Mobilising tax revenues to finance the health system in **Morocco**

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Foreword

The Global Fund to Fight AIDS, Tuberculosis and Malaria and the OECD Centre for Tax Policy and Administration (CTPA) are engaged in a joint project that aims at analysing countries' capacity to mobilise tax revenues to finance their health system, and particularly the fight against the three aforementioned diseases.

The project started with two pilot countries: Morocco and Côte d'Ivoire. The work with Morocco builds on a collaboration of CTPA with Morocco, which resulted in the 2019 report "*Morocco Tax Policy Review 2019"*, which was delivered as the OECD input to the discussions on strengthening the equity of the tax system in Morocco. This new report deepens the 2019 analysis with respect to health taxes and health financing. It is presented as an input to inform the ongoing discussions in Morocco on how to strengthen the financing of the health care system and the donor transition plan in the health sector.

The Key Messages and Recommendations section of the report presents the main tax policy recommendations to strengthen the financing of the health system and the fight against AIDS, Tuberculosis and Malaria in Morocco. More detail and analysis is included in the subsequent chapters of the report.

This report was written and coordinated by Céline Colin, Tax Economist in CTPA, with input and under supervision from Bert Brys, Senior Tax Economist and Head of the Country Tax Policy Team and of the Personal and Property Taxes Unit in the Tax Policy and Statistics Division, led by David Bradbury, of the CTPA. The report has benefitted from input from colleagues in CTPA, in particular Michèle Harding, Emmanuelle Modica, Gioia de Melo, Sarah Perret, Joseph Stead, Michael Stemmer, Jonas Teusch, Konstantinos Theodoropoulos, and Talita Yamashiro Fordelone. The report also benefitted from comments from Martin Kessler from the OECD Development Co-operation Directorate and Chris James from the OECD Directorate for Employment, Labour and Social Affairs.

The analysis is based on the discussions held and information gathered during a country mission to Rabat in November 2019, during which the OECD team met with a large number of Moroccan taxation and health experts whose contributions to this report were crucial and are very much appreciated.

The report was prepared in close collaboration with the Epidemiology and Disease Control Directorate and the Planning and Financial Resources Directorate in the Ministry of Health, along with the Department of Economic Studies and Financial Forecast and the Budget Department of the Ministry of the Economy, Finance and Administrative Reform. The team would like to thank Mohammed Youbi, Director of Epidemiology and Disease Control, Abdelouahab Belmadani, Director of Planning and Financial Resources, and Boutaina El Omari, Coordinator of the Global Fund Programme Management Unit in the Ministry of Health for their support. The team would also like to thank Mounssif Aderkaoui, Director of Economic Studies and Financial Forecast, and Fouzi Lakjaâ, Director of Budget in the Ministry of the Economy, Finance and Administrative Reform.

The report also benefitted from the support of the Global Fund, and in particular from Michael Borowitz, Chief Economist, Geir Lie, Health Financing Specialist, and Emina Rye-Florentz, Fund Portfolio Manager in the Middle East and North Africa team.

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Glossary

ANAM	National Health Insurance Agency
CCM	Morocco Coordinating Committee
CHI	Compulsory Health Insurance
CHU	University hospital
CIT	Corporate Income Tax
CNOPS	*Caisse Nationale des Organismes de Prévoyance Sociale* (National Social Security fund for the public sector)
CNSS	*Caisse Nationale de Sécurité Sociale* (National Social Security Fund for the private sector)
CSO	Civil Society Organisation
DAC	Development Assistance Committee
DCT	Domestic Consumption Tax
GAVI	Global Alliance for Vaccines and Immunisation
INDH	National Initiative for Human Development
MEFRA	Ministry of the Economy, Finance and Administrative Reform
NCA	Non-Concessional Assistance
OCP	Cherifien Office of Phosphates
ODA	Official Development Assistance
OOP	Out-Of-Pocket
ONCF	National Railways Office
PEPFAR	President's Emergency Plan for AIDS Relief
PIT	Personal Income Tax
PPP	Public-Private Partnerships
Ramed	Medical Assistance Plan for the Economically Disadvantaged
SDG	Sustainable Development Goal
SEA	Special Earmarked Account
Segma	Independently-managed state services
SMIG	Guaranteed minimum wage
SSC	Social Security Contribution
STA	Special Treasury Accounts
TB	Tuberculosis
VAT	Value Added Tax
WHO	World Health Organization

Note to the reader

This report was written at the end of 2019, prior to the COVID-19 health crisis. The analyses do not therefore take into account the important changes that have taken place in the health sector, including in relation to its financing, during the handling of this crisis. While some analyses remain consistent (such as the breakdown of growth in total health expenditure and public health expenditure), others offer an entry point to a more general discussion on health financing that will include specific elements related to the handling of the COVID-19 crisis.

Since this report was written, Morocco has adopted numerous health, economic and social measures aimed at mitigating the harmful effects of the crisis. Once the crisis is over, these measures will need to be integrated in the discussion on health financing.

A number of global observations can be made with regard to the post-crisis period:

- This health crisis will pave the way for fundamental health system reforms.
- In particular, increased health budgets will be essential to upgrade health systems and/or prepare for any crises that may occur in the future.
- Nonetheless, current health expenditure commitments will result in fiscal deficits, which are likely to increase significantly, making the financing of economies even more difficult.
- In this context, tax systems will have a major role to play in financing the post-crisis period. Tax reforms that may have been only partially implemented or even postponed cannot wait any longer, but will need to be adapted to the new economic and social context.
- Improvements in the quality of public health expenditure will be more necessary than ever.
- Earmarking resources will be a key topic, particularly if people are more inclined to support the health sector directly.
- There could be stronger calls for solidarity and progressive tax and benefit systems from the general public.
- Finally, the role of the State in the provision of health services is (and will be) tested in this crisis. In countries where people feel the State has fulfilled its role to the best of its ability, their trust may be strengthened. Elsewhere, the loss of trust will only be greater.

There is a risk that the financial support provided for the fight against AIDS, tuberculosis and malaria, will stagnate, or even decrease, in the future. This may be due to:

- The fact that increased health expenditure will not benefit these three diseases
- The fact that States' priorities are changing (such as, for example, placing greater attention on preparing for a future health crisis) and thus reallocating funding within the sector
- The fact that greater but insufficient health expenditure is resulting in reduced support for these three diseases

Executive summary

In recent years, Morocco has made progress in the health sector, with an increase in life expectancy and a reduction in the extent of communicable diseases. **That said, continued efforts are still needed**, in particular to achieve certain health targets set out in the Sustainable Development Goals or to reduce regional inequalities in health provision. Added to this is the burden of the epidemiological transition and population ageing, with the number of people aged over 65 expected to triple between 2020 and 2060, increasing health spending and threatening the budget balances of compulsory health insurance funds.

Morocco faces two challenges for health financing. First, financial resources for health are low, with total health expenditure accounting for 5.2% of GDP in 2017, which is lower than upper-middle-income countries and regional neighbours. Second, half of the health sector is financed through out-of-pocket expenditures, which is inequitable and regressive. In this context, the Ministry of Health began a debate on health financing in 2019.

At the same time, although there is no indication that the Global Fund to Fight AIDS, Tuberculosis and Malaria, which has supported Morocco since 2003, would leave the country, Morocco has started to prepare in case it would happen in the medium or longer run. Thus, the Ministry of Health has initiated a process to prepare for the transition, which provides an opportunity to strengthen the inter-ministerial dialogue on health financing. This is all the more necessary given that the financing risk in the health sector is particularly high during donor transition periods, as well as the fact that the COVID-19 crisis has demonstrated the need for greater resilience in the sector.

All of these observations underscore the importance of strengthening public health expenditure. Analysis over a long period reveals that *total* health expenditure growth is driven by public funding, and that *public* health expenditure growth is driven by economic growth and the priority for health within the general state budget. Several observations can be made. First, tax measures must not impede economic growth for the latter to continue to support public health expenditure growth. Second, even if health budget is being prioritised in the general state budget, it still remains at 5.6% of the budget in 2018, which is low compared to the World Health Organisation standard of 12% and when compared to other countries in the region.

To fund increased in public spending on health, two areas of action will be required. First, the design of health social security contributions needs to be improved. Second, greater use will need to be made of tax revenues, with an improvement of the design of each tax, in particular taxes with strong links to the health sector such as domestic consumption taxes (through their influence on consumer behaviour) and environmental taxes (through their indirect impact on the health of populations).

However, while an increase in public resources for health is necessary in the medium term, this cannot be achieved under current conditions. The first step will be to improve the efficiency and control of public spending on health, as well as to support the development of the private health sector, but without necessarily introducing new tax incentives.

Several options can be considered to increase the role of compulsory health insurance contributions in health financing. Morocco could better control the expenditure of the compulsory health insurance system, broaden the health social security contributions base, increase contribution rates, promote labour force participation, especially of women, and introduce a health insurance scheme for the self-employed.

Strengthening the role of tax revenues is needed to finance the increase in public health expenditure. There is room to increase domestic consumption taxes on products harmful for health.

Similarly, environmental taxation should have more prominence given its important role in sustainable growth and its positive health impacts. Conversely, earmarking a share of VAT revenues to health is not recommended without a sound budgetary framework to ensure that spending and financing forecasts are properly assessed. Similarly, the introduction of tax deductions for some types of private health expenditure is not recommended without targeting the health spending that could benefit from these moves and the prior broadening of the personal income tax base. Lastly, strengthened local financing will be necessary for local authorities to exercise their health powers.

Morocco could earmark more tax revenues from products harmful for health as the amounts at stake are limited. Many resources are earmarked through Special Treasury Accounts but relatively little for health. Discussions on earmarking more resources for health have been held before and could be resumed, which would be primarily a political choice. Accordingly, an inter-ministerial discussion could focus on i) earmarking all tax revenues from the domestic consumption tax on tobacco, and the new revenues that would result from a revision of this tax, ii) earmarking other domestic consumption taxes on products harmful for health, and iii) continuing earmarking the revenues generated by the subsidy reform toward social sectors. However, if Morocco were to start earmarking greater tax revenues for health, its success would depend on several conditions.

Morocco should have the budgetary capacity to successfully manage its transition away from the Global Fund. Tuberculosis control could be funded from the general state budget. This support would be essential to meet the current funding gap, and to offset the 5% funding from the Global Fund. The high prevalence of tuberculosis in Morocco makes this all the more important. With regard to AIDS funding, there are several options aimed at responding to the specificity of the disease that primarily affects vulnerable populations. The recommended options include funding through the Ministry of Health with an increase of the Ministry's budget, or through the special earmarked accounts "Social Cohesion Support Fund" dedicated for vulnerable populations, or the through the "Support Fund for the INDH"» that has been funding mother and child health programmes since 2018. Secondary options (and less recommended) exist, such as the creation of a new special earmarked account (though this would increase budget fragmentation), or funding by the regions (though regional governments still suffer from a lack of funding).

The financial risk associated with the transition of the Global Fund lies in the dependency of a small number of civil society stakeholders to the Global Fund's financing, in particular for programmes supporting target populations. This will give rise to several challenges. On the one hand, until now, public funding has only supported curative aspects, and not the human resources of civil society organisations supported by the Global Fund. On the other hand, there will be the matter of funding civil society's programmes to fight HIV and tuberculosis with public resources.

Key messages and recommendations

Although there is no indication that the Global Fund to Fight AIDS, Tuberculosis and Malaria, which has supported Morocco since 2003, would leave the country, Morocco has started to prepare in case it would happen in the medium or longer run in case it would happen in the medium or longer run. Thus, the Ministry of Health has initiated a process to prepare for the transition. At the same time, the Ministry has also begun a general debate on the health system financing.

One of the challenges of the transition will be to bring the issue of AIDS and tuberculosis (TB) financing into the mainstream of thinking about health financing, since better financing of the sector will facilitate opportunities to fund efforts to control the before mentioned diseases. This will require regular inter-ministerial dialogue, as several international experiences demonstrate.

This inter-ministerial approach is necessary as the financing risk in the health sector is particularly high during transition periods of donors. The resurgence of some epidemics in countries that have not allocated sufficient public funding after the withdrawal of the Global Fund shows that domestic financing has a crucial role to play in overcoming the challenge to finance the health system.

However, Morocco has sufficient time to prepare for the transition of the financing of HIV and TB programmes and has undertaken numerous reforms with an impact on health financing (tax reform, overhaul of the social welfare strategy, establishment of a single social register).

The health financing situation in Morocco

Currently, the financial resources for health are low. In 2017, total health expenditure accounted for 5.2% of GDP, which is similar to lower-middle-income countries (5.6% of GDP) but lower than upper-middle-income countries (6.7% of GDP), high-income countries (7.8% of GDP) or regional countries such as Tunisia (6.9% of GDP). Total health expenditure per capita was USD 161 (compared to an average of USD 471 in upper-middle-income countries, or between USD 250 and 340 for countries like Jordan or Tunisia).

The health sector is financed through out-of-pocket (OOP) expenditure (51%), social security contributions (SSCs, 24%), general taxation (22%), voluntary prepayments (1%) and less than 1% for international co-operation. As in other countries, the introduction of compulsory health insurance (CHI) in 2005 (9.5 M insured people, about 26% of population in 2018), and of the Medical Assistance Plan for the Economically Disadvantaged (Ramed) in 2013 (12.5 M insured people at the end of August 2019) has contributed to reducing OOP payments. Despite the reduction, OOP expenditure remains significant in Morocco. This makes the health system inequitable and regressive, as it leads to many households facing financial hardship because of the cost of care.

Reducing OOP expenditure will require an increase in public funding. As well as improving access, this will improve the quality of public health care. Alongside additional funding, other measures will also be necessary, such as the regulation of the private medical sector, the revision of the standardised health costs to patients, or the introduction of a CHI scheme for the self-employed.

In Morocco, growth in *total* health expenditure is driven by increased public funding (see analysis in Chapter 3). In addition, there is evidence that public spending on health helps reduce inequalities and the vulnerability of populations. This provides a strong rationale for increasing the scale of public health programmes.

In Morocco, the growth in *public* spending on health can to a large extent be explained by economic growth and the prioritisation of the health sector (see analysis in Chapter 3). Several observations can be made:

- First, economic growth has a role to play in public health spending growth and must continue. Therefore tax measures implemented to provide additional financing for the health sector must not impede growth.
- Second, Morocco has started to prioritise health within budget, with health budget increases since 2011. However, health budget in Morocco remains low (5.6% of the total state budget in 2018 compared to the World Health Organisation (WHO) standard of 12%, 10.7% in Algeria, 12.4% in Jordan or 13.6% in Tunisia). The prioritisation of health in the budget may reflect the importance given to the health sector at a high political level, as well as the effective dialogue between the Ministry of Health and the Ministry of the Economy, Finance and Administrative Reform (MEFRA).

Thus, health prioritisation in the budget is important to better finance the health system, together with economic growth as health prioritisation cannot be continually increased.

Apart from the budget of the Ministry of Health, there are many sources of public funding for health: public institutions under supervision of the state (the National Health Insurance Agency – ANAM, university hospitals – CHUs), independently-managed state services – Segma (provincial and regional hospitals) and special earmarked accounts (SEAs) (Central Pharmacy Fund, Social Cohesion Support Fund, National Initiative for Human Development (INDH) Support Fund). The difficulty of establishing a consolidated overview of the public accounts, fragments the overview of health sector financing in general.

Total public funding of health in Morocco, including SSCs for CHI, can be estimated at MAD 35 billion (excluding CHUs[1]) accounting for 3.5% of GDP: two-thirds of this comes from tax revenues and one-third from SSCs (see analysis in Chapter 2).

The need for an increase in public health financing

While Morocco has made progress in the health sector (increase in life expectancy and reduction in the burden of communicable diseases, in particular AIDS with a low prevalence of about 0.1%), **efforts are still needed.** In particular efforts are necessary to achieve the health targets (maternal and neonatal mortality) set out in the Sustainable Development Goals (SDGs), to control TB (Morocco remains one of the most negatively affected countries in the North Africa/Middle East region with an incidence rate of 86.8 and a mortality rate of 9.3 for 100 000 inhabitants in 2016), or to reduce regional inequalities in health provision. Added to this is the burden of the epidemiological transition and the ageing of the population. Between 2020 and 2060, the number of people aged over 65 is expected to triple. This increases health spending and threatens the budget balances of CHI funds, but could be better controlled by policies to promote healthy ageing.

[1]Excluding university hospitals given the complexity to access data.

These challenges highlight the need to strengthen health spending. In order to move closer to the SDG 3 targets by 2030, Morocco would need to increase health expenditure by 2.5 percentage points of GDP, to reach 8.2% of GDP, including 2.2 percentage points for public spending (see analysis in Chapter 3). This increase would raise per capita health expenditure from USD 170 in 2016 to USD 419 in 2030, and multiply the number of doctors by 2.6 and the number of medical staff by 3.6, if keeping current health workforce policies constant. This is equivalent to an increase of MAD 107 billion over the same period (an annual increase of MAD 7.7 billion), including an increase of MAD 77 billion in public spending (an annual increase of MAD 5.5 billion).

To fund the increase in public spending on health, two main lines of action will be required.

- **First, improving the design of health SSCs.** Compared with Morocco's level of development, the weight of SSCs in the tax structure is higher than that of many other countries.
- **Second, greater use will need to be made of tax revenues,** as well as the improvement of the design of each tax. Some taxes, such as domestic consumption taxes (DCTs) (through their influence on consumer behaviour) and environmental taxes (through their indirect impact on the health of populations), have stronger links to the health sector than others. These taxes have a particularly important role to play in health financing. Additionally, other revenues, from taxes such as value added tax (VAT), corporate income tax, personal income tax (PIT), or property taxes, also have a role to play in increasing the overall level of general tax revenues in the public budget, although they are not directly related to health.

However, while an increase in public resources for health is necessary in the medium term, this cannot be achieved under current conditions. The first step will be to improve the efficiency and control of public spending on health (see Chapter 4). As such, building the analytical capacities of the Ministry of Health, as observed in Mexico, Thailand and Turkey, will be useful in informing technical discussions with their respective counterparts in the MEFRA. This will increase negotiating power during budget trade-offs, better demonstrate the importance of funding disease prevention activities (with a view to reducing the costs of certain diseases, including AIDS), and facilitate access to funds granted in the form of budget support by donors. The next step will be to support the development of the private health sector, but without necessarily introducing new tax incentives.

Improving the design of health social security contributions

The CHI system is fragmented and its financial balances are deteriorating. The Caisse nationale des organismes de prévoyance sociale (CNOPS), the fund in charge of civil servants, has had a technical deficit since 2016. After the technical deficit of MAD 12.6 billion in 2017, the CNOPS faced a budget excess (MAD 30.1 billion) that can be explained by the reduction in reimbursements and dental care of -23%. The global balance, in deficit for the second consecutive year, was MAD 2.8 M in 2018 versus MAD 22.6 billion in 2017. The Caisse nationale de sécurité sociale (CNSS), the fund for the private sector, is in better fiscal shape (technical balance of MAD +3.2 billion in 2018, and global balance of MAD +3.8 billion, with an increase of MAD +1 billion compared to 2017), but from 2026, contributions are no longer expected to cover the scheme’s expenses.

Several options could be considered to bolster the role of health social security contributions (SSCs) in health financing (see Chapter 5):

- **Controlling CHI expenditure, a prerequisite for any change in the design of health SSCs**

This relates to renewal of national conventions, revising the standardised health costs, updating the classification of professional activities, treatment protocols and health professionals' reference document, and reinforcing the attractiveness of the public health care system.

- **Broadening the health SSCs base**

The health SSCs base of the CNSS is limited. Around 640 000 employees in 3 400 companies do not pay the employer's health SSC of 2.26% (in 2018, contributions represented MAD 6.52 billion for the private-sector fund and MAD 5.106 billion for the public sector fund). To ensure fairness, this group should be integrated into the standard CHI system, and pay the employer's contribution of 2.26%. If this were to happen, the effective tax rate on labour costs would remain moderate compared to other countries, so would not significantly reduce incentives to hire or the purchasing power of employees.

In the case of the CNOPS, the monthly CHI ceiling could be revised upwards, or possibly abolished, to enhance the progressive nature of the social benefit system and improve the alignment of the public and private-sector contributions. Indeed, while social security ceilings help strengthen the link between contributions and benefits, this link is relatively weak for health insurance since the benefit received is not proportional to the contributions paid.

- **Increasing health SSCs rates**

Any discussion on raising health SSCs must consider the burden of contributions on the workforce, which could have a negative impact on incentives to work, and indirectly on informal employment. To provide an overview of the burden on the workforce, these possible changes in rates must also be analysed alongside personal income tax brackets.

An analysis of several CNSS scenarios suggests that a more ambitious increase in the health SSCs rates than that envisaged by the CNSS (+0.14 pp), for example to align with the level in Tunisia, would have only limited impacts on incentives to work (see analysis in Chapter 5). Thus, raising rates to the level envisaged by the CNSS could be a first step.

There are also several arguments supporting an increase in health SSCs rates in the public sector. First, rates have not been increased since 2006, despite a significant rise in costs and a technical deficit over the last three years. Second, an increase in health SSCs rates would not have a negative impact on informal employment as in the case of private SSCs. Finally, as the average gross salary in the civil service is almost twice as high as in the private sector, an increase in the rate would be possible. An increase in contributions to the CNOPS, e.g. to the level of CNSS contributions, would therefore make sense, and would bring the public and private schemes more into line with each other.

- **Promoting participation in the labour market, especially of women**

Difficulties in financing the health system are exacerbated by the worrying labour market situation (low workforce participation, especially among women, high unemployment among young people and skilled people, widespread informal sector).

The tax system’s design does not appear to have a negative impact on women’s labour market participation, with women representing the majority of second earners. Nevertheless, in view of the situation, with less than 30% of women aged over 15 on the labour market, Morocco could adopt special tax provisions to promote their participation. These could include implementing an earned income tax credit to incentivise low-income female workers to join the labour market. Likewise, Morocco should keep the individual as the fiscal unit, and not move towards taxation by fiscal household as recommended at the National Conference on Taxation, as it tends to discourage second earners from participating in the labour market.

Formalising the economy and workers will also have a positive impact on the level of SSCs collected. The future introduction of a health insurance scheme for the self-employed is therefore to be welcomed.

- **Introducing a scheme for the self-employed**

This scheme, which is currently under review, is likely to cause distortions. The tax base will be fixed (a multiple of the guaranteed minimum wage, SMIG) and will vary according to the different income levels of occupational groups. However, this may encourage tax evasion and increase informal employment. The system should therefore be based to a greater extent on real incomes, possibly with a ceiling. This is especially relevant since the tax administration is making a concerted effort to gain a better understanding of the real incomes earned by the liberal professions.

Strengthening the role of tax revenues in health financing

- **There is room to increase domestic consumption taxes (DCTs)**

Of all the DCTs on products harmful for health, the tobacco DCT generates the most tax revenues. In 2019, the tobacco DCT represented 5% of total tax revenues (about 41% of DCTs) with a stable evolution over a long period. This is in line with the international trend, and reflects the increase in tobacco consumption in Morocco.

Analysis shows that Morocco complies with WHO's recommended standard of having taxes of at least 75% of the retail price for the cheapest, most expensive, or most sold cigarettes. While these figures could be compared with Ministry of Health studies, analysis nevertheless tends to confirm the finding that the DCT on tobacco is regressive.

However, according to WHO, cigarettes were more affordable in 2019 than in 2008. Thus, taxation of tobacco could be increased to make this product less affordable and thus reduce its consumption.

As in other countries in the region, the alcohol DCT generates little tax revenues. In particular, international comparisons highlight the potential to increase excise duties on wine in Morocco.

Sugar consumption in Morocco is very high, which increases the prevalence of certain diseases. Many changes to the DCT on sugary drinks were introduced in 2020 to encourage producers to reduce the sugar content of drinks. They had a greater focus on changing consumer behaviour than generating a significant increase in tax revenues (as in the case of alcohol). Finally, the sugar subsidy system, introduced in 1996, could also be reviewed due to its many limitations.

- **Environmental taxation should be given more prominence**

Despite the important role of environmental taxation in sustainable growth and positive health impacts (which allow environmental taxes to be classified as health-related taxes), it was absent from the discussions. Only one recommendation at the end of the National Conference on Taxation mentions the introduction of a tax dedicated to environmental protection, the revenues of which would be earmarked for the regions. This is a first (albeit still very generic) step that would be worth developing quickly, given the environmental and health challenges that Morocco faces. This approach would bring even more benefits given that Morocco's tax structure remains insufficiently diversified, still too focused on three pillars (VAT, personal income tax and corporate income tax), with little consideration for other types of tax, particularly environmental taxes.

- **Earmarking a share of VAT revenues to health is not recommended**

One of the recommendations of the National Conference on Taxation is to earmark a share of VAT revenues to expanding coverage and welfare benefits, based on the Single Social Register. This recommendation was taken up at the National Conference on Health Financing. The Economic, Social and Environmental Council has therefore proposed earmarking between two and four percentage points of the 20% VAT rate to fund social security (thus supplementing the income generated by SSCs) or to finance the Social Cohesion Support Fund.

However, earmarking two to four percentage points of the standard 20% VAT rate for social security and the health sector seems an ambitious measure, particularly in light of the amounts involved. Such a measure should be considered with caution, as it would represent between 26% and 52% of the Ministry of Health's budget (see Chapter 6). Given the current situation, with the Ministry's low budget execution, earmarking such amounts would seem inappropriate. Finally, a share of VAT is already earmarked for funding local authorities, whose delegated powers include health.

If Morocco were to commit to earmarking a share of VAT for health, a sound budgetary framework would be needed to ensure that spending and financing forecasts were properly assessed and remained under control. Earmarking part of VAT without a precise health budget, with information on costs and additional revenues needed, seems sub-optimal. Earmarking a fixed share of VAT without a sound budgetary framework, which would be discussed and approved by both the Ministry of Health and the Ministry of Finances, would likely lead to excessive public spending, and would not contribute to more efficient public health expenditure.

On the other hand, broadening the VAT base (rationalising the number of reduced rates and abolishing certain exemptions) **is more appropriate,** as this will increase tax revenues for the general state budget. Finally, since VAT support for the health sector is also provided indirectly through tax expenditure, efforts to exempt medicines from VAT should continue.

- **The introduction of tax deductions for some types of private health expenditure is not recommended**

Morocco has put forward the idea of introducing tax deductions for private health expenditure, which mostly benefit the middle and upper classes. Introducing such deductions would not only be regressive; it would also reduce personal income tax significantly and raise funding questions for the public health system. If Morocco decides to move towards introducing such provisions, the first step would be to significantly broaden the personal income tax base (for example by reducing generous allowances for employment expenses, for retirement savings, and for interest on mortgages, which are regressive), and to target the health spending that could benefit from these moves.

