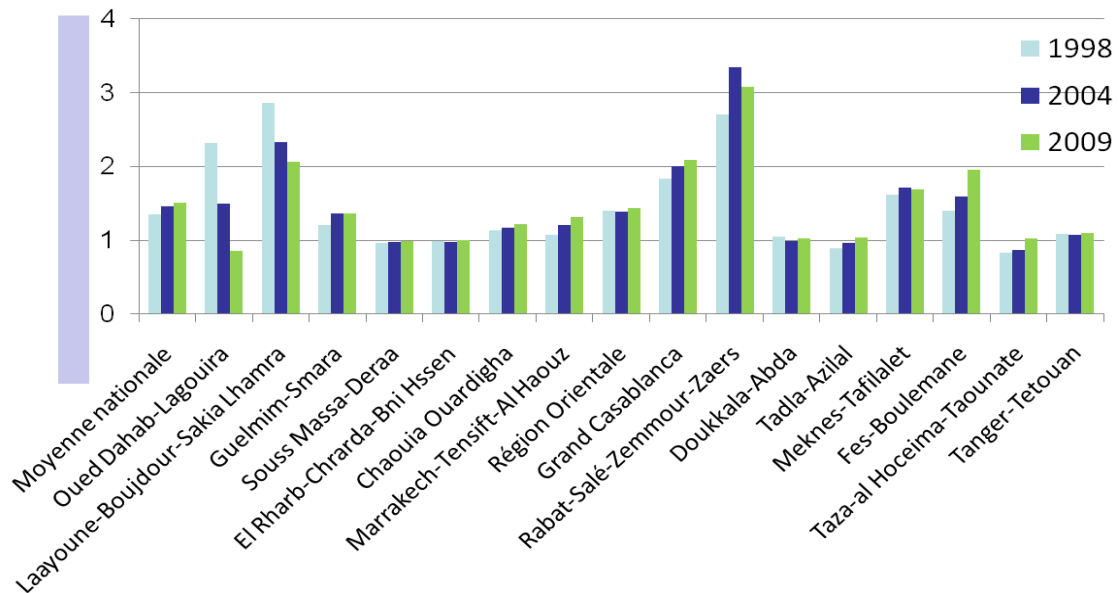


Age ranges (years)

Analysis of the structure of paramedical staff shows that the average age is 45.4 years, and six nurses out of ten are over 45 years old. The current retirement age is 60 years.

3.2 Oversight of the population by health professionals

Graph 8 - Ratio of health care professionals per 1000 inhabitants (number of doctors and nurses) by regions

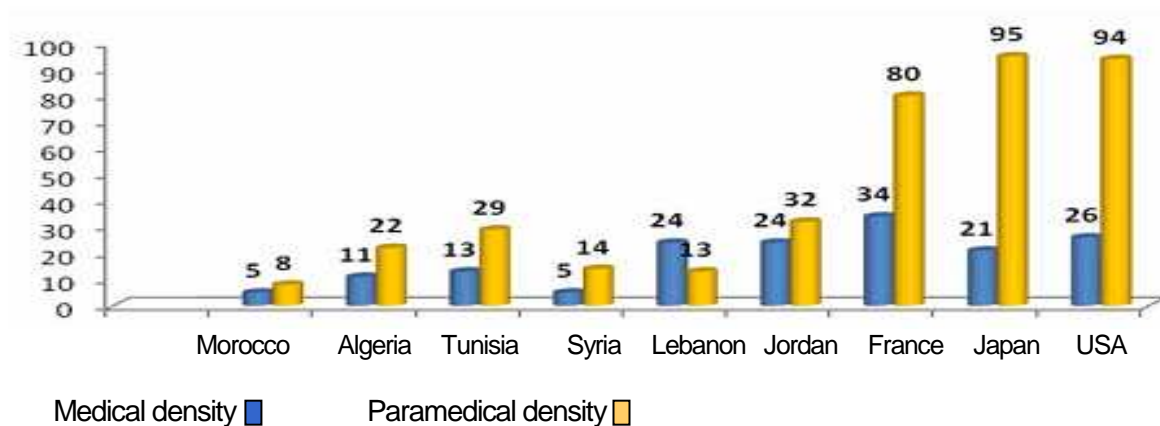


National average

The ratio of the population by health care professionals changes from one region to another. For 2009, only one region reached the level fixed by the WHO of a minimum of 2.3 professionals for every 1,000 inhabitants.

