BUILDING HUMAN CAPITAL
LESSONS FROM COUNTRY EXPERIENCES
MOROCCO
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BUILDING
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Morocco: Achievements and Challenges

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Abstract

This case study examines the policies, programs and processes undertaken in Morocco to improve its human capital outcomes since the 1990s. Sustained political commitment to education as a national priority across successive governments meant that while the net enrollment rate in primary school was 52.4 percent in 1990, by 2013 it had risen to over 98 percent. Not only are boys and girls enrolled at similar rates, rural areas were able to catch up to urban areas. Since 2000, investments in education have been large and sustained—between 5 and 6 percent of GDP. While still under implementation, the current Strategic Vision 2015–2030 seeks to provide equity and quality for all—particularly those from rural and less developed regions in Morocco.

Just as the government has stepped up its investments in education it has sought to tackle a variety of health challenges simultaneously. Reductions in infant and maternal mortality, curbing the fertility rate, limiting communicable and non-communicable diseases and improving the nutritional status of Moroccan children were prioritized not only through the development and better geographic distribution of health care services but also by encouraging a shift towards health insurance coverage in order to help citizens, particularly the poor, afford health care. A diligent immunization policy meant that 91 percent of Moroccan children are fully immunized. Coupled with this has been careful management of communicable diseases—including through the use of international partnerships.

As the country grapples with the next wave of challenges, the case study proposes the need to pursue more integrated multisectoral policies that not only address the interplay between health and education but a broad range of sectors including but not limited to transport, infrastructure, and the labor market. It proposes the broad outlines of a series of actions that will be critical to continue to build the human capital of generations to come.
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<tbody>
<tr>
<td>ALC</td>
<td>Debilitating and Costly Diseases/ Affections Lourdes et Coûteuses</td>
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<td>ALD</td>
<td>Chronic Diseases/ Affections Longue Durée</td>
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<td>AMO</td>
<td>Mandatory Health Insurance/ Assurance Maladie Obligatoire</td>
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<tr>
<td>ANAM</td>
<td>National Health Insurance Agency/ Agence Nationale d'Assurance Maladie</td>
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<tr>
<td>ANEAQ</td>
<td>National Evaluation and Quality Assurance Agency/ Agence Nationale d'Évaluation et d'Assurance Qualité</td>
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<tr>
<td>CERED</td>
<td>Center for Demographic Studies and Research/ Centre d'Études et de Recherches Démographiques</td>
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<tr>
<td>CHU</td>
<td>University Teaching Hospital/ Centre Hospitalier Universitaire</td>
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<td>CIDA</td>
<td>Canadian International Development Agency</td>
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<tr>
<td>CMB</td>
<td>Basic Health Care Coverage/ Couverture Médicale de Base</td>
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<tr>
<td>CNAE</td>
<td>National Accreditation and Evaluation Commission/ Commission Nationale d'Accréditation et d'Évaluation</td>
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<tr>
<td>CNEF</td>
<td>National Education and Training Charter/ Charte Nationale de l'Education et de la Formation</td>
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<td>CNOPS</td>
<td>National Social Insurance Fund/ Caisse Nationale des Organismes de Prévoyance Sociale</td>
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<tr>
<td>CNPN</td>
<td>List of National Pedagogical Standards/ Cahiers des Normes Pédagogiques Nationales</td>
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<tr>
<td>CNS</td>
<td>National Health Accounts/ Comptes nationaux de la santé</td>
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<tr>
<td>CNSS</td>
<td>National Social Security Fund/ Caisse Nationale de Sécurité Sociale</td>
</tr>
<tr>
<td>COSEF</td>
<td>Special Education and Training Commission/ Commission Spéciale pour l'Éducation et la Formation</td>
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<tr>
<td>CSE</td>
<td>Higher Council for Education/ Conseil Supérieur de l'Enseignement</td>
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<tr>
<td>DH</td>
<td>Moroccan Dirham</td>
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<tr>
<td>ENPSF</td>
<td>National Population and Family Health Survey/ Enquête Nationale sur la Population et la Santé Familiale</td>
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<tr>
<td>EPI</td>
<td>Expanded Program on Immunization</td>
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<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
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<tr>
<td>HCI</td>
<td>Human Capital Index</td>
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<tr>
<td>HCP</td>
<td>High Commission for Planning, Morocco/ Haut-Commissariat au Plan, Maroc</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education, and Communication</td>
</tr>
<tr>
<td>ILO</td>
<td>International Labour Organization</td>
</tr>
<tr>
<td>LMD</td>
<td>Bachelor’s-Master’s-Doctorate/ Licence-Master-Doctorat</td>
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<tr>
<td>MDG</td>
<td>Millennium Development Goals</td>
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MEFPRS  Ministry of Education, Vocational Training, and Scientific Research Ministère de l’Éducation de la Formation Professionnelle et de la Recherche Scientifique

MEN  Ministry of National Education Ministère de l’Éducation Nationale (the same as MEFPRS above, but the name has changed)

MENA  Middle East and North Africa

MENFP  Ministry of National Education and Vocational Training/ Ministère de l’Éducation Nationale et de la Formation Professionnelle (the same as MEFPRS above, but the name has changed)

NCD  Non-communicable diseases

NHDI  National Human Development Initiative (also INDH Initiative Nationale pour le Développement Humain)

OCP  Moroccan Phosphates Company/ Office Chérifien des Phosphates

ONDH  National Human Development Observatory (NHDO)/ Observatoire National du Développement Humain

ONE  National Electricity Company Office National d’Électricité

PHCF  Primary Health Care Facilities

PNI  National Immunization Program Programme National d’Immunisation

RAMED  Subsidized Health Insurance Scheme/ Régime d’Assistance Médicale aux populations Économiquement Démunies

RDH50  Fifty Years of Independence: Moroccan Human Development Report/ Rapport sur le Développement Humain du Maroc relatif au cinquantenaire (50) de l’indépendance

RSU  Unified Social Registry/ Registre Social Unifié

TAYSSIR  Conditional Cash Transfer Program to Keep Children in School/ Programme de transferts monétaires conditionnels pour le maintien des élèves en scolarité

WHO  World Health Organization
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1. Introduction

Governments around the world vary in their ability to develop the human capital of their workforce and foster its productivity. Some governments are consistently among the world’s top performers on standardized tests of learning achievement and in delivering quality healthcare, while others struggle to provide even the most basic services.

The Human Capital Index is a cross-country metric measuring the human capital that a child born today can expect to attain by her 18th birthday, given the risks of poor health and poor education prevailing in her country. The HCI brings together measures of different dimensions of human capital: health (child survival, stunting, and adult survival rates) and quantity and quality of schooling (expected years of school and international test scores). Using estimates of the economic returns to education and health, the components are combined into an index that captures the expected productivity of a child born today as a future worker, relative to a benchmark of complete education and full health. The index reveals that a child in one country might grow up to be only 29 percent as productive as she could be. That same child, in another country with stronger systems for health and education outcomes, could reach 88 percent of her potential productivity.

There is growing global evidence that outcomes have improved in many countries. Yet less evidence is available on the policies, programs and processes that these countries have used to achieve their results. Having information on how these countries have invested in their people and on what has and has not been effective would be useful for other governments as they strive to improve their own outcomes.

The goal of this case study is to assess the human capital development trajectory of Morocco, examine the factors that drove that trajectory, and draw lessons from this experience. The study explores not only how improvements were achieved but also what else could be done in the future to sustain and amplify the government’s investments in its people.

Analytical Framework

This case study uses a whole-of-government lens to look at issues of human capital investment and accumulation. This approach is based on three inter-related principles:

- **Continuity** – sustaining effort across political cycles
- **Coordination** – ensuring that sectoral programs and agencies work together
- **Evidence** – expanding and using the evidence base to improve and update human capital strategies.

These basic elements not only cut across politics, institutions, and silos of knowledge but often characterize the investments being made by the best performing countries throughout a person’s life. Some of these countries have achieved complete economic and social
transformations in just a few decades. While the study focuses on cross-sectoral efforts, it also examines the key sectoral initiatives that laid the necessary foundations on which other sectors have been able to build.

This case study focuses on improvements in Morocco’s adult survival rate, expected years of schooling and survival to age five. Across 155 countries over the period 2000-2017, the typical reduction in under-five mortality is 4 percent per year while Morocco has reduced this at a rate of 4.5 percent per year. Over this time span the average reduction in premature adult mortality is about 2 percent per year. Morocco on the other hand managed to improve this at a rate of roughly 5.1 percent per year.¹ Morocco’s performance in terms of improving expected years of schooling was also impressive; between 2005 and 2017, it increased from 8.5 to 10.6, roughly a 4 percent reduction in the distance to the frontier per year.² This is one of the best improvements seen in the data.³

Panel A of Figure 1 shows the evolution of the probability of survival to age five in Morocco. Panel B shows the evolution of adult survival while panel C shows the evolution of the expected years of schooling for Morocco.

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¹ There are 156 countries in the HGI dataset and the typical country has data starting circa 2000 and ending circa 2017. Using these two end points we compute the annual rate of change for each country. For Morocco the data are also from 2000 and 2017.
² The frontier is the maximum possible years of education for a child to complete by age 18 provided they start at age 4–14 years.
³ Providing a similar metric to compare across countries is difficult due to limited number of countries (84 in our sample) with a long time series data and the fact that the underlying enrolment rates may be different across countries and overtime.
Country Context
Morocco, with a per capita income of roughly US$3,500, is classified by the World Bank as a lower-middle-income country.⁴ Over the past 20 years, the country has made significant strides in improving its economic and social situation and has managed to increase its Gross Domestic Product GDP growth rate compared to its average rates between 1980 and the late 1990s. Morocco had an average annual growth rate of 3 percent in the 1990s, which jumped to 4.6 percent between 1999 and 2013 and to 4.7 percent between 2001 and 2015. Between 2008 and 2013, this rate was between 4 and 5 percent approximately, but only 3.7 percent between 2012 and 2015. Over the past 20 years, the per capita GDP growth rate has averaged roughly 3 percent.⁵⁻⁶

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⁶ See Annex Figures 1 and 2.
During this same period, Morocco has achieved a fair measure of success in the area of economic diversification by focusing on sectors with growth potential, such as the aeronautical industry, the automobile industry, and solar energy.

Encouraged by a number of positive results and indicators, including its political stability in a very turbulent environment, Morocco has set its sights on and is even striving to close its economic gap at a faster rate, particularly given its favorable geographical location (for trade), with the aim of joining the ranks of upper-middle-income countries.⁷

With this in mind, several large-scale and ambitious projects have recently been implemented. They include the Tangier-Med Port, the highway network, a high-speed train line, and many sectoral strategies related to agriculture, fisheries, the pharmaceutical, automobile, and aeronautical industries, and renewable energy and tourism.

From a social standpoint, Morocco’s performance has also been sound. It has virtually eradicated extreme poverty and has significantly reduced poverty, not only in terms of the national poverty line but also a multidimensional poverty measure.⁸

According to data from Morocco’s High Commission for Planning (HCP), the monetary poverty rate fell from 15.3 percent in 2001 to 4.8 percent in 2014. The reduction in the poverty rates was accompanied by a decline in the vulnerability rate. In fact, HCP data indicate that the vulnerability rate stood at 12.5 percent in 2014 compared with 22.8 percent in 2001 and that the multidimensional poverty rate fell from 28.5 percent in 2003 to only 6 percent in 2014.

Over the past 20 years, Morocco has also made remarkable progress in terms of its human development. The government made a commitment to achieve the Millennium Development Goals (MDGs) from the time of their adoption by the international community in 2000, and this commitment has contributed to the quest for and achievement of significant results. Data from the HCP show that life expectancy at birth in Morocco rose from 70 years in 2000 to 76 in 2017, in part as a result of significant investments in public infrastructure, including health infrastructure. Morocco has also significantly improved its education indicators, including the attainment of near-universal primary education, which is a major achievement.

In terms of the World Bank’s Human Capital Index (HCI),⁹ Morocco’s current score is estimated at 0.50, meaning that half of its human capital potential is not being achieved. In

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⁷ For a fuller treatment of the governance challenges facing service delivery, please see section 3 of the Background Paper for the Morocco SCD: Governance
⁸ See Annex Figures 3 and 4.
⁹ The Human Capital Index (HCI) is based on the amount of human capital that a child born today can expect to attain by the age of 18 given the education and health risks that prevail in the country where he or she was born relative to a benchmark of complete education and full health.
other words, the productivity of a child born in Morocco today will only be one-half of what it would have been had that child benefitted from a complete education and full health.

The HCI ranks Morocco 98th out of the 157 countries included in the index. Annex Table 1 taken from World Bank (2019) compares Morocco’s ranking with those of a selection of countries at the same level as Morocco and those of some that are at the level to which Morocco is aspiring. Morocco’s HCI ranking is roughly the same as those of comparable countries such as Egypt, Tunisia, and Algeria.

Morocco’s HCI is in fact lower than the average for the MENA (Middle East and North Africa) region but is higher than the average for countries in its income group. However, its HCI is lower than would be expected given its income level. Morocco has nonetheless made noteworthy progress given that its HCI rose from 0.46 to 0.50 between 2012 and 2017.10

A careful review of the HCI’s different components shows that Morocco ranks higher than its neighboring countries in terms of adult survival (0.98). Moreover, of every 100 children born, 98 will survive to the age of 5 and, among people currently aged 15, 93 percent will survive to the age of 60 under present conditions. However, close to 15 percent of children are at risk of having physical and cognitive deficits that can last a lifetime as a result of malnutrition.