- **Strengthened local financing is necessary for local authorities to exercise their health powers**

In the context of decentralisation, health has been delegated to local authorities. In practice, however, the latter do not have the budgets to exercise their powers. Their financial difficulties emerge at other levels, for example in the financing of the Ramed.

Thus, the authorities (subject to sufficient absorbing capacity), require additional funding to exercise their new powers. While central resources for health financing at the local level will have a major role to play (via the Regional Social Upgrading Fund and the Interregional Solidarity Fund, for example), local co-financing by communities may be desirable as it provides an incentive to rationalise local health expenditure. Local co-financing requires strengthening of local taxation. In this regard, the National Conference on Taxation has proposed a list of recommendations.

Earmarking tax revenues for health: a mechanism to be used with care

While many resources are earmarked in Morocco through Special Treasury Accounts[2] (STA) (20% of total public resources in 2020), **the resources of the three special earmarked accounts (SEA) for**

[2] STAs aim at implementing the government's orientations and earmarking budget resources. They are separated from the general state budget: STAs' revenues and expenditures are not included in the state budget, do not respect the rule of non-earmarking, and the Parliament has reduced authority on those accounts. They include: SEAs, financing accounts, monetary accounts, and other special accounts.

health account for just 2% of STA resources (see Chapter 7). A discussion on greater resource earmarking can therefore be initiated. According to the National Health Plan 2025, prevention measures, primary health care and certain equipment should be funded by introducing new tax provisions targeting products harmful for health, with revenues earmarked for the Central Pharmacy Fund.

In practice, the tax revenues to be earmarked are limited (5.4% of total tax revenues for DCT on tobacco and DCT on non-energy products). Earmarking more resources for health is therefore primarily a political choice. However, in order to finance the 2.5 percentage points of GDP increase in health expenditure, earmarking tax revenues from the DCT on harmful products for health will make it possible to increase, even to a low extent, the general level of resources for health. An inter-ministerial discussion could therefore focus on:

- **Earmarking *all* tax revenues from the DCT on tobacco**, and the new revenues that would result from a revision of this tax
- **Earmarking other DCTs on products harmful for health**, such as alcohol or sugary drinks
- **Continued earmarking to social sectors of the revenues generated by the subsidy reform (with a possible future abolition of the sugar subsidy)**

If Morocco were to start earmarking greater tax revenues for health, its success would depend upon several conditions (described in Chapter 7), the first being the alignment of objectives between the two ministries.

Post-transition: funding AIDS and TB control through tax revenues

Morocco should have the budgetary capacity to successfully manage its transition away from the Global Fund (which support is about USD 5 million in 2019). International co-operation has a relatively small role in the health sector, and within this sector, international support for AIDS and TB is limited, even if the latter represents a large share of the two diseases' strategic plans' budgets. In addition, the majority of international assistance for health goes through the Moroccan state budget, which gives the latter good visibility on the sector's funding.

However, the financial risk associated with the transition lies in the dependency of a small number of civil society stakeholders to the Global Fund's financing, in particular for programmes supporting target populations. There will therefore be several challenges:

- **On the one hand, until now, public funding has only supported curative aspects, not the human resources of civil society organisations (CSOs).** While the National Conference on Taxation recommended introducing measures to develop the cultural and voluntary sectors, it does not seem appropriate to introduce exemptions from personal income tax or VAT for CSOs, as this goes against the need to simplify tax expenditure.
- **On the other hand, civil society's programmes to fight HIV and tuberculosis should be financed with public resources.**

Beyond that, a framework to support CSOs' activities should also be put in place, such as establishing "social contracts" (inspired by "performance contracts" between the private sector and the state) between these organisations and the Ministry of Health. Without this, there is a very real risk that these programmes will be less effective, contributing to a resurgence of AIDS and TB cases. Finally, given the success of the Morocco Coordinating Committee (CCM)[3], it appears necessary to ensure its

[3] CCM are national committees that submit funding applications to the Global Fund and oversee grants on behalf of their countries. They include representatives from government, the private sector, donors, civil society and communities living with the diseases.

sustainability beyond the transition from the Global Fund. Its funding could come from the Social Cohesion Support Fund, which is dedicated to vulnerable populations.

TB control could be funded from the general state budget. Increased public funding for the disease is necessary to meet the current funding gap, and also to offset the 5% funding from the Global Fund. The high prevalence of TB in Morocco makes this all the more important.

With regard to AIDS funding, there are several options. They aim to respond to the specificity of AIDS, which primarily affects illegal vulnerable populations:

- **Through the Ministry of Health**: as with TB, the first option involves increasing the budget of the Ministry of Health. In particular, this would be necessary to fund CSOs and their prevention activities.
- **Through the SEA "Social Cohesion Support Fund"**, which relates to vulnerable populations.
- **Through the SEA "Support Fund for the INDH"**, which has been funding mother and child health programmes since 2018. However, this fund would need to authorise funding for human resources and prevention activities.
- **Through the creation of a new SEA**, which could, among other things, fund prevention. However, as there is already significant budget fragmentation, this is not the most appropriate option.
- **Through funding by the regions**, although this does not seem to be the most suitable option given the current lack of sufficient local financing. As the regions do not fund human resources and prevention any more than the central government does, it would fall to the various CSOs to convince each region. This would be a long and tedious task. Decentralisation has not occurred across all responsibilities and the regions still suffer from a lack of funding. Finally, the AIDS response needs to be coordinated, territory-wide, and implemented in a timely manner. Ensuring that after the Global Fund's withdrawal, every region provides sufficient and timely funding for items of expenditure for CSOs fighting AIDS, seems ambitious.

Structure of the report

This report is divided into eight chapters. Chapter 1 presents the opportunity offered by the Global Fund transition to strengthen an inter-ministerial review of health sector financing. Chapter 2 presents the sector's current funding situation in Morocco, while Chapter 3 focuses on the need to increase public funding and provides an estimate of the expected needs. Chapter 4 describes the prerequisites for any future increase in tax revenues for health. Chapters 5 and 6 suggest solutions to strengthen the design of health SSCs on the one hand and the role of tax revenues for health financing on the other. Chapter 7 discusses the mechanism for earmarking tax revenues to health. Finally, Chapter 8 assesses different sources of funding for AIDS and TB control.

Recommendations

Prerequisite before increasing public health financing: Improve the efficiency and management of public health expenditure

- *Improve public drug procurement procedures*
- *Revise the standardised health costs while ensuring dialogue with the private sector*
- *Strengthen the management capacities of the Ministry of Health*
- *Improve the Ministry of Health's budget execution capacity, especially for investment budgets*

Recommendation 1: Improve the design of health social security contributions to strengthen their role in health financing

Prerequisite: Greater control of CHI expenditure, a prerequisite for any change in SSCs

- *Renew national conventions*
- *Update the classification of professional activities, treatment protocols and health professionals' reference document*
- *Make public sector health care more attractive (develop health provision, reduce waiting times, equip health institutions with the necessary resources)*

Broaden the CNSS health SSC base so that all companies pay the 6.37% rate (not 4.11%)

Increase health SSCs rates

- Set up the National Council of Tax Levies
- In the case of the CNSS: increase the health SSC rates from employee and employer contributions to a more ambitious level than currently discussed (+0.14 pp)
- In the case of the CNOPS:
  - update the actuarial study on the financial sustainability of the CNOPS, taking into account the impact of new populations, health expenditure projections (in particular with the updated classification of professional activities and updating of certain treatment protocols), and the increase in the number of retired persons
  - revise upwards (or even remove) the CHI monthly ceiling of MAD 400

Promote labour force participation, especially of women, in the formal labour market

- Consider implementing an earned income tax credit to incentivise low-income female workers to join the labour market
- Keep the individual as the fiscal unit, and do not move towards taxation by fiscal household as recommended at the National Conference on Taxation

Introduce the social security scheme for the self-employed

- Finalise the study underlying this plan
- As envisaged in the reform, align the health SSCs rate with the rates already in place in the private sector
- Implement a tax base that will be based on actual income (not a fixed base that is a multiple of SMIG)
- Consider introducing a ceiling

Recommendation 2: Strengthen the role of tax revenues in health financing

Domestic consumption taxes

- Consider increasing the progressivity of tobacco taxation
- Increase DCT on wine
- Abolish the sugar subsidy system

Put the spotlight on environmental taxation

- Closely examine the National Conference on Taxation's recommendation concerning the establishment of a tax system dedicated to environmental protection.

Value added tax

- Do not earmark a share of VAT revenues to health, as recommended during the National Conference on Taxation
- Instead, broaden the VAT tax base to increase tax revenues for the general state budget
  - Rationalise the number of reduced VAT rates
  - Abolish certain VAT exemptions after a detailed analysis of their respective impacts
- Indirectly support the health sector by continuing the effort to exempt medicines from VAT
- Continue to improve the recovery of VAT credits, for the benefit of Moroccan civil society involved in health

Personal income tax

- Do not implement tax deductions for private health expenditure
- If, however, this option were chosen:
  - Significantly broaden the personal income tax base beforehand by reducing generous regressive tax allowances
    - For employment expenses
    - For retirement savings
    - For interest on mortgages
  - Target eligible private health expenditures
- Continue efforts to combat tax evasion in all liberal professions (including the private health sector) and strengthen the penalty system for fraud

Strengthen local funding to ensure local authorities exercise their health powers

- Ensure the local authorities have a degree of flexibility in mobilising funding from the Regional Social Upgrading Fund and the Interregional Solidarity Fund
- Strengthen local taxation so that communities have more resources at their disposal

Recommendation 3: Discuss several scenarios for earmarking certain tax revenues for the health sector

Prerequisite: Ensure that the objectives of the Ministry of the Economy, Finance and Administrative Reform and the Ministry of Health are aligned.

- Earmark all DCT tobacco tax revenues, and new revenues that would result from a revision of this tax, for health.
- Assign other DCTs on products harmful for health, such as alcohol or sugary drinks, to health.
- Continue earmarking revenues generated by the subsidy reform for health. In this context, consider earmarking the revenues generated by the abolition of the sugar subsidy.
- Use a set of conditions to restrict the earmarking of revenues, to lower the risks associated with this form of funding.

- Introduce the use of earmarked taxes as part of an overall health financing strategy.
- Establish awareness campaigns on the role of the earmarked tax and the health programme that will benefit from its funding.
- Ensure that the earmarked resources are first used to finance defined health programmes (in terms of budget, scope and objective). These programmes are subject to a prior needs assessment to take into account possible increases in their use or coverage. Therefore, consider earmarking resources for health programmes that are currently supported by donors, and which will see their funding decrease over time.
- Favour flexible resource earmarking mechanisms to limit budgetary rigidities.
- Introduce new earmarked resources only once the quality and effectiveness of public expenditure from the Ministry of Health has improved.
- Regularly evaluate the health programmes funded by these earmarked resources
- Limit the number of earmarked taxes to limit the fragmentation of funding sources.
- Ensure timely disbursement of earmarked resources for health programmes.
- Resource allocation should be conditional on the institutions' ability to absorb and manage new income flows.
- Clearly and transparently outline the resource earmarking mechanism.

Recommendation 4: Fund AIDS and TB programmes through tax revenues

Integrate preparations for the transition of AIDS and TB funding into the broader health financing debate

- Make the transition agenda a real inter-ministerial issue
  - Maintain a long-term dialogue between the Ministry of the Economy, Finance and Administrative Reform and the Ministry of Health
  - Ensure that the Ministry of the Economy, Finance and Administrative Reform is an active participant in the Morocco CCM, as well as in the workshops on transition
- Strengthen the economic analysis capacities of the Ministry of Health
  - Update the National Health Accounts and strengthen their use

Recommendations for both diseases

- Ensure the sustainability of public funding for CSOs involved in AIDS and TB control
  - Increase the share of public funding
  - Fund civil society's programmes to fight HIV and tuberculosis with public resources
  - Agree to fund CSOs' human resources
- In return, supervise CSOs as necessary
- Contrary to the recommendation made during the National Conference on Taxation, do not introduce exemptions from PIT or VAT for CSOs
- Keep the CCM to maintain the dialogue between the state, CSOs and representatives of the populations affected by the disease, and fund it through the Social Cohesion Support Fund, which is dedicated to vulnerable populations

Funding for tuberculosis

- Use the general state budget

Funding for AIDS

- Discuss different funding options
  - Recommended options
    - **Through an increase in the Ministry of Health budget**
    - **Through the Social Cohesion Support Fund,** which relates to vulnerable illegal populations
    - **Through the SEA INDH Support Fund**, provided that the fund authorises funding for human resources and prevention activities. Some funding from this source would make sense, as it has been funding mother and child health programmes since 2018.
  - Other options
    - **Through the creation of a new Fund,** which could, among other things, fund prevention. However, there is already significant budgetary fragmentation between the general budget, STA and Segma.
    - **Through regional funding.**

Recommendation 5: Work with the private sector to provide health infrastructure and services

- Approach public-private partnerships (PPPs) cautiously, given the complexity of such operations
- Avoid using tax incentives to encourage private-sector development in health. However, if this option were chosen:
  - Incentives should be conditional upon business costs rather than profits
  - Favour temporary tax incentives
  - Systemise the conditions associated with these incentives (e.g. the number of jobs created)
- Maintain the role of the state in providing health infrastructure and services

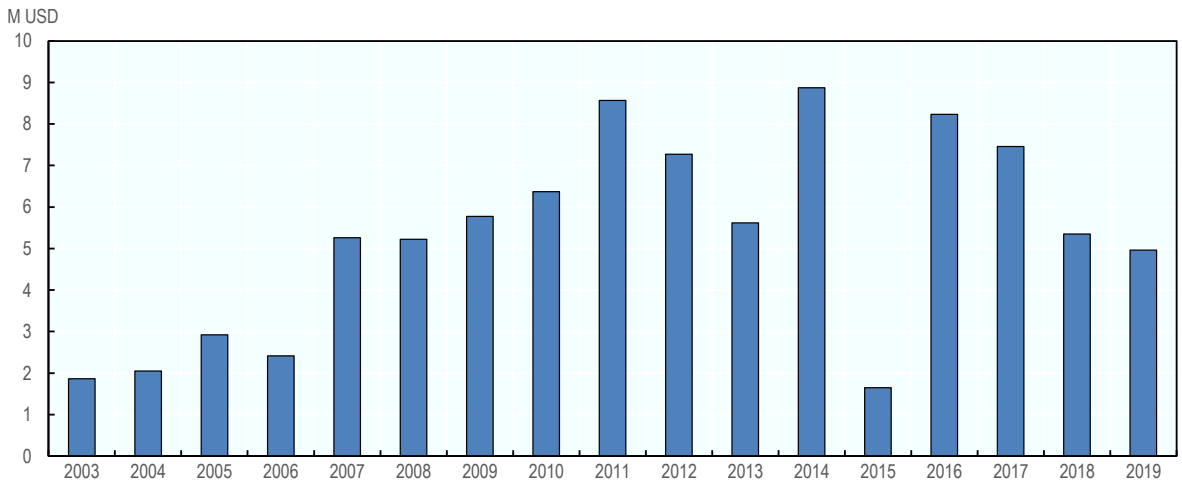
1 Preparing for the Global Fund withdrawal: an opportunity to enhance inter-ministerial discussions on health financing

Morocco is preparing for the Global Fund transition

The Global Fund to Fight AIDS, Tuberculosis and Malaria has supported Morocco since 2003, with nearly USD 100 million in grants to support the implementation of national AIDS and TB strategies. The main beneficiaries are the Ministry of Health and Moroccan civil society organizations (CSOs) involved in efforts to fight against these two diseases. These grants mainly support purchases of medicines and medical supplies and prevention, coordination and monitoring & evaluation activities.

Although there is no indication that the Global Fund to Fight AIDS, Tuberculosis and Malaria, which has supported Morocco since 2003, would leave the country, it would nevertheless be wise not to disregard such a transition and to prepare in case it would happen in the medium or longer run. Morocco will continue to receive financial support for the 2021–23 funding cycle. However, the Global Fund has been significantly decreasing its financial support since 2017 (40% drop between 2017 and 2019), a trend that is expected to continue over time (Figure 1.1).

Figure 1.1. Global Fund grants to Morocco have been declining since 2017



Source: Global Fund database.

In anticipation of the Global Fund's withdrawal, the Ministry of Health has initiated a process to prepare for the transition. Since 2016, reports have been produced on Morocco's preparedness for the AIDS and TB transition in general, and on the sustainability and preparedness for the transition of its procurement and stock management system for TB and AIDS products. In 2019, the Ministry of Health organised transition workshops and an action plan was drafted.

Preparations for the transition should be integrated into a broader discussion on health financing

Alongside the preparation for Global Fund withdrawal, the Ministry of Health has launched a discussion on Morocco's health system financing. The process included a National Conference on Health Financing held in June 2019 which led to 36 recommendations, some of which are discussed in this report (Box 1.1).

One of the challenges of the transition is integrating the issue of AIDS and TB funding into the broader health financing discussion. Indeed, better general health financing would facilitate financing options for AIDS and TB strategies.

The transition agenda should therefore be treated as an inter-ministerial issue, and not restricted to the Ministry of Health's authority. At the political level, the recent appointment of a new Minister of Health should provide high-level support for a discussion on health financing. The technical teams at the Ministry of the Economy, Finance and Administrative Reform are open to dialogue and interested in taking a joint approach on this issue. Close inter-ministerial collaboration would reduce the risk of an isolated approach to health financing and would facilitate the implementation of a coherent health financing strategy. Having the Ministry of the Economy, Finance and Administrative Reform as an active participant in the Morocco Coordinating Committee (CCM[4]) and in the transition workshops would be a first step in that direction. Experiences from several countries demonstrate the importance of these political factors for successful health sector reforms (Box 1.2).

This approach is all the more likely to succeed, given that Morocco has adequate time to prepare for the transition. The Global Fund will continue disbursing grants during the next financing cycle (2021-23). At the same time, Morocco has undertaken numerous reforms that will have an impact on health financing. In particular, the tax reform initiated in 2019 is expected to continue, allowing specific health tax measures (such as the domestic consumption tax increase on harmful products for health) to be introduced. An overhaul of the social welfare strategy, and in particular the Ramed, is also under way. Finally, the simultaneous establishment of the Single Social Register is another flagship measure that will enable better targeting of poor and vulnerable populations. However, one of the challenges for the Ministry of Health will be maintaining a long-term dialogue with the Ministry of the Economy, Finance and Administrative Reform.

[4] CCM are national committees that submit funding applications to the Global Fund and oversee grants on behalf of their countries. They include representatives from government, the private sector, donors, civil society and communities living with the diseases.

Box 1.1. Selection of some of the National Conference on Health Financing's recommendations (June 2019)

The 36 recommendations include, amongst others, the following:

- Ensure the financial sustainability of the compulsory health insurance (CHI) and the Ramed schemes by channeling innovative funding to ensure long-term financing
- Increase earmarked revenues for health by implementing the recommendations of the Third National Conference on Taxation: broaden the VAT base and earmark the surplus generated to social welfare
- Increase the Ministry of Health's budget share in the total state budget to move closer to international standards
- Continue efforts to exempt medicines from VAT in order to reduce the cost of care for the population
- Ensure equitable funding by adopting the same contribution rate for all insured people and the same basket of care to harmonise and converge health schemes

Source: (Ministère de la Santé, 2019[1]).

Box 1.2. Common political economy factors that facilitated health sector reforms in Mexico, Thailand and Turkey

Mexico, Thailand and Turkey carried out health sector reforms in the 2000s. All of these reforms aimed to improve access to health services, enhance protection against financial risks and expand universal health coverage. The following political economy factors were common in all three countries:

- High-level political support, with a recently appointed Minister of Health
- Reform at the national level is prioritized, beyond the scope of the health sector
- Strong and ongoing involvement of technocrats from several ministries (particularly Health, Economy, and Labour) during the reform's preparatory phase to facilitate its adoption and implementation

Source: (OECD, 2018[2]); (OECD, 2008[3]), (WHO, 2019[4]), (OECD, 2019[5]), (OECD, 2016[6]).

This inter-ministerial approach is necessary as the financing risk in the health sector is particularly high during donors' transition periods

As countries develop, their financing needs and the structure of available financing change. Two major trends emerge: first, the replacement of external financing flows with domestic financing flows, followed by the replacement of public domestic flows with private flows[5] (OECD, 2019[7]).

[5] Investment flows.

These changes occur at different levels of development and at different paces across sectors. Figure 1.2 shows trends in official development assistance (ODA – which are concessional flows) and non-concessional assistance flows (NCA); the latter can be seen as a proxy for the development of private flows, since they are closer than concessional flows to market conditions. Several observations can provide information on the health sector's level of vulnerability during the transition:

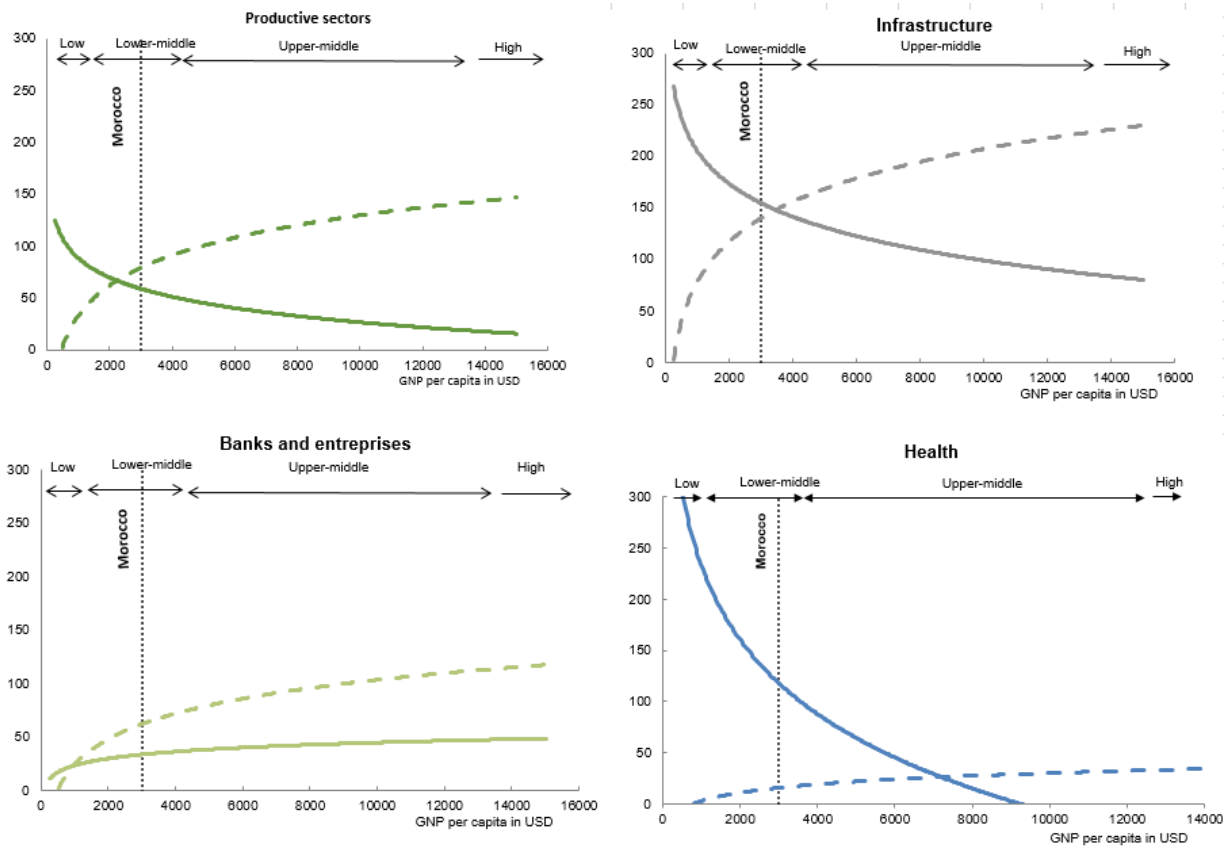
- In countries with low levels of development, relatively high levels of concessional flows are injected into the health sector, particularly compared with other sectors such as infrastructure or productive sectors (agriculture, fisheries, and industry). However, donors withdraw faster than in other sectors and, unlike in other sectors, concessional flows do not appear to be fully offset by non-concessional flows. The health sector thus faces a paradox: while it initially attracts high levels of concessional flows, it then experiences a rapid reduction in these flows, which are not fully offset. **This suggests that the health sector experiences a significant funding risk during the transition. At this stage, domestic financing plays a crucial role, which the authorities must anticipate and prepare for.**
- The tipping point between concessional and non-concessional flows occurs at different levels of development depending on the sector: at a gross national product (GNP) per capita of USD 1 000 for banking/business services, USD 2 000 for productive sectors, USD 4 000 for infrastructure, and USD 7 500 for health. **Health thus appears to be one of the last sectors in which public flows are replaced by private flows. This can be explained by its unattractiveness to the private sector,** with fewer private investment flows, particularly when compared with more profitable sectors such as banking, infrastructure or industry (as highlighted by the lower slope of the dotted line for health in Figure 1.2).

These observations underscore the importance of the need for public resources to support health financing during donors' transition. This support is essential because i) private sector development is slow and does not fully offset donor funding, ii) the sector's needs are significant and increase as countries develop and populations age, and iii) the quality of the response to infectious diseases such as HIV or TB is very closely linked to overall funding levels.

In the past, countries that failed to allocate adequate public funding after the Global Fund's withdrawal have seen a resurgence of certain epidemics. Romania, for example, experienced a resurgence of the HIV epidemic among target populations after the Global Fund withdrew in 2010. AIDS prevalence among people who inject drugs increased from 3.3% in 2009 to 27.5% in 2013. This may be due to the lack of adequate domestic funding after the withdrawal of the Global Fund, particularly for prevention activities and for CSOs working with target populations.

Figure 1.2. Donors' withdrawal creates a particularly high funding risk for the health sector

Disbursements in M USD from Development Assistance Committee (DAC) and non-DAC donors, multilaterals and private donors, average 2012–2017. Solid lines represent ODA flows. Dotted lines represent non-concessional flows.



Note: The graph is based on logarithmic regression values with GNP per capita as an independent variable and ODA and NCA flows by sector as dependent variables. The productive sector includes agriculture, fishing, industry, mining and construction. The health variable includes the categories of health, population policies and programmes, and reproductive health from the Creditor Reporting System (CRS) database. Private donors are included in the ODA flows for health insofar as they traditionally contribute a significant share of health flows in the form of donations. Note that 39 out of 122 countries do not have data on private donor assistance in health.
Source: Database: World Development Indicators (for GNP per capita) (World Bank); Database: Creditor Reporting System (OECD); (OECD, 2019[7]).

2 Overview of health financing in Morocco

Financial resources for health are low

Morocco does not allocate a significant level of funds to the health sector. Health expenditure accounted for 5.2% of GDP in 2017 (WHO data[6]), which is similar to lower-middle-income countries (5.6% of GDP[7]) but lower than upper-middle-income countries (6.7% of GDP), high-income countries (7.8% of GDP) or regional countries such as Tunisia (6.9% of GDP).

