The struggle to make ends meet

A harsh economic climate has obliged Morocco's health sector to improve its use of resources and to seek additional support, both internally and externally. Despite the considerable efforts that have been made, there remains a serious shortage of funds. Reforms on the international scale are necessary if Morocco and other developing countries are to achieve the health-for-all goals.

In Morocco the health-for-all goals have been translated into measures including the gradual extension of immunization coverage to all children under five years of age, the improvement of nutrition, and the expansion of primary health care activities in general.

During the 1980s, however, the financing of these measures has become a problem: the country has an internal treasury deficit and an external deficit in the balance of trade.

A stand-by arrangement has been made with the International Monetary Fund whereby part of the external debt with private banks and certain countries has been rescheduled and loans are being obtained from the World Bank, other agencies, and, possibly, certain other banks. The agreement requires that Morocco's internal deficit be reduced through a cut in budget expenditure and an increase in fiscal revenue, and that the external deficit be reduced by cutting imports and increasing exports.

The measures have been firmly applied and have resulted in a drastic reduction in the growth rates of the budgets of various sectors, particularly that of health. There have been reductions in the real value of investment budgets, the building of large regional hospitals having been stopped and the construction of smaller local hospitals having been delayed. Restrictions on running costs have affected:

- the recruitment of paramedical personnel, the replacement of retiring staff, and the number of doctors' posts;
- the purchase and maintenance of equipment;
- the maintenance of buildings;
- hospital catering services and drug procurement.

These restrictions have had disastrous effects. Patients have virtually lost confidence in the ability of dispensaries and hospitals to provide care in the remoter areas where access is relatively difficult. Consequently, there has been a movement of patients from these areas to the parts of the country with the best facilities, which have thus become overloaded.

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Rationalization and better deployment of resources

Restrictions on the credits allocated to the Ministry of Public Health have forced it to work out better ways of using its resources.

In response to slack management it was decided to set up boards with administrative and financial autonomy in the university teaching hospitals. These boards represent all the parties involved in the hospitals and are competent to discuss budgets, personnel recruitment, and equipment, and may also review charges and retain income. Seven regional hospitals with 500 beds were given financial autonomy and allowed to keep and use their incomes. The greatest problem was to find managers capable of developing and implementing management plans and making rational use of resources. A general maintenance service was established and contracts were drawn up with companies that could provide training for the personnel concerned.

External assistance helps to alleviate financial and economic problems but is subject to conditions that make it very precarious.

The number of drugs used by intensive care units for the usual range of diseases has been reduced. Large savings are being made on equipment and drugs through the computerization of central pharmaceutical supplies. Procurement has been substantially improved by giving careful consideration to the range of products available and reducing delays in purchasing; expenditure has thus been cut. Improvements have been made in the transportation and distribution of drugs from producers to consumers in the provinces.

New methods of personnel management have been introduced, and this has given a better picture of the deployment of personnel and has shown that too many paramedical and medical staff are concentrated in the large urban areas. There is also a concentration of specialists in the two largest cities, Rabat and Casablanca. Recruitment by competitive examination has been introduced for medical specialists, general practitioners and paramedical staff. Refresher courses are being instituted and attendance will become compulsory for physicians wishing to continue in practice. A general inspection system is being introduced to monitor the management of hospitals, programmes and personnel.

Efforts are being made to achieve improved information facilities and analytical capabilities at the central and local levels, through the establishment of a central computer data processing unit, a statistical information and study unit, and a methodology unit, a review of organizational structure in the Ministry of Public Health, and the initiation of studies aimed at contributing to the formulation of health policy, including ones on hospital management, health financing, and the costing of alternative technologies, both curative and preventive, in hospital units.

In spite of these endeavours, it has not been possible to raise the funds needed and it has been necessary to seek other ways of financing our attempts to attain health for all.

Mobilization of national resources

Greater participation by the population was the first step considered. Three groups can be distinguished:
— the poor who are unable to pay;
— people with social security cover;
— people who can pay directly.