In terms of education, Morocco remains below its neighbors on the HCI in terms of learning-adjusted years of school (6.2). This means that a child who starts school at the age of 4 can be expected to complete an average of 10.6 years of schooling by the age of 18. However, this child will in fact have received the equivalent of only 6.2 years of effective schooling given the quality of the instruction received. Despite the efforts that have been made, Morocco is still not managing to make the human capital progress that it desires, particularly in the area of education.

Girls fare better than boys on the HCI and its basic components, even in the education-related components11 where girls lagged behind boys for a long time (see Annex Table 2). This gap has actually closed significantly in the past 20 years.

This case study is structured as follows. Section 2 presents a chronological review of Morocco’s education and health policies and strategies over the last 20 years and explains in detail how Morocco has improved its human capital indicators in these areas. Section 3 highlights several deficits that will need to be addressed, as well as the prospects and challenges faced by Morocco in these areas. Section 4 draws conclusions from the analysis about what may be in store for Morocco’s human development in the future.

2. How Has Morocco Improved its Human Capital Indicators?

For several years, especially since the inauguration in 1998 of what has been called the Government of alternation (Gouvernement d’alternance) in Morocco and following the installation of King Mohammed VI in 1999, sustained efforts have been made to improve all of the country’s human development indicators. Considerable progress has been made in this regard, both in urban and rural areas, as a result of a whole range of strategies, programs, initiatives, and actions to assist disadvantaged population groups. Not only have health and education indicators improved (almost universal access to primary education for example), but also household access to basic social services has been greatly expanded, in particular to electricity (especially in rural areas) and the supply of potable water to households, which currently exceeds 95 percent.

The most prominent national program in this context is the National Human Development Initiative (NHDI). Started in 2005, it was described by King Mohammed VI in his launch speech as “a royal project that places the human element at the center of national policies.” In its first phase alone (NHDI 1), which covered the 2005–2010 period, the program facilitated the execution of more than 22,000 development activities and projects that benefitted more than 5 million people. During this phase, the government emphasized reducing poverty in rural areas, tackling social exclusion in urban areas, and reducing vulnerability in general. Of the activities conducted during this period, 3,700 were income-generating in nature. Morocco mobilized DH 14.1 billion (roughly US$145 million) to finance this first phase.

Using the same approach and format, two new phases of this initiative were designed following the end of NHDI 1. NHDI 2 covered the 2011–2015 period and targeted 702 rural communes and 532 urban neighborhoods, far more than had been covered by NHDI 1.

In addition to the NHDI, a special territorial infrastructure upgrading program was established. With a budget envelope of DH 5 billion (US$514 million), this program targets people living in mountainous and remote areas.

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12 See Box 1 for a brief overview of the recent political economy of reform in Morocco.
13 For more information on NHDI projects and sources of financing, see http://www.inhdh.ma or http://www.ondh.ma.
14 This programme targets remote locations aiming at improvements of their infrastructure (roads, facilities, etc.)
15 Despite its broad scope, the NHDI has not replaced the programs of other government entities. Each sector continues to implement its own development strategy to achieve specific objectives.
Box 1: The Political Economy of Reform in Morocco

In March 2011, HM King Mohammed VI introduced a series of political reforms that was widely supported by the Moroccan people in the constitutional referendum of July 2011.

The new Constitution:

1. lays the foundation for a more open and democratic society. It strengthens the country’s governance framework through a greater separation and better balance of powers among the King, the government, and the Parliament, and lays the foundation for advanced regionalization and decentralization as a democratic and decentralized system of governance.

2. strengthens the principles of good governance, human rights, and protection of individual freedoms. It reaffirms a number of fundamental economic, civil, and political freedoms such as the right to own property, the right to enterprise and free competition, the right to freedom of assembly and peaceful protest, the right to free association, and the right to belong to a trade union or political party.

3. provides a significant list of civil and political rights that had not been recognized in the 1996 Constitution, including the right to life, the right to security of person, the right to physical or moral integrity, the right to protection of private life, the presumption of innocence and the right to a fair trial, the right to access to justice, the right to access to information, and the right to present petitions. It also recognizes a number of economic, social, and cultural rights such as the right to health, the right to social protection, the right to work, and the right to decent housing.

4. introduces institutional changes in order to strengthen the separation, balance, and collaboration among the authorities and enhance institutional responsibility and accountability. The main institutional changes pertain to (a) strengthening of the role of Parliament through increased legislative powers and greater oversight of the government; (b) the promotion of the role of the Prime Minister as head of the government appointed by the winning political party in the legislative elections; (c) strengthening of the independence of the courts; and (d) strengthening of oversight institutions, in particular the National Human Rights Council, the Competition Council, and anti-corruption bodies.

5. establishes institutions tasked with guaranteeing equal treatment, parity, and youth participation such as the Parity and Anti-Discrimination Authority and the Youth Advisory Council (Autorité de lutte pour la parité et contre les discriminations et le Conseil consultatif de la jeunesse).
Building Human Capital

- recognizes the principles of regionalization as a democratic and decentralized system of governance. Far-reaching constitutional amendments were made to enhance the accountability and transparency of local and regional councils, as well as increase citizen participation in the management of local affairs and public services.

Source: Madani, Maghraoui, and Zerhouni 2013 as adapted from Box E.5 of Chaffour, 2018.

In the rest of this section, we discuss Morocco’s education and health policies and strategies over the last 20 years to explore which have been most responsible for the country’s improved human capital outcomes.

**Education**

Since achieving independence in 1956, Morocco has been engaged in a lengthy process to provide universal access to education and to improve its quality. Significant progress has been made in terms of expanding and achieving universal access. Particularly since 1990, policymakers have consistently implemented new approaches aimed at developing the national education system. These approaches have revolved around:

- Increasing efficiency;
- Enhancing the contribution of the different stakeholders, including the local authorities;
- Deconcentrating responsibilities to various levels;
- Streamlining in resource allocation and utilization.

We discuss the actions taken by scholastic level (preschool, primary school, lower secondary school, and upper secondary school) and then conduct a chronological review of recent developments in education policy and strategies.

**Preschool Education: Considerable Efforts to Close the Gap**

The Moroccan authorities have clearly understood (admittedly with a slight lag) that preschool education, the foundation of the education system, serves as a cornerstone of the development of a child’s personality. It is at this age that a child’s cognitive abilities are shaped. Preschool education offers an early introduction to civic values and respect for others and contributes to student retention in later levels of the school system, thus reducing school dropout rates and unequal opportunities.

Cognizant of the fact that preschool education had for a long time been overlooked, in 2000 the Moroccan government organized the passage and enactment of law No. 05–00 related
to preschool education. The law defined preschool education as the instruction provided by institutions that accept children aged between 4 and 6 years and established a clear legal framework to govern and regulate these institutions and the instruction that they provide. The ultimate objective was to guarantee equal access to this level of education and to expand it to include all children between the ages of 4 and 6. The medium-term objective was to incorporate preschool education as a common core of primary education. This law does not apply to institutions catering to children under the age of 4.

Law No. 05–00 specified that local governments should be involved in managing preschool education by, for example, making appropriate buildings available, constructing new buildings, and outfitting, upkeeping, and maintaining them. The law also made provisions for the involvement of civil society organizations and parents in financing with the hope of achieving universal preschool education fairly quickly.

In parallel with Law No. 05–00, the government continued with the introduction of some 3,600 preschool classes in primary schools in the context of an “Emergency Plan” covering the period from 2009 to 2012.

As a likely result of all these efforts, the net preschool enrollment rate for both boys and girls aged 4 to 5 rose from roughly 40.5 percent in 1990–1991 to almost 54 percent in 2013–2014 according to HCP data. The increase was significantly greater among girls, with their rate rising from 25.1 percent to 47.6 percent. It should be borne in mind that these percentage increases were also associated with a net decline in the number of school-age children, evidenced by a downward trend in the total fertility rate, which fell from 4.0 in 1992 to 2.38 in 2018.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Boys</td>
<td>563,913</td>
<td>69.4</td>
<td>491,974</td>
<td>64.4</td>
<td>419,955</td>
<td>56.3</td>
</tr>
<tr>
<td>Girls</td>
<td>248,574</td>
<td>30.6</td>
<td>272,226</td>
<td>35.6</td>
<td>326,036</td>
<td>43.7</td>
</tr>
<tr>
<td>Total</td>
<td>812,487</td>
<td>100</td>
<td>764,200</td>
<td>100</td>
<td>745,991</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Ministry of National Education and Vocational Training (MENFP)

To properly assess the figures presented in Table 1, it is necessary to be aware that it is not exactly clear what is encompassed in the definition of preschool education in Morocco. The category includes modern public and private institutions alongside a network of traditional Koranic schools (kuttab and rsidi). All of these institutions are under multiple different forms of oversight and are not subject to the same legal provisions. Also, their missions are generally

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17 Ministry of Health
Building Human Capital

not the same. In all likelihood, the figures shown in Table 1 cover all these forms of preschool education.

Moreover, as preschool education is not an integral part of basic compulsory education and thus is not standardized, any figures on this education level are likely to lack reliability and precision.

**Effective Efforts to Achieve Universal Primary Education**

In the late 1980s, only 55 percent of children aged 6 to 11 years were enrolled in school in Morocco, but the pace towards achieving universal access to education has increased markedly over the past 20 years. In 1990–1991, the net school enrollment rate was 52.4 percent but by 2013–14, this had risen to over 98 percent, and the rates for both boys and girls became similar.

By way of comparison, it took the United States of America 40 years (1870 to 1910), albeit under conditions that were very different, to increase the school enrollment rate of girls from 57 percent to 88 percent. Morocco achieved the same feat in 11 years as a result of several simultaneous actions that rightly focused on increasing school enrollment in general and girls’ enrollment in particular.

These are the levels and trends in school enrollment rates that prompted the High Commission for Planning to state that Morocco had virtually achieved the Millennium Development Goal related to universal primary education before the deadline of 2015.

The desire to move in this direction was reaffirmed at the highest state level. In his speech to the Moroccan people on August 20, 2012, King Mohammed VI stressed the basic principles of the national education system by declaring that “... this system, which is currently a matter of concern to us, should not only ensure equal and equitable access to schools and universities for all our children, but should also guarantee them the right to quality education that is highly attractive and suited to the life that awaits them.” As with all speeches delivered by the King of Morocco, this one served as a kind of mandatory roadmap for the government. Therefore, officials at various levels have taken several steps to improve all quantitative indicators in the sector.
An Upward Trend in Lower and Upper Secondary School Education

The trend toward universal education, which began at the primary level with the increase in the school enrollment rate illustrated in Figure 2, was naturally reflected at the secondary level and, to a lesser extent, at the post-secondary level, despite high school dropout rates.

In Morocco, children who have obtained a primary education certificate attend lower secondary school for three years. Those who successfully complete lower secondary go on to upper secondary education, which also lasts three years. In 2015, 1,627,381 students were enrolled in lower secondary, while 975,294 students were attending upper secondary school.

Enrollment rates at the lower secondary level (Figure 3) have risen sharply in recent years, from 75.4 percent in 2010 to 87.6 percent in 2014.\(^{(18)}\) Despite this achievement, the lower secondary dropout rate remains high and was over 10 percent in 2014.

In upper secondary school, students follow a core curriculum for the first year and spend the next two years preparing for the *baccalauréat*. Enrollment rates at this level have been rising but are lower than those for primary and lower secondary education. For children aged 15 to 17, the enrollment rate was 50.3 percent in 2010 and 61 percent in 2014. As a result, the annual number of *baccalauréat* holders (*bacheliers*) rose from roughly 50,000 in 1990 to more than 205,000 in 2014 and is expected to climb to more than 300,000 by 2020, based on the projections of the Ministry of National Education (MEN). However, slightly fewer than one in two *baccalauréat* holders end up obtaining a higher education degree. In 2017, only around

\(^{(18)}\) MENFP (2015)
100,000 people had obtained a higher education degree, although this is projected to rise to between 125,000 and 130,000 in 2020 according to the same projections.

**Figure 3: Lower Secondary Gross Enrollment Rates by Gender, 1991–2008**

Source: Department of Statistics, Strategy, and Planning (DSSP), MEN

**Chronology of Recent Education Policies and Strategies**

To understand the reasons behind these trends, we now explore the phases and stages of the country’s education policies and strategies over recent decades. While not wishing to go too far back in time, it is impossible to overlook the colonial legacy in this regard. Morocco’s history includes a period of French and Spanish colonization from 1912 to 1956. During this period, the education system was very limited and segregated, accompanied by a diminution of the features of the traditional Muslim education system being marginalized. In the immediate post-independence period, the country was left with very little in the way of trained human resources and access to fairly formal education. In 1956, the adult illiteracy rate was estimated to be 82 percent. The situation in the parts of Morocco that had been under Spanish colonial rule (northern and southern Morocco) was even worse, with illiteracy rates of roughly 95 percent. In 1955, Morocco’s last year as a Protectorate, only around 212,000 children of a school-age population of close to 2 million were actually enrolled in the different kinds of schools (colonial, nationalist, and traditional). This legacy is clearly the root cause of the subsequent buildup of some of Morocco’s human development deficits in terms of illiteracy and directly explains the priority necessarily accorded to education in the immediate post-independence period.

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20 UNESCO (2010)
Morocco

The post-independence government quickly established universal primary education as a key national objective and made sizeable investments towards this goal. A Royal Commission was created in 1957, just one year after independence, that established four basic principles for the Moroccan education system: (i) unification; (ii) universal access; (iii) Moroccanization; and (iv) Arabization. These same principles unarguably underpin all education strategies that have followed right up to the present.

When the Government of alternation (Gouvernement d’alternance) came to power in 1997, it made a renewed political commitment to achieving universal primary education. Responding to various dysfunctions that had been found in the education system between 1980 and 1990, it introduced several reforms to support and modify the national education system.