In 2017, health expenditure per capita in Morocco was USD 161, well below the average for upper-middle-income countries (USD 471), or countries such as Thailand, Jordan or Tunisia (between USD 250 and 340).

Out-of-pocket payments are the sector's primary funding source

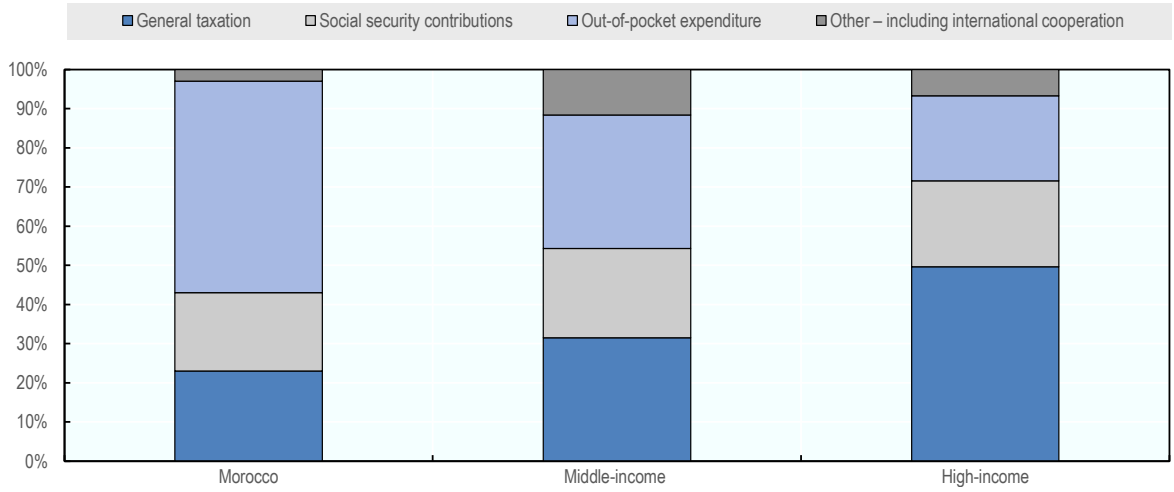
The health sector is financed through out-of-pocket expenditure (51%), social security contributions (SSCs, 24%), general taxation (22%), voluntary prepayments (3%) and less than 1% for international co-operation. This financing structure is similar to countries such as Chile, Greece or Singapore. Compared to the average for middle-income countries (Figure 2.1), Morocco has a greater dependence on out-of-pocket payments (which are a key determinant of catastrophic household expenditure). Conversely, a relatively smaller share of health financing is reliant on general taxation and international co-operation.

[6] Health expenditure represents the final consumption expenditure on health goods and services (excluding investments, exports and intermediate consumption). These include HF.1 (Government schemes and compulsory contributory health care financing schemes); HF.2 (Voluntary health care payment schemes); HF.3 (Household out-of-pocket payments); HF.4 (Rest of the world financing schemes – non-resident).

[7] Unweighted average.

Figure 2.1. Out-of-pocket payments dominate health financing in Morocco

Composition of health financing (2017)



Source: Database: Global Health Expenditure (WHO).

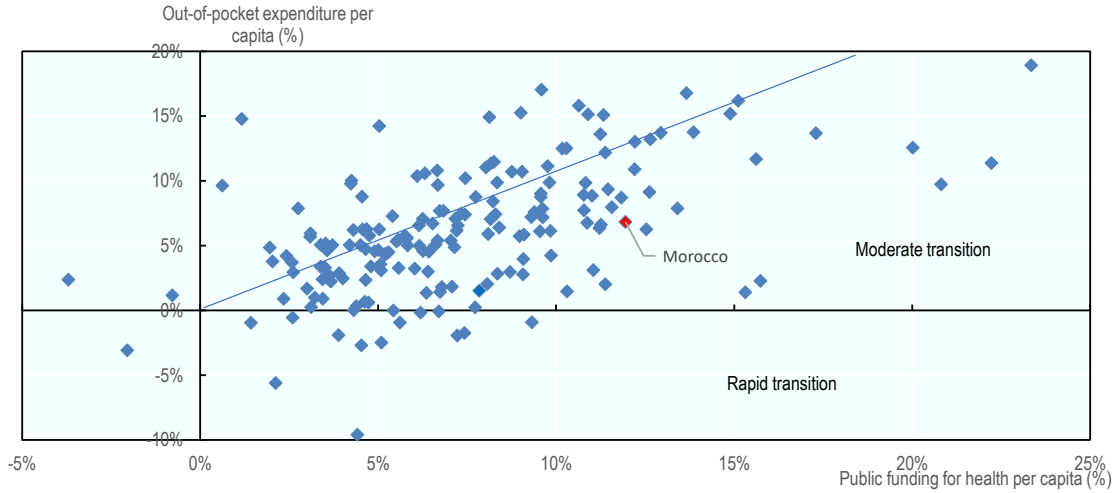
As in other countries, the introduction of compulsory health insurance (CHI in 2005 and Ramed in 2013) has helped reduce out-of-pocket payments. Before 2006, only 16% of the Moroccan population was covered by a health insurance scheme (civil servants, employees of public companies or very large private companies). Now nearly 60% of the population is covered. In this way, out-of-pocket payments have reduced by 6%, and by 38% for those covered by Ramed (Ministère de la Santé, 2019[8]), thereby reducing out-of-pocket payments inhealth financing from nearly 70% in 2000 to 50% in 2016.

However, out-of-pocket payments remain significant, making the Moroccan health financing system inequitable and regressive. For example, people insured under the CNSS with serious medical conditions pay on average MAD 4 300 per year, while 50% have an average monthly salary of less than MAD 2 500 and 87% earn less than MAD 6 500. There are several reasons for this. The quality of care provision in the public sector is low, which leads patients to seek care in the private sector, in which does not reimburse the payments of patients as well as the public sector. 40% of the Moroccan population is not eligible for CHI (family workers, self-employed, sole traders). The actual costs incurred by the patient may be higher than the national standardised health costs (and therefore the costs reimbursed under CHI). Finally, some medical procedures and medications are not included in the CHI basket of care.

Reducing out-of-pocket expenditure will require an increase in public funding. In particular, this will help improve the quality of public care provision and incentivise individuals to seek care in the public sector, or reduce the remaining cost to be covered by patients. An increase in public funding for health will also enable Morocco to speed up its "financing transition", defined as the relative increase in health expenditure financed by an increase in public funding, and a relative decrease in out-of-pocket payments and international assistance. Comparisons between growth rates of public and private sources of funding show that Morocco has a moderate health financing transition rate (Figure 2.2).

Figure 2.2. In Morocco, public funding for health is growing at a faster rate than out-of-pocket payments

Average annual growth rate (%) between 2000 and 2016



Source: Database: Global Health Expenditure (WHO).

However, increased public funding will not be the only solution to reduce the share of out-of-pocket payments. It will also be important to regulate the private medical sector. According to the National Health Accounts, in 2013, half of household expenditure went to the private health sector (for those with Ramed cover, this was 41% of their expenditure) (Ministère de la Santé, 2015[9]). This trend can also be seen at private clinics, where 70% of their income is from households, compared to just 30% from insurance schemes. Reducing out-of-pocket payments must therefore involve stricter regulation of the private medical sector (for example better regulation of "dual practice"), alongside other measures, such as revising national standardised health costs to better reflect real medical costs, or introducing a CHI scheme for self-employed.

Public funding for health is fragmented

Various public institutions have a role to play in the health sector (Table 2.1), with funding coming from several sources (Table 2.2):

- The Ministry of Health
- Public institutions under supervision of the state (the National Health Insurance Agency – ANAM, university hospitals – CHUs)
- Independently-managed state services (Segma), which are linked to the Ministry of Health (provincial and regional hospitals)
- Health-related special earmarked accounts (SEAs): Central Pharmacy Fund (linked to the Ministry of Health), Social Cohesion Support Fund (Ministry of the Economy, Finance and Administrative Reform), National Initiative for Human Development (INDH) support fund (Ministry of the Interior).

Table 2.1. Roles of the various public institutions involved in the health sector

Public institutions		Roles
Ministry of Health		Developing and implementing government policy on population health; standardising guidelines and coordinating objectives and actions that contribute to improving health at the country level; taking action to ensure effective allocation of resources; developing and implementing national policy on drugs and pharmaceuticals; providing oversight of medical, paramedic and pharmacy professions
Public institutions under supervision of the state	ANAM	Ensuring financial equilibrium through ongoing technical supervision and the regulation of the CHI system Managing resources earmarked for Ramed
	CHU	Providing tertiary level care (routine and specialist medical and surgical services – emergency and planned) Providing medical and pharmaceutical under- and post-graduate clinical teaching and engage in practical training of nursing staff Conducting medical and nursing care research
Segma	Provincial and regional hospitals	Provincial hospitals : Providing primary health care Regional hospitals: Providing secondary health care
Health-related SEAs	Central Pharmacy Fund	Joint procurement for public hospitals and basic health care facilities of reagents, chemicals, tests, pharmaceuticals and medical consumables
	Social Cohesion Support Fund	Funding the Ramed[1] system
	INDH Support Fund	Financing various programmes, including the health component of the territorial upgrading programme (housing for medical staff, dispensaries and health centres, acquisition of ambulances), and the health component of the programme to reduce territorial and social disparities in rural areas. More recently, this SEA has also been used to fund maternal and child health programmes.

1. Only roles relating to health are listed in this table.
Source: OECD.

The fragmentation of public funding sources make it difficult to have a consolidated view of public accounts and health financing in Morocco (OECD, 2018[10])**.** There are many budgetary exceptions: carryovers of funds from one year to the next, earmarking of particular resources to particular expenditure, parafiscal taxes, etc. Moreover, autonomous institutions operating in parallel with the state or delivering a public service exercise strong financial control in terms of the funding itself and setting out objectives, where the funds come from and how they will be collected and used. This negatively impacts on the coherence of public initiatives and means that the legislative power and the government do not have a full overview of public policies or the full capacity to make decisions and to evaluate these policies.

Table 2.2. Overview of public funding for health in Morocco

Public institutions		Sources of funding	Budget in MAD (according to the Finance Act 2019)
Ministry of Health		General state budget	Operating budget: 15.33 billion[1] Investment budget: 3.334 billion **Total: 18.684 billion**
Public institutions under supervision of the state	ANAM	Share of the CHI budget (i.e. SSCs paid to the CNOPS and CNSS) and share of the Ramed budget (i.e. share of the Social Cohesion Support Fund)	*Information not available*
	CHU		*Information not available*
Segma	Provincial and regional hospitals	Ability to raise their own revenue	Operating expenses: 935.5 million Investment expenditure: 84 million **Total: 1.0195 billion**
Health-related SEA[3]	Central Pharmacy Fund	Budgetary allocation from the Ministry of Health's operating budget + Transfer from the Social Cohesion Support Fund	3.33 billion (2017)
	Social Cohesion Support Fund	Profits generated from compensation reform[5] + Earmarked taxes: • part of the DCT on tobacco; • 50% of the solidarity tax on air travel; • tax on insurance contracts; • one-off revenues (e.g. 50% of the deductible contribution on assets and liquidity held abroad in 2014); • overhaul of sugar subsidy; • income from the 1% corporate income tax surcharge for companies with a turnover > MAD 50 million	In 2017: 1.225 billion for the Ministry of Health 350 million for the Central Pharmacy 875 million for university hospitals **Total: 2.45 billion**
	INDH Support Fund	Payments from the general state budget + Payments from local and regional authorities + International co-operation payments	410 million (2017)[4]
Total			**22.6 billion[2]**

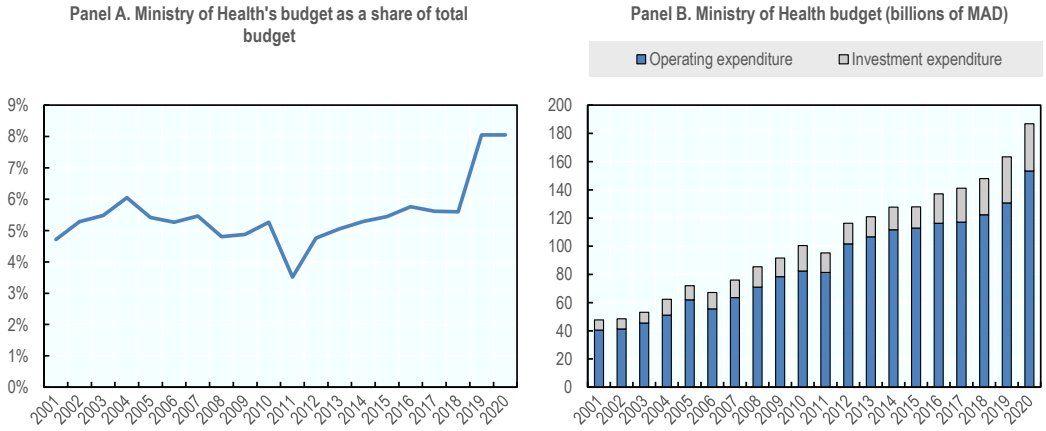
1. 2020 Finance Law.
2. This total should be assessed with caution:
(i) The budget for public institutions under state supervision is not taken into account.
(ii) SEAs information is taken from 2017, as information for 2019 is not available.
(iii) The Central Pharmacy Fund is not included as such in the calculation because it is financed from the Ministry of Health budget and the Social Cohesion Support Fund.
3. SEAs funding is an exception to the general rule of non-earmarking of resources.
4. The MAD 410 million for the INDH Support Fund represents funding for health programmes under the INDH's programme to reduce territorial and social disparities in rural areas.
5. Compensation reform relates to subsidy reform.
Source: Finance Act 2019 for the Ministry of Health and Segma figures. MEFRA STA 2019 report for SEAs (2017 data).

The Ministry of Health budget is low but has been increasing since 2011 (Figure 2.3). In 2018, the Ministry's budget accounted for 5.6% of the general state budget (operating and investment budget). Although it has been increasing since 2011 (a threefold increase between 2001 and 2018), it nevertheless remains relatively low compared with the WHO standard of 12%.

SSCs for CHI are collected by the CNOPS in the public sector and CNSS in the private sector. In 2018, SSCs amounted to MAD 5.106 billion for public CHI and MAD 6.52 billion for private CHI, i.e. MAD 11.6 billion in total.

Therefore, total public funding of health in Morocco can be estimated at MAD 35 billion, i.e. about 3.5% of GDP (excluding university hospitals). Two-thirds of this amount comes from tax revenues and one-third from SSCs.

Figure 2.3. The Ministry of Health budget is low but increasing



Notes: Data from 2001 to 2018 are from MEFRA. Data for 2019 and 2020 come from the information contained in the final draft of the budget ("morasse budgétaire").
Source: MEFRA.

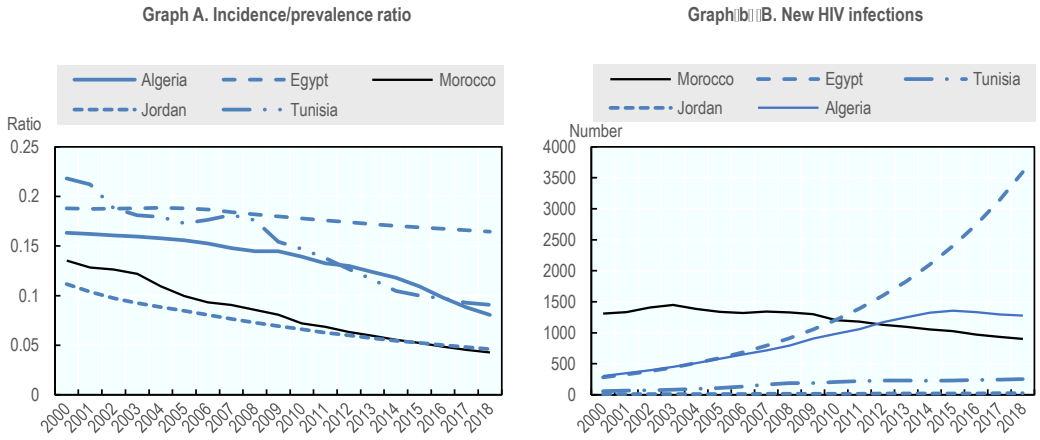
Despite some progress, considerable challenges remain in the health sector, highlighting the need to strengthen its financing

Morocco has made some progress in the health sector. Life expectancy increased from 64 to 76 years between 1990 and 2017, notably through the reduction of infant and child mortality (due to vaccinations), and a reduction in the burden of communicable diseases (Ministère de la Santé, 2018[11]).

Morocco's AIDS response is performing well. HIV prevalence remains low (around 0.1%, although higher among key populations), and new infections were reduced by 25% between 2010 and 2017 (Figure 2.4). Achieving the 90-90-90 targets, however, will require additional effort. By the end of 2019, of the 21 500 people living with HIV, 78% knew their status; 70% were receiving treatment, and 64% had an undetectable viral load.

Efforts are still needed to achieve health-related SDG targets in particular. In 2018, the maternal mortality ratio per 100,000 live births was 72.6 in Morocco (44.6 in urban areas and 111.1 in rural areas) – far higher than the target of 70 by 2030, which Egypt, Jordan and Tunisia have met already for several years (SDG 3.1). In terms of neonatal mortality (SDG 3.3), the ratio is 14.4 per 1 000 live births in Morocco – higher than the target of 12, and higher than other countries in the region.

Figure 2.4. AIDS is on the decline in Morocco

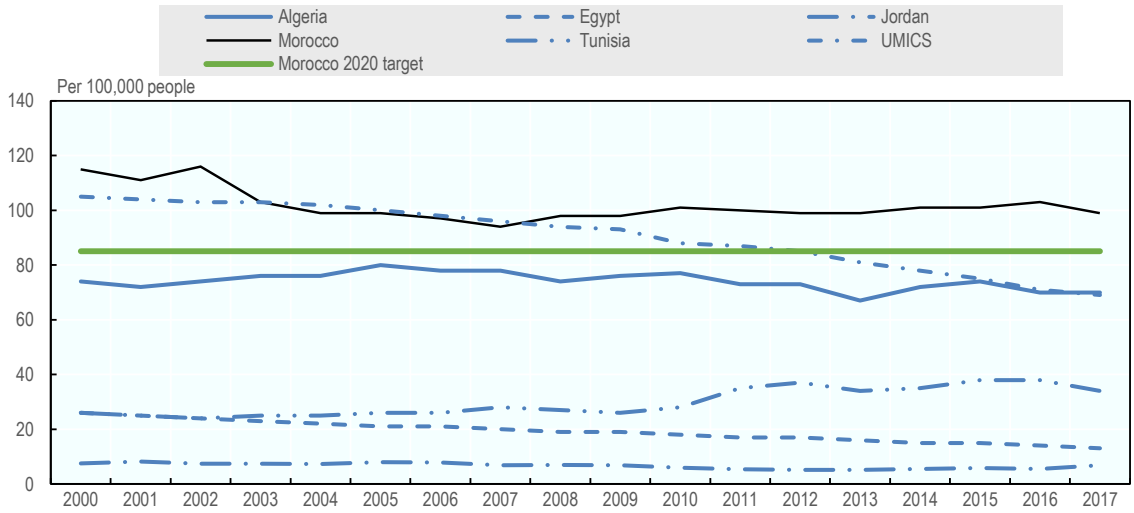


Note: HIV incidence is the number of new infections, while HIV prevalence is the number of people living with the disease.
Source: UNAIDS database.

Morocco remains one of the Middle East and North Africa countries most affected by TB. Incidence (86 cases per 100 000 population in 2016 – Figure 2.5) and mortality rates (9.3 per 100 000 population) remain high (Ministère de la Santé, 2017[12]) and drug-resistant TB and TB/HIV co-infections have increased (OMS et Programme National de Lutte Antituberculeuse du Maroc, 2019[13]). Therefore, although since 2000 there has been a decrease in incidence and mortality rates, with detection rates above 85% and improvement in treatment efficacy, these results remain insufficient (Nouria Brikci et Dieudonné Bassonon, 2018[14]).

Figure 2.5. TB remains an issue in Morocco

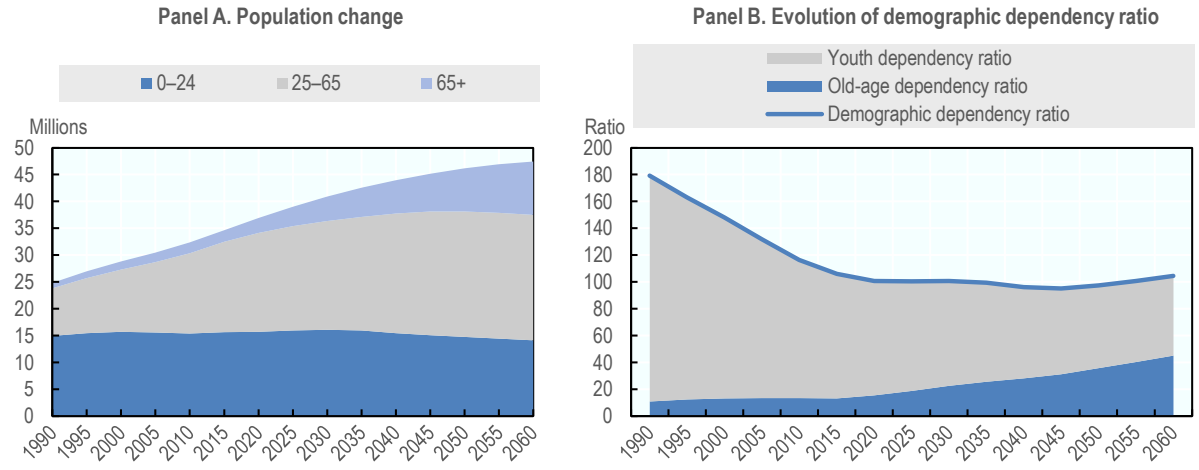
Incidence rate



Note: The TB incidence rate is the estimated number of new and relapsed TB cases in a given year, expressed as a rate per 100 000 people. Morocco has set itself the target of reaching an incidence rate of 85 cases per 100 000 people by 2020 (then 55 cases by 2025, and under 20 cases by 2030). The WHO figure presented in this figure (103) differs from the Moroccan figure (86) in 2016.
Source: WHO.

Added to this is the burden of epidemiological transition (shift of the burden of morbidity and mortality from infectious to non-communicable diseases) **and an ageing population**. Between 2020 and 2060, the number of people aged over 65 is expected to triple (Figure 2.6), resulting in an increase in total health expenditure, and threatening the budget balances of CHI funds. However, the upward trend in spending can be controlled if the ageing population remains healthy (Lorenzoni et al., 2019[15]).

Figure 2.6. Morocco's population is ageing



Note: An average fertility rate is assumed.
Panel B: The demographic dependency ratio is defined as the population aged 0–24 and 65+ divided by the population aged 25–64. The old-age dependency ratio is defined as the population aged 65+ divided by the population aged 25–64. The youth dependency ratio is defined as the population aged 0–24 divided by the population aged 25–64.
Source: Database: World Population Prospects: The 2017 Revision (United Nations).

The health system faces many other challenges, such as regional disparities in health care and the lack of human resources. The number of doctors and nurses per capita is far below the critical threshold of 2.5 health professionals per 1 000 inhabitants and is uneven across different regions of the country. There are also disparities in access to essential health services, particularly between rural and urban areas, but also between rich and poor populations (World Bank, 2018[16]).

3 The need to increase public funding in the health sector

Total health expenditure growth is driven by public funding, with health prioritised within the state budget

An analysis of the drivers that have underpinned health expenditure growth in the past is necessary to understand the reforms that will be expected in the future to increase financing of the health sector. To do this, *total* health expenditure growth is first broken down between the different funding sources: public funding, out-of-pocket expenditure, and international co-operation. The analysis then focuses on *public* health expenditure growth, using a fiscal space analysis to decompose the role of economic growth, changes in public spending as a share of GDP, and public health expenditure as a share of total public spending.

Breakdown of total health expenditure growth

Total health expenditure growth is driven by different funding sources: public funding, out-of-pocket expenditure, international co-operation (and possibly also voluntary prepayments).

In Morocco, total health expenditure growth is driven by public funding. The breakdown of total health expenditure growth (as well as health expenditure per capita growth) shows that the largest contributor in nominal terms and over time is public funding (Table 3.1 and Figure 3.1).

It appears that public health expenditure in Morocco helps reduce inequalities and population vulnerability (AFD, DEPF et ONDH, 2019[17])**.** In particular, the Ramed scheme is highly progressive. Excluding the Ramed scheme, results by market income quintile are less clear-cut, with CNOPS and CNSS benefits focused on the richest quintile. This provides a strong rationale for increasing the scale of public health programmes. Improving the quality of public health care and reducing the dysfunctions affecting the Ramed scheme would help make the state's actions for health more effective and efficient.

Table 3.1. Health expenditure growth in Morocco is driven by increased public funding

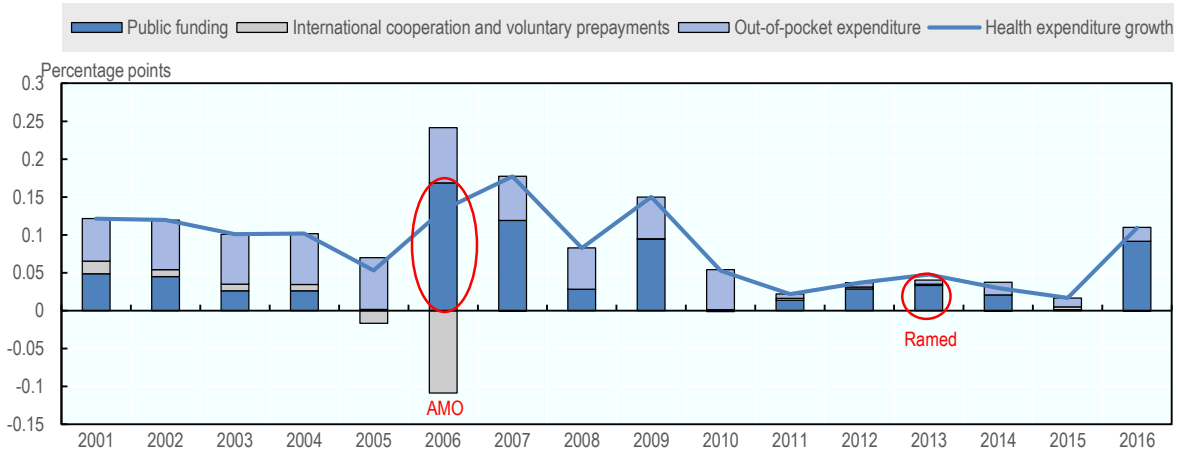
Breakdown of health expenditure growth over the 2000–2016 period, nominal term

		Total health expenditure	Health expenditure per capita
Health expenditure growth (%)		**2.61**	**2.20**
Breakdown (percentage points)	Public funding	1.52	1.25
	Out-of-pocket expenditure	1.21	1.01
	International co-operation	0	0.02
	Voluntary prepayments and other[1]	-0.12	-0.09

Notes: Results in real terms, not presented here, show the same trends.
1. These are categories FS5 (voluntary prepayments) and FS6 (excluding out-of-pocket payments) in the Global Health Expenditure database (WHO).
Source: OECD based on: Global Health Expenditure (WHO).