Health services are available free of charge to the first group. Their involvement is nevertheless required in respect of nutrition, social security contributions, and, for people who can afford them, contributions towards the cost of medicines. The medical profession operates a system of compensatory payment to meet the cost of drugs required by those who cannot pay for them. This means obtaining voluntary contributions from those who can afford them towards the cost of care for those who cannot. The second and third groups pay for their care in both public and private hospitals. The drugs available in the hospitals are reserved in the first place for emergencies.

In the past, all requirements were covered by the budget. Until relatively recently, charges had not been revised for 20–25 years. The rates charged for hospitalization did not even cover the cost of water and electricity. A review of costs was clearly necessary with a view to revising hospital charges.

A large number of private charities being active in the health field, it was decided to mobilize them so as to help towards remedying the shortage of funds. Doctors have proved to be very good at fund-raising in the private sector. This is comparatively easy in the big cities with well-developed economies, but not very productive in the poorer regions. However, it does permit the country to channel its limited resources into basic health activities. In this connection, it is worth observing that health policies can easily disintegrate when heads of department become independent and no longer integrate their activities into the overall hospital activity.

Increasing numbers of small and medium-sized, relatively well-equipped clinics are being established, especially in the big cities. The state exercises a fairly good degree of control over their charges, and the physicians’ national professional association regulates ethical matters. Doctors’ surgeries are being established throughout the country by general practitioners who accept relatively low salaries and are sometimes remunerated in kind. The state is encouraging this development in the hope that a type of country doctor will emerge.

Some 1000 communes are proposing to take responsibility for the construction and even the operation of rural dispensaries and health centres and for the recruitment of paramedical personnel and doctors. While the recruitment of doctors by municipal health departments in the big cities seems desirable, that of paramedical personnel by elected institutions could be dangerous, jeopardizing the overall consistency of the state’s health policy and the implementation of its general preventive programmes.

**Mobilization of external resources**

Even after mobilizing all possible resources at the local level, Morocco still needed further funds to achieve its health-for-all goals. Substantial assistance has been received from international agencies and friendly countries. The World Bank has lent 28 million dollars for primary health care services in three provinces; the United Nations Children’s Fund (UNICEF) is helping to finance the country’s immunization campaign; the United Nations Fund for Population Activities (UNFPA) is participating in several programmes,
particularly in family planning campaigns; the United States Agency for International Development is contributing to the cost of programmes providing a package of domiciliary health services; and the World Health Organization is participating in the financing of health policy studies and analyses.

Many communes are proposing to take responsibility for the construction and operation of rural dispensaries and health centres.

External assistance is greatly appreciated and undoubtedly helps to alleviate financial and economic problems, but is somewhat precarious and cannot provide definitive solutions because of:

— the use of foreign experts and the payment of salaries abroad;

— the purchase of products from the countries providing the assistance;

— the unpredictability of the level of external support and the danger that important programmes based on it may have to be abandoned.

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It should be noted that several agencies dealing with health problems in Morocco require separate examination, as their problems do not arise directly from restrictions on public spending. They include the health services of the mutual insurance sector, the public corporations, and the military.

In spite of the attempts at rationalization and the unceasing efforts to mobilize external assistance, the health sector is still suffering from a shortage of funds. The policies of macroeconomic adjustment practised in recent years have resulted in the country being unable to raise counterpart contributions in local currency to enable it to receive loans in hard currency.

Restrictions on budgetary allocations do not always follow a completely logical economic line, for the centres of financial decision are influenced by the international mass media and sometimes release credit for activities because they make a big impact on public opinion. Thus we have arrived at a policy giving AIDS control precedence over the control of the major classic diseases that kill young children.

Countries no doubt need some overall policy of adjustment to re-establish financial balance, but their future and overall development should not be sacrificed to short- or medium-term policies. While it is true that such policies lead to better and more rigorous management and stimulate a search for new sources of financing, they do not create new resources. International economic and financial agencies should be recommended to stipulate, when entering into agreements with countries, that a certain percentage of national budgets be reserved for expenditure on health. The percentage should be related to gross national product, so as to halt the steady decline in the share of budgets set aside for basic health care. It would then be for each country to define the resources needed to attain the Alma-Ata objectives. At present the developing countries appear to be falling behind in this matter.

If the international community fails to introduce reforms making the health-for-all goals realistic, they will have to be reviewed. There is no point in constantly repeating the phrase “health for all by the year 2000” without understanding what it means.