As early as 1999, King Hassan II had ordered the establishment of a Special Education and Training Commission (Commission spéciale pour l’éducation et la formation COSEP) and appointed one of his very close advisers to chair this body. This Commission was tasked with preparing a reform proposal for all Moroccan schools. The government then drafted and adopted a new National Education and Training Charter (CNEF) and launched resulting reform measures in 2000 to cover the 2000–2010 period. Education was thus declared to be a national priority at the highest state level. In 2002, it was decreed, by law that schooling was compulsory and free for all children between the ages of 6 and 15.

Massive investments have been made in the education sector since 2000 with the aim of expanding access, decentralizing authority, reducing all kinds of inequalities, and adapting programs. Since that time, the general education subsector (all education cycles) has consistently received between 25 percent and 28 percent of the general state budget annually (between 5.3 percent and 5.8 percent of GDP). 21 The 2015 figure was 5.6 percent of GDP. Based on figures from the Ministry of National Education and Vocational Training (MENFP), in current terms, the share of the state budget allocated to education increased 2.5 times from DH 24.8 billion in 2001 to over DH 61.7 billion in 2011. 22 These budget increases appear to have been made as a direct response to the explicit recommendation of the CNEF calling for a minimum 5 percent annual increase in the total budget for the education and training system.

All of these efforts produced some impressive results and were followed up in 2005 by the development of a new Strategic Framework for the Development of the National Education System (Cadre stratégique pour le développement du système éducatif national) revolving around three main priorities:

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22 MENFP (2015)
• Building effective management capacity at different levels;
• Improving the quality of education and reducing school failure rates;
• Providing universal preschool education, followed by universal primary and lower secondary education.

However, it did not receive enough financing and, for this reason, it was only minimally operationalized. Its relevance was even called into question.

When education outcomes failed to meet the expectations of policymakers, King Mohammed VI ordered the reactivation of the Higher Council for Education (CSE) in a speech delivered at the opening session of parliament in the fall of 2007. This was a permanent and independent body that monitored and evaluated public policies related to education. In 2014, it was renamed the Higher Council for Education, Training, and Scientific Research (CSEFRS) but retained the same mission.

In 2009, based on an in-depth analysis of the challenges facing the Moroccan education system, the CSEFRS prepared an “Emergency Plan” that was adopted and then launched by the government. This Plan was supposed to serve as a roadmap for the sector with a view to enhancing and expediting the reforms envisioned for the 2009 to 2012 period. Its aim was “to consolidate the gains achieved and make necessary readjustments while ensuring full application of the guidelines of the National Education and Training Charter” and to give renewed impetus to this Charter. The general consensus was that this Plan failed to achieve its set objectives, and several problems were identified and highlighted even by the Audit Office.

In 2014, the CSEFRS drafted a new strategy for the 2015–2030 period within this same framework. Titled “Strategic Vision 2030” its explicit goals were “to provide schools that offer equity, equal opportunity, and quality for all as well as individual development.” It even authorized the introduction and acceptance of positive discrimination favoring children from the less developed parts of Morocco, particularly those in rural areas. All the current actions and interventions in the sector have been designed and implemented in the context of this vision. To the best of our knowledge, there is no complete rigorous assessment of the initial results of this Strategic Vision, which is still being implemented.

In July 2019, following very difficult parliamentary discussions, the draft framework Law No. 51.17 on the education, teaching, training, and scientific research system was finally adopted and subsequently published in the Official Gazette. This law integrated most of the objectives of the strategic vision for the 2015–2030 reform and placed great emphasis on the need to achieve universal preschool education for all children between the ages of 4 and 6. To implement this new framework law, the government will need to adopt no fewer than six laws, 79 ministerial decisions, and 80 decrees in three years. Therefore, a raft of sweeping changes is expected in the next few years in Morocco’s education sector.
Morocco

*Targeted and Very Concrete Actions to Achieve Precise Objectives*

Within the context of these strategies, specific targeted actions were taken to achieve their stated goals. For example, to narrow the gap in access between urban and rural areas, 99.66 percent of the 5,614 additional public primary school classrooms created between the 2000–2001 school year and the 2013–2014 school year were located in rural areas according to data from the Ministry of National Education and Vocational Training (MENFP)—see Table 2.

**Table 2: Increase in the Number of Urban/Rural Public Primary Classrooms**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>27,233</td>
<td>35,602</td>
<td>33,621</td>
</tr>
<tr>
<td>Rural</td>
<td>35,546</td>
<td>48,523</td>
<td>54,118</td>
</tr>
<tr>
<td>Total</td>
<td>62,779</td>
<td>84,125</td>
<td>89,739</td>
</tr>
</tbody>
</table>

*Source:* MENFP

In addition, the number of lower secondary schools rose from 740 in the 1990–1991 school year to 1,781 in the 2013–2014 school year, an average annual increase of roughly 45 new lower secondary schools, and once again, rural areas benefitted more from these investments. The lower secondary school coverage rate in the rural communes climbed to 60.9 percent in 2013–2014 from only 48.2 percent in 2007–2008.

Per student, education expenditure in Morocco has risen to the level of upper-middle-income countries. For example, annual nominal public expenditure per primary school student rose from the equivalent of US$300 in 2001 to over US$480 in 2011.21

To address the school dropout problem, the authorities launched the Tayssir program at the start of the 2008–2009 school year. This is a conditional cash transfer program aimed at encouraging households to keep their children (aged 6 to 15) in school for as long as possible. Monthly per student grants (for up to three children per household) were set at DH 60 (US$6.4) for the first and second years of primary school, DH 80 for the third and fourth years of primary school, and DH 100 for the fifth and sixth years of this education cycle. In the case of lower secondary school, the monthly grant was set at DH 140 per student. Transfers to households are generally supposed to take place on a quarterly basis.

There was supposed to be a rigorous, publicly available impact assessment of the Tayssir program to evaluate its impact on several outcome variables related to the beneficiary households and their children. However, no such evaluation has been undertaken. The Audit Office explicitly stated in its 2016–2017 report that "no quantifiable indicators are available to

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21 World Bank (2018)
monitor the different programs and prepare annual progress and financial reports that enable evaluation of the performance of these programs.”

However, the Minister of National Education stated in a speech in September 2018 that the Tayssir program had led to a 57 percent reduction in the school dropout rate and to a significant increase (37 percent) in the reenrollment rate of students who had dropped out of school.

However, since the program was started, there have been several problems with its financing mechanism. Its annual budget has been consistently less than its expenditures, and there are always delays in making the transfers to households. The program also seems to be hobbled by both inclusion and exclusion targeting problems. The Audit Office clearly pointed out all these challenges in its 2016–2017 report.

Several adjustments were made to this program from one year to the next. For the 2018–2019 school year, the budget allocated to the program stood at DH 2,170 million (approximately US$231,000), a 41 percent increase over the 2017–2018 school year. In the 2017–2018 school year, the Tayssir program is estimated to have reached 2,087,000 beneficiaries compared with 706,000 in the previous school year. In a matter of only one year, the number of beneficiaries had virtually tripled by targeting the neediest households by urban/rural area and other household characteristics. This targeting system is expected to be further improved following the anticipated implementation and finalization of a Unified Social Registry (RSU) in Morocco.

Alongside this major program, a royal initiative known as “one million schoolbags” was also introduced at the start of the 2008–2009 school year. Beginning in the 2015–2016 school year, it became the “four million schoolbags” operation. It involves the annual distribution of kits containing the necessary textbooks and school supplies to more than 80 percent of children at the primary and lower secondary levels. The composition of the kits naturally varies depending on the student’s place of residence and academic level.

The program was supposed to have a steering and evaluation committee, but this never became operational, so no meaningful program impact evaluation has ever been done or at least made available to the public. In its report covering the 2016–2017 period, the Audit Office wrote that “there are no quantifiable indicators for the “one million schoolbags” program or [any] impact study that makes it possible to assess the contribution of this program to lowering school dropout rates.”

The Audit Office also indicated that the program was constrained by problems at various levels including the ineffective and inaccurate targeting of eligible households, delays in the

distribution of school kits, a lack of storage spaces for the textbooks used in the schoolbags, and governance issues.

The government has made major efforts to build student boarding facilities and to provide schools with electricity, potable water, and latrines with the aim of improving the conditions under which students are served and educated in general. The government also reassessed the daily allocation for boarding facilities and school meals, which benefits close to 1,500,000 students.

A special effort was made to target assistance to rural and remote regions where the needs are greater, for example, by providing school meals only to primary and lower secondary students who live in rural areas. Also, the government established a school transportation program in several rural communes where students lived far away from their schools. This program benefitted around 154,000 students in 2017–2018, according to MENFP data. Table 3 presents information about the financing of these operations. Table 4 summarizes a variety of programs that the government has undertaken to support the education sector. Box 2 provides a brief overview of the role of social protection programs in human capital development in Morocco.

**Table 3: Resources and Costs of the Tayssir and “One Million Schoolbags” Programs**

<table>
<thead>
<tr>
<th>School Year</th>
<th>“One Million Schoolbags” Royal Initiative</th>
<th>Tayssir Program</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of Beneficiaries</td>
<td>Cost commitment (DH millions)</td>
</tr>
<tr>
<td>2008/2009</td>
<td>1,273,846</td>
<td>249</td>
</tr>
<tr>
<td>2009/2010</td>
<td>3,778,500</td>
<td>429</td>
</tr>
<tr>
<td>2010/2011</td>
<td>3,867,580</td>
<td>364</td>
</tr>
<tr>
<td>2011/2012</td>
<td>3,939,979</td>
<td>330</td>
</tr>
<tr>
<td>2012/2013</td>
<td>3,933,749</td>
<td>388</td>
</tr>
<tr>
<td>2013/2014</td>
<td>3,897,542</td>
<td>391</td>
</tr>
<tr>
<td>2014/2015</td>
<td>4,164,259</td>
<td>368</td>
</tr>
<tr>
<td>2015/2016</td>
<td>4,013,897</td>
<td>341</td>
</tr>
<tr>
<td>2016/2017</td>
<td>Management of the program was transferred to the Ministry of Interior (under the NHDl)</td>
<td>Undisbursed allocations of DH 777 million corresponding to 860,100 students targeted by the program</td>
</tr>
</tbody>
</table>

Source: MEN
Table 4: An Overview of Education Support Programs in Morocco

<table>
<thead>
<tr>
<th>From 4 to 5 Years Old</th>
<th>Direct Beneficiaries</th>
<th>Budget (million in MAD)</th>
<th>Year</th>
<th>Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preschool (traditional and modern)</td>
<td>706,000</td>
<td>55</td>
<td>2007</td>
<td>Ministry of Education, Foundation Md VI and Habbous</td>
</tr>
<tr>
<td>Jardins d’enfants / Kindergartens</td>
<td>20,187</td>
<td>NA</td>
<td>2009</td>
<td>Entraide Nationale</td>
</tr>
<tr>
<td>From 6 to 18 Years Old</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cantines primaires / Primary school cafeterias</td>
<td>1,212,628</td>
<td>896</td>
<td>2013/2014</td>
<td>Ministry of Education</td>
</tr>
<tr>
<td>Cantines colleges / Secondary school cafeterias</td>
<td>54,481</td>
<td></td>
<td>2013/2014</td>
<td>Ministry of Education</td>
</tr>
<tr>
<td>Internat, Boursiers / Boarding schools and Fellowships</td>
<td>132,344</td>
<td>NA</td>
<td>2013/2014</td>
<td>Ministry of Education</td>
</tr>
<tr>
<td>Dar Taliba</td>
<td>700</td>
<td>NA</td>
<td>2008/2009</td>
<td>Ministry of Education</td>
</tr>
<tr>
<td>Tayssir&lt;sup&gt;a&lt;/sup&gt;</td>
<td>825,000</td>
<td>713</td>
<td>2013/2014</td>
<td>Ministry of Education</td>
</tr>
<tr>
<td>Transport</td>
<td>100</td>
<td>NA</td>
<td>2008/2009</td>
<td>Ministry of Education</td>
</tr>
<tr>
<td>1 million de cartables / 1 million schoolbags&lt;sup&gt;b&lt;/sup&gt;</td>
<td>3,906,948</td>
<td>367</td>
<td>2013/2014</td>
<td>Ministry of Education</td>
</tr>
<tr>
<td>Soutien pedagogique / Teaching support</td>
<td>166,900</td>
<td>11</td>
<td>2008/2009</td>
<td>Ministry of Education</td>
</tr>
<tr>
<td>Hebergement / Lodging</td>
<td>59,000</td>
<td>229</td>
<td>2008/2009</td>
<td>Entraide Nationale</td>
</tr>
<tr>
<td>Ecole de la deuxieme chance / Second Chance schools</td>
<td>33,100</td>
<td>23</td>
<td>2008/2009</td>
<td>Entraide Nationale</td>
</tr>
<tr>
<td>18 Years Old and up</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bourses / Scholarships</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cites universitaires, internats / University Cities, Boarding schools</td>
<td>33,600</td>
<td>429</td>
<td>2008/2009</td>
<td>Ministry of Education</td>
</tr>
<tr>
<td>Bourse de licence / License scholarship</td>
<td>10,100</td>
<td></td>
<td>2008/2009</td>
<td>Ministry of Education</td>
</tr>
<tr>
<td>Bourse de master / Masters scholarship</td>
<td>9,200</td>
<td></td>
<td>2008/2009</td>
<td>Ministry of Education</td>
</tr>
<tr>
<td>Bourse de doctorat / Doctoral scholarship</td>
<td>1,600</td>
<td></td>
<td>2008/2009</td>
<td>Ministry of Education</td>
</tr>
<tr>
<td>Bourse de merite / Merit scholarship</td>
<td>600</td>
<td>16</td>
<td>2008/2009</td>
<td>Ministry of Education</td>
</tr>
<tr>
<td>Bourse post-Bac / Post-Baccalaureate scholarship</td>
<td>40</td>
<td>NA</td>
<td>2008/2009</td>
<td>Entraide Nationale</td>
</tr>
</tbody>
</table>

Notes:
<sup>a</sup> The overall objective of this program was to provide support for the education of children from disadvantaged households and reduce school dropout rates in rural areas. The estimated cost was DH 3.18 billion for the launch period through 2018. 774,000 students in 2017/2018 benefited from the program.