Figure 3.1. Following the introduction of the CHI, public funding has been the main driver of health expenditure growth

Breakdown of health expenditure growth, nominal term



Source: OECD based on: Global Health Expenditure (WHO).

Breakdown of public health expenditure growth

The fiscal space methodology can be used to break down the various drivers of public health expenditure growth (Box 3.1): (i) economic growth, (ii) changes in public spending as a share of GDP, and (iii) public health expenditure as a share of total public spending, which reflects the extent to which government regards health as a priority for public action over a given period.

Box 3.1. Methodology of the fiscal space for health

Fiscal space is the leeway that allows a government to dedicate resources to pursue objectives without jeopardising its fiscal sustainability, given existing budgetary conditions and long-term imperatives. This concept, which can be applied in general or to a specific sector such as health, is not intended to provide a normative indication of a particular level of public spending to be achieved, and focuses only on public spending (omitting interactions with private household spending, for example).

Breaking down public health expenditure growth, which is a proxy for fiscal space, makes it possible to separate out its various drivers (Table 3.2): (i) economic growth, (ii) changes in public spending as a share of GDP, and (iii) public health expenditure as a share of total public spending, which reflects the extent to which government regards health as a priority for public action over a given period.

WHO data (extracted from its Global Health Expenditure database) can be used to produce a comparative analysis of the weight of the various drivers (otherwise the use of national data is preferable).

Table 3.2. Example of fiscal space breakdown

Drivers	Variable		2000	2016	Ln				Share
					t	t+1	Growth rate	Annual growth rate	
Macroeconomic conditions	GDP per capita (USD)	Y	1 347	2 937	7.21	7.99	78%	4.9% (Y')	**43% (Y'/P')**
Role of public spending	Total public spending (% GDP)	E	24.63	30.16	3.20	3.41	20.3%	1.3% (E')	**11.2% (E'/P')**
Prioritising health within public action	Public health expenditure (% of total public spending)	H	3.98	9.07	1.38	2.20	82.3%	5.1% (H')	**45.6% (H'/P')**
Public health expenditure per capita (USD)		P	13.21	80.34[1]	2.58	4.39	180.6% (=Y+E+H)	11.3% (P')	100% (P'/P')

1. This figure, derived from calculations based on WHO database (Global Health Expenditure Database – GHED), differs from the national orders of magnitude shown in Table 3.5, thereby underscoring the importance of using Moroccan figures to calculate the fiscal space breakdown.

According to WHO data, health sector prioritisation and economic growth explain public health expenditure growth in Morocco (Table 3.3). Health sector prioritisation is more important in Tunisia and Jordan than in other countries such as Egypt where the fiscal space for health has increased through economic growth and growth in public spending only.

Table 3.3. Breakdown of fiscal space for health, based on WHO data, 2000–16

		Public health expenditure per capita growth (%)	Breakdown of fiscal space (% share)		
			Economic growth	Change in total public spending	Prioritising health within public action
Morocco	Nominal	**11.3%**	**43%**	**11%**	**46%**
	Real	**10%**	**36%**	**13%**	**52%**
Tunisia	Nominal	5.6%	57%	14.3%	29.3%
	Real	1.9%	-29%	42%	86%
Egypt	Nominal	2.6%	160%	53%	-112%
	Real	6.9%	122%	19%	-41%
Jordan	Nominal	4.2%	133%	-23.6%	-9.8%
	Real	-0.5%	-204%	215%	89%

Notes: Methodology similar to the paper (World Bank, 2018[18]). For calculations in real terms, 2010 prices.
Source: OECD based on: Global Health Expenditure (WHO).

The Moroccan figures confirm this trend, but with greater emphasis given to economic growth, which exceeds health sector prioritisation (Table 3.4**).** This minor difference can be explained by the time periods of reference (2000–2016 or 2012–2018), the fact that the WHO data do not include Segma and STAs, or the possibility of high variability in economic growth between the time periods. These analyses could be improved in partnership with the Moroccan authorities, for example by including university hospitals expenditure or by refining the data used for the Social Cohesion Support Fund SEA (Box 3.2). In this respect, updating the National Health Accounts, which date from 2013, would be beneficial to the discussion on health financing in Morocco.

Several observations can be drawn from the breakdown of fiscal space for health (Table 3.4):

- **First, economic growth has a role to play in public health expenditure growth and this must be maintained.** Therefore, tax measures to provide additional financing for the health sector must not impede growth. **Secondly, the fact that the change in total public spending (as a percentage of GDP) is not a significant driver for the growth in public health expenditure per capita is positive.** This means that public spending, measured as a share of GDP, does not increase, or that public spending does not have a crowding out effect on public investment.
- **Finally, the prioritisation of health within budget is an important driver of per capita public health expenditure growth.** Morocco has started to prioritise health within the general state budget, with health budget increases since 2011 (see the trend of the health budget in the general state budget – Figure 2.3). However, the health budget in Morocco remains low (5.6% of the total state budget in 2018) compared with the WHO standard of 12% and 10.7% in Algeria, 12.4% in Jordan or 13.6% in Tunisia. The prioritisation of health in the budget may reflect the priority given to the health sector at a high political level, as well as an effective dialogue between the Ministry of Health and the Ministry of the Economy, Finance and Administrative Reform.

Therefore, while health priorisation is a major driver in health financing, economic growth also plays an important role, since the entire state budget cannot be channelled solely into this sector.

Table 3.4. Breakdown of the fiscal space for health, based on Moroccan data

2012–2018

	Public health expenditure per capita growth (%)	Breakdown of the fiscal space (% share)		
		Economic growth	Change in total public spending	Prioritising health within public action
Constant prices	6.22%	51%	9.5%	40%
Current prices	4.96%	64%	-13.5%	50%

Notes: See box for detailed calculations.

Box 3.2. Detailed calculation of the fiscal space for health, based on Moroccan data

The approach is similar to the previous box. Details of the figures used are described below. The calculation covers the 2012–2018 period as the Social Cohesion Support Fund SEA was created in 2012. The Central Pharmacy SEA is not considered in the analysis because it is financed partly from the Ministry of Health budget, and partly from the Support Fund for Social Cohesion SEA (for the Ramed share). Finally, the INDH Support Fund SEA is not included as the mother and child health programmes only date from 2018 and account for small amounts.

Table 3.5. Figures used to calculate the fiscal space for health (Moroccan data)

Drivers	Variable	2012	2018	Source & comments
Macroeconomic conditions	**GDP per capita (MAD)**	**25 132**	**30 391**	World Bank
Prioritising health within public action	Ministry of Health budget (operation + investment) (MAD M)	11 625	14 790	MEFRA
	Total state budget (MAD M)	*244 138*	*264 143*	
	Social Cohesion Support Fund expenditure (MAD M)	1 000	3 780	STA report
	Total SEA expenditure (MAD M)	*41 873*	*96 224*	
	Total Segma health expenditure (MAD M)	1 049	1 410	Segma report
	Total Segma expenditure (MAD M)	*2 140*	*2 849*	
	Public health expenditure (MAD M)	13 674	19 981	Calculation based on the above figures
	Total public spending (MAD M)	*288 152*	*363 218*	
	Public health expenditure (% of total public spending)	**4.75%**	**5.50%**	
Role of public spending	Total public spending (MAD M)	288 152	363 218	Calculations based on the figures below
	Total public spending (% GDP at constant GDP)	**36%**	**37%**	International Monetary Fund (IMF) World Economic Outlook for the GDP figures[1]
	Total public spending (% GDP at current GDP)	**34%**	**33%**	
At constant prices:				
Public health expenditure per capita (MAD)		**427**[2]	**620**	
Public health expenditure per capita (USD)		43	62	
At current prices:				
Public health expenditure per capita (MAD)		**405**[2]	**546**	
Public health expenditure per capita (USD)		40	55	

1. The GDP figures for 2012 are: MAD 804 726 million (constant prices) and MAD 847 881 million (current prices). The GDP figures for 2018 are: MAD 978 978 million (constant prices) and MAD 1 112 568 million (current prices).
2. These figures are broadly aligned with those of the 2014 National Health Accounts, which indicate a per capita budget for the Ministry of Health of MAD 375 in 2013. This figure is slightly lower than the figure presented in the table as the table does not only take into account the per capita expenditure of the Ministry of Health.
Source: OECD.

To move closer to the health-related SDGs by 2030, Morocco would have to increase the level of health expenditure by 2.5 percentage points of GDP

A methodology developed by the IMF provides orders of magnitude of the financing needed to move closer to the SDGs by 2030 (IMF, 2019[19]) (Box 3.3). Applied to the case of Morocco, the analysis shows that health expenditure should thus represent 8.2% of GDP, i.e. an increase of 2.5 percentage points of GDP (Table 3.6). This increase would raise health expenditure per capita from USD 170 in 2016 to USD 419 in 2030, and multiply the number of doctors by 2.6 and the number of medical staff (excluding doctors) by 3.6 (keeping current health workforce policies constant). Morocco is in the average range compared with other countries Figure 3.2.

Health expenditure would rely more on the public health expenditure. According to the analysis, health expenditure in 2016 represented 5.7% of GDP, divided equally between the public expenditure share and the private expenditure share. By 2030, health expenditure would rise to 8.2% of GDP, of which 5% would be from the public expenditure share and 3.1% from the private expenditure share. Thus, public sector funding would become more important than at present, with implications for tax revenues to be collected. It should be noted that private expenditure funding would continue to play an important role.

Table 3.6. To reach the health SDGs by 2030, Morocco would have to increase health expenditure by 2.5 percentage points of GDP

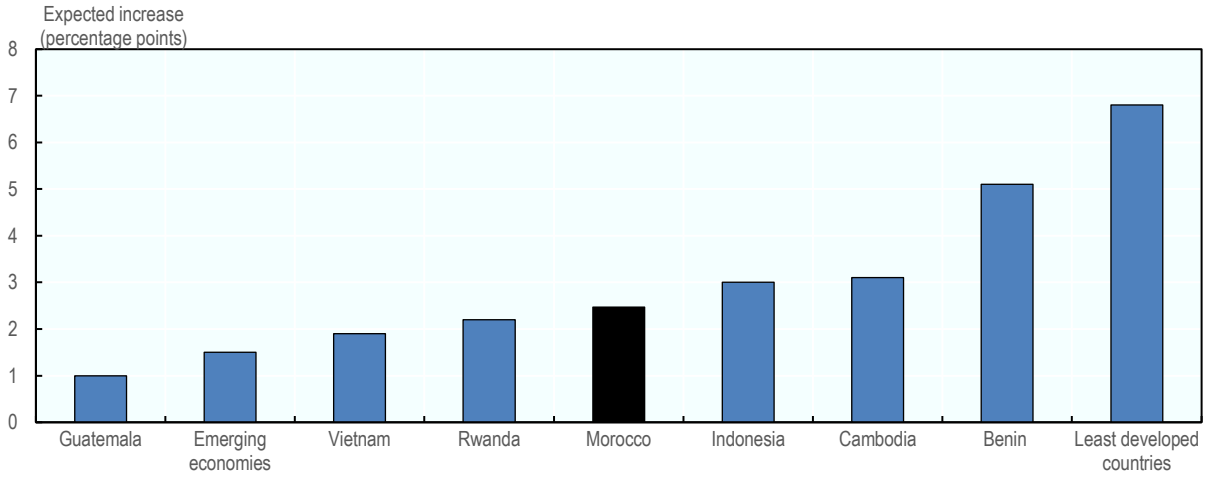
		Countries with GDP per capita of between USD 3 000 and 6 000 in 2016			Morocco			
		All countries	Low-performing countries (SDG index < 78)	High-performing countries (SDG index > 78)	2016	2030	Increase 2016–2030	Annual increase
GDP per capita (USD)		4 070	3 898	4 986	2 997	5 131	+71%	
GDP (constant prices, USD M)					103.3	203.5	+97%	
SDG 3 index		74.9	72.5	80.8	73.7	>78		
Factors	Doctors (per 1,000 people)	1.2	0.84	1.60	0.6	1.6	x 2.6	
	Other medical staff (per 1,000 people)	5.9	5.61	6.22	1.7	6.2	x 3.6	
	Doctors' salaries (ratio to GDP per capita)	7.1	7.1	7.1	15.6	7.1		
	Non-salary health expenditure (% of total health expenditure)	62.3	61.1	62.3	59.4	59.4		
	Ratio of other medical staff's salaries to doctors' salaries	0.5	0.5	0.5	0.5	0.5		
	Private expenditure (% of total expenditure)	42.4	43.6	38.2	50.1	38.2		
Results	**Health expenditure (% of GDP)**	**7.73**	**6.65**	**8.79**	**5.69**	**8.16**	**+2.47 pp**	**+0.18 pp**
	Public health expenditure (% of GDP)	4.5	3.7	5.4	2.8	5.0	+2.2 pp	+0.16 pp
	Private health expenditure (% of GDP)	3.3	2.9	3.4	2.8	3.1	+ 0.3 pp	
	Health expenditure per capita (USD)	**314.7**	**259.3**	**438.1**	**170.5**	**418.7**	**+ USD 248 (MAD 2 482)**	**+ USD 17.7 (MAD 177)**

Notes: This analysis does not take into account demographic aspects or the differentiated cost of health expenditure according to population age (in general, children under 5 years of age and people over 60 years of age have higher health expenditure than the young or working population).
Source: OECD.

In nominal terms, the 2.5 percentage points of GDP increase in health expenditure would amount to an increase over the period of MAD 107 billion (i.e. an annual increase of MAD 7.7 billion), including MAD 77 billion of public spending (i.e. an annual increase of MAD 5.5 billion) (Table 3.7).

Figure 3.2. Morocco's expected increase in health expenditure is in the average range compared with other countries

Expected increases in health expenditure to reach the health SDGs by 2030



Note: For Morocco, OECD calculation. For Cambodia: (IMF, 2019[20]). For Benin: (IMF, 2018[21]). For Rwanda: (IMF, 2019[22]). For other countries: (IMF, 2019[19]). In this methodology, emerging economies are those with GDP per capita of between USD 3 000 and USD 6 000 (72 countries). Least developed countries' GDP per capita is under USD 3 000.
Source: OECD and IMF.

Table 3.7. A 2.5 percentage points of GDP increase in health expenditure is equivalent to an increase of MAD 107 billion over the 2016–30 period

		2016	2030	Increase 2016–2030	Annual increase
As a % of GDP	**Health expenditure**	5.69	8.16		
	Public health expenditure	2.8	5.0		
	Private health expenditure	2.8	3.1		
In MAD billion	**Health expenditure**	58.8	166.1	+107.3	+7.7
	Public health expenditure	29.4	102.6	+73.2	+5.2
	Private health expenditure	29.4	63.4	+34	+2.4
Total tax revenues (including SSCs)[2] (in MAD billion)		276.1	483.6[1]		
As a % of tax revenue	Public health expenditure	9.4%	21.2%		

1. Assuming an average annual increase of 4.2% in tax revenues between 2019 and 2030, as observed over the 2014–18 period.
2. Data from Revstats (OECD).
3. The health expenditure considered includes both public and private expenditure, hence the high ratio for 2030.
Source: OECD.

Box 3.3. Details of the methodology developed by the IMF

The methodology developed by the IMF identifies the main cost drivers in the health sector (number of doctors, medical staff, remuneration of doctors and medical staff, demographic factors and share of non-compensation health expenditure). These cost drivers are used in an equation to estimate health expenditure as a percentage of GDP in 2016.

To estimate health expenditure as a percentage of GDP in 2030, the cost drivers used are the median values of a small group of countries. These countries are those (i) with GDP per capita of between USD 3 000 and USD 6 000 in 2016, and (ii) the best-performing countries in terms of health (with an SDG 3 index > 78). These countries are also those for which health expenditure is most effective. As a comparison, in 2016, the SDG 3 index for Morocco was 73.7.

The expected increase in health expenditure for Morocco to reach the level of countries with similar incomes but superior health performance is thus calculated as the difference between health expenditure in 2016 and 2030.

One possibility is to consider differentiated health costs according to the age of the population, in particular considering the share (and health costs) of the population under 5 and over 65 years of age.

Source: (IMF, 2019[19])

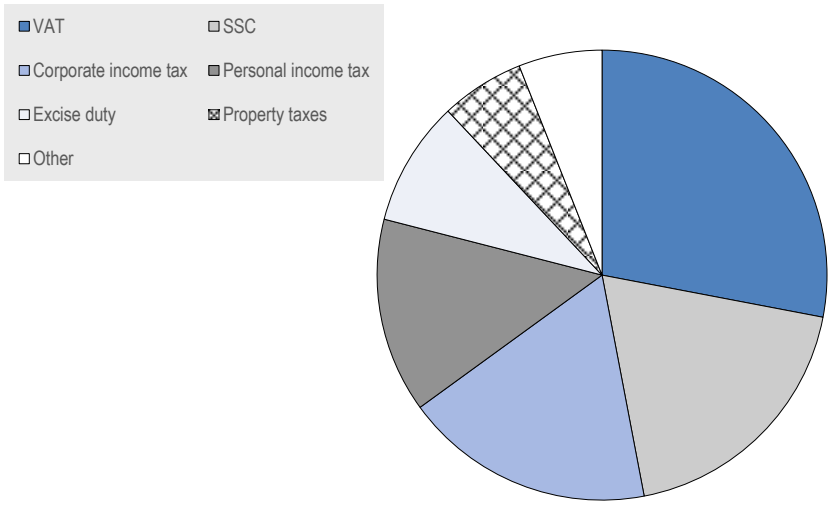
An increase in public health expenditure means improving SSCs design and making greater use of tax revenues

The 2.5 percentage points of GDP increase in public health expenditure can be financed by economic growth (which will automatically translate into public health expenditure growth – see previous sections) and a tax reform (which will create room for budgetary maneuver). The tax reform should therefore be equitable and not detrimental to growth (and thus aligned with the principles of the 2019 National Conference on Taxation).

This tax reform should focus on broadening the tax base rather than raising tax rates. Morocco's tax structure relies on VAT, which is the main source of tax revenues (28% of total tax revenues in 2017), followed by SSCs (19%), corporate income tax (18%), personal income tax (14%), excise duties (or domestic consumption taxes) (9%), and property taxes (6%) (Figure 3.3). As highlighted in the following chapters, SSCs and VAT base broadening will have a key role to play, together with improving the design of the PIT and other taxes, such as the CIT.

Figure 3.3. Morocco's tax structure relies primarily on VAT

As a % of total tax revenue, 2017

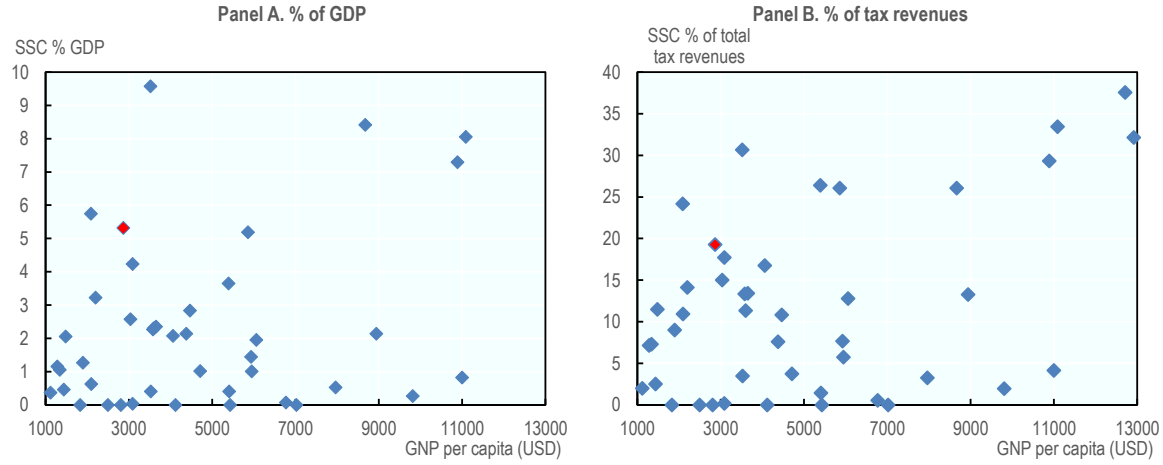


Source: Database: Revenue Statistics (OECD).

The importance of SSCs in the overall tax structure distinguishes Morocco from many other countries. Revenues from SSCs (health, retirement, unemployment, etc.) are important for Morocco's level of development, both in terms of their weight in GDP (Figure 3.4 – Panel A) or their weight in the tax structure (Figure 3.4 – Panel B). This is reflected in the structure of health financing in Morocco: for its level of development, the share of SSCs is relatively high (Figure 3.5 – Panel A) while the share of tax revenues is relatively low (Figure 3.5 – Panel B).

Figure 3.4. Revenues from SSCs are high in Morocco

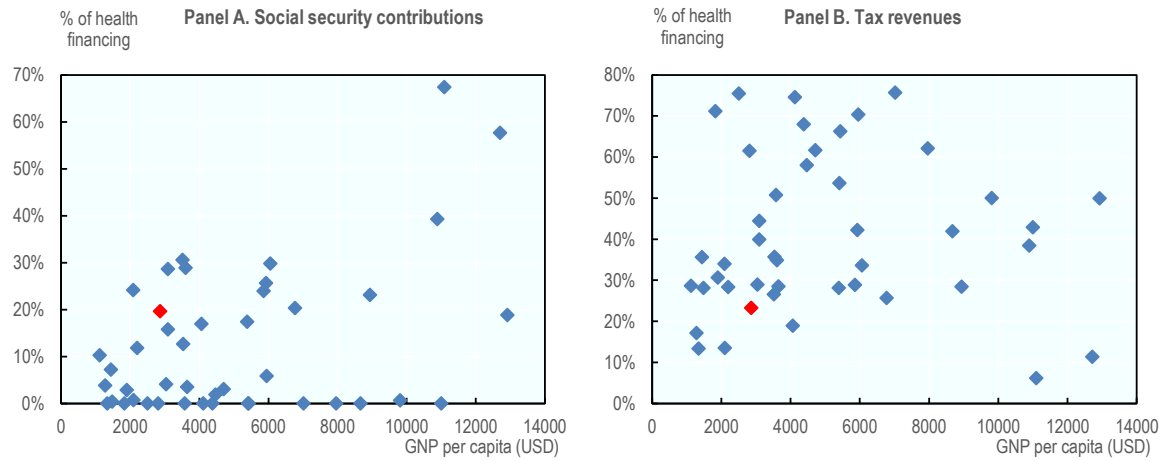
Revenue from SSCs



Note: Only middle-income countries (lower and upper-middle-income) are presented in this figure, i.e. those with GNP per capita of between USD 1 000 and USD 13 000.
Source: Database: Revenue Statistics (OECD).

Figure 3.5. For its level of development, health financing relies more on SSCs than on taxation

% of total health financing, 2017



Notes: Only middle-income countries (lower and upper-middle-income) are presented in this figure, i.e. those with GNP per capita of between USD 1 000 and USD 13 000.
Source: Database: Global Health Expenditure (WHO).

However, the role of SSCs, combined with the ageing population and the rising demand for health care, is putting pressure on the health system financing. Thus, while improving the design of SSCs (rates and bases) has a role to play in health financing, it seems that diversifying the sector's funding structure (with a greater role for tax revenues) will also be crucial.

In order too increase tax revenues, the design of each tax should be improved. Some taxes, such as domestic consumption taxes (through their influence on consumer behaviour) and environmental taxes have stronger links to the health sector than others. These taxes have a particularly important role to play in health financing. Additionally, other tax revenues, from taxes such as VAT, CIT, PIT, or property taxes, also have a role to play in increasing the overall level of tax revenues, but are not directly related to health.

For example, tax revenues appear vital for financing the Ramed scheme. A study into the future of the Ramed scheme is under way, with several options being considered. One is to consider moving from an assistance scheme to an insurance scheme. Given Ramed's needs, the "innovative" financing options (such as a tax on the telecommunications service sector; a surcharge imposed on companies with a very high turnover; lease-back arrangements for certain university hospitals; etc.) sometimes put forward (see Box 1.1) do not seem sufficient. Indeed, with 11.5 million active beneficiaries (nearly a quarter of the population), the system is very expensive. In this context, other options can be considered such as flexible earmarking of tax revenues from DCTs on products harmful for health to finance the Social Cohesion Support Fund, or the greater use of general tax revenues from the state budget.

Thus, both a change in the design of health SSCs and a strengthening of the role of taxes – particularly those with strong links to health – are expected in Morocco. In 2019, the OECD analysis of the Moroccan tax system put forward 11 strategic guidelines and 80 recommendations for improving the tax system design. These recommendations are set out in the OECD "Morocco Tax Policy Review" report (OECD, 2019[23]). They aim to improve the design of each type of tax, rather than introducing new taxes, which would complicate the tax system. The Finance Act 2020 introduces numerous tax measures, some of which are favourable to health sector financing. Table 3.8 compares these tax measures with the recommendations of the National Conference on Health Financing (organised by the Ministry of Health in June 2019) and the OECD recommendations from 2019. It therefore does not include

the new OECD recommendations for health system financing presented at the beginning of this report, which are an extension of the OECD's 2019 analysis.

Chapters 6 and 7 discuss ways to improve the design of health SSCs and to strengthen the role of tax revenues in health financing respectively.