3.3 Medical and paramedical density compared to other countries

Graph 9 - Country comparative analysis of medical and paramedical density between 2002-2006 (for 10000 inhabitants)



As shown in Graph 9, medical density varies from 5 doctors for 10,000 inhabitants in Morocco, to 34 doctors for 10,000 inhabitants in France. Equally, paramedical density varies between 8 to 95 for 10,000 inhabitants in Morocco and Japan respectively.

In this context, the strategy of the Ministry of Health with regard to human resources is based on education and training, both basic and ongoing, in order to respond to the urgent needs of health care professionals. The opening and extension of the Institutes for Training in Health Care Careers (ITHCs) is part of this initiative as is the plan to train 3,300 doctors by 2020. Such initiatives are insufficient in themselves as there is a need to retain human resources, understand their motivation, and put in place social programmes as well as career management plans. The improvement of work conditions can be a fundamental factor to retain staff and increase stability for health care professionals as a whole.

CHAPTER 4: PRACTICE ENVIRONMENTS

Positive practice environments are health care systems that are efficient from the point of view of costs, which reward excellence, provide decent work, and have the capacity to attract and retain staff improving their satisfaction, security, and patient service. Typically, this type of environment:

- guarantees the health, security and well-being of staff;
- promotes quality of care for patients; and
- reinforces motivation, productivity and performance of both individuals and organisations.

In Morocco, attention paid to this particular issue of health care professionals work is sparse, non-structured, and does not come under a specific strategy. Nevertheless some changes have been made in order to create an environment conducive to practice by health care professionals, due to expressions of discontent that have been mainly expressed through militant unionism and the ever-growing demand for quality service from the population as a whole.

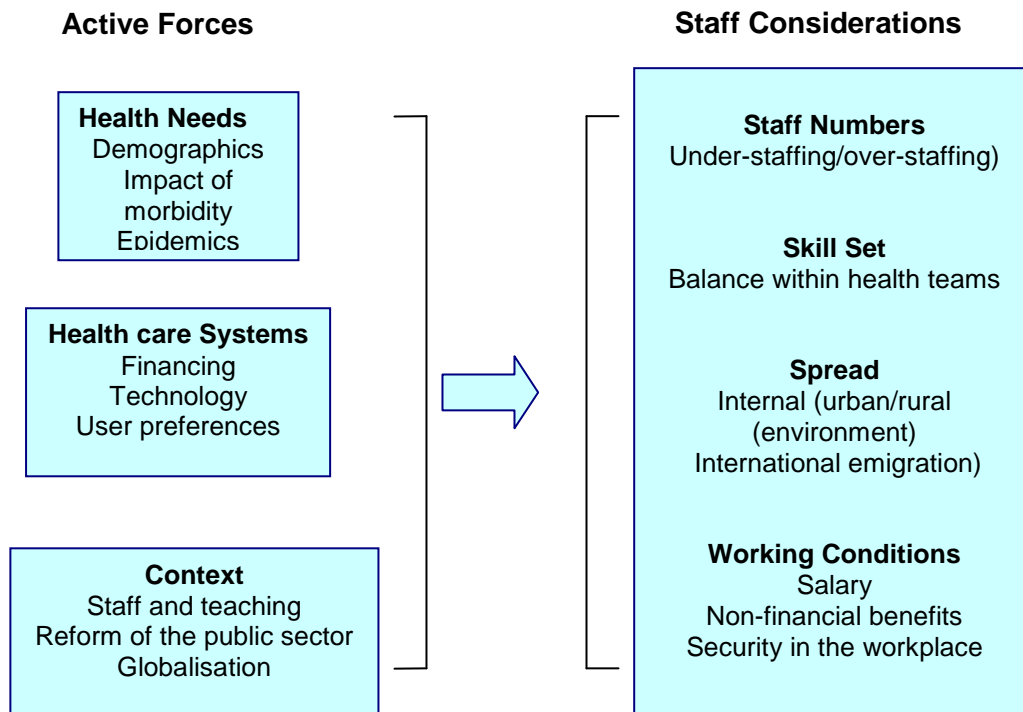
Developing and supporting positive practice environments is influenced by a number of interdependent factors, including, for example:

- under financing of health systems aggravated by the current economic and financial crisis;
- unsatisfactory conditions of work aggravated by insecurity, violence and over-work;
- lack of tools to manage human resources aggravated by the lack of visibility with regard to career management; and
- exodus of health care professionals.

In general, the working conditions of health care professionals in health care centres remain below expectations when compared to other countries of similar levels of economic development. It is evident that lack of financial means is a constraint to the development of positive practice environments and it is also clear that any projected solution to this problem must contain a new strategy to manage human rights and to reorganise the health system.

4.1 Theoretical model

Figure 3 - Theoretical model on forces impacting health care professionals (WHO, 2006)



4.2 The main findings on Positive Practice Environments in Morocco

A certain number of findings are reported in relation to the health care staff within the public sector, such as:

- Moonlighting. Although this is not permitted when employed in the public sector it is, however, known to occur. Some figures indicate that approximately 50% of staff in private clinics are also employed in public hospitals (these health care professionals work outside their normal hours in the latter hospitals, and during their days off). The main reasons for moonlighting are:
 - poor remuneration and salaries for health care professionals as a whole in the public sector;
 - the incapacity of the private sector to provide regular salaries in order to recruit full time staff, due to the fact that hiring staff from the public sector is generally cheaper;
 - a relaxing of mechanisms for control and inspection of the workplace; and
 - the lack of motivation of staff in the public sector.
- Absenteeism is often reported as being high in public health care facilities. However, no information is available to estimate its impact in terms of workdays lost as well as its impact on the productivity of the health care establishment.
- A problem with morals in the health care sector, as corruption is rife among health care providers. A study carried out in 2001 by a Moroccan NGO of more than 1,000 households over 13 large towns and rural locations showed that 80% of the polled households believed that corruption in the health care system is a common practice (Transparency Maroc).
- Little investment in order to motivate health care professionals, in particular social programmes (such as a 13th month of salary, production bonuses, recognised training programmes, organised trips, etc.).

Introduction of quality assurance

The introduction of quality assurance in health care facilities is relatively recent and aims to ensure public safety whilst ensuring that quality of care does not suffer due to an illicit appropriation of professional bodies by factions that are more concerned with their own interests and gains.

Quality assurance aims to install or reinforce a constant improvement in the heart of organisations, and must be based mainly on the creation of standards and a constant self-evaluation. Through these activities, all players must progressively develop a “quality culture”, wherein each understands the role they must play in the expression or satisfaction of an ever-increasing demand for quality care.

It is this change of mindset that represents the most important advantage of quality assurance, as each professional aims to achieve a common goal of quality which is the ultimate indicator of success. Unfortunately this culture is still lacking in Morocco’s health care structure.

Recognition of health care professionals at work

In Morocco, the lack of professional recognition at the level of health care facilities has been reported in several cases (MoH 2003, Mougli 1999). Thus, the lack or indifference of laws governing the work of health care professionals can be a stumbling block to the relationship of trust that is supposed to exist between professionals and their patients.