<sup>b</sup> The overall objective was to assist children enrolled in school from rural and urban areas. The estimated cost was DH 1.47 billion for the launch period through 2018. 4.1 million students benefited in 2017/2018.

Box 2: Social Safety Nets and Human Capital in Morocco

Over the years Morocco has developed a variety of social safety nets programs. These cover several sectors and support a range of human capital outcomes. In addition to the RAMED and TAYYSIR programs covered elsewhere in this case study, there are programs which aim to achieve universal education and reduction of school drop-out, especially in rural areas through the provision of school bags, subsidized transport, food, school supplies and materials for students enrolled in the first two years of primary school and in the first year of secondary school. Such programs benefit about 4 million students yearly. In addition, there is also social assistance targeted to disadvantaged groups:

- **Programs for Disabled Individuals**: these programs (led by the SDA) seek to support local initiatives and strategies that support individuals with disabilities to improve their quality of life. Also, the *Entraide Nationale* manages polyvalent centers for persons with disabilities. These centers are managed either by the agency directly or by local NGOs. Centers provide school enrollment modules (following official schooling but delocalized in the center, physical therapy services, paramedical), and training activities to disabled individuals. About 10,989 persons with disabilities benefit from these programs on a yearly basis.

- **Social Protection Centers**: The centers provide support to individuals (youth, adults, and elderly) who are in difficult and vulnerable situations such as abandoned children, women that are socially excluded, victims of family abandonment, and elderly people without any support. There are more than 1,347 social protection centers which provide support to about 160,000 people yearly.

- **Centers for Training & Education**: The centers provide support to girls and women in difficult socio-economic conditions, by covering the cost of their education and some medical support. Beneficiaries also receive training to acquire marketable skills, aimed at increasing their chances of economic insertion. It focuses on those generally not eligible for formal vocation training services, either because they fall out of eligible age groups or because they lack previous academic backgrounds.


**Health**

In the area of health, the government of Morocco has had to act on several fronts. From a demographic standpoint, it has had to take simultaneous measures to reduce infant and maternal mortality while also curbing the fertility rate. It has also had to take steps to curb communicable and non-communicable diseases and to improve the nutritional status of
Moroccan children. This was all supposed to be achieved through the development and better geographic distribution of health care services. To expand access to health services and health care, the government also had to encourage a shift towards health insurance coverage in order to help citizens, particularly the poor, to afford the costs associated with health care and health services. In this section, we examine these efforts and assess the extent to which the goals have been met, particularly with respect to survival rates for adults aged between 15 and 60 years old, which is the health indicator of the HCI.

However, it is useful to present a very brief review of some characteristics of the Moroccan health system. The health care supply is ensured by the public sector, the non-profit private sector, the for-profit private sector and the traditional informal sector (besides some specific facilities like military hospitals etc.). Despite a rather quick increase of the private health sector supply (number of physician cabinets and clinics), the public sector remains the main health care provider in the country.

As for the financing of the health sector, direct contribution of households is still counting for more than half the total cost, despite continuous efforts of the government to reduce the pressure on household budgets.

Health care coverage in Morocco is good, especially since 2002 by Law 65.00 on the Basic Medical Coverage (CMB), which is provided through two plans: mandatory health insurance (AMO) for workers of the public and for the private sectors and the subsidized health insurance scheme (RAMED) for the poor.

Controlling Demographic Growth

The population of Morocco was close to 35 million in 2017. As a result of the exodus of Moroccans from rural areas into the cities driven by the search for employment and better living conditions, the reclassification of several rural localities, and extension of the boundaries of urban localities, 62 percent of the population lives in urban areas in 2017. This urbanization rate was 29 percent in 1960, 55 percent in 2004, 60 percent in 2014. In Morocco, urban areas usually have better health care and health services than rural areas so new migrants have increased access to these services.

The government’s efforts in the health sector have led to a significant and steady increase in life expectancy at birth (as officially measured), which rose from 47 years in the immediate post-independence period to 76.1 in 2017.

The government very quickly became aware of the need to control its population growth in order to achieve economic and social development. The population policy, adopted just after independence, focused on reducing fertility and was greatly bolstered by significant financial

support from the international community. As a result, Morocco’s total fertility rate fell from an estimated 7 children per woman in 1960 to 2.19 children per woman in 2015.

Since Morocco’s independence, the government has accorded paramount importance to family planning. Its first programs aimed to increase awareness of contraception through radio and television commercials and extensive national and local communication efforts and provided free contraceptives in health facilities and via mobile health workers who made home visits. This approach made it possible to reach the residents of remote rural areas.

In 1992, the National Family Planning Program implemented a national information, education, and communication (IEC) strategy involving the various public, private, and non-profit stakeholders and partners, working closely with the other ministries, particularly at the provincial level.

The undeniable contribution of the international community to the success of family planning in Morocco should be underscored. The assistance provided by the international donor community rose from DH 18 million in 1991 to DH 201.5 million in 1997–1998—a remarkable increase of 45.3 percent per year—while state funding increased by an annual average of merely 7.6 percent.\(^{28}\)

**Combatting Infant and Maternal Mortality**

Data from the 2016–2017 National Population and Family Health Survey (ENPSF)\(^{29}\) show that the maternal mortality rate (death of a woman from complications related to childbirth) plummeted from 332 deaths per 100,000 live births in 1992, to 112 in 2010, and 72.6 in 2016. The infant and child mortality rate (deaths among children under 5 years old) also declined sharply over the past three decades from 76 per 1,000 live births between 1987 and 1991 to 22 deaths per 1,000 live births in 2017. The infant mortality rate (deaths among children under 1 year old) decreased from 57 deaths per 1,000 live births between 1987 and 1991 to 18 deaths per 1,000 live births in 2017.\(^{30}\)

Pregnancy monitoring programs have been in place since 1970 initially provided preventive actions only for children before gradually incorporating maternity risk prevention as well. These programs paved the way for achieving these excellent results. In 1987, the country’s pregnancy and childbirth monitoring program introduced the tetanus vaccine, began providing prenatal and postnatal visits, and equipped health centers with birthing beds to encourage women to give birth under medical supervision.

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\(^{28}\) CERED (2011).


\(^{30}\) The reduction in infant mortality will also have a positive impact on the surviving children’s health status in later years.
Building Human Capital

Pregnancy monitoring and assisted childbirth programs organized by the Ministry of Health, as well as integrated care strategies for mothers and their children, have played a key role in curbing infant and maternal mortality and improving their health.

Other programs and activities have also contributed to the achievement of these outcomes. The NHDI, provided ambulances and constructed Dar Al Oumouma centers. Interventions carried out in the health sector with the contribution of the NHDI between 2005 and 2017 included the acquisition of 1,050 ambulances and 124 mobile medical units aimed at providing remote communities with access to health facilities, the building and equipping of delivery rooms and Dar al Oumouma centers where care is provided to expectant mothers, the purchase of medical equipment, and the provision of funding for 158 clinics, 613 health centers and hospitals, and 191 dialysis centers. Following a recent speech by King Mohammed VI calling for an overhaul of the national health system to reduce stark regional disparities, a program was recently (in 2019) launched as part of the NHDI, in collaboration with other partners, designed to improve maternal and child health in three regions in Morocco\(^\text{31}\) that are lagging significantly behind in terms of their health and nutrition indicators.

**Combatting Disease**
Morocco is experiencing an epidemiological transition from communicable diseases and perinatal disorders to non-communicable diseases and trauma.

Structured programs implemented since the 1960s have helped to eradicate many diseases responsible for the previous high mortality rate (such as poliomyelitis, diphtheria, malaria, schistosomiasis, trachoma, neonatal tetanus, and leprosy) and have mitigated the severity of others, maintaining them at very low incidence levels and identifying and taking early steps to control any potential epidemics.

These programs eliminated malaria, which had claimed many lives and wrought economic hardship in rural communities in the 1950s and 1960s, with the World Health Organization (WHO) certifying Morocco as malaria-free in 2010. Schistosomiasis, another major public health issue, was also eliminated in 2005. Trachoma, leprosy, and neonatal conjunctivitis are also well on the way to being eliminated and no longer pose any risk.

However, Morocco is now facing a growing threat from non-communicable diseases such as cardiovascular diseases, cerebrovascular accidents, diabetes, cancer, and chronic respiratory diseases. These are some of the leading causes of death and disability globally and are the result of modifiable lifestyle risk factors such as smoking, poor diet, and lack of physical activity as well as non-modifiable risk factors including age and genetics. During this

\(^{31}\) Those regions are Draa Tafilalet, Marrakech Safi, and Khénifra Béni Mellal. Fourteen provinces were selected to pilot this program. [https://m.hespress.com/femme/444068.html](https://m.hespress.com/femme/444068.html)
epidemiological transition when the global burden of non-communicable diseases is greater than that of communicable diseases, Morocco is facing a double burden of morbidity.\textsuperscript{32}

The WHO-Morocco 2017–2021 Cooperation Strategy indicates that current death rates in Morocco are 104 per 100,000 inhabitants in the case of communicable diseases compared to 597 per 100,000 inhabitants for non-communicable diseases and 37 per 100,000 inhabitants for trauma. The epidemiological transition is well underway as deaths attributable to non-communicable diseases currently account for 75 percent of all deaths. Cancer, metabolic diseases such as diabetes, and cardiovascular diseases account for 40 percent of the leading causes of death.\textsuperscript{33}

Morocco has also been grappling with a significant rise in chronic disease prevalence in recent years. The share of people suffering from at least one chronic disease increased from 18.2 percent in 2011 to 21 percent in 2018 (see Annex Figure 5). The proportion of diabetics rose from 3.3 percent to 4.8 percent, while the percentage of people suffering from hypertension increased from 5.4 percent to 6.8 percent during the same period. Morocco’s routine monitoring system also revealed a sharp increase in the number of hypertensive people and diabetics being treated in primary health care facilities. Based on trends, it is estimated that an average of 300,000 new diabetes cases and 80,000 new hypertension cases are recorded each year in primary health care facilities. The number of diabetics increased from 460,000 in 2011 to 576,000 in 2014, while the number of hypertensive patients rose from 351,000 in 2012 to 540,000 in 2014.\textsuperscript{34}

The 2016–2025 Multisector Strategy for the Prevention and Control of Non-Communicable Diseases (Stratégie Multisectorielle de Prévention et de Contrôle des Maladies Non Transmissibles) is the fulfillment of the commitment made by Morocco and the other member countries of the United Nations to combat non-communicable diseases (NCDs).\textsuperscript{35} The strategy analyzes the NCD epidemiological situation in Morocco and the health care system’s related response. It also provides a detailed description of the strategy’s four areas\textsuperscript{36} and their breakdown into 18 actions and 57 measures. A total budget of this program is estimated around 5.4 billion DH.

Civil society and NGOs have played a key role in combatting NCDs with encouraging results. The Lalla Salma Cancer Prevention and Treatment Foundation is one example of a civil society organization that can serve as a model for other health programs targeting chronic diseases. Since its creation in 2005, the Foundation has been working to improve patient care,


\textsuperscript{33}https://apps.who.int/iris/bitstream/handle/10665/254388/CGS_Maroc_2016_fr_19364.pdf?sequence=5

\textsuperscript{34}https://apps.who.int/iris/bitstream/handle/10665/254388/CGS_Maroc_2016_fr_19364.pdf?sequence=5

\textsuperscript{35}Ministry of Health

\textsuperscript{36}These Strategic Areas are (1) Creating an effective system of cross-sectoral collaboration (2) Reducing the impact of common modifiable risk factors for NCDs on individuals (3) Improving the health system response to NCDs (4) Establishment of a standard framework for epidemiological surveillance, monitoring and evaluation of progress on NCDs. (Source: Multisectoral Strategy of Prevention and Control of NCDs 2016–2015 Ministry of Health 2016).
promote prevention, and make the battle against cancer a public health priority in Morocco. It is also involved in scientific research, expanding partnerships in Morocco and across the globe. The Foundation’s Access to Medicines Program now provides chemotherapy treatment to almost 15,000 low-income patients each year. The Foundation has also helped to establish oncology centers throughout Morocco (for example, in Rabat, Mohammedia, and Fez) and to refurbish and expand existing centers.37

It should also be borne in mind that all necessary treatments for several chronic diseases (Affections Longue Durée or ALD) and debilitating and costly diseases (Affections Lourdes et Coûteuses or ALC) are covered by health insurance. In the case of chronic diseases, the remaining costs to be covered by insured individuals are either partially or fully waived by the same health insurance. The 2016 report from the National Health Insurance Agency (ANAM) showed that 26.4 percent of ALD-related expenses for people with mandatory health insurance (Assurance Maladie Obligatoire or AMO) pertained to terminal chronic renal failure, 24 percent to malignant tumors, 11.7 percent to hypertension, and 11 percent to diabetes.