Table 3.8. Comparison of tax measures relating to health financing by the Ministry of Economy, Finance and Administrative Reform, the Ministry of Health, and the OECD

	Ministry of the Economy, Finance and Administrative Reform (Measures set out in the Finance Act 2020)	**Ministry of Health** (Recommendations from the National Conference on Health Financing – June 2019)	**OECD** (Morocco Tax Policy Review – 2019)[3]
VAT	VAT exemption (domestic and import) for vaccines and medicines to treat fertility and multiple sclerosis[1]	Continue efforts to exempt medicines from VAT in order to reduce the cost of care for the population	
	Abolition of the reduced VAT rate (10%) for palm oil, now subject to the standard rate of 20%	Increase the revenues to be earmarked for the health sector by implementing the concluding recommendations of the Third National Conference on Taxation: broaden the VAT base and earmark the surplus generated to social welfare	
Domestic consumption tax	50% increase in DCT on non-alcoholic beverages		Increase in the DCT rate for certain products, for example alcoholic beverages
	Introduction of a progressive rate for DCT on non-alcoholic sweetened beverages (such as fruit juices and lemonades)		
	Introduction of a DCT on energy drinks		
	Phasing-in of specific VAT quotas into the DCT quota for alcoholic beer, wine, and platinum/gold/silver items		
	Introduction of a DCT on electronic cigarette refill liquids		
SSCs		Ensure equitable funding by adopting the same contribution rate for all insured people and the same basket of care to harmonise and converge health schemes	Do not dissociate SSCs from taxes, but take an overarching view of the tax burden on labour
			Broaden the SSCs base: • Introduce SSCs for self-employed • Gradually increase the ceilings for SSCs, in particular for pension SSCs. At the same time, analyse the impact on the overall tax burden at different income levels and, if necessary, adjust the income tax scales
			Do not lower employee SSCs rates
			Have a long-term strategy for financing the social security system
Other	Exclusion of tobacco retailers from the scope of the 0.25% stamp duty		
	Allocation of the 50% of the		

	proceeds from voluntary regularisation of the deductible contribution on assets and liquidity held abroad to the Social Cohesion Support Fund[2]		

1. This is in addition to the existing VAT exemption for anti-cancer drugs, antiviral drugs for hepatitis B and C, and drugs to treat diabetes, asthma, cardiovascular diseases, AIDS and meningitis.
2. The remaining 50% is allocated to a new STA called the "Special Fund for the Promotion and Improvement of the Education and Training System".
3. This does not include the new OECD recommendations for health system financing presented at the beginning of this report. These new recommendations are thus a continuation of the analysis carried out in 2019 by the OECD, whose recommendations related to health financing are shown in this table.
Source: (Ministère des Finances, 2020[24]), (Direction Générale des Impôts, 2020[25]), (Ministère de la Santé, 2019[26]), (OECD, 2019[23]).

4 Prerequisites are needed for any future increase in tax revenues

This chapter does not aim to assess the quality of public health expenditure in Morocco, but offers a general overview of the prerequisites needed for any future increase in tax revenues.

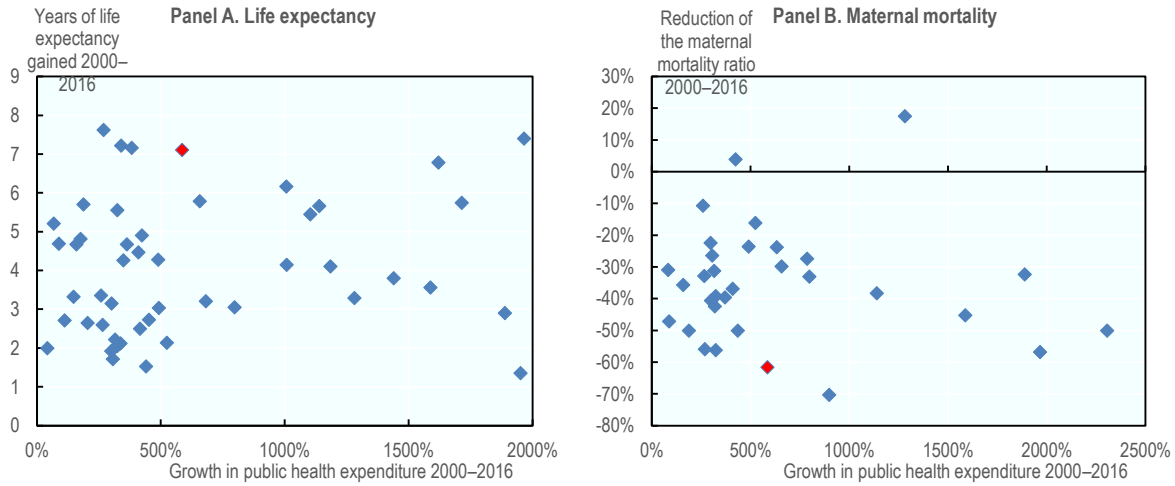
Public health expenditure must become more efficient

There are four non-mutually exclusive options for ensuring the financial sustainability of health systems: increasing tax revenues and the state budget, prioritising the health sector within the state budget, improving the efficiency of public health expenditure, and redesigning the relationship between public and private health care (OECD, 2015[27]).

In Morocco, while an increase in public funding for health is necessary in the medium term, this cannot be achieved under current conditions. An increase in resources would improve the quality of care provision and reduce out-of-pocket expenditure. However, increasing the state budget for health does not seem appropriate without a significant improvement in the efficiency of public health expenditure.

Compared with other countries, public health expenditure in Morocco is reasonably efficient, but can nevertheless be improved. Figure 4.1 shows the public health expenditure growth between 2000 and 2016 and the number of years of life expectancy gained (Panel A) and the scale of the reduction in the maternal mortality ratio (Panel B). In both cases, Morocco performs well given its level of public spending growth, with a significant increase in life expectancy and a marked reduction in the maternal mortality rate. However, other countries with lower increases in public health expenditure have experienced similar or close improvements, suggesting that these countries make more efficient use of the resources available. Estonia, for example, has managed to increase life expectancy by seven years for a lower public health expenditure growth (Panel A), while countries such as Belize, Samoa or the Solomon Islands have managed to reduce maternal mortality by more than half, again for a lower level of public health expenditure growth (Panel B).

Figure 4.1. Public health expenditure in Morocco is reasonably efficient but can be improved



Note: In Panel A, only countries with a life expectancy of between 65 and 72 years in 2000 are shown, to avoid countries with a very low level of life expectancy in 2000 that have made very significant progress skewing the results.
In Panel B, only countries with a maternal mortality ratio between 70 and 300 per 100 000 live births in 2000 are shown, for the same reason as above.
Source: Database: Global Health Expenditure (WHO); World Development Indicators (World Bank).

Numerous measures are expected to improve the efficiency of public health expenditure and thus ensure that tax revenues produce better results. These include measures for improving the health system's governance (setting up a geographical information system, a system for regulating and monitoring health care providers, and an appropriate decentralisation policy), or for reducing the fragmentation of the CHI management system (World Bank, 2018[16]) (Ministère de la Santé, 2018[11]). Similarly, greater autonomy in hospital management, for example by allowing financial resources to be redeployed between hospitals with a surplus and those with a deficit, would be beneficial. Finally, tendering and procurement procedures would benefit from being simplified to be more fluid, quicker and cheaper, particularly in the area of drug procurement. Importantly, the Finance Act 2020 now allows the Ministry of Health to initiate drug procurement procedures for the following year, in anticipation of the credits of up to MAD 500 million that will be earmarked for drug procurement in the 2021 budget year (Article 33 of the Finance Act 2020). However, further progress is still awaited, such as the establishment of a single central purchasing office, in order to achieve economies of scale.

Several improvements are also needed in relation to controlling public health expenditure. This will involve improving procurement procedures, but also revising standardised health costs while ensuring dialogue with the health private sector. The Ministry of Health must also strengthen its management capacities, particularly in the area of human resources (financial controllers and accountants). Lastly, improving the Ministry of Health's budget execution capacity will be essential, especially for investment budgets.

Finally, the Ministry of Health should strengthen its analytical capacities. Mexico, Thailand and Turkey have all set up economic analysis units within the Ministry of Health that have helped inform technical discussions with their counterparts in the Ministry of the Economy on the various reform scenarios and their financial and budgetary implications. This would enable the Moroccan Ministry of Health to strengthen its negotiating power during budget trade-offs, to better demonstrate to the MEFRA the importance of funding disease prevention activities (with a view to reducing the costs of certain diseases in the medium/long term, including HIV), and to facilitate access to funds granted in the form of budget support by donors. For example, while the exact cost of the Ramed scheme per beneficiary is not known,

it is important to have a good understanding of the costs of this type of schemes, taking into account demographic changes. Similarly, the overall cost of HIV testing, which is more than just the cost of the test, is not known.

The private sector will have a role to play in supporting the state in health sector financing

Morocco is keen to involve the private sector in developing the health system. According to the National Health Plan 2025, private-sector investment should be promoted through incentives (including tax incentives), especially in remote areas, and through increased use of public-private partnerships.

However, tax incentives do not systematically achieve their objectives. In OECD countries, for example, tax incentives for private medical insurance have not supported its development (Box 4.1).

In the case of Morocco, there are several arguments against increasing the private sector's involvement in health through tax incentives. First, because tax incentives for private investment would result in distortions, which is contrary to the principle of tax neutrality. Secondly, because they could be potentially very costly for the state, and do not appear essential as the health private sector is already growing without them. Finally, because this response would be out of line with some of the obstacles encountered by the private sector, such as the lack of an integrated strategy involving the private sector, of a cohesive regulation of private health care facilities location, of private sector evaluation tools and of a reliable information system, or the limited culture of partnership between the public and private sectors (Ministère de la Santé, 2018[11]). Therefore, the government should focus more on providing a business environment that is conducive to investment and private-sector development in health, rather than providing tax incentives that would be sub-optimal in that they would not address businesses' non-tax challenges.

If Morocco decided to opt for tax incentives to stimulate the development of private health infrastructure in remote areas, they should be conditional on costs rather than profits. Tax incentives (such as exemptions or preferential tax rates) that are conditional on profits reduce the amount of tax payable, regardless of the level of profit made. This type of tax incentive is therefore more favourable to companies that make significant profits, which are not those requiring state support, and which would probably have made the investment even without the incentive. As a result, tax incentives that are conditional on profits are generally costly for the state, and may also promote tax optimisation (artificial profit transfers). Conversely, cost-based tax incentives (such as earned income tax credits, deductions and accelerated depreciation) reduce input costs. In this case, the size of the tax reduction is independent of the level of profit made by the company and depends on the amount invested. Finally, if Morocco were to put in place this type of incentive, it would be a matter of promoting temporary tax incentives, and systematising the conditionality associated with these incentives (for example, the number of jobs created).

Public-private partnerships (PPPs) may be developed, but cautiously due to their complexity. First, it will be necessary to establish the precise objectives of using PPPs (for example, the need for new infrastructure or health services, or the need to create short-term financial leeway), and to ensure several preconditions are met (such as *ex-ante* analysis of needs and socio-economic implications, monitoring mechanisms, supervising and regulating the private sector and the existence of a unit for implementing and monitoring this type of partnership within the Ministry of Health). The 2020 Finance Act sets up a PPP with the lease-back contract for the Moroccan Pension Fund's purchase of five university hospitals for MAD 4.6 billion, half of which will earmarked for the general state budget and the rest for the Social Cohesion Support Fund.

Regardless of the level of private sector involvement in health, the Moroccan state should continue to play a role in providing health infrastructure and services. Recent demonstrations in Chile, a

country that has largely privatised its health sector, serve as a reminder that the health sector needs a fair balance between public and private-sector involvement. Indeed, private-sector dominance in health can lead to imbalances, such as higher prices for medical services, which directly affect out-of-pocket expenditure and health care accessibility. However, as noted above, the government should do more to provide a business environment that is conducive to investment and private-sector development, which will benefit companies involved in the health sector.

Box 4.1. Developing private medical insurance through tax incentives offers mixed results in OECD countries

Some OECD countries have encouraged the use of private medical insurance to supplement the health insurance provided under universal health systems. These policies have often taken the form of tax breaks (subsidies) on private medical insurance premiums to encourage individuals to take out private medical insurance, the hope being that the cost reduction in the public medical sector would outweigh the cost of these tax breaks.

However, these tax breaks have not reduced fiscal pressure in the public medical sector in Australia, Spain, Ireland or the United Kingdom. Cost-benefit analyses of these incentives have often concluded that their costs are far greater than the savings in the public health sector, and that they are regressive measures.

Source: (OECD, 2015[27]).

5 Improving the design of health social security contributions

The compulsory health insurance system is fragmented and its financial balances are deteriorating

Compulsory health insurance (CHI) is managed by two different funds, the CNOPS for the public sector (3 million insured people) and students (65 000), and the CNSS for the private sector (6 million insured people). The basket of services covered by each fund is similar, but the level of benefit reimbursement and contribution rates differ.

- In the public sector, the contribution rate is 5% for the working population (2.5% for employers and 2.5% for employees), and has remained unchanged since the CHI system was introduced in 2006. For retired civil servants, the rate is 2.5%. There is a ceiling of MAD 400 per month and a minimum threshold of MAD 70.
- In the private sector, the contribution rate is 6.37%: the standard contribution of 2.26% for employers, a 1.85% solidarity contribution paid by employers, and the standard contribution of 2.26% for employees (except for the "population 114" which does not pay the 2.26% employers' contribution – see discussion below). For retirees, the contribution rate is 4.52%. There is no ceiling. Contribution rates have been increased once, in 2016. Table 5.1 provides a reminder of all SSC rates for the private sector.

Table 5.1. CNSS contribution rates for employees in 2019

Benefit category		Employer contribution rate (%)		Employee contribution rate (%)	Total (%)	Base
Family allowances		6.40		-	6.40	Total salaries for the period (month/quarter)
Short-term welfare benefits	Sickness, maternity, death	0.67		0.33	1	Total salaries capped at MAD 6 000
	Unemployment allowance	0.38		0.19	0.57	
Long-term welfare benefits	Retirement	7.93		3.96	11.89	
Compulsory health insurance		**Standard contribution**	**2.26**	**2.26**	**6.37**	**Total salaries for the period (month/quarter)**
		Solidarity contribution	**1.85**			
Vocational training tax		1.6		-	1.6	
Total		**21.09**		**6.74**	**27.83**	

Source: CNSS.

The CNOPS is seeing a deterioration in its financial balances. Contributions raised MAD 4.9 billion, and expenditure amounted to MAD 4.49 billion in 2017. The technical deficit, which emerged in 2016,

became an overall deficit[8] in 2017 (Cours des comptes, 2019[28]). This deterioration of the economic situation can be explained by: the lack of contribution rates increases since 2006, a decline in the demographic ratio (from 3.26 in 2006 to 1.81 in 2017, resulting in a loss of employer contributions since retirees pay only the employee contribution) and growth in expenditure. The latter is increasing due to the growing share of insured persons, the prevalence of long-term and chronic diseases (which account for 50% of the CNOPS' expenditure), the rise in certain expenditure items (such as dental expenses, drugs and biological interventions), the fact that public hospitals account for a limited share of spending because they are viewed as unattractive, and the rise in the claims rate. This situation could be aggravated with the integration of the populations covered by Article 114 (approximately 250 000 people), whose internal funds will be affiliated to the public CHI (ONCF, OCP, etc.). The actuarial study on the financial sustainability of the CNOPS carried out in 2010 should be updated and extended, taking into account the impact of these new populations, health expenditure projections (in particular with the updated classification of professional activities and updating of certain treatment protocols), and the increase in the number of retired people.

The CNSS is in better fiscal shape, but from 2026, contributions are no longer expected to cover the scheme's expenses. Its current income is MAD 7.7 billion, compared with expenditure of MAD 3.8 billion. Expenditure is increasing by 31% per year, compared with a 13% increase in income. A technical deficit could therefore emerge as early as 2026, unless contribution rates and the contributory base are revised and expenditure is controlled (Cours des comptes, 2019[28]).

Several options could be considered to increase the role of health SSCs in health financing

These options will help to improve the fiscal position of the CHI funds. They are described in detail below:

- Controlling the CHI expenditure
- Broadening the health SSC base
- Increasing contribution rates for the CHI
  - For the CNSS
  - For the CNOPS
  - In the event that all contribution rates and ceilings across both public and private schemes are harmonised (see Box 1.1)
- Promoting participation in the labour market, especially for women
- Introducing a health insurance scheme for the self-employed

Controlling expenditure

Control of the CHI expenditure is a prerequisite for any change in SSCs. This will be a question of renewing national conventions, revising standardised health costs, and updating the classification of professional activities, treatment protocols and health professionals' reference documents (Cours des comptes, 2019[28]). It will also require making the public health care system more attractive by developing better healthcare provision, reducing waiting times and having better equipment in health facilities (Cours des comptes, 2019[28]).

[8] Which takes into account the net result, and is defined as contributions + net financial gains from investments – expenses.

Broadening the health SSC base

The health SSC base of the CNSS is limited. Around 640 000 employees in 3 400 companies do not contribute at the rate of 6.37% but at 4.11% (by paying only the employee contribution of 2.26% and the employer-paid solidarity contribution of 1.85%, but not the employer's contribution of 2.26%). This situation was inherited from Act 65-00 Article 114, which provides an exemption for companies that were already offering health insurance to their employees before the introduction of the CHI scheme in 2006 (called “population 114”). These employees thus continue to benefit from private funds, which do not fall under the responsibility of the CNSS. On average, this group earns a higher salary than those who are covered by the CNSS. The average monthly salary of a CHI insured person is MAD 3 000 to 4 000, compared with MAD 9 134 for "population 114" and MAD 5 100 for the private sector population as a whole (CNSS, 2018[29]). To ensure fairness, “population 114” should be integrated into the standard CHI system, and pay the employer's contribution of 2.26%.

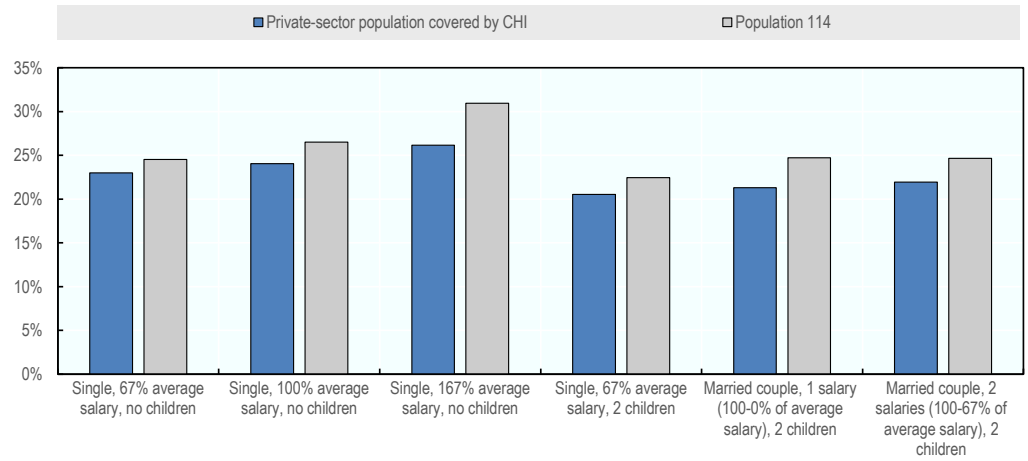
The “population 114” has higher effective tax rates on labour costs than the private sector population in the CHI system (Figure 5.1**).** The effective tax rate on labour costs (or average tax wedge) measures the difference between the labour cost to the employer and the net salary received by the employee. The lower the effective tax rate on labour costs: (i) the higher the purchasing power of employees (reduction in the employee's tax burden), (ii) and/or the greater the incentive for employers to hire (reduction in employer contributions). Thus, for a single person without children, earning the average salary, the effective tax rate on labour costs is 24% for the private sector population in the CHI system. In other words, 24% of labour costs are levied by the tax and contribution system. For the same individual in "population 114", the rate is 26.5%: a larger share is thus levied by the tax and contribution system. In this case, the fact that "population 114" has higher effective tax rates on labour costs than the private-sector population in the CHI system is explained by the fact that their salaries (labour costs) are much higher, and are thus subject to a higher marginal rate of income tax. These elements thus outweigh the fact that they have a lower CHI contribution rate (4.11% instead of 6.37%).

Even if "population 114" were integrated into the CHI system (and paid a higher rate of employer contributions, with a weighted average monthly salary of MAD 5 129), the effective tax rate on labour costs (average tax wedge) would remain at a moderate level compared with other countries. It would be lower than the OECD average and in Turkey, but higher than in Mexico (Figure 5.2). For a single person without children earning the average salary, the effective tax rate on labour costs would be 25%. Thus, increasing the rate of employer contributions for "population 114" would neither sharply reduce incentives to hire, nor significantly reduce the employees’ purchasing power.

In the case of the CNOPS, the monthly CHI ceiling of MAD 400 could be revised upwards or even abolished. Social security ceilings help strengthen the link between contributions and benefits in that they limit the amount of SSCs paid and limit the amount of benefits received in return. While this link is strong in the case of pension contributions, it is weaker in the case of health insurance since the benefit received is not proportional to the contributions paid (except in the case of dental costs, where there is a ceiling on benefits). Morocco has opted for a public sector CHI ceiling. Raising the ceiling (or even abolishing it) would, on the one hand, provide an opportunity to make the welfare system more progressive (through higher contributions that could be invested in improving the quality of the health care system), and on the other, align the design of public and private sector contributions more closely.

Figure 5.1. "Population 114" has higher effective tax rates on labour costs than the private sector population in the CHI system

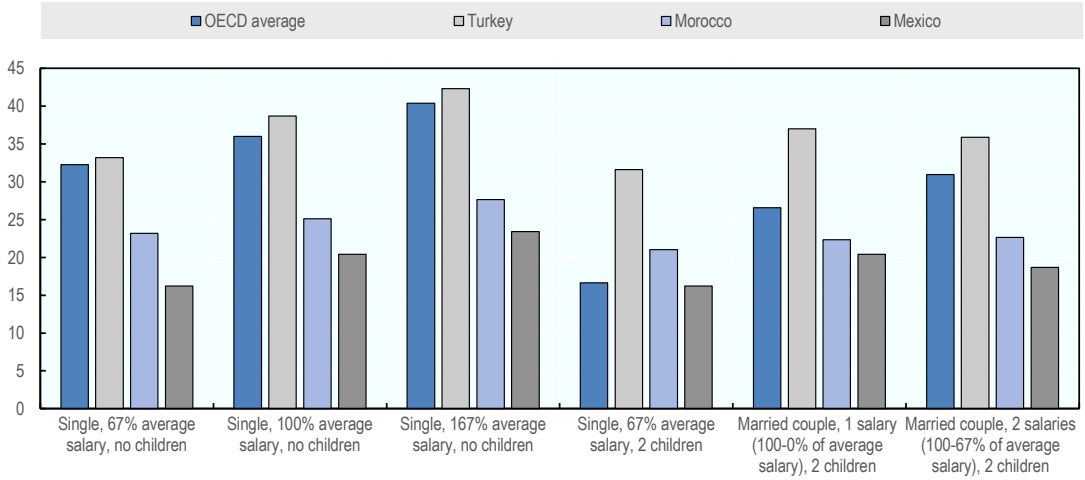
Comparison of average tax wedges (2017), as a percentage, private sector population currently in the CHI system, "population 114", and possible future scenario (integration of both populations)



Note: Calculations are based on an average monthly salary in the private sector currently in the CHI system of MAD 4 150 in 2017, and MAD 9 135 for "population 114". For "population 114" the employer's contribution to the CHI system is the 1.85% solidarity contribution.
Source: OECD.

Figure 5.2. Even if "population 114" were included in the CHI system, the average tax wedge would be lower in Morocco than in Turkey and close to that of Mexico

Comparison of average tax wedges (2017), as a percentage, assuming "population 114" is included in the CHI system



Note: Calculations are based on an average monthly salary in the formal private sector of MAD 5 129 in 2017 (weighted average). The assumption is that the health SSCs rate is 6.37% (2.26% employee contribution, 2.26% employer contribution, and 1.85% solidarity contribution paid by the employer).
Source: (OECD, 2019[23]).

Increasing contribution rates

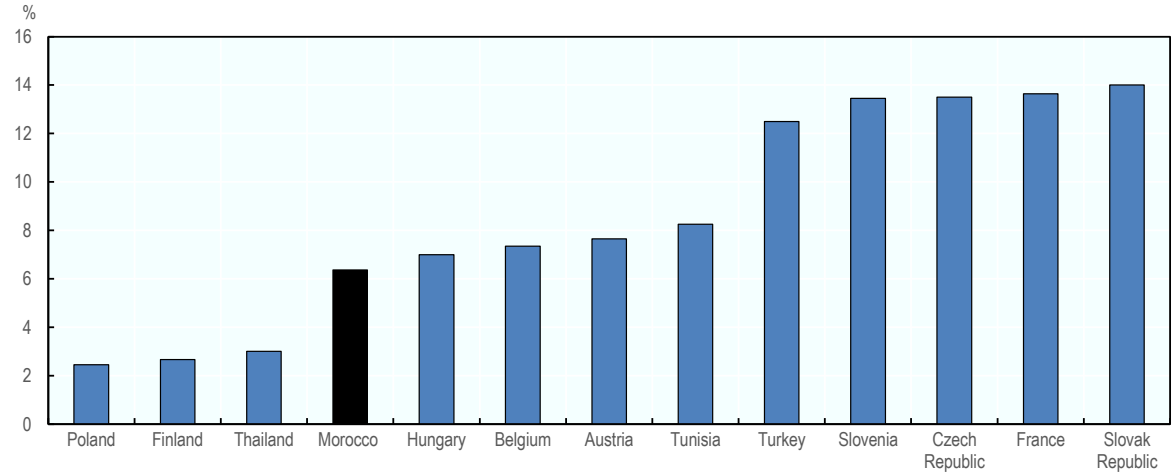
Any discussion on raising health SSCs must consider the burden of contributions on labour and, indirectly, on informal employment. Indeed, any increase in health SSCs will increase the total SSC rate and thus could have a negative impact on incentives to hire and work. Moreover, to provide an overview of the tax burden on labour, these possible changes must also be analysed alongside PIT brackets. In this respect, the recommendation of the National Conference on Taxation to set up a National Council of Compulsory Levies is relevant and in line with the OECD recommendation not to dissociate SSCs from taxes, but to have a global view of the tax burden on labour.

In the private sector

There are several arguments supporting an increase in health SSC rates in the private sector. First, the health contribution rate is lower than in countries such as Tunisia or Turkey (Figure 5.3). The overall SSCs rate (27.83%) is close to the OECD average rate (employee contribution of 6.74% and employer contribution of 21.09%). Second, it appears that the tax burden on labour is not particularly high compared with other countries, such as Mexico or Turkey (see discussion above). Finally, given that the OECD recommends changing the way family allowances are financed, which currently resembles an implicit employer's contribution that may discourage hiring, drawing instead on the general state budget. This would provide room for manoeuvre to increase the employer's health SSC.

Figure 5.3. In the private sector, the health SSC rate is lower than in many countries, including Tunisia and Turkey

Health SSC rates (employer and employee contributions) in the private sector, latest year available



Source: OECD.

Three scenarios for increasing health SSC rates are presented below (Table 5.2):

- Scenario 1: An increase of 0.14 percentage points (pp) for employer and employee contributions, as envisaged by the CNSS.
- Scenario 2: Moderate increases to reach the same level as Tunisia (increases of less than 1 pp for employer and employee contributions).
- Scenario 3: Higher increases to reach the level of Turkey (marked increase in the employee contribution and moderate increase in the employer contribution).