A recent study on nursing staff satisfaction levels in the workplace took place at the University Hospital Centre of Rabat from which the following conclusions were drawn:

- Heads of care units and of nursing care units underlined the vital importance of recognising nurses as a factor for motivation, commitment and reinforcement of self-esteem.
- Nurses enjoy the respect and support of their nursing colleagues in more than 90% of cases, and communication is sufficiently well developed among nurses through their close working relationships and information-sharing.
- Communication and quality relationships with immediate hierarchical superiors are lacking in more than 50% of cases.
- The lack of coordination of meetings was identified as a factor creating feelings of lack of worth and lack of responsibility among the majority surveyed.
- In more than 50% of cases, polled staff reported the lack of recognition of skills was due to a feeling among hierarchically superior staff that this might cause a loss of power.
- The lack of consideration of the workload and the non-availability of resources required for an ergonomic workplace, favourable to productivity and creativity, causes indifference to the interests of the institution and was felt to be another factor engendering feelings of lack of worth and lack of responsibility.
- The annual performance bonus is considered as demotivating as it does not correlate to efforts made. In addition, there is no objective assessment of performance and abilities of staff, leaving a wide margin for subjective grading and a lack of transparency, in particular to explain a lack of promotion (Alahiane & Chennaq, 2009).

Legislative and regulatory aspect

A legal and regulatory framework, which regulates practice and establishes responsibilities for the different health care professionals, would augment the development of positive practice environments, thereby improving health, safety and well-being of staff, and would enhance

delivery of quality care. It could improve motivation, productivity and the performance of individuals as well as of organisations. In this regard, like the National Order of Physicians, Dental Surgeons and Pharmacists, a national order of nurses is urgently needed to oversee the nursing profession, regulate access, protect the population and ensure respect of both ethics and deontology.

Training

Training for health care professionals is specific and requires a theoretical education with a solid practical internship with a focus on addressing health problems while preparing professionals for a changing health care environment and new diagnostic and care technologies.

The training of all categories of professional health care providers suffers from a lack of quantity and quality due to certain problems inherent within training programmes, teaching methods and the location of internships. Unfortunately, there is a lack of data on the requirement of human resources, which can be a real obstacle to planning, and compromises efforts to respond to the health care needs of the population.

Thus, the evaluation of earlier training programmes has been rather negative, and the adoption of an integrated vision for training programmes for health care professionals must be underpinned by evidence. In depth studies are required, the results of which will help in clearly determining actual needs and future projections with regard to teaching, competencies and accreditation. In the meantime, any plan to change current teaching practices and methods must be done in a framework in which all relevant bodies in the health field may contribute. There are many questions to be answered, such as should training programmes for human resources in health care be adopted that are based on supply and demand or on the needs of the population? Or should they be based on progress in the health field in the epidemiological, social and technological fields?

Safety at work

Article. L. 230-2 of the *Code of Work* contains the following general principles of prevention:

- avoid risks;
- evaluate unavoidable risks;
- confront risks at the source;
- adapt the work to the employee (workstations, work equipment, methods of work and production, etc.);
- replace what is dangerous by what is not dangerous, or, at the very least, less dangerous;
- plan for prevention (integrating technology, work organisation, conditions of work, social relationships, environmental factors);
- prioritise collective security measures over individual security measures; and
- give appropriate instructions to workers.

Health in the workplace teams have an important role to play in this area as they are often in possession of pertinent information, both medical and technological, on health care professionals, risks faced and the work environment. Communicating this information to claimants is both a legal and deontological obligation, as many professionals either do not know and/or are not aware of the nature and eventual consequences of their exposure to risks.

Workplace stress

Professional stress is a damaging emotional and physical reaction caused by the interaction of the employee and their workplace once the requirements of their employment exceeds capacities or resources required to deal with them. Due to their activities and responsibilities, health care employees endure high levels of pressure at work, in particular in “hot” wards (emergencies, resuscitation, maternity, surgery). This pressure is accentuated by lack of resources, insufficient communication, lack of recognition and no opportunity of career progression.

4.3 Future areas of growth

Three strategic pillars must support future areas of growth:

1. The need to increase the number of health care professionals;
2. The need to improve training programmes; and
3. The need to improve working conditions for health care professionals.

These strategic areas must take into account:

- professional recognition;
- a modern, efficient and participatory management;
- ongoing training and counselling-supervision;
- health and security at work; and,
- actions to reinforce and support the PPEs.

Steps must be taken at three levels: institutional, organisational and the individual.