With respect to Moroccans covered under the subsidized health insurance scheme (RAMED), since the scheme was expanded, it has provided its members with:

- More than 500,000 hospitalizations
- 3.8 million outpatient diagnostic procedures
- More than 1 million specialist outpatient consultations
- More than 880,000 treatments for chronic diseases and debilitating and costly diseases (for example, 7,641 renal failure patients who underwent close to 840,000 hemodialysis sessions.38

University teaching hospitals have had to make a tremendous effort to meet the additional and growing demand created by RAMED beneficiaries. They have had to meet this demand with the same level of human and material resources that they had prior to the expansion of RAMED. In 2014 alone, university teaching hospitals provided treatment to over 187,000 patients suffering from chronic diseases (ALD) as well as debilitating and costly diseases (ALC), admitted more than 118,000 patients, handled 337,000 specialist outpatient consultations, and conducted over 1.5 million medical checkups and outpatient diagnostic procedures.

A Diligent Immunization Policy

The routine immunization of children under the age of 5 against tuberculosis, diphtheria, pertussis, tetanus, poliomyelitis, and measles since the early 1970s has helped to reduce infant

37 The Foundation established “maisons de vie” (temporary living facilities) in several cities across Morocco to provide accommodation for patients and their families during their outpatient treatment, ensure regular monitoring of patients, and provide patients with the necessary moral and psychosocial support. https://www.libe.ma/la-Fondation-Lalla-Salma-continue-sa-lutte-acharnnee-contre-le-cancer_a52390.html 07/24/2014.
38 ANAM (2015).
and child mortality. Vaccination coverage increased from under 50 percent in 1987 to 87.7 percent in 2011.\textsuperscript{39} According to data from the 2018 ENPSF, in 2017, 87.6 percent of Moroccan children were fully immunized (92.7 percent in urban areas and 82.5 percent in rural areas).

The most significant dates in the history of Morocco’s immunization policy are as follows:\textsuperscript{40}

- 1929: Introduction of the smallpox vaccine;
- 1949: Introduction of the tuberculosis vaccine (BCG);
- 1963: Introduction of the combined vaccine against diphtheria, tetanus, pertussis (DTP), and polio (OPV);
- 1981: Introduction of the Expanded Program on Immunization (EPI) and adoption of a national schedule with five antigens (BCG, DTP, and OPV);
- 1987: Restructuring of the EPI into the National Immunization Program (PNI);
- 1999: Introduction of the Hepatitis B vaccine;
- 2003: Introduction of the measles (2\textsuperscript{nd} dose) and rubella (MR) vaccine;
- 2007: Introduction of the Haemophilus Influenzae B vaccine;
- 2008: Introduction of the second DTP-OPV booster;
- 2010: Introduction of the pneumococcal and rotavirus vaccine; and
- Since 2010: campaigns to strengthen the PNI.

From this, it is clear that child immunization has been and continues to be one of the pillars of Morocco’s health policy. A National Technical and Scientific Immunization Advisory Committee was created by ministerial decision on July 6, 2015. This committee is tasked with providing scientific and technical advice to the Minister of Health on: (i) the national immunization policy; (ii) the latest scientific advances, innovations and recommendations relating to immunization; and (iii) requirements regarding revising the national immunization schedule.

This policy has yielded impressive results. As illustrated in Annex Figure 6, the immunization rate in Morocco increased significantly between 2011 and 2017. In a mere seven years, the proportion of fully immunized children rose from 84 percent to 91 percent, with this growth being even greater among rural children.

\textit{A Policy to Promote Access to Medicines}

Morocco is among the few developing countries with a domestic pharmaceutical industry that can meet the country’s demand for medicines. Up until 1997, almost 80 percent of the medicines consumed in Morocco were manufactured domestically.\textsuperscript{41} However, this percentage has declined sharply in recent years. According to the Moroccan Pharmaceutical

\textsuperscript{39} Ministry of Health
\textsuperscript{41} http://apps.who.int/medicinedocs/pdf/s9233f/s9233f.pdf
Industry Association (AMIP), the domestic production of medicines fell in 2006, meeting only 70 percent of domestic demand.\(^{42}\) This proportion had declined to 65 percent by 2012 by which time Morocco was exporting 7 percent of its domestically manufactured medicines.\(^{43}\)

As part of its strategies to increase the access of the poor to health care and services, the government decided in 2014 to lower the price of 1,578 medications and virtually all therapeutic classes. The price reductions for these medicines varied between 20 percent and 80 percent. The medications included:

- Drugs to treat cardiovascular diseases, whose prices were reduced by between 50 percent and 78 percent;
- Drugs to treat metabolic diseases;
- Drugs to treat diabetes;
- Antibiotics (such as ofloxacin and amoxicillin); and
- Antineoplastic medications used to treat cancer.

Furthermore, in the interest of transparency, all medicines that only had a hospital price was also given a public sales price and could therefore be sold legally, if necessary, in a retail pharmacy.\(^{44}\) On February 7, 2019, the list of 60 additional medications whose prices had been reduced (11 brand name and 49 generic) was published in the Official Gazette. Products to treat skin cancer, arthritis, myeloma, diabetes, Hepatitis C, hypertension, and epilepsy were included in this list.

**Health Care Services to Address Significant Geographical Disparities**

Morocco’s health care services are provided by: (i) the public sector; (ii) the non-profit private sector; (iii) the for-profit private sector; and (iv) the informal traditional sector. Health interventions by the state cover:

- Health risk prevention
- Health education
- The promotion of healthy lifestyles
- Health control
- The provision of preventive, curative, palliative, and rehabilitative care.

Health care services in Morocco are currently governed by framework law No. 34–09 (2011) on the health system and health care services.\(^{45}\) Health care services are provided in accordance with a health map and a regional plan for health care services, as set forth in title III of the framework law. The aim of the health map and regional plan for health care services

\(^{44}\)http://dmp.sante.gov.ma/actualiteid-9
\(^{45}\)Official Gazette No. 5962 of July 21, 2011.
is to provide for and foster the necessary changes in public and private health care delivery, with a view to optimally meeting national health care needs, achieving harmony and equity in the geographic distribution of material and human resources, correcting regional and intraregional imbalances, and managing the expansion of health care services.\textsuperscript{46} Figure 4 shows how the system is organized.\textsuperscript{47}

\textbf{Figure 4: Structure of the Moroccan Health System}

This framework law seeks to correct longstanding geographical imbalances in Morocco’s health care services. As recently as 1987, Morocco had only one university teaching hospital. The country currently has five operational university teaching hospitals, which are located in Rabat (a 2,900-bed facility established in 1983), Casablanca (a 1,560-bed facility established in 1983), Fez (an 800-bed hospital built in 2009), Marrakech (a 1,548-bed hospital built in 2010), and Oujda (a 653-bed facility established in 2014). An additional three hospitals are under construction in Agadir, Laayoune, and Tangier. Morocco also has two private university teaching hospitals (in Casablanca and Rabat). It bears noting that university teaching hospitals are established by grouping together existing hospitals rather than by building new ones.

\textsuperscript{46} Article 20.
\textsuperscript{47} https://www.slideshare.net/adilnadam/le-systme-de-sant-marocain
The regional distribution of these university teaching hospitals is aimed at rebalancing health care services across Morocco. This process has occurred in tandem with an increase in the number of medical, dental, and pharmaceutical schools in a bid to boost the country’s health care workforce. Medical degree programs in Morocco vary in length from seven years for general medicine to 12 years for specializations. Morocco currently has roughly 12 medical schools located in Rabat, Casablanca, Fez, Marrakech, Agadir, Tangier, and Oujda.

Despite the undeniable growth of the private health sector, particularly in recent years and in certain fields, the state has been the leading health care provider since independence. In January 2018, there were more general practitioners and specialists in the private sector (12,142) than in the public sector (11,232). However, in terms of bed capacity, as illustrated in Table 5, the 356 private clinics had 9,719 beds while the public sector had 148 hospitals with 21,692 beds, 10 psychiatric hospitals with 1,146 beds, and 106 hemodialysis centers with 1,195 dialysis machines. The state continues to make investments in order to provide the human and material resources needed to guarantee health care for all Moroccans, while encouraging the development of private health services to help to reduce existing geographical disparities, in accordance with framework law No. 34–09.

### Table 5: Health Care Services in Morocco

<table>
<thead>
<tr>
<th></th>
<th>General practitioners</th>
<th>Specialists</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Public</strong></td>
<td>3,818</td>
<td>7,414</td>
<td>11,232</td>
</tr>
<tr>
<td><strong>Private</strong></td>
<td>4,624</td>
<td>7,518</td>
<td>12,142</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>8,442</td>
<td>14,932</td>
<td>23,374</td>
</tr>
</tbody>
</table>

- **Private clinics**
  - Number of clinics: 356
  - Number of beds: 9,719
- **Public hospitals**
  - Number of hospitals: 148
  - Number of beds: 21,692
- **Public psychiatric hospitals**
  - Number of hospitals: 10
  - Number of beds: 1,146
- **Public hemodialysis centers**
  - Number of centers: 106
  - Number of machines: 1,195


**Mandatory Health Insurance Supplemented by Assistance for Poor Households**

Morocco has had a longstanding commitment to providing universal health care coverage in order to ensure that all Moroccans have access to health care and health services. This commitment was bolstered in 2002 by Law 65.00 on the Basic Medical Coverage (CMB) (See Figure 5).

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Figure 5: How Basic Health Care Coverage (CMB) Works


Basic medical coverage is provided through two plans: mandatory health insurance (AMO) and the subsidized health insurance scheme (RAMED). Under the law, mandatory health insurance is available to all employees in the public sector (whose cases are managed by the National Social Insurance Fund or CNOPS) and in the private sector (whose cases are managed by the National Social Security Fund or CNSS). Following the implementation of a pilot in one region (see Box 3), RAMED was rolled out in all regions of the country in 2012, in order to provide coverage to poor families who are not covered under the AMO.
Box 3: The RAMED Pilot Project in the Tadla-Azilal Region

Before its extension in 2012 to all regions of the country, the RAMED subsidized health insurance scheme was rolled out as a pilot project in the Tadla-Azilal region between 2008 and 2010. The objective of RAMED is to provide poor and vulnerable populations with free access to the range of health services available in public hospitals. A number of procedures are used to determine eligibility, including their location and self-reported as well as a score based on the socioeconomic conditions of households. This targeting method was designed to overcome the shortcomings of the former system that relied on certificates of indigency.

The RAMED program is part of the government’s social protection policy and benefits more than 8.5 million low-income beneficiaries (28 percent of the total population). Of this total, an estimated 4 million people living in extreme poverty are eligible to access health care completely free of charge. The remaining estimated 4.5 million vulnerable individuals benefit from subsidized care and are required to make an annual contribution of DH 120 per person, with the total per family capped at DH 600.

This new social protection program covers the medical and surgical services provided at health centers, as well as at local, provincial, prefectural, regional, and university hospitals and specialized hospitals. Emergencies and hospital admissions are also covered.

The pilot project targeted an eligible population of approximately 420,000 people across a geographical area comprising 1.5 million people. The pilot has had mixed results, especially in the following areas:

- The mechanisms for identifying low-income people were found to be accurate.
- Beneficiaries had a high level of satisfaction with the program.
- Service costs were not really reduced for the users;
- Higher pressure of demand on public health facilities.

RAMED was introduced to close the critical health care access gaps faced by poor and vulnerable population groups. In the past, poor people needed a certificate of indigence to enable them to access free health services in regional hospitals. However, this mechanism had several limitations: the opaqueness of the eligibility criteria and the subjectivity of many eligibility decisions; (ii) each certificate being valid only for one episode of care; (iii) the exclusion of family-based care and other services, especially emergency care, from the

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scheme; and (iv) the lack of financial stability of the system as hospitals were not allocated budgets specifically to provide care to individuals with certificates of indigency.

These limitations prompted the government to adopt a comprehensive reform of the health system, including the creation of RAMED, a subsidized health insurance scheme. The reform had several aims:

- Overcoming barriers to accessing health care and reducing catastrophic health expenditures
- Expanding health care coverage to all poor and vulnerable households
- Extending the duration of access under RAMED to three years (if classified as poor) or one year (if classified as vulnerable) based on the beneficiary’s estimated standard of living
- Providing free or subsidized coverage to RAMED beneficiaries
- Making eligibility criteria more transparent
- Making patients more accountable by requiring them to follow a specific care protocol
- Introducing billing for health care services in order to make hospitals solvent.

Figure 6 illustrates the distribution of basic health care coverage (Couverture Médicale de Base or CMB) among the total population in 2015. It shows that 40 percent of the population was not covered by any scheme. The AMO covered 17 percent of the population, schemes provided by employers covered 5 percent, and private insurance covered 11 percent. RAMED\(^{30}\) covered 28 percent of the population as of 2015. Efforts are continuing to ensure the coverage by some type of health insurance of liberal professionals (such as architects, lawyers, and physicians), self-employed workers, and all other population categories who are currently not covered.

\(^{30}\)There were 10.4 million RAMED beneficiaries in 2016 from over 4 million households. Of these, 7 million had valid cards, according to the 2017 draft budget law from the Ministry of Health.
3. Challenges Facing Morocco in Education, Health, and Other Aspects of Human Capital

As demonstrated above, Morocco has made considerable progress in health and education, as well as in various other aspects of human development, particularly over the past twenty years.

Nevertheless, the country still has a long way to go to bridge the gap that separates it from developed countries. There is still a lot of work to be done, especially to address the challenges in the health and education sectors, which are the two key drivers of human development.

Furthermore, the interaction between these two factors must be borne in mind, as health depends on education and vice versa. They also have a direct impact on employment while other factors, such as transport infrastructure, living conditions, housing, and nutrition, are also key determinants of human capital. This means that the Government of Morocco will need to pursue an integrated, multisectoral policy to develop the required human capital in its future generations.