Table 5.2. Description of the three scenarios for increasing health SSC rates in the private sector

		Morocco Benchmark[1]	Scenario 1: CNSS level	Scenario 2: Tunisia level	Scenario 3: Turkey level
Health SSC	Employee contribution	2.26%	2.4% (i.e. +0.14pp)	3.17% (i.e. +0.91pp)	7.5% (i.e. +5.24pp)
	Employer contribution	4.11%	4.25% (i.e. +0.14pp)	5.08% (i.e. +0.97pp)	5% (i.e. +0.89pp)
	Total	**6.37%**	**6.65% (i.e. +0.28pp)**	**8.25% (i.e. + 1.88pp)**	**12.5% (i.e. +6.13pp)**
Total SSC	Employee contribution	6.74%	6.88%	7.65%	11.98%
	Employer contribution	21.09%	21.23%	22.06%	21.98%
	Total	**27.83%**	**28.11%**	**29.71%**	**33.96%**

1. The "Morocco benchmark" refers to a possible future scenario in which “population 114” would be integrated into the CHI system.
Source: OECD

An analysis of the three scenarios suggests that a more ambitious increase in health SSC rates than that envisaged by the CNSS, for example to align with the level in Tunisia, would have only limited impacts on work incentives. In scenario 1 (+0.14 pp for employer and employee contributions, as envisaged by the CNSS) and scenario 2 (+0.91 pp for employee contributions and +0.97 pp for employer contributions, to reach the same level as Tunisia), the cost of labour, the average effective tax rate and the average tax wedge increase very moderately, while net take-home pay also falls slightly (Table 5.3). However, these changes are much more significant in scenario 3, characterised by an increase of 5.21 pp for the employee contribution and 0.89 pp for the employer contribution. Raising rates to the level envisaged by the CNSS could therefore be a first step towards a more ambitious increase, to get closer to the Tunisia level.

The following tables provide additional information and comparing each scenario with the current benchmark, for each type of household. In all scenarios, increasing employer contributions lead to an increase in total labour costs (particularly in scenario 3). In scenario 1, in all household types, the employee's net income falls very slightly (-0.1%) as higher employee contributions are offset by lower personal income taxes (Table 5.4). A similar situation occurs in scenario 2, but on a larger scale. In other words, given the current PIT schedule, in both scenarios, an increase in employee contributions will have very little effect on employees' net income: an increase in employee contributions amounts to a larger reduction in income subject to PIT, thus reducing the actual amount of income tax payable (Table 5.5). In some sense, an increase in employee health SSCs corresponds to a shift in tax revenues (generated by the PIT) towards the social security system. However, this may change if Morocco revises its PIT schedule and rates. In scenario 3, the “positive” effect on the employee of the decrease in his or her PIT is less pronounced than in the other two scenarios (Table 5.6). In other words, while the decreases in PIT relative to the benchmark case appear much larger than in scenarios 1 and 2 as the increase in employee contributions is much larger, the decrease in net income is also much more significant.

Table 5.3. Impacts of the three scenarios for increasing health SSCs in the private sector

	Type of household		Morocco Benchmark[1]	Scenario 1: CNSS level	Scenario 2: Tunisia level	Scenario 3: Turkey level
Total labour costs[3] (in MAD)	Single	67% average salary, no children	51 437	51 496	51 849	55 001
		100% average salary, no children	76 771	76 860	77 386	82 090
		167% average salary, no children	125 165	125 314	126 192	134 049
		67% average salary, 2 children	56 237	56 296	56 649	59 801
	Married couple	1 salary (100-0% of average salary), 2 children	81 571	81 660	82 186	86 890
		2 salaries (100-67% of the average salary), 2 children	133 008	133 156	134 035	141 891
Net take-home pay (in MAD)	Single	67% average salary, no children	39 503	39 450	39 155	37 389
		100% average salary, no children	57 482	57 402	56 963	54 492
		167% average salary, no children	90 534	90 431	89 860	86 651
		67% average salary, 2 children	44 415	44 356	44 028	42 189
	Married couple	1 salary (100-0% of average salary), 2 children	63 362	63 282	62 843	60 372
		2 salaries (100-67% of the average salary), 2 children	102 865	102 732	101 998	97 761
Average effective tax rates[2] (%)	Single	67% average salary, no children	7.0%	7.1%	7.8%	12.0%
		100% average salary, no children	9.3%	9.5%	10.2%	14.1%
		167% average salary, no children	14.5%	14.6%	15.1%	18.2%
		67% average salary, 2 children	-4.6%	-4.4%	-3.6%	0.7%
	Married couple	1 salary (100-0% of average salary), 2 children	0.1%	0.2%	0.9%	4.8%
		2 salaries (100-67% of the average salary), 2 children	2.8%	3.0%	3.7%	7.7%
Average tax wedge[5] (%)	Single	67% average salary, no children	23.2%	23.4%	24.5%	32.0%
		100% average salary, no children	25.1%	25.3%	26.4%	33.6%
		167% average salary, no children	27.7%	27.8%	28.8%	35.4%
		67% average salary, 2 children	21.0%	21.2%	22.3%	29.5%
	Married couple	1 salary (100-0% of average salary), 2 children	22.3%	22.5%	23.5%	30.5%
		2 salaries (100-67% of the average salary), 2 children	22.7%	22.8%	23.9%	31.1%

1. The "Morocco benchmark" refers to a possible future scenario in which “population 114” would be integrated into the CHI system.
2. Average effective tax rate: term used when personal income tax and employees’ SSCs, after deduction of cash benefits, are expressed as a percentage of gross salary.
3. Total labour costs = gross salary + employer contributions.
4. Net take-home pay = gross salary - employee contributions - personal income tax + welfare benefits.
5. The tax wedge measures the difference between the labour costs to the employer and the corresponding net remuneration received by the employee. It can be represented by the equation (personal income tax + employee and employer contributions - welfare benefits) / labour cost to the employer (= gross salary + employer contributions).
Source: OECD, income tax model.

These observations reinforce the idea that Morocco can increase its SSCs for the CHI in a more ambitious way than currently stated, provided that "population 114" is integrated into the CHI system beforehand. They also show the need for gradual reform, which would first prioritise broadening the base over introducing a too large increase in contribution rates.

Table 5.4. Details of Scenario 1 – CNSS Level

	Single				Married couple	
	67% average salary, no children	100% average salary, no children	167% average salary, no children	67% average salary, 2 children	1 salary (100-0% of average salary), 2 children	2 salaries (100-67% of the average salary), 2 children
Total labour costs	51 496 (+0.1%)	76 860 (+0.1%)	125 314 (+0.1%)	56 296 (+0.1%)	81 660 (+0.1%)	133 156 (+0.1%)
- Employer contributions	9 018 (+0.7%)	13 460 (+0.7%)	19 436 (+0.8%)	13 818 (+0.4%)	18 260 (+0.5%)	27 278 (+0.5%)
= Gross salary	**42 478 (0%)**	**63 400 (0%)**	**105 878 (0%)**	**42 478 (0%)**	**63 400 (0%)**	**105 878 (0%)**
- Employee contributions	2 922 (+2.1%)	4 362 (+2.1%)	5 767 (+2.6%)	2 922 (+2.1%)	4 362 (+2.1%)	7 284 (+2.1%)
- Personal income tax	106 (-5.3%)	1 636 (-0.5%)	9 681 (-0.5%)	0 (0%)	556 (-1.5%)	662 (-2.2%)
+ welfare benefits	0 (0%)	0 (0%)	0 (0%)	4 800 (0%)	4 800 (0%)	4 800 (0%)
Net income	39 450 (-0.1%)	57 402 (-0.1%)	90 431 (-0.1%)	44 356 (-0.1%)	63 282 (-0.1%)	102 732 (-0.1%)

Note: Variations to the "Morocco benchmark" case – a possible future scenario where "population 114" would be integrated into the CHI system – are indicated in brackets.
Source: OECD.

Table 5.5. Details of Scenario 2 –Tunisia level

	Single				Married couple	
	67% average salary, no children	100% average salary, no children	167% average salary, no children	67% average salary, 2 children	1 salary (100-0% of average salary), 2 children	2 salaries (100-67% of the average salary), 2 children
Total labour costs	51 849 (+0.8%)	77 386 (+0.8%)	126 192 (+0.8%)	56 649 (+0.7%)	82 186 (+0.8%)	134 035 (+0.8%)
- Employer contributions	9 371 (+4.6%)	13 986 (+4.6%)	20 314 (+5.3%)	14 171 (+3%)	18 786 (+3.4%)	28 157 (+3.8%)
= Gross salary	**42 478 (0%)**	**63 400 (0%)**	**105 878 (0%)**	**42 478 (0%)**	**63 400 (0%)**	**105 878 (0%)**
- Employee contributions	3 250 (+13.5%)	4 850 (+13.5%)	6 582 (+17.1%)	3 250 (+13.5%)	4 850 (+13.5%)	8 100 (+13.5%)
- Personal income tax	73 (-34.8%)	1 587 (-3.5%)	9 436 (-3%)	0 (0%)	507 (-10.2%)	580 (-14.3%)
+ welfare benefits	0 (0%)	0 (0%)	0 (0%)	4 800 (0%)	4 800 (0%)	4 800 (0%)
Net income	39 155 (-0.9%)	56 963 (-0.9%)	89 860 (-0.7%)	44 028 (-0.9%)	62 843 (-0.8%)	101 998 (-0.8%)

Note: Variations to the "Morocco benchmark" case – a possible future scenario where "population 114" would be integrated into the CHI system – are indicated in brackets.
Source: OECD.

Table 5.6. Details of Scenario 3 –Turkey level

	Single				Married couple	
	67% average salary, no children	100% average salary, no children	167% average salary, no children	67% average salary, 2 children	1 salary (100-0% of average salary), 2 children	2 salaries (100-67% of the average salary), 2 children
Total labour costs	55 001 (+6.9%)	82 090 (+6.9%)	134 049 (+7.1%)	59 801 (+6.3%)	86 890 (+6.5%)	141 891 (+6.7%)
- Employer contributions	12 523 (+39.8%)	18 690 (+39.8%)	28 171 (+46.1%)	17 323 (+25.9%)	23 490 (+29.3%)	36 013 (+32.7%)
= Gross salary	**42 478 (0%)**	**63 400 (0%)**	**105 878 (0%)**	**42 478 (0%)**	**63 400 (0%)**	**105 878 (0%)**
- Employee contributions	5 089 (+77.7%)	7 595 (+77.7%)	11 166 (+98.7%)	5 089 (+77.7%)	7 595 (+77.7%)	12 684 (+77.7%)
- Personal income tax	0 (-100%)	1 312 (-20.2%)	8 061 (-17.1%)	0 (0%)	232 (-58.9%)	232 (-65.7%)
+ welfare benefits	0 (0%)	0 (0%)	0 (0%)	4 800 (0%)	4 800 (0%)	4 800 (0%)
Net income	37 389 (-5.4%)	54 492 (-5.2%)	86 651 (-4.3%)	42 189 (-5%)	60 372 (-4.7%)	97 761 (-5%)

Note: Variations to the "Morocco benchmark" case – a possible future scenario where "population 114" would be integrated into the CHI system – are indicated in brackets.
Source: OECD.

In the public sector

There are several arguments supporting an increase in health SSC rates in the public sector. First, rates have not been increased since 2006, despite a significant rise in costs and a technical deficit over the last three years. Second, an increase in health SSC rates would not have a negative impact on informal employment as in the case of private SSCs. Finally, as the average gross salary in the civil service is almost twice as high as in the private sector (MAD 9 338 in 2017 according to Bank Al-Maghrib), an increase in contributions, for example to the level of those paid into the CNSS, would be possible.

Harmonisation of all rates and ceilings across both public and private schemes

One of the recommendations of the National Conference on Health Financing (June 2019) was to ensure equitable funding by adopting the same contribution rate for all insured people and the same basket of services to harmonise and converge the various schemes. As discussed above, increasing (or even abolishing) the monthly ceiling for health SSCs in the public sector (which does not exist in the private sector) is recommended, as it would provide more room for manoeuvre for the CNOPS while aligning the public and private schemes. Rate increases for private sector health SSCs also need to be taken into account, as discussed above. Alignment of the CNOPS rates with those to be decided by the CNSS could also be considered, subject to a detailed analysis of the impacts for public sector employees (similar to the analysis presented above).

Increasing participation in the labour market, especially for women

Difficulties in financing the health system are exacerbated by the worrying labour market situation, with low workforce participation, especially among women, high unemployment among young people and skilled people and a strong informal sector. Since better labour market performance would automatically increase revenues from SSCs and certain taxes (PIT and VAT), there is an urgent need to implement

measures in this direction. This would improve the financial situation of the two CHI funds in the context of an ageing population. The design of the tax system in Morocco does not appear to have a negative impact on women's labour market participation, with women representing the majority of second earners.[9] Similarly, Morocco has put in place non-tax measures to promote their participation.[10]

Nevertheless, given the situation, with less than 30% of women over the age of 15 on the labour market, Morocco could adopt special tax provisions to promote their participation. It could, for example, consider implementing an earned income tax credit to incentivise low-income female workers to join the labour market. This would need to be accessible based on a minimum number of hours worked in the formal sector, be repayable, and be tapered as income increased so as not to discourage people from obtaining higher-paid jobs. Employment-related tax credits are one of the main measures used by OECD countries to reduce unemployment or inactivity traps. These measures can also reduce poverty, when targeted at the poorest workers, and increase work incentives to work.

Similarly, Morocco should keep the individual as the fiscal unit, and not move towards taxation by fiscal household as recommended at the National Conference on Taxation. This type of taxation tends to discourage second earners from participating in the labour market. In many countries, the fiscal unit is the individual coupled with tax provisions based on household income. If Morocco were to move in that direction, it would then be necessary to ensure that those tax provisions did not create obstacles to women's participation in the labour market.

Finally, formalising the economy and workers will also have a positive impact on the level of SSCs collected. The future introduction of a health insurance scheme for the self-employed is therefore to be welcomed.

Introducing a health insurance scheme for the self-employed

The health insurance scheme for the self-employed is not yet operational. According to the Moroccan authorities, this scheme will increase coverage of the population to 90% by 2025. The scheme will be managed by the CNSS, independently of the CHI scheme for the private sector.

This scheme, which is currently under review, is likely to cause distortions. The contribution rate would be aligned with that of the CNSS, at 6.37%. However, the tax base will not depend on actual income, but will be fixed. It will be a multiple of the guaranteed minimum wage (SMIG), and will vary according to the different income levels of occupational groups. However, this characteristic is difficult to justify as it may encourage tax evasion and increase informal working. Instead of a fixed base that is a multiple of SMIG, the system should be based on actual incomes, possibly with a ceiling. This is especially relevant since the tax administration is making significant effort to have a better overview of the real incomes earned by those workers.

[9] In terms of taxation, there are several elements that can discourage second earners from working: taxation of the fiscal household rather than the individual, the use of tax breaks or credits for dependent spouses, or the use of benefits and tax credits based on household income rather than individual income. In Morocco, the fiscal unit is the individual. There are no transferable tax credits. Moreover, while Morocco has tax breaks for dependent spouses, these are not tied to women's income levels and thus do not act as a disincentive to labour market participation. Only welfare benefits based on household income may be disincentives.

[10] In 2014, for example, Morocco introduced a maternity leave scheme that complies with the recommendations of the International Labour Organization (14 weeks' leave on full pay, funded through the social security system).

6 Increasing the use of tax revenues for health financing

There is room to increase domestic consumption taxes

Domestic consumption taxes (DCTs) generated MAD 27.4 billion in Morocco in 2017: 57% from energy products and 36% from tobacco. Excluding energy products, DCTs account for 1.1% of gross domestic product (GDP) or 5.2% of total tax revenues.

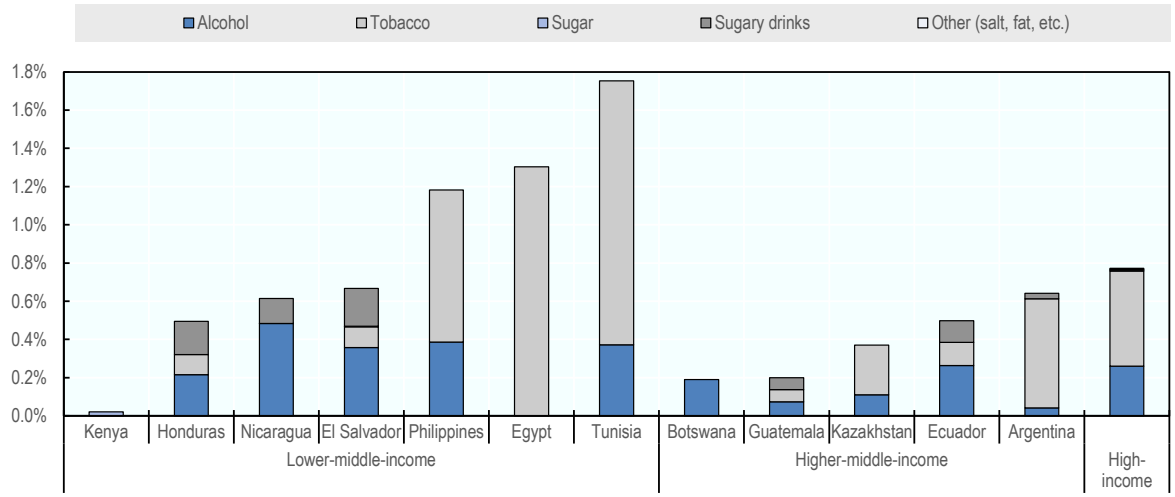
General characteristics of excise duties on products harmful for health

Excise duties on products harmful for health (equivalent to DCTs in Morocco) offer many advantages. They can raise tax revenues (Figure 6.1), while contributing to improving the health of the population (if the demand for the product is sufficiently price elastic), correcting market and information failures (as consumers may not have a reliable understanding of the consequences of these products for their health), and can – if properly designed – providing incentives for producers to change to the content of their products, etc.

However, such taxes also have disadvantages. They are generally regressive, are not always passed on to the consumer (due to adjustments of producers' margins), may be associated with efficiency losses due to unanticipated changes in consumer behaviours (for example, substituting one product for another), and may have the effect of increasing smuggling. Finally, tax revenues they generate may, in some cases, be limited in comparison with the associated administrative costs (enforcement and control).

Figure 6.1. Excise duties on products harmful for health have the potential to raise tax revenues

% of GDP



Note: The high-income category is an average of OECD and non-OECD countries for which a breakdown by type of excise duty exists in the Revenue Statistics Database (RevStats), i.e. 34 countries. It should be noted that the RevStats database does not have disaggregated information on excise duties for Morocco.
Source: OECD Revenue Statistics Database

In the long term, reducing the consumption of products that are harmful for health can reduce their tax base. This will not only reduce public health expenditure, but also reduce the revenue from the tax itself.

There are several elements to consider when designing such taxes. The issue is whether to focus on the product itself or on the level of the substance that is harmful for health contained in the product; on the value of the product (*ad valorem* tax), the quantity (*ad quantum* tax) or both; and to consider the tax rate (possibly, in a more complex way, with gradual rate increases over time); whether or not there is a minimum threshold; or the place where the tax is levied (at the producer, importer, or at the point of sale), etc.

Irrespective of their design, these taxes are only one of many instruments for changing consumer behaviour. Information campaigns, regulations (such as smoking bans in public places) and co-operation with the private sector are still necessary.

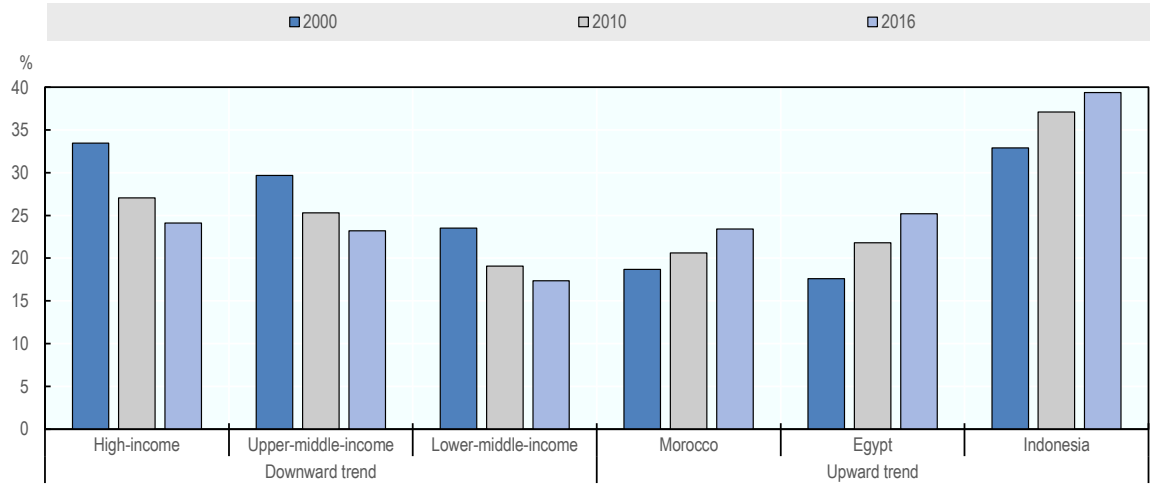
Finally, the political economy surrounding this type of tax must be taken into account. The introduction of such taxes is often subject to lobbying pressure. In Greece and Latvia, for example, excise duties on alcohol have recently been reduced to support local production. New taxes may also be poorly perceived. This can be addressed by earmarking their revenues for the population to better accept them. Mexico, for example, earmarks revenue from the tax on sugary drinks to finance health care. In Hungary, all tax revenues on products harmful for health are earmarked for a Health Fund.

Domestic consumption tax on tobacco

Tobacco consumption in Morocco is increasing (Figure 6.2). 31% of Moroccans consume tobacco and it is believed to cause a quarter of cancers and more than 8% of deaths (Ministère de la Santé, 2018[11]), (Ministère de la Santé, 2017[12]).

Figure 6.2. Contrary to the international trend, tobacco use in Morocco is increasing

Smoking prevalence (% of population over 15 who smoke regularly)



Source: WHO.

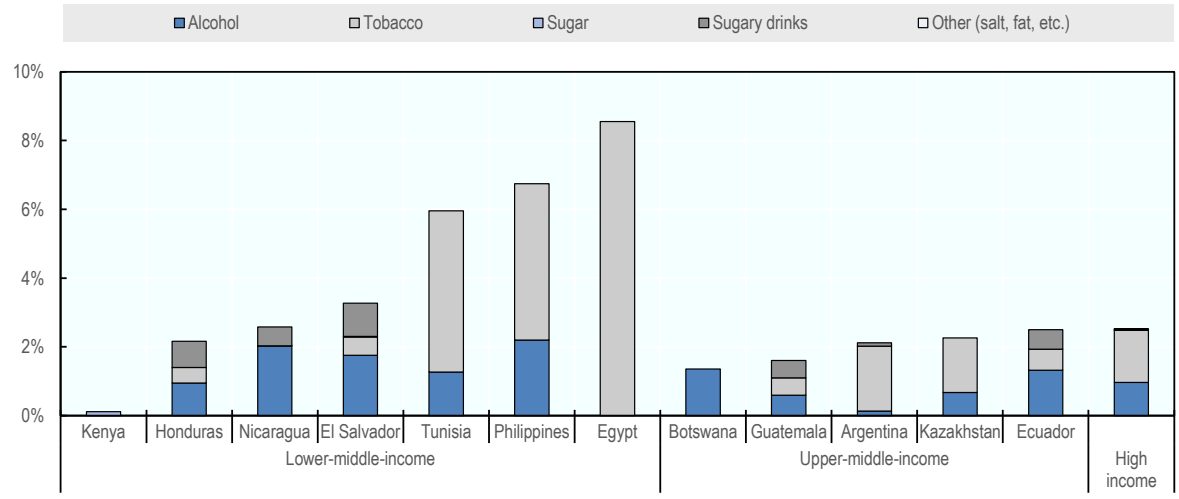
Of all the DCTs on products harmful for health, the DCT on tobacco generates the most tax revenues. In 2018, the DCT on tobacco represented 5% of total tax revenues (about 38% of DCTs) with a stable evolution over a long period. This is close to the levels of Tunisia or the Philippines, but lower than Egypt (Figure 6.3). More generally, this is in line with the international trend, with tobacco excise duties accounting for the majority of the revenue from taxes on products harmful for health.

The system of taxing cigarettes through a DCT, introduced in 2013, is based on three components (Table 6.1): 1) A "standard" DCT with a specific share and an *ad valorem* share applied to the pre-tax retail price; 2) A minimum collection threshold; 3) A minimum tax burden. These three components are calculated separately and the revenue received is the highest amount of the three.

However, as shown in Table 6.1, the three components are calculated separately and then compared with each other, with the revenue received based on the highest amount. Table 6.2 provides an overview of the three components for the three types of cigarette (rows A, B, and C). For the most expensive cigarettes, component 3 (minimum tax burden) is used, as it is the highest of the three. Together with VAT, the tax burden amounts to 75% of the retail price. For the most sold and cheapest cigarettes, component 2 (minimum collection threshold) is used, increasing the tax burden (including VAT) to 78% and 95% respectively. In the case of the most sold cigarettes, Morocco's tax burden is close to comparable countries in the region (Figure 6.4).

Figure 6.3. Of all excise duties on products harmful for health, those on tobacco and alcohol generate the most tax revenues

% of total tax revenues



Note: The high-income category is an average of OECD and non-OECD countries for which a breakdown by type of excise duty exists in the Revenue Statistics Database (RevStats), i.e. 34 countries. It should be noted that the RevStats database does not have disaggregated information on excise duties for Morocco.
Source: OECD Revenue Statistics Database

Table 6.1. Tobacco taxation

Products		DCT				VAT
		Component 1		Component 2	Component 3	
		Specific excise duty	***Ad valorem* excise duty (% of the public retail price excluding VAT and specific DCT)**	**Minimum collection threshold**	**Tax burden**	
Cigarettes		MAD 462 per 1 000 cigarettes	25%	MAD 630 per 1 000 cigarettes	58% of the public retail price including taxes	20%
Cigars and cigarillos		MAD 500 per 1 000 units	35%	MAD 1 000 per 1 000 units		20%
Other manufactured tobacco	Smoking tobacco for rolling cigarettes	MAD 750 per 1 000 grams	25%	MAD 950 per 1 000 grams		20%
	Water pipe tobacco	MAD 280 per 1 000 grams	25%	MAD 450 per 1 000 grams		20%
	Other	MAD 158 per 1 000 grams	25%	MAD 220 per 1 000 grams		20%

Source: MEFRA.

Two observations can be made on the basis of this analysis. On the one hand, Morocco complies with WHO's recommended standard of imposing taxes of at least 75% of the retail price for all types of cigarette. On the other hand, while these figures could be compared with Ministry of Health studies, internal analysis

tends to confirm the finding that the DCT on tobacco is regressive (AFD, DEPF et ONDH, 2019[17]) (Figure 6.4). This analysis could be extended to other types of tobacco (cigars, rolling tobacco, water pipe tobacco) subject to the availability of retail price information.

However, according to WHO, cigarettes were more affordable in 2019 than in 2008. Buying 2 000 cigarettes in 2019 amounts to spend 6.48% of GDP per capita, compared with 7.66% in 2008. This may reflect the faster rise in GDP per capita compared with the rise in cigarette prices.