1. Institutional level

The development of human resources in the health field is a major concern for the Ministry of Health. However, development is currently insufficient, as every step taken is influenced by the MoH's budget and by political choices that will contextualise reforms that could bring real answers to the multiple needs in this area.

Solutions must be considered within the context of a committee or a national observatory dedicated to research on public health. This institution should include all professions in the health field in Morocco (university professors, demographers, sociologists, health care professionals, unions, representatives of users of the health care system, patient groups etc.). The regional model of management could respond to the various challenges, in particular those linked to planning and management of human resources.

2. Organisational level

- The implementation of two strategic planning tools, namely the Health Map and the Regional Scheme of Offer of Care (RSOC), which together constitute a major organisational step, will allow for:
 - Redistribution of the offer of care, based on proximity and land use;
 - Revision of the current hierarchy in health care institutions at various levels, adapted to the needs of the population; and
 - Assessment of the size of health care infrastructure to be put in place, as well as their location and catchment area.
- The departmentalisation of hospital care with the aim of rationalising the use of available hospital resources.

- The organisation of work and solving of problems through teamwork are means of saving time and energy and using resources effectively.
- Reviewing training strategies by capitalising on what is done at the regional level, with the creation of new work channels, whilst adopting the training system (Diploma, Masters, Doctorate) for paramedical staff. For this training system to be effective, it is necessary to set up the Training Institutes for Careers in Health as further-education establishments.
- Work channels are a new means of organising, planning and training human resources that the civil service is attempting to develop. These aim to separate in practice the management of technical careers from those of management careers. This is done through the organisation of two axes: a managerial axis, based on versatility and increased flexibility; and a technical axis, based on specialisation and career stability in a particular field.
- Given the variety of fields within the paramedical professions, a positive step would be to organise technical “streams” by area in order to cover all specialisations and functions responding logically to the needs of the population with regard to care (geriatric care, palliative care, etc.).
- The creation of scientific norms to manage human resources: these norms must be based on case studies, on workload per structure, and on the real needs of the population in the context of the epidemiological, demography and environmental situation.
- Staff retention must be addressed through staff appreciation, reviewing statuses and salaries, removing internal promotion quotas, putting into place a benefits system linked to workload, the general use and application of benefits linked to on-call duty, strain and travel.
- Within the workplace developing and improving health and safety through education and training of staff is essential.
- Training is a duty for those bodies in charge of the institution and must be adapted to the nature of the risks, their growth and the apparition of new risks, on an on-going basis.
- Continuous professional development occurs at different times of professional life, such as when newly qualified, when changing post or when a new technology is introduced.
- Information is required at different times in relation to risk management, for example, counselling and opting for measures that preserve staff is needed at the emergence of a risk: and, when the risk is known, periodic, collective and individual reminders to health care professionals are needed in order to keep security measures up to date.
- Adopting criteria for allocating resources, two elements must be taken into consideration before any resource allocation: the characteristics of the region to be covered, and the nature of the health care services to be provided.

Understanding the regional profile is a determining factor in resource allocation and must provide information on:

- size and structure of the population;
- morbidity;
- standard of living of the population;
- training capacity of human resources;
- stability and mobility of staff;
- available resources;
- volume and quantity of activities;
- number of health care structures; and
- organisation and use of services.

As for the nature of services and their delivery, these are closely linked to the resources that will be granted. Data that must be taken into consideration in this regard are linked to:

- structures and services existing within the region;
- volume of day-patient care;
- specific services offered to vulnerable groups (children, women, elderly, disabled, etc.);
- community participation;
- emergency services;
- health care promotion and education;
- discharge services; and
- diagnostic centres and support structures.

3 – Individual level

The strategy must take into account:

- adapting personal preferences to need to provide health care services despite movement of staff;
- improving salaries and compensation provided for overtime;
- developing social action; and
- putting into place mechanisms to motivate and keep professional staff in their post (developing skills, career plans, validation etc.).