Education

Education is a vital prerequisite for human capital accumulation. As stated earlier, the Moroccan education system has made considerable progress in terms of increasing access to education, but it continues to face a number of challenges.
Morocco

_Thousands of Children Still Not in School_

Despite a growing awareness of its critical importance, preschool education is still the weak link in the national education system. The net preschool enrollment rate for children aged 4 to 5 remains below 50 percent for the country as a whole. Moreover, there are considerable variations in enrollment between different parts of the country, which is creating inequalities in opportunities later in the education system.

In addition, an extremely high number of school-age children are currently not in school for a variety of reasons. The transition rate from primary to lower secondary school remains extremely low. By cross-checking different variables, such as access to secondary and higher education, categories of per capita household expenditure, and public expenditure allocations to different levels of public education, it becomes clear that members of the most privileged social classes are the biggest beneficiaries of the education system. For example, 29 percent of pupils enrolled in secondary and higher education come from the 20 percent most well-off households compared with only 10 percent from the most vulnerable 20 percent of households.

_Extremely Low Average Years of Schooling_

The average number of years of schooling in Morocco is only 5.64 according to the CSEFRS. This average is low even in comparison with Morocco’s immediate neighbors. For example, the equivalent figures in Tunisia and Algeria are 7.5 and 6.7 years. The rate is even lower when compared to rates in other developing countries such as Malaysia (10 years) and Mexico (9.8 years). This negative performance may be partly due to Morocco’s high school dropout rate, particularly in the final years of secondary school. This phenomenon has a clear negative impact on the competitiveness and productivity of human capital in Morocco. When one considers that not all time spent in school is translating into time spent learning the challenge becomes even starker.

_Significant Inequalities at Different Levels_

Regardless of what approach or indicators are used, the Moroccan education system is marked by significant inequalities of both opportunity and outcome to the detriment of children from poor backgrounds and those whose parents have a low level of education. According 2014 figures from the CSEFRS, Morocco’s inequality years of schooling as measured by the Gini index (which measures inequality) was 0.555, far higher than those of other countries of the region, such as Egypt (0.374), Tunisia (0.36), and Turkey (0.28).

_Inefficiencies and Low Quality_

While Morocco has made positive progress in terms of quantitative education indicators, the quality of learning is still low. For a variety of reasons, the education system is in a state of perpetual crisis. The educational outcomes of children exiting the system are generally low and are clearly inadequate in terms of meeting the skill and knowledge needs of the labor market. The unemployment rate among graduates speaks volumes in this regard, even if
Building Human Capital

thousands of graduates of the system perform well in different positions, both in Morocco and outside the country. Each year thousands of students drop out of university without receiving their degree.

In 1999, on the day following his accession to the throne, King Mohammed VI declared: “...despite the unrelenting efforts made over four decades to enable our education system to support the recovery of our independence and the building of our independent nation, we recognize that it remains in a state of chronic crisis.” This sums up the challenges highlighted in this case study.

All the available data show that pupils in the Moroccan education system do not acquire the basic knowledge required at each level in relation to reading and mathematics. Figures from international surveys (PIRLS and TIMSS) show that only 21 percent of 10-year-old Moroccans master the basic elements of reading, compared to a global average of 87 percent. An evaluation on school outcomes done in 2008 by the CSEFRS shows that Moroccan students assimilate less than 30 percent of the teaching across all disciplines. Furthermore, the results of international tests (PIRLS and TIMSS) confirm the continuing decline of education quality in Morocco. The number of years of schooling, adjusted for education quality, was barely 6.2 in Morocco compared with 6.8 in Algeria, 6.3 in Tunisia and Egypt, and 7.6 in Jordan.31

**Ineffective and Uncoordinated Plans and Strategies**

Many of the strategies and programs that have been implemented have proved to be ineffective. For example, the “Emergency Plan” for the sector was acknowledged to be a complete failure by the country’s highest authorities. In his address on August 20, 2013, King Mohammed VI explicitly deplored the lack of results and lack of continuity in the actions of successive governments, as well as the failure to build on the achievements of their predecessors.

In the final analysis, it is clear that the problem facing the Moroccan education system is, by its nature, structural. The government must intervene urgently and effectively to rectify the situation in this sector that is so essential to the country’s human, economic, and social development. It will have to start treating education as the main engine of development. The vision and strategy to be developed will have to be carefully integrated, and priorities will also need to be established to ensure the success of each stage in the process.

**Discussions Underway on New Reforms**

Starting at the preschool level and through primary, lower secondary, and upper secondary school to vocational training, targets should be set for the optimal acquisition of competencies that the labor market will require in the future and that will significantly enhance the competitiveness of Moroccan students. The details of the operational measures to be taken in relation to each education cycle are obviously critical but are outside the scope

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31 According to the HCI database.
of this case study. Furthermore, several national and international institutions have already made specific efforts in this regard. The suggestions that we make here are merely broad outlines of the actions that could be developed in this area:

1) Make public schools open to all and free of charge to avoid exacerbating inequalities and determine the role to be played by the private education sector. There have been extensive discussions on this issue recently after the government signaled that it might consider imposing registration fees for public education, without specifying when, how, or where they would apply. This motion was largely interpreted as the beginning of the end of free education in Morocco. In 2016, the CSEFRS outlined its serious reservations about such an approach on the grounds that it could further exacerbate the current inequalities of the Moroccan education system. Similarly, a 2014 UN report on the right to education made it unequivocally clear that the way in which the private education sector had developed in Morocco represented a threat to the equal right to education. “The increasing privatization of fees, in favor of schools in Morocco motivated by profit, for example, leads to discrimination and inequalities in education for children from disadvantaged backgrounds by creating a system that favors those who have financial means over the ‘have-nots,’ and heightening the risk of developing a two-speed education system. Furthermore, research has shown that the support mechanisms designed to provide low-income parents with the means to choose a private school actually end up promoting social differentiation.”

2) Redesign the curricula and pedagogical programs at all education levels. These new curricula and programs should reflect the needs of the modern world and the knowledge economy and should be based on the acquisition of skills needed by the current and future labor market.

3) Reconsider the language of instruction. This is an issue that is still a problem in Morocco and one that is the subject of extensive discussions. The change in the language of instruction from Arabic to French in the transition from upper secondary school to university has proved to be catastrophic, as noted unequivocally by the CSEFRS. It has been an obstacle to effective learning and has negatively affected the productivity of graduates in the job market. This is a major challenge that has to be overcome for the good of the Moroccan education system and its economy.

4) Fundamentally review the method of selecting, training, evaluating, promoting and even remunerating teachers. The CSEFRS has shown that, over time, the recruitment of teachers without sufficient or appropriate teacher training has had a negative impact on the quality of education and its performance in Morocco. Absenteeism by teachers also needs to be reduced, particularly in rural areas.

52 UN (2014)
5) *Introduce, disseminate, and expand the use of information and communications technology at the different education levels.* It is necessary for the education system to keep pace with the technological and skills requirements demanded by the labor market now and in the future, meaning that education and training need to anticipate these needs in order to satisfy them on time.

6) Redesign and rollout the 2021 National Vocational Training Strategy (Stratégie Nationale de la Formation Professionnelle or SNFP). This can be done by streamlining and integrating it appropriately with the 2015–2030 Strategic Vision for Education Reform (Vision Stratégique de la réforme de l’éducation). This will require the vocational training sector to be expanded and to become more flexible, attractive to potential students, and better adapted to the real needs of the labor market. The increase in the unemployment rate among vocational training graduates (as outlined in the figures provided by the HCP) shows quite clearly that the existing programs are not meeting the demands of the labor market. Various internal and external evaluations have shown that unemployment rates tend to rise among graduates as they attain a higher level of training from vocational training institutions. As a result, and in accordance with the instruction of King Mohammed VI in February 2019, the government has launched a complete overhaul of vocational training. In setting the stage for this overhaul, the King emphasized “the need to adopt a realistic approach to establishing a truly comprehensive program of vocational training credentials and to modernizing degree courses and teaching methods.” This will require the upgrading of vocational training courses as well as extensive modifications to higher education degree courses. A complete roadmap for the sector has been prepared and a high-level steering committee has been set up to monitor the implementation of the King’s directives in this area. There are also plans to construct job counselling, guidance, and training complexes, so-called “Cités des métiers,” and to roll them out on a phased basis across the country’s 12 economic regions. The centers will offer training in a variety of areas, such as aeronautics, the automobile industry, agriculture, tourism, handicraft, and health. The plan is for the “Cités” to be financed through public-private partnerships. One of the first steps in implementing the centers was to identify what skills would be in demand in all sectors over the next five to ten years. The aim is to produce graduates with the skills to meet the real needs of the Moroccan economy. Ways to transfer between general education and vocational courses also need to be implemented.
7) Undertake an in-depth review of the future of higher education and scientific research in the country that addresses issues of quality and international competitiveness. This will require the examination of a number of areas in the context of the 2015–2030 Strategic Vision for Education Reform. Every effort will have to be made to ensure that they are rolled out effectively. Experience has shown that the Bachelor’s-Master’s-Doctorate (LMD) system, which has not really been evaluated more than 15 years after it was put in place, has a number of shortcomings that need to be examined (see Box 4). Nevertheless, abrupt policy reversals should be avoided, and the review should seek to capitalize on the positive achievements from previous reforms and find ways to complement them.

**Box 4: Higher Education Reforms**

Higher education has almost always been considered as a separate case in the various reforms of the Moroccan education system. This does not mean, however, that it has always been completely ignored.

In 1997, for example, for the first time in the history of independent Morocco, a Ministry of Higher Education was created. Prior to that date, this sector had always been under the umbrella of the Ministry of National Education. The move was seen as a very good sign of the government’s commitment to this sector. In the same year (1997), the regulations governing professors-researchers, which were first enacted in 1975, were changed in response to longstanding trade union demands. These changes were made in conjunction with two other reforms. The first redefined the degrees awarded in higher education, while the second changed the procedures for recruitment and promotion at universities and colleges. A National Accreditation and Evaluation Commission (CNAE) was also established to oversee the process of accrediting the degrees being offered. However, in general, these actions were quite limited.

In 2004, the government undertook a much more in-depth reform of higher education. This pedagogical reform set up the Bachelor’s-Master’s-Doctorate (LMD) system in Morocco, in keeping with the practice used in a number of European countries. It was designed as a part of the National Education and Training Charter. For the first time in this subsector, this reform and this charter went beyond the framework of “management development” that had been the traditional role played by the country’s institutions of higher learning. The Charter made explicit reference to the following objectives:

- Skills training and promotion, as well as the development and dissemination of know-how in all fields of knowledge
- Support for the scientific, technological, professional, economic, and cultural advancement of the nation, while taking account of the country’s needs in the areas of economic and social development
• Mastery in, and the development of, science, technology, and know-how (savoir faire) through research and innovation
• Promotion of Morocco’s cultural heritage and the projection of its ancestral values.

In both its design and implementation, the reform initiative tended toward a participatory and decentralized approach. One of the main benefits of this reform was its strengthening of the autonomy of university institutions in the decision-making process.

In 2009, the government revised the pedagogical component of the reform, partly to support its “Emergency Plan.” Its main thrust was to strengthen certain degree courses and to enhance the professionalism of others. It was in this context that Morocco had adopted the training program known as “10,000 engineers and related professionals” per year to meet the demands of the various sector plans and government initiatives. The revisions undertaken were generally very limited in scope and did not really rise to the level of a “reform.”

In 2014, following a review of the quality of higher education, the Bachelor’s level was revised to include proficiency by students in languages and in information and communications technology. This led to revisions to the List of National Pedagogical Standards (CNPN) for this degree level.

Finally, between 2014 and 2016, initiatives were launched to enable universities to enter into ad hoc contractual arrangements with the government. These contracts were based on the two management concepts of results-based management and accountability. Also, in 2014, the government established the National Evaluation and Quality Assurance Agency (ANEAQ) for Higher Education and Scientific Research as a tool to monitor and improve the governance of institutions of higher learning.

**Timeline of Key Actions in Higher Education Since the 1990s**

<table>
<thead>
<tr>
<th>Education Reform</th>
<th>Pedagogical Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>2009</td>
</tr>
<tr>
<td>Higher Education System Reform</td>
<td>Pedagogical Standards Review</td>
</tr>
<tr>
<td>2004</td>
<td>2014</td>
</tr>
</tbody>
</table>
Health

Notwithstanding the improvements made in the area of health over the past 20 years, it is clear that major challenges remain in relation to health care services, as well as to health insurance coverage (mandatory and subsidized), the burden borne by households for out-of-pocket spending, and the inadequate health budget. Furthermore, the government will have to address the inequalities that exist among population groups and among regions, the burden of chronic diseases that is increasing with each passing year, and the risks associated with emerging and re-emerging diseases as well as with environmental threats and psychosocial issues.\(^{53}\)

Insufficient and Inequitably Distributed Health Care Services

One of the main problems related to health services is that there just are not enough of them, even more so in some areas than others. A second issue relates to the substantial disparities in access that exist between cities and rural areas, as well as among different regions of the country.

Morocco is one of the countries whose health care services are below the critical thresholds established in WHO standards, as illustrated in Table 6. For example, in terms of mental health services, Morocco provides less than one bed per 10,000 inhabitants, substantially below the global average of 4.4.