Accordingly, if Morocco complies with the WHO standard of taxing tobacco at 75% of the retail price, tobacco taxation could be further strengthened to make this product less affordable for the population and thus reduce its consumption.

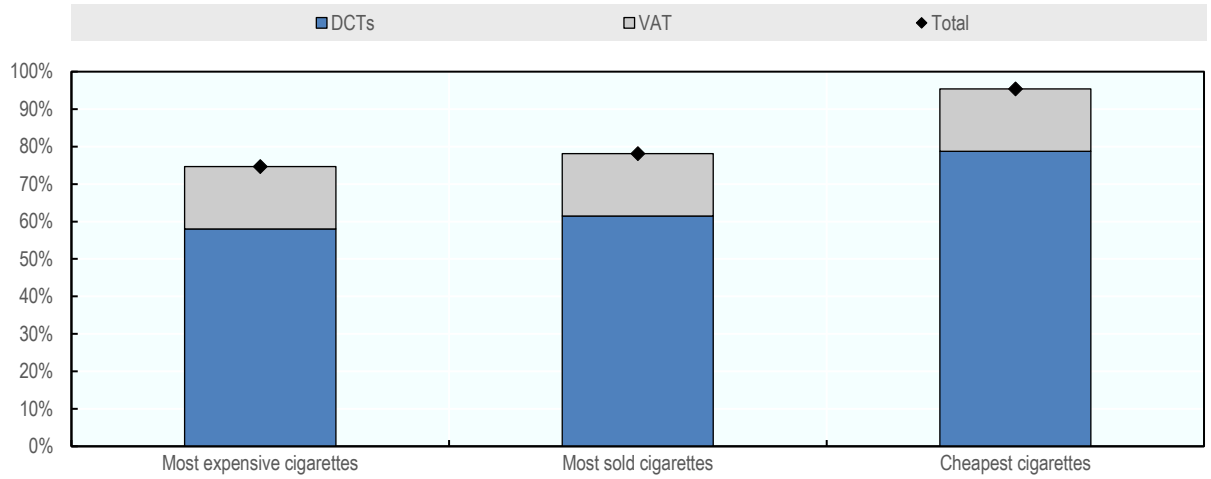
Table 6.2. Calculation of the three DCT components and VAT on cigarettes

		Most sold cigarettes	Cheapest cigarettes	Most expensive cigarettes
Retail price per 1 000 cigarettes		1 025	800	1 750
Specific excise duty		462	462	462
Ad valorem duty		25%	25%	25%
VAT		20%	20%	20%
Component 1	Retail price excluding tax (MAD)	314	164	797
	A. Total DCT (MAD)	**540**	**503**	**661**
	Total DCT (% retail price)	53%	63%	38%
	Total VAT (MAD)	171	133	292
	Total VAT (% retail price)	17%	17%	17%
	Total tax paid (MAD)	711	636	953
	Total tax paid (% retail price)	69%	80%	54%
Component 2	**B. Minimum collection of DCT (MAD)**	**630**	**630**	**630**
	Retail price excluding tax	224	37	828
	VAT (MAD)	171	133	292
	Total tax paid (MAD)	801	763	922
	Total tax paid (% retail price)	78%	95%	53%
Component 3	**C. Minimum tax burden rate (MAD)**	**595**	**464**	**1 015**
	Retail price excluding tax	260	203	443
	VAT (MAD)	171	133	292
	Total tax paid (MAD)	765	597	1 307
	Total tax paid (% retail price)	75%	75%	75%

Note: In the case of the most sold cigarettes, if component 1 were retained, the total tax burden would be 69%, close to the rate presented in the country profile published by WHO in 2019 (71%) (WHO, 2019[30]).
Source: OECD.

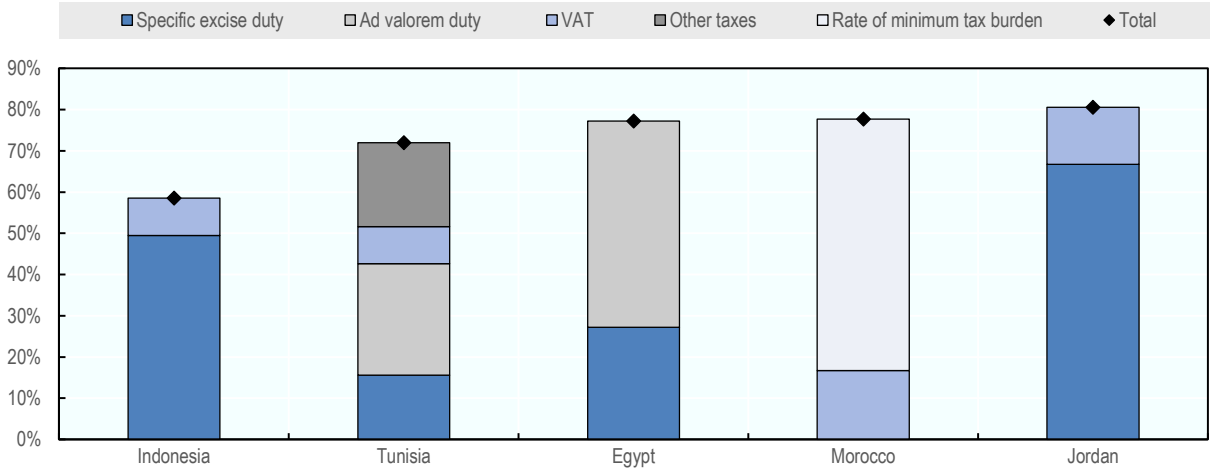
Figure 6.4. Cigarette taxation is regressive

As a % of retail price



Note: Component 2 for the most sold and cheapest cigarettes. Component 3 for the most expensive cigarettes.
Source: OECD.

Figure 6.5. When comparing tax burdens on the most sold cigarettes, Morocco is in line with countries in the region



Source: OECD and (WHO, 2019[31]).

Domestic consumption tax on alcohol

As in other countries in the region, the DCT on alcohol generates limited tax revenues. It would be interesting for Morocco to have precise details of the revenues generated by this DCT over the long term in order to analyse trends with regard to the measures introduced in successive Finance Acts.

Alcohol taxation is based on a specific DCT (MAD 800 or MAD 1 000 MAD per hectolitre), **a 20% *ad valorem* VAT and a parafiscal tax** (MAD 5 per hectolitre) (Table 6.3). The Tax Annex 2020 abolished the specific VAT of MAD 100 per hectolitre to simplify the system. International comparisons highlight the potential to increase excise duties on wine in Morocco (Figure 6.6).

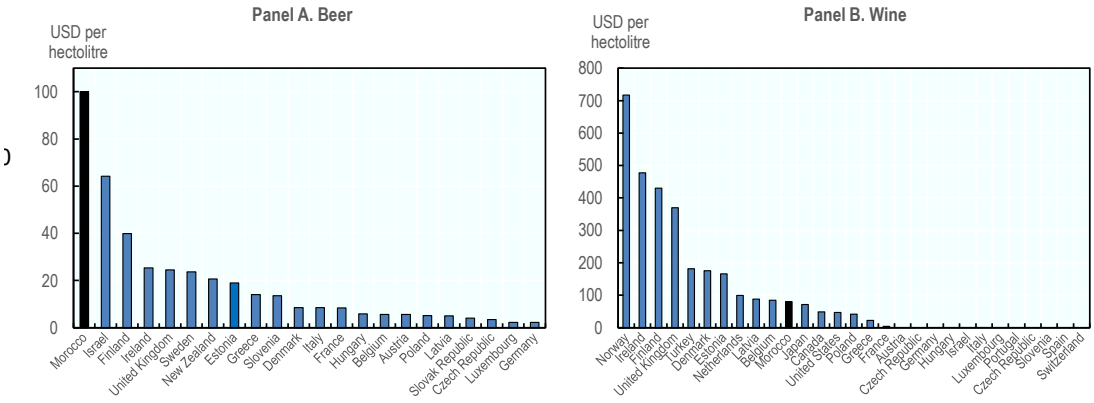
Table 6.3. Alcohol taxation

	DCT applied	Ad valorem VAT	Parafiscal tax for the Red Crescent (MAD per hectolitre)
Beer	MAD 1 000 MAD per hectolitre	20%	5
Wine	MAD 800 per hectolitre		

Note: Alcoholic beverages other than beer and wine are excluded from this table.
The Finance Act for 2020 repealed the provisions of Article 100 of the General Tax Code relating to specific VAT rates. Thus, as of 1 January 2020, these products are subject to the DCT managed by the customs administration.
Source: MEFRA.

Figure 6.6. Specific excise duties on wine may be increased

Excise duty, per hectolitre per degree of alcohol



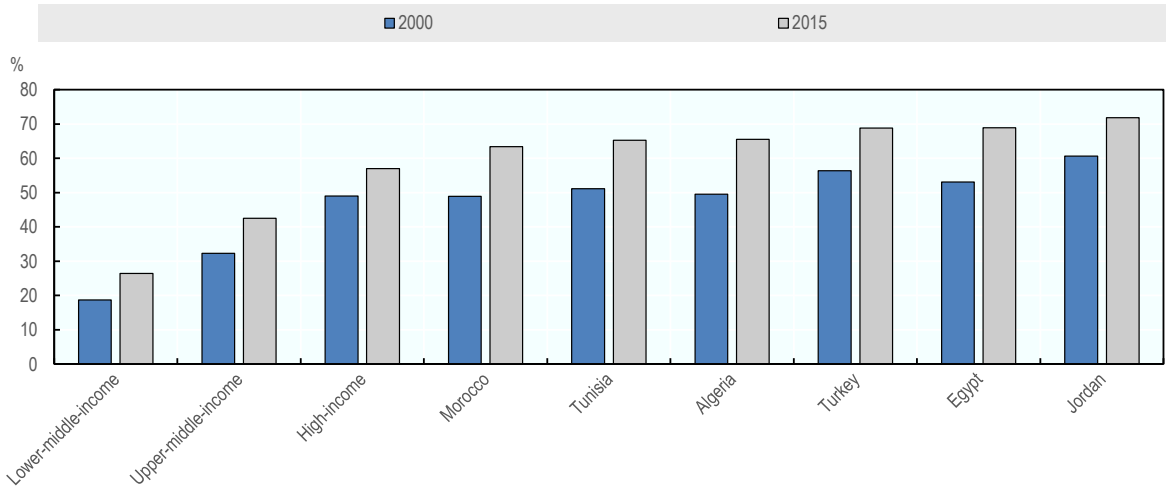
Note: These calculations do not take into account the ad valorem VAT (20%) nor the parafiscal tax to finance the Moroccan Red Crescent (MAD 5 per hectolitre).
Source: (OECD, 2018[32]).

Domestic consumption tax on sugary drinks

Sugar consumption in Morocco is very high, which increases the prevalence of certain diseases (Figure 6.7). The per capita sugar consumption is 36 kilos per year, i.e. four times higher than the amount recommended by WHO (CNOPS, 2018[33]). 7% of the population is diabetic and 13% are overweight (Ministère de la Santé, 2017[12]).

Figure 6.7. The number of people who are overweight is growing worldwide, and Morocco is no exception

% of the population over 15 who are overweight (body mass index higher than 25)



Source: WHO.

The 2020 Finance Act introduces many changes to the DCT on sugary drinks to encourage producers to reduce the sugar content in beverages (Table 6.4). Morocco is in line with the international trend, with a large number of countries introducing taxes on sweetened beverages. While it appears that the revenue generated by this DCT is modest, again reflecting the international trend, and that the main objective is rather to change consumer behaviour, more details on the revenue generated by this tax would be useful (as in the case of the DCT on alcohol).

Table 6.4. DCT on sugary drinks

Unit of trade, in MAD

Tax collection unit: hectolitre volume	Sugar content		
	Per addition of 5 g/100 ml or less	Per addition of more than 5 g/100 ml and less than 10 g/100 ml	Per addition of 10 g/100 ml or more
Carbonated or non-carbonated waters, mineral, table or other waters flavoured by the addition of less than 10% of edible fruit juice or its equivalent in concentrated juice; Lemonades prepared with less than 6% lemon juice or its equivalent in concentrated juice	30	40	45
Carbonated or non-carbonated waters, mineral, table or other waters, flavoured by the addition of 10% or more of edible fruit juice or its equivalent in concentrated juice; Lemonades prepared with 6% or more of lemon juice or its equivalent in concentrated juice	10	12.5	15
Energy drinks[1]	600		

1. With a caffeine content of more than 14.5 mg/100 ml and less than 32 mg/100 ml, with the addition of other stimulating substances such as taurine, glucoronolactone, guarana, ginseng, or any other plant extract, where appropriate.
Source: (Ministère des Finances, 2020[24]).

Some countries have gone further and introduced excise duties on sugar, such as Norway (1981) or Iceland (introduced in 2013 and withdrawn in 2015) (Box 6.1). **In Morocco, rather than introducing a DCT on sugar in the short term, the first step would be to abolish the sugar subsidy system introduced in 1996.** In 2018, the sugar subsidy amounted to MAD 3 billion, or 17.5% of total subsidies. The system faces several limitations, which aim is to stimulate local production:

- Although it is increasing, local production continues to account for a lower share of consumption than imports (49% in 2019).
- The consumer price is abnormally low compared with other countries: the price of granulated sugar is MAD 4.6 in Morocco compared with MAD 10.2 in Algeria, MAD 9.9 in Egypt and MAD 8.9 in Mauritania (Cours des comptes, 2014[34]).
- Since 2007, the refund of the refined sugar subsidy by the sugar-based food processing industries whose products are not intended for export has been abandoned, except for producers of carbonated and non-carbonated drinks who continue to refund half of the subsidy to the Social Cohesion Support Fund (flat-rate levy of MAD 1 000 on each tonne of sugar used). As a result, biscuit factories, chocolate factories, confectionery manufacturers, fruit canneries, producers of milk derivatives and ice cream factories no longer refund it (Ministère de l'Economie et des Finances, 2018[35]). In 2013, MAD 88 million were refunded (Cours des comptes, 2014[34]).

Box 6.1. Examples of countries that have introduced excise duties on products harmful for health

Iceland. The sugar tax, introduced by Iceland in 2013, was imposed at a rate of ISK 210 per kilogram of sugar. To minimise administrative and compliance costs, the tax was based on the average sugar content of each item in the customs classification code. The tax also applied to artificial sweeteners at the rate of ISK 42 per gram.

Norway. Norway taxes natural and artificial sweetened beverages (the tax was introduced in 2007, replacing one on carbonated soft drinks and other non-alcoholic beverages dating from 1924), chocolate, sweetened products, and sugar (NOK 7.93 per kilo of sugar, imposed on producers or importers). These taxes were originally introduced to increase tax revenues, but have continued to be used for public health purposes. Norway also considered nutrient-based taxes, but ultimately did not introduce them due to their complexity (need for specific laws governing product labelling).

Brazil. Between 2006 and 2011, Brazil increased excise duties on cigarettes, leading to a 34% increase in the real price per packet and a 19% reduction in cigarette consumption. In 2012, rate increases were higher than the inflation rate. As a result, between 2012 and 2016, prices rose by 33% and consumption fell by 50%.

Russia. In 2005, Russia introduced control measures on alcohol: a ban on alcohol-related advertising, restrictions on purchasing, and increased costs through taxes and minimum pricing. By 2014, these measures had reduced alcohol consumption by a third, leading to a decrease in non-communicable diseases and mortality rates.

Colombia. In 2016, Colombia increased the specific tax on cigarettes by 200%, and introduced an annual increase of 4 pp in addition to the inflation rate. Cigarette consumption fell by 23% between 2016 and 2017, and cigarette-related tax revenues increased by 54%. In 2016, Colombia also increased taxes on alcohol, adopting a combination of an *ad valorem* tax (25%) and a specific tax based on alcohol content. This reform resulted in a 17% increase in revenue from this tax in 2017.

Source: OECD; (Bloomberg Philanthropies, 2019[36]).

Environmental taxation should be given more prominence

The National Conference on Taxation addressed all types of taxes at the central and local levels. The guidelines for tax reform resulting from the Conferences therefore cover a wide range of topics.

Despite its important role in sustainable growth and positive health impacts, environmental taxation was absent from the discussions. Only one recommendation of the National Conference on Taxation mentions the introduction of a tax dedicated to environmental protection, whose revenues would be earmarked for the regions. This is a first (albeit still very generic) step that would be worth developing quickly, given the environmental and health challenges that Morocco faces. This approach would bring even more benefits given that Morocco's tax structure remains insufficiently diversified, still too focused on three pillars (VAT, PIT and CIT), with little consideration for other types of tax, particularly environmental taxes.

Earmarking these tax revenues for the regions is an idea that could be explored. This would meet some of the funding needs of local and regional authorities, and it would give them an incentive to implement such taxes. Finally, it could potentially support the funding of certain health programmes in the context of decentralisation, or the Medical Assistance Plan for the Economically Disadvantaged (Ramed) scheme that local authorities s are struggling to fund.

Earmarking a share of VAT revenues for health is not recommended

One of the recommendations of the National Conference on Taxation is to earmark a share of VAT revenues for expanding coverage and welfare benefits, based on the Single Social Register. This recommendation was taken up at the National Conference on Health Financing (Box 1.1). The Economic, Social and Environmental Council has therefore proposed earmarking between two and four percentage points of the 20% VAT rate to fund social security (thus supplementing the income generated by SSCs) or to finance the Social Cohesion Support Fund. Table 6.5 gives an order of magnitude of what this would represent, and provides a comparison with the Ministry of Health budget if all of these revenues were earmarked for health.

Table 6.5. Order of magnitude of VAT revenues that could be earmarked for social security/social sectors

	In MAD billion	As a % of the Ministry of Health budget[3]
VAT revenues in 2018 (domestic and import[1])	**93.8**	
Revenue generated by the standard VAT rate of 20%[2]	**75.04**	
VAT revenue generated by 1 point of the standard rate	3.752	
VAT revenue generated by 2 points of the standard rate	7.504	46%
VAT revenue generated by 4 points of the standard rate	15.01	92%

1. Domestic VAT in 2018 was MAD 29.134 billion (Annual Report of the Budget Directorate), and VAT on imports was MAD 54.7 billion (Annual Report of the Customs and Excise Administration (ADII)).
2. The standard VAT rate of 20% generates approximately 80% of total VAT revenues.
3. The budget of the Ministry of Health includes the operating budget and the investment budget for 2019, i.e. MAD 16.331 billion (MEFRA Budget Directorate).
Source: OECD.

Earmarking between 2 and 4 percentage points of VAT for social security and the health sector would seem to be an ambitious measure, particularly given the amounts involved. This approach should therefore be considered with caution (see Chapter 5 for a discussion of the benefits and risks

of the principle of earmarking resources). In this case, earmarking 2 to 4 percentage points of the standard VAT rate of 20% for the health sector would represent between 46% and 92% of the Ministry of Health's budget. Given the current situation, with the Ministry's low budget execution, earmarking such amounts would seem inappropriate. Finally, a share of VAT is already earmarked for funding local authorities, whose delegated powers include health. In 2018, this amounted to MAD 29 billion, or 31% of total VAT revenues (domestic VAT and VAT on imports).

If Morocco were to commit to earmarking a share of VAT for health, a sound budgetary framework would be needed to ensure that spending and financing forecasts were properly assessed and remained under control. Earmarking part of VAT without a precise health budget, with information on costs and additional revenues needed, seems sub-optimal. Earmarking a fixed share of VAT without a sound budgetary framework, which would be discussed and approved by both the Ministry of Health and the Ministry of the Economy, Finance and Administrative Reform, would likely lead to inefficient and excessive public spending, and would not contribute to improving the efficiency of public health expenditure.

Conversely, broadening the VAT base is a more appropriate measure, since this will increase tax revenues for the general state budget. On the one hand, the number of reduced VAT rates (0%, 7%, 10% and 14%), which is high compared with other countries, could be rationalised. The standard VAT rate (20%), which is relatively high by international comparison, should be maintained since a possible reduction would not necessarily have the expected impact on reducing consumer prices. On the other hand, the abolition of certain VAT exemptions, after a detailed analysis of their respective impacts, would also make it possible to broaden the tax base.

VAT support for the health sector is also provided indirectly through tax expenditure. In 2019, there were 13 tax expenditure measures linked to reducing the costs of health care, mainly VAT-related (exemption or application of reduced rates). They represent MAD 446 million, or 1.6% of total tax expenditure, which is fairly modest.

Certain medicines continue to be taxed at the reduced VAT rate of 7%, unlike in many OECD countries and other countries in the MENA region, which make greater use of the 0% rate. Although reduced VAT rates, or 0% rates, are generally considered to be sub-optimal because they benefit richer households relatively more than poor households (as a percentage of their income), this argument is less valid in the case of medicines that are consumed occasionally according to patients' needs. Efforts to exempt medicines from VAT should therefore be continued (see Box 1.1).

Finally, difficulties in recovering VAT credits also affect the health sector. For example, CSOs, including those involved in AIDS and tuberculosis control, may experience significant delays in these processes, thus penalising their financial situation in the short and medium terms. Improving the recovery of VAT credits therefore seems important for Moroccan CSOs working in the health sector.

The introduction of tax deductions for some types of private health expenditure is not recommended

During the discussions at the National Conference on Taxation, the idea was put forward of introducing tax deductions for private health expenditure, which would mostly benefit the middle and upper classes. Introducing such deductions would reduce PIT significantly and raise funding questions for the public health system. If Morocco decides to move towards introducing such provisions, the first step would be to significantly broaden the PIT base while making it more progressive (for example by reducing generous allowances for employment expenses, for retirement savings, and for interest on mortgages, which are regressive) (OECD, 2019[23]), and to target the health spending that could benefit from these moves.

The efforts of the tax administration to ensure that all liberal professions, including those operating in the health sector, pay their fair share of tax are to be welcomed and continued. The tax administration has collected a lot of information and data with the aim of gaining an accurate picture of taxpayers who do not pay their fair share of taxes. In this respect, the tax administration has recently highlighted that some liberal professions contribute very little in PIT. Currently, about 3% of personal income tax is levied on professional income, much less than in other countries such as the Czech Republic, Ghana or Israel. Efforts to combat tax fraud must therefore continue within all liberal professions, and be accompanied by a strengthening of the system for penalising fraud.

Strengthening local financing is necessary for local authorities to exercise their health powers

Fiscal autonomy of local authorities is limited as their own tax revenues represent their third source of financing. 64% of local government revenue comes from endowments and subsidies from the general state budget; 26% from tax revenues; 3.6% from tariff and royalty revenues; 3% from property income and 3% from other sources. Dependence on central government transfers is particularly high in the regions (94% of their total funding) and in prefectures/provinces (80%) (Table 6.6) (OECD, 2018[37]).

In the context of decentralisation, health has been delegated to local authorities. Prefectures and provinces are in charge of rural health care, prevention/hygiene and identifying the health population's needs. Municipalities are responsible for local clinics and health care centres. In theory, these devolved powers must be accompanied by a transfer of the financial resources needed to exercise them. In practice, however, local authorities do not have the budgets to exercise their powers.

The financial difficulties of local authorities in the health sector are emerging at other levels, for example in the financing of the Ramed scheme. While up to 15% of Ramed funding comes from rural and urban communes (MAD 40 per beneficiary viewed as poor, i.e. with an income of less than MAD 300 per month, which represents 84% of recipients), many local authorities do not manage to honour their commitments. There are several reasons for this situation: (i) The communes with the highest concentration of poor people are also those experiencing the greatest financial difficulties and therefore receive the most transfers from the central government; (ii) Initial forecasts of the population living in poverty (55%) proved to be wrong, the actual figure is 80%, increasing the cost to local authorities; (iii) Difficulties have been observed in the procedures for disbursing funds to the Social Cohesion Support Fund (the SEA in charge of financing the Ramed). As a result, the local authorities' deficit is believed to be around MAD 140 million, with a total annual cost for the Ramed of MAD 4 billion (estimated at MAD 3 billion per year before its implementation).

Local authorities need resources to implement their new powers, which include health, namely:

- **The necessary resources from central government** (shared tax revenues, endowments and subsidies). In this respect, the financing possibilities available to local authorities through the Regional Social Upgrading Fund (to eliminate deficits in human development, infrastructure and equipment) and the Interregional Solidarity Fund (to distribute resources to reduce disparities between regions) could be a first step (OECD, 2018[37]). In particular, the Social Upgrading Fund could be a funding source for the provision of care at the regional level (health infrastructure, coverage of certain benefits, etc.).
- **More of their own resources, through the strengthening of local authority taxation** (OECD, 2018[37]).

Table 6.6. Local authority funding in Morocco

Source of income	Detail of income source		Use of income	2018
64% from transfers from central government	Share of earmarked taxes *(86% of total)*	VAT (80% of total transfers) at 1% for regions, and 30% for prefectures, provinces and municipalities	100% to the SEA relating to the share of local authorities in VAT revenue	29.1 billion
		5% of PIT to the regions	90% to the SEA Special Fund relating to the proceeds of tax revenues earmarked for the regions 10% to the Interregional Solidarity Fund	3.5 billion
		5% of CIT for the regions		
		Tax on insurance policies up to 20% for the regions		517 million
		Funding from the general state budget		2.25 billion
	Grants *(14% of total, mainly for the regions)*	Through the Competition and Grants Fund		
		Interregional Solidarity Fund	Funded by 10% of earmarked CIT, PIT and tax on insurance policies	697 million
		Social Upgrading Fund	Funded by part of the general contribution from the state budget	10 million (including 2 million for health)
26% from tax revenues	5 recurring property taxes *(16.5% of total funding for local and regional authorities; 82% of tax revenues, or 0.8% of GDP)*	3 taxes collected by the tax administration on behalf of local authorities (75%)	Housing tax	398 million
			Municipal Service Tax	3.9 billion
			Business tax	2.7 billion
		2 taxes collected by municipalities (25%)	Taxes on undeveloped urban land	1.5 billion
			Building Construction Tax	728 million
	Other taxes managed by local authorities *(18% of tax revenues)*	Taxes levied by the municipality (on drinks, tourism, etc.)		730 million
		Taxes levied by the prefecture/province		
		Taxes levied by the region		
3.6% from tariff and royalty revenues				
3% from property income				
3% from other sources				

Note: The Interregional Solidarity Fund and the Social Upgrading Fund were established in 2016 but funded for the first time in 2018. The orders of magnitude in this table are not necessarily the final figures for 2018.
Source: (OCDE et SNGWOFI, 2019[38]); MEFRA.

Central resources for health financing at the local level will have to play a major role. On the one hand, this is because local authorities are already facing difficulties in funding other programmes, such as the Ramed, and on the other, because the local tax yield remains sub-optimal. Finally, health care demands are significant and are expected to grow over time. Thus, as the capacity to collect tax revenues varies from region to region (poorer regions have lower capacities to collect local tax revenues), there is a risk of having a two-tier public health system, where richer regions will be able to provide better health care than poorer regions, which is both inequitable and undesirable.