CHAPTER 5 – FUTURE CONSIDERATIONS

The need is to develop a health care system that:

- respects fundamental and universally recognised human rights, in particular those related to the integrity, dignity and freedom of the individual;
- aims to provide quality care and security at work;
- is based on intangible principles such as:
 - equity in the organisation of health care provision;
 - responsibility and accountability of health care professionals; and
 - ethics and deontology.
- is capable of creating favourable conditions allowing health care professionals to play a role which supports development.

Based on these principles, the following recommendations need to be considered by local, regional, national and international actors in the Moroccan health system.

5.1 Recommendations

Training capacity

- Training in health administration through harmonising the health care training system along with the provisions for reforming higher education (INAS and TICHs).
- Medical teaching:
 - revising the training curriculum for general practitioners by developing, among others, community medicine, health care economics, geriatrics and family health;
 - revising the training curriculum for specialists;
 - adapting training modules to new needs; and
 - reviewing arrangements for access and training for specialists.
- Base training for nursing staff:
 - creating and extending training institutions for health care careers; and
 - creating new training “streams”.

Continuous professional development and recognition

- Establishing and implementing a new obligatory system of ongoing training, formative oversight, and guidance for health care professionals in order to improve performance.
- Implementing rules and administrative procedures and other frameworks to guarantee professional recognition to all those working in the health care system.

Structural reform

- Putting into place norms and procedures ensuring health and security for professionals at work by:
 - developing research and epidemiological studies aiming to examine the impact of professional risks and working conditions on employee health; and,
 - creating an oversight council for professional risk, in order to put into place a global preventive strategy for professional risks and for better intersectoral coordination.
- Reinforcing infrastructure, technical facilities and a system to ensure the availability of basic supplies.

- Adopting clear and transparent criteria to allocate resources in order to reduce disparities between and within regions, including those between urban and regional areas.

Leadership

- Oversight and administrative leadership encouraging modern and participatory management.
- Reinforcing partnerships and intersectoral action, partnerships with local communities, the private sector and civil society.

Terms and conditions

- Revising salaries and other benefits upwards, so that they can ensure preservation of the dignity of health care professionals.
- Ensuring the rights of health care professionals are respected, for example, the right to information.

Legislative and regulatory frameworks

- Reinforcing and updating the judicial arsenal of the Ministry of Health to bring it into line with the growth of the system on the one hand and to harmonise with international health care legislation, in particular with regard to positive practice environments and improved ethics in the health care sector.
- Conceptualising and putting into place a judicial support framework for managing health care infrastructure (including politicians, the population and Ministerial departments).

International

- Creating a WHO Code for positive practice environments which governments would include in their national health care policy.
- Encouraging international cooperation and coordination for positive practice environments which respond to challenges and to the multiple qualitative and security needs of an increasingly aware population.

Conclusion

In Morocco, the current health context is characterised by a number of positive developments, which should be consolidated. However, there are a number of disparities between service providers, inconsistency in quality of care, and availability of human resources which hinders the development of sustainable positive practice environments. It should be therefore a priority for the Ministry of Health to examine the current working framework for all health care professionals in order to improve working environments.

In Morocco, installing positive practice environments will be a long process, requiring the allocation of considerable financial, human and material resources, significantly increased from current levels.

There is a discrepancy between the level of human resources available and the level required to meet the health care needs of the population. Unfortunately, this is not well known among users of the health care system, who, often unjustly accuse health care providers of not providing appropriate and timely health care.

It is time for the health care system to develop the fundamental support systems upon which every health professional can rely, with norms and references helping each professional to appropriately fulfil their tasks. These fundamental systems must allow for the creation of a social network able to create positive practice environments and find answers to three essential issues: the need for human resources, the behaviour of health care professionals at their place of employment and the phenomenon of migration of these professionals.

To this end, the government has a duty to invest in human resources and commit to their training, supporting and ensuring the loyalty of health care professionals upon which the improvement of the quality of health care provision and the productivity of the different branches depends.

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The Global Health Workforce Alliance is the PPE supporting partner



Positive practice environments for health care professionals
Quality Workplaces for Quality Care

Patients and the public have the right to the highest performance from health care professionals and this can only be achieved in a workplace that enables and sustains a motivated well-prepared workforce.

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