<table>
<thead>
<tr>
<th>Number per 10,000 inhabitants</th>
<th>Morocco</th>
<th>Algeria</th>
<th>Tunisia</th>
<th>Libya</th>
<th>Spain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors</td>
<td>6.2</td>
<td>12.1</td>
<td>11.9</td>
<td>19</td>
<td>37.1</td>
</tr>
<tr>
<td>Paramedics</td>
<td>8.9</td>
<td>19.5</td>
<td>32.8</td>
<td>68</td>
<td>51.6</td>
</tr>
<tr>
<td>Hospital beds</td>
<td>11</td>
<td>17</td>
<td>21</td>
<td>31</td>
<td>32</td>
</tr>
</tbody>
</table>

*Source: Chauffour (2018)*

Furthermore, contrary to international recommended practice, primary care has always received and continues to receive fewer resources (financial, human, and material) than hospital care in Morocco.

The disparities between the cities and rural areas as well as among the country’s regions have long been a defining factor in health care services in Morocco, and it does not appear that these disparities have been sufficiently overcome. For example, at the end of 2015, the average bed occupancy rate was 63.8 percent, but this national average varied between 43.1 percent and 78.8 percent by region.\(^{54}\)

Rural areas also lag significantly behind cities in terms of births attended by skilled health personnel. At the national level in 2018, 86.6 percent of women gave birth attended by a

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\(^{53}\) Ministry of Health (2012).
\(^{54}\) High Commission for Planning (2018).
skilled health professional. Whereas almost all births in urban areas (96.6 percent) were attended by skilled health personnel, the equivalent percentage of rural births was 74.2 percent, meaning that around a quarter of women in rural areas still do not benefit from this service according to data from the 2018 ENPSF. The availability of prenatal care services provided by skilled health personnel varies by region, ranging from 73 percent in the Dakhla-Oued Eddahab region to 37 percent in the Béni Mellal-Khénifra region.

**Mandatory Health Insurance Still Incomplete**

Morocco has been implementing a mandatory health insurance (AMO) scheme since 2005 by instituting automatic affiliation for public sector workers and by requiring membership by all private sector salaried workers. The employers of private sector salaried workers are obliged by law to declare their full complement of staff to the National Social Security Fund (CNSS) and to pay half of their insurance premiums with the other half being paid by the worker.\(^{35}\)

With the aim of expanding coverage, the government has established a health insurance system for students in higher education and vocational training. In 2016, about 56,404 students were enrolled in this AMO student scheme, 12 percent of whom were in higher education and the remaining 88 percent in vocational training.\(^{36}\) This means that less than 20 percent of the students targeted at the start of the AMO student scheme were actually covered, out of an estimated student population of 288,815 in 2015–2016.

In view of the high number of poor and vulnerable individuals in the Moroccan population who are not eligible for the AMO, the government established RAMED, an assistance system for disadvantaged households that provides free or subsidized access to basic health services provided by public sector institutions. This system targets around 28 percent of the country’s population.

Currently, the biggest challenge to basic health insurance is how to provide coverage to independent workers (self-employed) and those in the liberal professions (private physicians, lawyers, etc). The legislation to extend AMO to these workers has only recently been adopted, but implementation is not expected to be easy.

It should be noted once again that the process of reforming Morocco’s health system is a cumbersome one, and there is always a risk of losing sight of the strategic objectives. It appears that, with the AMO having been launched 15 years ago and RAMED 7 years ago, there is an even greater level of expectation among the citizens. These expectations are not confined simply to access but relate also to questions of inequality. However, as long as a sizeable section of the population is not effectively covered by the AMO, then there will be

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\(^{35}\) However, the system for monitoring these declarations is not perfect. The CNSS deploys monitoring missions, as far as it is able, to detect and try to address any non-declarations or under-declarations. This means that there are some individuals who qualify for mandatory health insurance remain without coverage.

\(^{36}\) ANAM (2016).
very little chance of implementing the RAMED system correctly.\textsuperscript{57} especially since RAMED, despite its laudable objectives, is plagued by a number of problems involving targeting, financing, and its expected impact on the supply and demand for health services.

This shows quite clearly that, for the reform of basic health care coverage to succeed, the government will have to have the political will to adopt firm and far-reaching provisions to bring it into effect. Two inter-ministerial committees were recently created under the direct purview of the Head of Government, one to steer the reform of health insurance and the other a technical committee. These committees should be given the authority to facilitate the level of inter-ministerial collaboration needed to develop a common and coherent approach to the extension of health care coverage. This initiative should be complemented by consultations with the other stakeholders in the sector, such as patients, health care providers (including private providers), and private insurers.\textsuperscript{58}

**Multiple Inefficiencies Related to RAMED**

RAMED has swiftly increased the health care coverage rate from almost one-third to over half of the country’s population. However, it is strongly suspected that the program suffers from significant errors of inclusion and exclusion in terms of its targeting of poor and vulnerable populations. Indeed, the government is currently re-examining the RAMED provisions in their entirety (targeting, access, structure, governance, financing), following several evaluation studies conducted by various agencies and departments.

There are a number of questions surrounding RAMED. First, it was considered essential (by institutions like ONDH, CESE and by the government itself) to review the methodology used for establishing the procedures for targeting the beneficiary population. Second, the fact that the number of beneficiaries has increased rapidly and that they are entitled by law to access the health care, medicine, facilities, and services available (only) in the public sector health establishments has put heavy pressure on these facilities (particularly hospitals) to meet the increased demand. This has made it difficult for them to respond appropriately to the needs of beneficiaries, leading to increasingly long wait times for appointments and patients having to pay for private sector services for scans and other treatment. Furthermore, the cost recovery response brought about by this level of demand, especially for public hospitals, also presents a number of difficulties (Even funds expected to be provided by the state are not regularly disbursed. See Table 7).

The National Human Development Observatory (ONDH\textsuperscript{59}) conducted an evaluation of RAMED and concluded that the proposals emanating from the RAMED pilot were not taken on board when the scheme was scaled up across the country. These proposals included the need for: (i) more transparent eligibility criteria to ensure equitable access to RAMED; (ii) an

\textsuperscript{57}As mentioned before, around 40 percent of the country’s population is still not covered by any scheme, despite the very large number of beneficiaries that were quickly covered by RAMED.  
\textsuperscript{58}Chauffour (2018).  
\textsuperscript{59}A public institution in charge of the evaluation of human development public policies. www.ondh.ma
integrated information system to monitor services taken up by beneficiaries; (iii) a clear strategy to modernize health care services; and (iv) an appropriate management and financing processes to secure sustainable financing for RAMED and to control expenditure. The issue of the scheme’s viability was brought to the fore in 2014 when the number of RAMED cards distributed increased very rapidly (a two-fold increase in one year up to 6.5 million people), even though there had been no increase in the supply capacity (human-material) number of health care services. The resource levels provided over the years to finance RAMED have not been sufficient to meet the need for free or subsidized health insurance. In 2013, RAMED’s total costs were DH 5.3 billion, while actual financing was below DH 1.4 billion, as indicated in Table 7.

**Table 7: Planned and Actual Expenditure on RAMED by Source of Financing (in billions of DH)**

<table>
<thead>
<tr>
<th>Source of Financing</th>
<th>Forecast</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Cost</td>
<td>5.32</td>
<td>1.40</td>
</tr>
<tr>
<td>State</td>
<td>5.09</td>
<td>1.20</td>
</tr>
<tr>
<td>Vulnerable groups</td>
<td>0.04</td>
<td>0.04</td>
</tr>
<tr>
<td>Local authorities</td>
<td>0.19</td>
<td>0.16</td>
</tr>
</tbody>
</table>

*Source: ANAM and 2013 actuarial report, RAMED Assessment Report, ONDH (2017).*

**Large Household Contribution to Health Care Costs**

One of the main aims of Morocco’s health care policy is to lessen the financial burden on households of paying for health care. The costs borne by households have not declined significantly over the last two decades, and this is a key factor determining the extent to which they can afford to access and use health services. The national health accounts for 2015 show that households continue to bear half the total costs of health services in Morocco.\(^{60}\)

While this share has decreased slightly over the past few years (50.7 percent in 2013 down from 53.6 percent in 2010\(^{61}\)), it is still very high compared to countries at a similar level of development. For example, the equivalent figures for Tunisia and Lebanon are 36.4 percent and 37.5 percent respectively. The share of health care costs borne by households in Egypt is as high as in Morocco, but this share is only 26.4 percent in Algeria and 22.5 percent in Jordan. Of course, this figure is much lower in most of more developed countries.

\(^{60}\) Ministry of Health (2015).

Morocco

Insufficient Share of GDP Allocated to the Health Sector
As a percentage of GDP, total expenditure on health care is also slightly lower in Morocco than in comparator countries (see Table 8). Box 5 examines whether the public financial management system in the country is conducive to efficient and effective service delivery.

Table 8: Morocco’s Level of Health Expenditure Compared to Other Countries, 2013

<table>
<thead>
<tr>
<th></th>
<th>GDP per capita in international $</th>
<th>Total health expenditure per capita in international $</th>
<th>Total health expenditure-to-GDP ratio (%)</th>
<th>Ratio of direct expenditure by households to total health expenditure (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Turkey</td>
<td>18,701</td>
<td>1,007</td>
<td>5.4</td>
<td>16.8</td>
</tr>
<tr>
<td>Egypt</td>
<td>10,383</td>
<td>567</td>
<td>5.5</td>
<td>56.2</td>
</tr>
<tr>
<td>CNS Morocco</td>
<td>7,575</td>
<td>436</td>
<td>5.8</td>
<td>50.7</td>
</tr>
<tr>
<td>WHO Morocco</td>
<td>7,224</td>
<td>429</td>
<td>5.9</td>
<td>59.2</td>
</tr>
<tr>
<td>Iran</td>
<td>16,095</td>
<td>1,045</td>
<td>6.5</td>
<td>47.1</td>
</tr>
<tr>
<td>Lebanon</td>
<td>15,573</td>
<td>1,033</td>
<td>6.6</td>
<td>37.5</td>
</tr>
<tr>
<td>Algeria</td>
<td>12,055</td>
<td>859</td>
<td>7.1</td>
<td>26.4</td>
</tr>
<tr>
<td>Jordan</td>
<td>10,550</td>
<td>763</td>
<td>7.2</td>
<td>22.5</td>
</tr>
<tr>
<td>Tunisia</td>
<td>10,978</td>
<td>797</td>
<td>7.3</td>
<td>36.4</td>
</tr>
<tr>
<td>France</td>
<td>37,801</td>
<td>4,370</td>
<td>11.6</td>
<td>6.4</td>
</tr>
<tr>
<td>USA</td>
<td>53,190</td>
<td>8,988</td>
<td>16.9</td>
<td>11.5</td>
</tr>
</tbody>
</table>


Box 5: Is the Public Financial Management System Conducive to Efficient and Effective Service Delivery?

The Moroccan public finance management (PFM) system’s performance meets the objectives of fiscal discipline. However, it requires more attention for the achievement of the strategic allocation of resources and provision of quality public services objectives.

Despite some delays in the implementation of the major investment projects, budget programming is credible and budget execution benefits from an adequate information management system, as well as, from robust internal controls.

The Supreme Audit Institution (SAI), whose independence is well guaranteed, ensures an effective ex-post control. However, multi-year budget planning, execution and management; financial supervision and internal and external risks control, as well as revenue collection and the production of annual financial statements, could still be improved.
A more strategic allocation of public resources remains a priority for the Government. While Ministries now possess sectoral strategies, these are sometimes unaligned with the budgets. Multi-year budgetary programming is at an early stage of implementation. Consequently, strategic priorities are not budgeted rigorously.

The PFM Organic Act introduced a performance-based approach and provides targets and indicators on the quality of the services. In order to translate the ambitions of the PFM Organic Act in improving the quality of public services, several conditions must be met including a better programming of large-scale investment in line with specific sector needs, both at the central and decentralized levels. Also, the ongoing deployment of the new performance-based approach and reporting tools, such as performance contracts, must be accompanied by a thorough change management process and a conducive environment which will spearhead players’ incentives. In addition, budget documents (annual performance plan, performance reports on budget execution, and related performance indicators) should be made available to the public to account for the public action on the provision of public services. Lastly, the State must reinforce its oversight on the external operators by moving from traditional financial supervision to operational supervision with a focus on the provision of improved basic public services by these operators. To this end, the PFM Organic Act offers an opportunity to better track of the public service providers’ resources and performance, including from the point of view of efficiency and quality of services.


In summary, any real reform of Morocco’s health system will need to overcome multiple challenges including the need to: (i) extend coverage to the informal sector; (ii) overcome the current shortage of human resources and their uneven distribution among the regions; (iii) encourage successful public-private partnerships, which have great potential but are difficult to manage effectively; (iv) extend the RAMED essential health care package to cover all service providers, not just those in public sector facilities; (v) conduct an economic assessment of funding for the RAMED package of health care benefits; (vi) mobilize more financing for health care at the national level to reduce the significant out-of-pocket expenditures currently incurred by households and to effectively finance RAMED to deal with the rise in ALD and ALC; (vii) improve the governance of the system, possibly via regionalization; and (viii) develop an information system that would enable meaningful monitoring and evaluation at various levels.62

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Other Aspects of Human Development

Education and health are the main pillars of human capital, and the two are interconnected. However, they both affect and are affected by other drivers of human development that policymakers must take into account when designing broad strategies to build Morocco’s human capital.

To guarantee an adequate level of good quality education and good health for future generations and thus enhance their productivity, it will be necessary to address the structure and operations of the labor market, early childhood development, housing conditions, transport infrastructure, and so-called health risk behavior. Therefore, it is being increasingly recommended that all aspects of human capital development be viewed as a whole when devising public policies.