Local co-financing by communities may nevertheless be desirable as it helps rationalise local health expenditure. This requires a stronger role for local taxation, and a step-by-step approach will be needed (OECD, 2019[23]). In the short term, for example, it will be a matter of retaining the business tax, but abolishing it in the long term when property taxation is further developed (transformation of the legal land register into a tax land register, revision of the collection of housing tax, revision of the market values of property for greater recourse to recurring taxes on real estate, etc.). In this respect, closer collaboration between the tax administration and the National Agency for Land Conservation, the Land Register and

Cartography, whose data are more robust, could make it possible to set up a large-scale computerised real estate valuation system.

The recommendations of the National Conference on Taxation go in this direction by proposing measures to strengthen local taxation:

- Evaluating and rationalising the various local taxes with a view to examining the relevance of maintaining them.
- Replacing the current business tax on investment with a tax based on economic activity.
- Replacing local taxes based on rental value and the tax on undeveloped urban land by a local property tax based on market value.
- Instituting a tax system dedicated to environmental protection (eco-taxation) and earmarking its revenues for the regions.

Whichever option is chosen for health financing at the local level (transferred resources or own resources), access to sufficient financial resources is a prerequisite for implementing local health policy. Otherwise, there is a risk that the quality of public health care will stagnate or even deteriorate. Decentralisation and the policy of administrative devolution (transfer of powers from central government to state services in the regions), a corollary of successful decentralisation, are opportunities to improve state action at the local level.

Box 6.2. National health policy and decentralisation: international examples

In OECD countries, health accounts for 18% of subnational spending on average (2015). Although this is a significant share, central governments nonetheless continue to have a high level of decision-making power. This is explained by the desire to ensure equitable and efficient provision throughout the country. As a result, the decision-making power of subnational authorities is often constrained by nationally imposed standards, regulations and legislation.

Central governments often have power over the decision-making aspects of health policies (e.g. in relation to the legal framework, regulation of private hospitals), health policy objectives, and the collection and allocation of funding (funds earmarked for health, base for and level of health SSCs, etc.).

In the case of Denmark, for example, 75% of public expenditure is decentralised (this is the highest rate). However, the equivalent is not observed in terms of revenue decentralisation, and the regions continue to be largely financed by central government. Similarly, the regulation of public health expenditure in the regions is very strongly dependent on the central level. The implementation of Denmark's regional health policy is therefore more akin to a delegation of power than real autonomy.

The prevailing trend in OECD countries over the last two decades has been towards the decentralisation of the health sector. However, countries such as Chile, Greece or Iceland continue to have a highly centralised health system, unlike countries such as Canada, Spain or Switzerland. Finally, countries such as Germany, Australia and Sweden have tended towards recentralisation of their health care systems. In Norway, the responsibility for health policy has been transferred (back) from the municipalities to the regions, which now have administrative competence. Indeed, international evidence shows that too much decentralisation of public health expenditure can lead to fragmentation and increased health costs. This situation, which is specific to the health sector, is not observed in the case of education, for example.

Source: Annual meeting of the Fiscal Federalism Network (2019); (Lorenzoni et al., 2019[15]); (OCDE et SNGWOFI, 2019[38]).

7 Earmarking tax revenues for health: a mechanism to be used with care

Despite disadvantages, the earmarking of tax revenues remains widespread

Many countries earmarked resources. Earmarking can be rigid ("*hard earmarking*") or flexible ("*soft earmarking*"). Hard earmarking means that all revenue from a tax is kept separate from the state's general revenue, and can only be used to finance a specific expenditure programme in its entirety. Another case of hard earmarking is when a fixed share of the revenue from a particular tax finances a specific expenditure programme in its entirety (for example, 1 percentage point of personal income tax are earmarked for a specific expenditure programme). In the case of soft earmarking, the earmarked tax finances only part of an expenditure programme, with the remainder financed from the general state budget. SSCs, for example, are a form of earmarking. Internationally, earmarking taxes on products harmful for health is frequent.

There are several advantages to earmarking.[11] It:

- **Strengthens political legitimacy.** It is easier to obtain popular support for (new) taxes that are earmarked for specific social objectives. However, hard earmarking can also be an easy way to avoid both saving money in the sector and reorganising priorities.
- **Provides guidance to taxpayers on the actual cost of programmes.** In health care, this improves the population's awareness of the significant costs of the sector. This argument is less valid in the case of soft earmarking.
- **Supports the principle that individuals contribute up to the level of benefits received from a state programme.** However, in the case of health, this principle should not apply: a population affected by a disease should not have to pay a specific tax earmarked for the treatment of that disease.
- **Increase visibility of programme funding sources.** This strengthens long-term planning and budgeting, depoliticises a minimum level of income, and provides some stability of funding. This is particularly important in the health sector, where some types of expenditure are fixed and cannot be postponed over time. However, in some cases, it will be difficult to know in advance precisely how much revenue will be earmarked.

There are also many limitations, including:

- **The effect of crowding out public resources**. Other sources of funding, such as general revenue from the state budget, may be reduced by earmarking.

[11] Discussion based on (Boakje, 2016[40]), (Carling, 2007[41]), (Murray, 2018[42]), (Wright & al, 2017[44]), (OECD et World Bank, 2014[45]), (WHO, 2016[43]).

- **Reinforcement of budgetary inflexibility.** Earmarking reduces government discretion and flexibility. This may, in some situations, jeopardise macroeconomic stability by hampering the scope for fiscal adjustments. To reduce this risk, some countries have created reserve funds into which earmarked taxes can be directed if new priorities emerge.
- **Lack of variation in funding according to programme needs.** Earmarked funds do not vary according to the size of the programmes or projects they fund. As a result, they do not necessarily fund the entire requirement. In the health sector, this may become unsustainable if coverage or utilisation rates increase. In particular, rigid earmarking of resources does not appear to be financially sustainable for funding universal health coverage, due to the scale of this type of programme.
- **Risk of inefficiency in programmes funded by earmarked resources** as these programmes are often subject to less evaluation. In the health sector, this can lead to inefficiencies in public spending.
- **Risk of pro-cyclical financing.** Some earmarked taxes may generate pro-cyclical revenues, in particular earmarking a share of PIT. This can lead to very large fluctuations in funding, which is opposite to the need for stable financing, particularly in the health sector. However, health programmes financed by counter-cyclical earmarked taxes may be better protected from budget cuts.
- **In the case of flexible earmarking of resources, the fragmentation of funding sources** makes programme management more complex.

In Morocco, earmarking more resources for health is a political choice, given the limited amounts under discussion

Many resources are earmarked in Morocco through Special Treasury Accounts (STA). The Moroccan public sector comprises the central administration, 71 STAs (including 56 SEAs) and 208 autonomously managed government services. In the 2020 Finance Act, the STAs account for MAD 85.1 billion, i.e. 20% of total public resources. However, SEAs are legally separate from the general state budget. As their expenditure and revenue are not included in the budget, they are exempt from the rule of non-earmarking. However, the resources of the three SEAs for health account for only 2%[12] of total STA resources.

In the health sector, there is a need for discussion on greater resource earmarking. According to the National Health Plan 2025, prevention measures, primary health care and the equipment deficit should be funded by introducing new tax provisions targeting products harmful for health (tobacco, alcohol, sugar, salt, flour, fizzy/energy drinks, sweets and fatty products). The plan states that revenues from this should be earmarked for the Central Pharmacy Fund.

In practice, the tax revenues to be earmarked, from the DCT on products that are harmful for health, are limited. In 2018, they amounted to MAD 12.58 billion (from the DCT on tobacco and DCT on non-energy products), i.e. 5.4% of total tax revenues. Thus, the political decision to earmark more resources for health will better reflect the national priority given to it by the government. Although there is no apparent causal link, countries that have implemented this mechanism have observed an improvement in health performance. In practice, introduction of this mechanism reflects strong political will to strengthen the financing of the health sector, which goes beyond simply earmarking resources.

[12] See Table 2.2: both the Social Cohesion Support Fund (MAD 2.45 billion), and the health share of the INDH Support Fund (MAD 410 million) are included, but not the Central Pharmacy Fund in that it is funded partially through the Ministry of Health budget and partially through the Social Cohesion Support Fund.

In light of the financial needs of Morocco's health sector, earmarking tax revenues from the DCT on products harmful for health will make it possible to increase, even to a low extent, the general level of resources for health. While earmarking a share of VAT revenues for social services, as agreed at the National Conference on Taxation, does not appear to be the best option given the amounts and the absorbing capacity of key stakeholders (see Chapter 4), the options envisaged by the Ministry of Health as described above could nonetheless be discussed with the Ministry of the Economy, Finance and Administrative Reform, in particular:

- **Earmarking *all* tax revenues from the DCT on tobacco**, and the new revenues that would result from an increase in its tax rate (see Chapter 4). Table 7.1 provides examples of countries that earmark a large share of tobacco taxation for health.
- **Earmarking other DCTs on products harmful for health**, such as alcohol or sugary drinks. As an example, Uganda has decided to earmark its excise duty on alcohol and sugary drinks for financing AIDS programmes (USD 2.5 million).
- **Continuing to earmark income generated by the subsidy reform to social sectors.** In this context, earmarking the revenues generated by abolition of the sugar subsidy should be considered. This is all the more relevant as sugar subsidies are less progressive than other subsidised products (the richest populations benefit most from sugar subsidies), so this has little impact in terms of reducing inequalities (AFD, DEPF et ONDH, 2019[17]).

Table 7.1. Examples of countries that earmark a large share of tobacco taxation to health

Country	Description
Argentina	A 7% tax on the selling price of cigarettes is earmarked to finance health and social programmes.
Cape Verde	All revenue from tobacco excise duty is earmarked for sport and health.
Colombia	All revenues from *ad valorem* excise duty (10% of the selling price) and the majority of revenues from specific excise duties (COP 2 100 per packet) are earmarked to finance health insurance. A small share of the specific excise duty is earmarked for funding sport.
Costa Rica	All revenues from specific excise duty are earmarked to finance programmes for preventing and treating tobacco-related diseases, cancer treatment and sport.
Egypt	An additional EGP 0.1 is levied on each packet of cigarettes to finance student health insurance. An additional EGP 0.75 is levied on each packet of cigarettes to finance the health insurance system.
El Salvador	35% of the tax revenues from excise duty on tobacco, alcohol and weapons is earmarked to finance the Solidarity Fund for Health.
Guatemala	All revenues from tobacco excise duty are used to fund health programmes.
Indonesia	A 10% surcharge is imposed on tobacco excise duty. At least 50% of revenues from this are earmarked for regional health programmes, 75% of which is earmarked for financing the health insurance system. In addition, 2% of tobacco tax revenues are earmarked for regional governments, a proportion of which must be used for health.
Panama	50% of revenues from tobacco taxation are earmarked for the National Cancer Institute and the Ministry of Health (to prevent cigarette smuggling).
Paraguay	40% of revenues from tobacco excise duty are earmarked for the Ministry of Health for the prevention and treatment of non-communicable diseases and 18% is earmarked for the National Sports Development Fund.

Source: (WHO, 2019[31]).

Several conditions should be met before opting for greater earmarking of resources

If Morocco were to start earmarking greater tax revenues for health, **its success would depend upon several conditions.** An underlying prerequisite for all the conditions described below is a closer relationship between the Ministry of Economy, Finance and Administrative Reform and the Ministry of Health. The introduction of earmarked taxes clearly reflects political support for one or more health

priorities, which requires an alignment between the two ministries in terms of the objective(s) to be achieved. The conditions below should also be met to counteract, either fully or in part, the limitations of this type of funding as described above.

- The introduction of earmarked taxes should not be an isolated measure, but an integral part of an overall health financing strategy.
- It must be supported by awareness campaigns on the role of the earmarked tax and the health programme that will benefit from its funding.
- The earmarked resources should be first used to finance defined health programmes (in terms of budget, scope and objective), which are subject to a prior needs assessment to take into account possible increases in their use or coverage. It would therefore make sense to earmark resources for health programmes that are currently supported by donors, and which will see their funding decrease over time.
- Priority should be given to flexible resource earmarking mechanisms to limit budgetary rigidities.
- The implementation of earmarked resources should be accompanied by specific measures for the management of health programmes. For example, the Ministry of Economy, Finance and Administrative Reform could accept the introduction of earmarked taxes dependent on an improvement in the quality and effectiveness of public expenditure from the Ministry of Health.
- The implementation of earmarked resources should be accompanied by regular evaluations of the programmes that benefit from them, to ensure accountability.
- The number of earmarked taxes should be limited to avoid the fragmentation of funding sources.
- There should be timely disbursement of earmarked resources to the health programmes they fund.
- Resource allocation should be conditional on the institutions' ability to absorb and manage new income streams.
- The resource earmarking mechanism should be clearly and transparently outlined. Paraguay is a counter-example in this respect (Box 7.1).

Box 7.1. Earmarking public revenues for health in Paraguay

Paraguay introduced a tax reform in 2019 designed to modernise and simplify the tax system (Act 6380). This includes an increase in taxes on tobacco, alcohol and sugary drinks, and creates a fund for strengthening infrastructure and human capital (especially social protection, health and education programmes). The fund will be financed by a mechanism for earmarking the additional tax revenues generated by the reform. However, the resource earmarking mechanism is not defined. The Act states that the Ministry of the Economy must establish the methodology to be used to identify the additional tax revenues generated by the reform, which at this stage provides little clarity as to the extent of the revenues that will actually be earmarked.

Source: Paraguay Multi-dimensional Country Review (MDCR) Volumes 2 and 3.

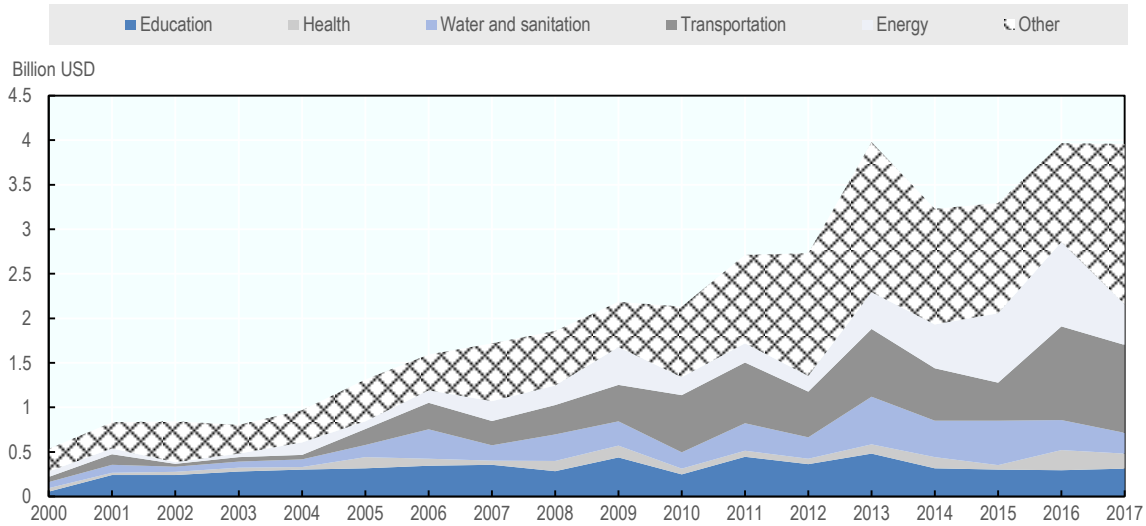
8 Post-transition: funding AIDS and TB control through tax revenues

Morocco should have the financial capacity to successfully manage the Global Fund transition

International co-operation has a relatively small role in the health sector in Morocco (Figure 8.1), similar to what is observed in other countries in the region. This is reflected in its limited role in health sector financing (see Chapter 2), and significantly reduces the particularly high financing risk for the health sector described in Chapter 1.

Figure 8.1. Health represents a small share of international co-operation funding streams in Morocco

Payments from all donors (bilateral, multilateral and private)

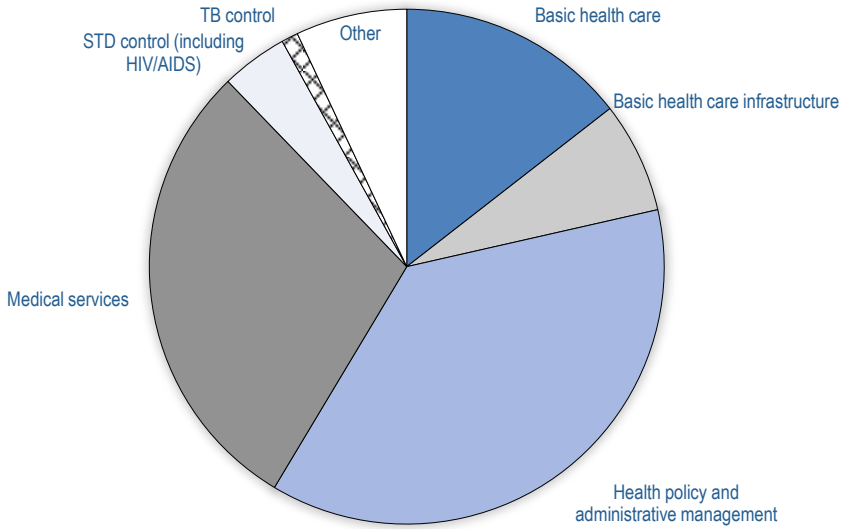


Note: The health variable includes the Creditor Reporting System (CRS) database categories “Health” and “Population Policies/Programmes & Reproductive Health”. The "Other" series includes assistance to civil society, the industrial sector, agricultural sector, etc.
Source: Database: Creditor Reporting System (OECD).

Morocco should have the capacity to finance AIDS/TB programmes from domestic resources after the transition. Within the health sector, international support for AIDS and TB is limited (Figure 8.2; Table 8.1), but it is critical in that it is targeted at vulnerable populations that are not well integrated and accepted in society.

Figure 8.2. AIDS and TB control accounts for a small share of donor funding for health

Average payments 2012-17



Note: The selected categories account for 93% of health sector aid. The figure includes the CRS database categories "Health" and "Population Policies/Programmes & Reproductive Health".
Source: Database: Creditor Reporting System (OECD).

Table 8.1. International funding for AIDS and TB control comes mainly from international donors

Total payments 2012-17

	Bilateral Donors		Multilateral Donors		Total	
	Millions USD	%	Millions USD	%	Millions USD	% of total
Basic health care	54	51%	52	49%	106	15%
Basic health care infrastructure	52	100	0	0%	52	8%
Health policy and administrative management	130	47%	145	53%	275	40%
Medical services	215	100	0	0%	215	31%
STD control, including HIV/AIDS	1.3	4%	30	96%	31.3	5%
TB control	1.4	18%	6.3	82%	7.7	1%
Total	**454**		**233**		**687**	**100**

Note: The selected categories account for 93% of health sector aid.
Source: Database: Creditor Reporting System (OECD).

In addition, the majority of international assistance for health goes through the Moroccan state budget, which gives the latter good visibility on the sector's funding. Funding from many international health organisations is not integrated into state budgets. These include grants from the Global Fund, the GAVI Alliance, the President's Emergency Plan for AIDS Relief (PEPFAR) and some philanthropic organisations. While this mechanism has the advantage of ensuring a rapid response in contexts where government capacity and governance are sometimes limited, while ensuring some control over the use of funds by the donor, it has the disadvantage of reducing the visibility of health sector funding for the government. In Morocco, the majority of external funds are provided in the form of budget support (such as from the European Union, the African Development Bank or the French Development Agency), as organisations such as GAVI, PEPFAR and the Bill & Melinda Gates Foundation do not operate in Morocco.

In the case of the Global Fund, funding does not flow through the general state budget but, as discussed in Chapter 1, the amounts involved are limited.

However, the transition may threaten the activities of Moroccan civil society involved in AIDS and TB control

The financial risk associated with the transition lies in the dependency of a small number of civil society stakeholders to the Global Fund's financing, in particular for programmes supporting target populations. In practice, the Global Fund finances organisations that work in the field with target populations and manage certain prevention activities, such as SOS Tuberculose or the Association de Lutte contre le SIDA (ALCS) (providing 40% of the latter's funding).

On the one hand, until now, public funding has only supported curative and prevention aspects, not the human resources of CSOs. At ALCS, for example, out of an annual budget of approximately MAD 30 million, human resources represent 30% of expenditure (or 40% including the allowances paid to the 150 people working in the field). ALCS is currently funded 40% from the Global Fund, 20% from Moroccan private donors (mainly collected during events such as Sidaction), 20% from Coalition PLUS, 2% from Moroccan government funds (mainly in the form of donations of MAD 10 000-20 000 from the regions) and the remainder from other partners. Government funds are not only limited but also allocated on an ad hoc basis; moreover, they can only be used to purchase drugs or equipment and not to finance the association's human resources. This example illustrates the need to finance the human resources of AIDS or TB associations from public funds, following the transition away from the Global Fund. However, while the National Conference on Taxation recommended introducing measures to develop the cultural and voluntary sectors, it does not seem appropriate to introduce exemptions from PIT or VAT for CSOs, as this goes against the need to simplify tax expenditure.

On the other hand, the share of public funding for prevention programmes implemented by civil society stakeholders for vulnerable populations that are considered to be illegal in Morocco, including persons involved in prostitution, homosexuals, and drug users, **should be increased**. In the case of AIDS, these populations account for most cases. For example, 7% of people who use drugs are HIV-positive; 4% of homosexuals are infected; and 67% of new infections occur amongst vulnerable populations and their partners. Financing programmes targeting these vulnerable populations will therefore be of paramount importance in controlling the epidemic.

As well as ensuring the long-term sustainability of public funding for CSOs involved in AIDS and TB control, a framework should also be put in place to support their activities. In particular, if there is more significant public funding of their activities, it would be appropriate to establish "social contracts" (inspired by "performance contracts" between the private sector and the state, and as implemented in countries such as India or Mexico) between these organisations and the Ministry of Health. These could take the form of an agreement for the provision of predefined services, with specific objectives to be achieved (e.g. in prevention, testing, and psychological support), performance measurement indicators and a binding budget calculation. To enable this, the Ministry of Health will first need to conduct an accurate estimation of the funding needs of these bodies, in particular for prevention activities. In addition, a study to analyse the unit costs of the services would be helpful and serve as a basis to implement the social contracts.

Meanwhile, the Morocco Coordinating Committee (CCM) is viewed by all stakeholders as a body that functions well and should continue to exist beyond the transition away from the Global Fund. The CCM enables dialogue between the state, associations and representatives of the populations affected by the disease. It would need to be established as a formal institution, for example by transforming it into a non-profit foundation (or any other relevant type of institution) with a board of directors. Funding for its current expenditure could come from the Social Cohesion Support Fund, which is dedicated to vulnerable populations.

While TB control could be funded from the general state budget, AIDS control may require several options

TB control

Regardless of the future transition away from the Global Fund, the National Strategic Plan for TB Prevention and Control 2018-2023 is underfunded. The budget of MAD 513 million (excluding the wage and salary bill) is 65% funded by the Ministry of Health (for purchase of drugs and diagnostic materials), with 30% from other national sources (local authorities, INDH) and 5% from the Global Fund (for purchase of drugs and capacity building for field staff). However, 30% of the plan's needs are not currently covered (OMS et Programme National de Lutte Antituberculeuse du Maroc, 2019[13]).

Increased public funding for TB control is a necessity. On the one hand, to meet the current funding gap and on the other, to replace the 5% of funding that comes from the Global Fund. The general state budget, which is derived from tax revenues, could fulfil this role. The high prevalence of TB in Morocco makes this all the more important (see Chapter 2).

AIDS control

The National Strategic Plan for AIDS control 2017-2021 estimates funding needs at MAD 612 million. The 2019 National AIDS Spending Assessment (NASA) shows that expenditure in 2016 and 2017 was funded as follows: 57% from public funding (state and local authorities), 38% from international funding (including 29% from the Global Fund), and 4% from NGOs or the private non-profit sector (ONUSIDA et Fonds mondial, 2019[39]). Prevention activities account for 46% of expenditure, followed by care and treatment (32%). The report highlights that expenditure outturns in 2017 were approximately 20% higher than the budget estimates.

There are several options for funding control of the disease once the Global Fund has withdrawn. They aim to respond to the specificity of AIDS, which primarily affects vulnerable illegal populations.

- **Through the Ministry of Health**: as with TB, the first option involves increasing the budget of the Ministry of Health. In particular, this would be necessary to fund CSOs and their prevention activities. Thus, the Ministry of Health would cover the financial cost of testing and treating, which would be carried out in the field by associations, as happens in other countries such as France.
- **Through the SEA Social Cohesion Support Fund**, which relates to vulnerable illegal populations.
- **Through the SEA INDH Support Fund**, provided that it authorises funding for human resources and prevention activities. Some funding from this source would make sense, as it has been funding mother and child health programmes since 2018.
- **Through the creation of a new special earmarked account**, which could, among other things, fund prevention. However, as there is already significant budget fragmentation between the general account budget, STAs and Segma, this is not the most appropriate option.

- **Through funding by the regions and local governments.**

Regional funding of the AIDS response does not seem to be the most suitable option given the current lack of sufficient local financing. Firstly, since the regions do not fund human resources or prevention any more than the central government does, it would fall to the various CSOs to convince each region. This would be a long and tedious task. Secondly, decentralisation has not occurred across all responsibilities and the regions still suffer from a lack of funding to exercise their authority in areas including health, which is one of their devolved powers. Finally, the AIDS response needs to be coordinated, territory-wide and implemented in a timely manner. Ensuring that after the Global Fund's withdrawal, every region provides sufficient and timely funding for items of expenditure (human resources and prevention) for all CSOs fighting AIDS, seems ambitious.

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This report analyses the health-related tax measures that will allow Moroco to mobilise more revenues to finance its health system. Although there is no indication that the Global Fund to Fight AIDS, Tuberculosis and Malaria, which has supported Morocco since 2003, would leave the country, Morocco anticipates and prepares the transition in case it would happen in the medium or longer run in order to ensure the programmes' financial sustainability. The graduation from this international support will require raising more tax revenues. This goal is important in itself but also because Morocco does not reach all of the health targets set out in the Sustainable Development Goals.

Morocco faces two main health financing challenges. Total health spending is low as the country's total health expenditure accounts for only 5.2% of GDP in 2017, which is lower than upper-middle income countries. An excessive share of this funding comes from household out-of-pocket expenditure, which makes the health system financing inequitable and regressive.

The report recognises that financing aid graduation and meeting the health targets of the SDGs will ultimately require an increase in public health spending financed through a tax reform. The report presents detailed tax recommendations on how Morocco could improve the design of its tax system in general and its health taxes in particular. This includes improving the design of health social security contributions, raising more tax revenues from products that are harmful for health, and giving more prominence to environmentally-related taxes to improve the quality of both the environment and the health of the Moroccan population at large.

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