The Labor Market

In Morocco, there has been a continuous decline in rates of economic activity in recent years. It is estimated that the population aged 15 or older consists of around 26 million people as of 2018. Of this total, 12 million are of working age, with around 11 million being employed and 1.2 million unemployed. This means that a total of 14 million people remains outside the labor market. Between 2017 and 2018, the population in activity age (aged 15–59 years) increased at a rate of 1.7 percent. The economically active population increased by only 0.5 percent over the two years.63 HCP data show that the economic activity rate fell from 46.7 percent in 2017 to 46.2 percent in 2018, from 42.4 percent to 41.8 percent in urban areas and from 54.1 percent to 53.9 percent in rural areas.

A key feature of the labor market in Morocco is then the persistently low employment rates for women. The economic activity rate for men is 70.9 percent, while the rate for women is only 22.2 percent. In urban areas, only 14 percent of women of working age have a job. Furthermore, despite the recent improvements made in terms of educational achievement and qualifications, the employment rate has remained low even among young women between the ages of 25 and 35 (19 percent). This is a factor that could hamper the country’s growth and development.

In terms of Morocco’s recent job creation track record, between 2000 and 2014, the economy generated around 1.66 million non-agricultural jobs. Only two sectors have accounted for more than one-third of these new jobs: (i) construction and (ii) catering and hotels. During this same period, average annual net job creation stood at approximately 110,000 jobs. Between 2010 and 2015, this average number dropped to 66,000 jobs, but between 2016 and 2017, this increased to 86,000 jobs and in 2018 to 112,000 jobs (91,000 in urban areas and 21,000 in rural areas). In terms of employment by sector in 2018, 19,000 jobs were created.

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63 The data used are the most recent HCP data on the labor market in Morocco, rounded to the nearest million. The HCP is the official source of data on the subject and includes the findings of numerous surveys, including Employment Surveys.
in agriculture, forestry, and fisheries; 18,000 in industry and crafts; 65,000 in services; and 15,000 in construction and public works.

As for employment, between 2017 and 2018, the number of unemployed people dropped from 1,216,000 to 1,168,000, a decrease of 48,000 (25,000 in urban areas and 23,000 in rural areas). The highest unemployment rates were for women (14 percent), university graduates (17.1 percent), and youths aged between 15 and 24 (26 percent).

Morocco’s labor productivity remains low in relation to that of comparable developing countries, hampering companies’ ability to contend with international competition in both domestic and external markets.

This is compounded by the low levels of skills and qualifications of Morocco’s workforce, which is linked to and may even be the cause of low productivity. Meanwhile, underemployment is becoming increasingly widespread. In the same vein, the proportion of unpaid work remains high in relation to countries at a comparable level of development, and there has been a marked increase in informal employment.

The historic low quantity and quality of education in Morocco has yielded a workforce with a low education level. For example, in 2018, 57.8 percent of workers did not have a diploma or degree; 28.6 percent only had a secondary school diploma; and only 13.6 percent had a higher education degree. The educational level of the agricultural workforce is even lower. Also, 72.2 percent of self-employed workers do not have a diploma or degree, compared to 44.2 percent among salaried workers.

In principle, this situation can be expected to improve in the future as a result of greater educational attainment and quality improvement in recent years, which will be necessary to produce workers with the high levels of qualifications that are increasingly in demand in the modern knowledge economy.

**Early Childhood Development**

Investments in early childhood are an important aspect of human development as has been recommended by many international institutions, such as the World Bank, WHO, and UNICEF. These investments are critical for the three reasons. First, they yield a very high return. Second, it is difficult, if not impossible, to be caught up by actions and policies concerning adulthood. Third, it allows, above all, to effectively combat inequality of opportunity. Investments made in early childhood, particularly by parents and communities by providing their care and time, is essential not only to protect the rights of children and to reduce different forms of exclusion, determinism, and social inequalities but also to increase economic efficiency, productivity, and wealth accumulation in the long term.

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64 El-Kogali et al (2016).
65 Chauffour (2018).
Morocco

From birth (and even before birth through pregnancy monitoring), children are entitled to equal access to adequate health and education services, to acceptable living conditions and parental care, and to be safe from violence and discrimination regardless of their gender, religion, ethnicity, or color.

The circumstances faced by young children will have lasting repercussions for their physical, cognitive, social, and emotional development. Their performance in school, their health as adults, and their on-the-job productivity will, to a large extent, depend on the quality of investments made in their early childhood, not only by their families but by the state.

Public and private investments in early childhood involve several sectors and several public and private entities and require coordination among the strategies and policies of the various stakeholders involved, which presents a significant challenge for a country with limited capacity like Morocco.

*Other Drivers of Human Capital*

Enhancing the development of human capital in any country requires a recognition by policymakers that many factors influence education and health outcomes including housing conditions (which have a particularly important impact on health), road and transport infrastructure, and adequate and broad-based social protection. This means that there is a need to devise integrated policies and strategies that take these important factors into account.

With respect to housing, the Government of Morocco has expended considerable effort since the 1990s to widen access to household amenities such as potable water and sanitation facilities and to close the gap between rural areas and urban areas. These efforts have made a significant contribution to improving the population’s health.

According to the results of the past two General Population and Housing Censuses (RGPH 2004 and 2014), the proportion of households connected to the electricity grid rose from 71.6 percent to 91.6 percent (Table 9). The increase in rural areas has been even greater, from 43.2 percent to 84.6 percent. Connections to the drinking water network and the availability of toilets in homes have also risen significantly in rural areas. By contrast, the sewage system remains woefully inadequate, particularly in rural areas.

Table 9: Growth in Rates of Connection to Household Utilities (%)

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Urban</td>
<td>Rural</td>
</tr>
<tr>
<td>Toilets</td>
<td>96.0</td>
<td>59.0</td>
</tr>
<tr>
<td>Electricity</td>
<td>89.9</td>
<td>43.2</td>
</tr>
<tr>
<td>Running water</td>
<td>83.0</td>
<td>18.1</td>
</tr>
<tr>
<td>Public sewer system</td>
<td>79.0</td>
<td>1.7</td>
</tr>
</tbody>
</table>

*Source: RGPH 2004 and 2014, [www.hcp.ma](http://www.hcp.ma)*
Moreover, according to the results of the 2017 ONDH household panel survey, 76.1 percent of rural households live less than two kilometers from a primary school, 55.5 percent live less than five kilometers from a clinic or health center, and 60.6 percent live less than two kilometers from a paved road (which implies that urban residents have more access to all of these services). With regard to social protection, Morocco’s social security and assistance system needs to be reformed in order to provide all its citizens with adequate coverage at every stage of their lifecycle. Social protection is a right and an obligation due to every individual in the community, and it is the state’s responsibility to ensure its efficacy. The most recent World Social Protection Report 2017–19 from the International Labour Organization noted that the human right to social security is not yet a reality for 65 percent of the world’s population, which leaves them “vulnerable to poverty, inequality, and social exclusion across the lifecycle, thereby constituting a major obstacle to economic and social development.” Morocco is one of the countries that invest the least in this area, with public expenditure on social protection representing less than 5 percent of its GDP. Morocco is also among the few countries that still assign responsibility for workplace accidental risk coverage to private companies instead of social security organizations. However, at the invitation of King Mohammed VI, new discussions on the Kingdom’s development model have begun in the country.

4. Conclusion

Morocco has made considerable progress in terms of its health and education indicators as well as in various other aspects of human development, particularly over the past 20 years.

For this reason, Morocco currently receives an estimated score of 0.50 on the World Bank’s Human Development Index. The country is ranked 98th out of 157 countries, with a lower HCI score than the average for the MENA region but a higher score than the average for other countries in its income classification. Given that its HCI score rose from 0.46 to 0.50 between 2012 and 2017, the country has clearly made solid progress. Morocco ranks higher than its neighboring countries on the HCI in terms of adult life expectancy but ranks lower on, for example, learning-adjusted years of schooling.

However, Morocco is still a long way from closing the gaps that separate it from developed countries. Several shortcomings remain, and there are many areas where efforts must be made to meet the challenges in the health and education sectors in particular, as these are the two key drivers of human development. Morocco’s 0.50 HCI score indicates that half of the country’s human capital potential is not being achieved.

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67 Based on a map in this report outlining social protection public expenditure excluding health (as a percentage of GDP).
68 Economic, Social, and Environmental Council (2018).
Morocco

With respect to education, the extraordinary deficit in the area of preschool education was not acknowledged or seriously addressed until recently. As preschool education is still not an integral part of basic compulsory education, it is characterized by considerable heterogeneity owing to the many actors involved. The objective of the actions taken by the government at this level has been to curb dropout rates and reduce inequalities in access to and attainment in future schooling.

Achieving universal primary education is the area where Morocco has focused its greatest efforts and where it has been most successful since the beginning of the 21st century.

As a result of successive government strategies involving large investments in conditional transfers, school supplies, school transport, boarding facilities, and school meals, primary enrollment rates are now close to 100 percent. The goal of providing universal primary education has, therefore, almost been achieved. Now of course, the government must try to achieve the same goal for the other education cycles, particularly lower and upper secondary education, which will require more sustained efforts. In addition, it will be necessary to improve the quality of all levels of education and to reassess its relationship with the vocational training component and the job market.

With respect to health, Morocco has had to act on various fronts. The government has launched efforts to combat child and maternal mortality while controlling fertility rates through intensive, sustained family planning programs. Similar efforts have been successful in substantially increasing life expectancy at birth.

Morocco has thus successfully and effectively curbed the spread of communicable and, increasingly, non-communicable diseases, which has improved the nutritional status of children and has led to the development and better geographical distribution of health care services. Access to health services has been significantly enhanced as a result of the expansion of health insurance coverage and the establishment of the system for providing subsidized care to disadvantaged groups, among other initiatives.

However, there is still much work to be done to bridge the gap between Morocco’s indicators and those of developed countries. Health care services have not yet achieved the recommended thresholds in terms of human resources and infrastructure, and their geographical distribution is still plagued by major disparities between urban and rural areas and between different regions of the country.

Moreover, despite the establishment of mandatory health insurance about 15 years ago and a system for providing subsidized care to the poor and vulnerable, seven years ago, health coverage has proven to be largely fragmentary and ineffective. It is absolutely critical that Morocco redouble its efforts to provide high-quality, universal coverage. This will not be an easy task as the one-third of the total population that still lacks coverage is so heterogeneous and diverse (lawyers, physicians, etc. but also many informal sector workers and self-
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employed) that its coverage risks taking too much time and hence jeopardizing the entire universal coverage project. Considerable efforts will also be required to improve the quality of care and secure the future financing and governance of the entire health system.

This case study has sought to demonstrate how Morocco, particularly over the past 20 years, has improved its standing in terms of the HCI indicators. It has tracked in detailed and chronological order the strategies, plans, programs, and actions that have been implemented in the education and health sectors and has used various reliable sources of data to document the progress that has been made.

The case study has also shown that numerous shortcomings and challenges remain. It appears that mitigating these challenges as much as possible will require continued political will and even stronger coordination, specifically in the areas of health and education, the two key drivers of human development. However, it will also be necessary to take into account all other aspects of human development to ensure that the efforts to build Morocco’s human capital are as effective as possible.

In sum, it is recommended that the government develop a more integrated multisectoral policy for human capital development. For example, a national investment and early childhood development strategy would appear to be both quite promising and an indispensable element of the country’s approach to building human capital throughout the lifecycle.

Morocco possesses a number of assets with which to develop its human capital and prepare future generations for the rapid transformations taking place on the job market. In particular, it has had strong political will from the top of government for its recent reforms in the areas of education and health. These strategies, initiatives, and reforms should be rigorously evaluated on a regular basis so that any necessary adjustments can be made to ensure that they remain effective. It would then be appropriate to step up the pace and carry out these reforms in a more coherent and coordinated manner.
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## Annexes

### Annex Table 1: Human Capital in Morocco and Select Comparator Countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Probability of survival to age 5</th>
<th>Expected years of schooling</th>
<th>Harmonized test scores</th>
<th>Learning-adjusted years of schooling</th>
<th>Child stunting rate (%)</th>
<th>Adult survival rate</th>
<th>Human Capital Index</th>
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</thead>
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<tr>
<td>Mauritania</td>
<td>0.92</td>
<td>6.3</td>
<td>342</td>
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*Source: World Bank (2019)*

### Annex Table 2: HCI Components by Gender

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<th>Girls</th>
<th>Total</th>
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<td>0.50</td>
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<tr>
<td>Survival to age 5</td>
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<td>0.98</td>
<td>0.98</td>
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<tr>
<td>Expected years of schooling</td>
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<td>10.7</td>
<td>10.6</td>
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<tr>
<td>Harmonized test scores</td>
<td>359</td>
<td>376</td>
<td>367</td>
</tr>
<tr>
<td>Learning-adjusted years of schooling</td>
<td>6.1</td>
<td>6.4</td>
<td>6.2</td>
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<tr>
<td>Adult survival rate</td>
<td>0.93</td>
<td>0.94</td>
<td>0.93</td>
</tr>
<tr>
<td>Stunting rate</td>
<td>0.83</td>
<td>0.87</td>
<td>0.85</td>
</tr>
</tbody>
</table>

*Source: World Bank (2018)*

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Annex Figure 1: GDP Growth Rate, 1999–2006 and 2007–2016 (%)

Source: High Commission for Planning

Annex Figure 2: Per Capita GDP Growth Rate, 1980–2015 (%)

Source: High Commission for Planning
Annex Figure 3: Trend in Absolute Poverty Rate by Place of Residence (%)

Source: High Commission for Planning

Annex Figure 4: Trend in Multidimensional Poverty (%)

Source: High Commission for Planning
Annex Figure 5: Chronic Diseases 2011–2018

Annex Figure 6: Immunization of Children 2011–2018