Inequalities in access to healthcare in Morocco: issues and perspectives

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Abstract. This article examines different types of inequalities in access to health care in Morocco, including geographic, socio-economic and institutional factors. While Morocco has made progress towards reforming health care access through RAMED and AMO, inequalities still exist between urban and rural areas, between cities in already developed areas and cities in isolated regions, and among different social classes. The causes of these inequalities are rooted in the unequal distribution of health care providers (physicians located almost exclusively in cities), the inadequate or non-existent health care infrastructure in rural areas, economic barriers (the high cost of health care and the burden of paying for it directly), inadequate governance (the extreme concentration of power and the lack of effective coordination), and sociocultural factors (high rates of illiteracy and the unequal position of women). The authors of this article propose various reforms aimed at achieving a more equitable health care system, including decentralization, strengthening primary health care, and improving access to health care.

Keyword: *Health inequalities – Access to care – Morocco – RAMED – AMO – Medical deserts – Health policy – Universal coverage – Health justice – Decentralization*

1 Introduction

The right to health care and access to it are internationally recognized by major global institutions such as the United Nations and the World Bank, notably through Sustainable Development Goal 3: "Ensuring healthy lives and promoting well-being for all people at all ages" [1, 2]. Health status and quality of life are key indicators of human development, economic stability, and social cohesion. The COVID-19 pandemic further highlighted the critical importance of equitable access to quality health care, particularly in low- and

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middle-income countries. Over the past two decades, Morocco has implemented significant health system reforms aimed at reducing infant mortality, expanding access to medical consultations, and increasing healthcare infrastructure [3]. Despite these advances, access to healthcare remains uneven due to geographic and socioeconomic disparities, raising concerns about equity and system performance [4]. Evidence also questions the state's capacity to ensure fair access for all citizens [5]. Regional inequalities persist in the distribution of hospital infrastructure, medical personnel, and essential equipment, with some areas experiencing severe shortages [6, 7]. These disparities disproportionately affect vulnerable populations due to economic constraints (e.g., transportation costs), educational and cultural barriers (illiteracy, gender norms), and institutional limitations linked to centralized governance. These inequities extend beyond physical resource availability and are shaped by structural factors such as political decision-making, funding mechanisms, and resource allocation policies [3, 9]. This paper aims to review the literature on healthcare access disparities in Morocco and to analyze the structural mechanisms sustaining these inequalities, particularly in relation to health equity and public policy effectiveness. It seeks to contribute to a clearer understanding of Morocco's current healthcare context and to support discussions on necessary reforms [10, 11]. The study adopts a multidimensional approach, integrating economic, geographic, and institutional perspectives, to illustrate how healthcare supply, demand, and governance interact to generate unequal access [12, 13]. Methodologically, it relies on documentary analysis of national statistics and institutional reports [6, 4, 3], international sources [1, 5], academic literature [10, 9, 8], and recent reforms such as the generalization of social coverage and advanced regionalization [14, 7].
The article is structured into six sections, covering the theoretical framework, an overview of healthcare access inequalities in Morocco, their structural and socioeconomic determinants, and policy-oriented recommendations aimed at fostering a more inclusive and equitable healthcare system.

2 Conceptual and theoretical framework of inequalities in access to care

To analyze disparities in access to medical services in the United States, two key concepts must be defined. *Access to medical services* refers to the ability of individuals or groups to obtain necessary care from appropriate providers without major financial, geographic, social, or institutional barriers. Beyond availability, effective access also depends on financial capacity, location, cultural acceptability, and institutional support. *Health Equality* denotes a situation where all individuals have the same access to healthcare services. However, equality does not ensure *Health Equity*, as some groups may still face barriers due to greater or more complex needs. Health Equity therefore seeks to address structural factors that disadvantage underrepresented populations. *Health Justice* extends this concept further by addressing social determinants of health and structural conditions that negatively affect well-being [15, 16, 8]. Healthcare access inequalities arise from multiple sources, including geographic disparities (urban vs. rural or affluent vs. disadvantaged areas), socioeconomic differences (income, education, employment), and gender-related factors, particularly those affecting women's access to reproductive and gynecological services.
Traditional supply-and-demand models highlight imbalances between healthcare needs and system capacity but often fail to explain structural inequalities. More recent critical approaches focus on social determinants of health, information asymmetries, and healthcare market failures [8]. Rawls' social justice theory provides a strong framework, emphasizing that just systems should prioritize the most disadvantaged by ensuring equitable resource distribution, particularly for vulnerable and rural populations [15]. Similarly, Sen's Capability Approach underscores the importance of enabling individuals to achieve real

health capabilities by addressing education, living conditions, and income, recognizing both state responsibility and individual rights to health [16]. Andersen's behavioral model explains healthcare utilization through predisposing, enabling, and need-based factors, offering valuable insights for developing equitable health policies [17]. Together, these frameworks demonstrate that healthcare access inequalities are largely structural and institutional rather than random. In middle-income countries such as Morocco, disparities in health coverage and social access present distinct challenges [5, 18]. Improving access must be accompanied by effective service delivery, targeted support for vulnerable populations, needs-based resource allocation, and transparent health governance systems [9, 11].

3 State of play of inequalities in access to care in morocco

In Morocco, inequalities in healthcare access are more pronounced between rural and urban areas than between social classes. Urban centres benefit from better infrastructure, higher concentrations of trained professionals, and easier access to medical specialties, whereas rural areas face severe shortages of facilities, healthcare workers, and specialists. According to the HCP, over 65% of physicians practice in urban areas, while nearly 40% of the population lives in rural zones, creating a significant imbalance in healthcare availability [6]. Regional disparities further exacerbate these inequalities. Casablanca-Settat and Rabat-Salé-Kénitra are the best-equipped regions, while Drâa-Tafilalet and the Oriental region suffer from limited infrastructure and long distances to healthcare facilities [7]. Chronic underfunding of rural health services [3, 5], combined with income inequalities, disproportionately affects rural populations. Although social protection schemes cover basic care for low-income groups, many rural households still cannot afford out-of-pocket expenses. As a result, more than 30% of rural residents have never accessed healthcare, compared to about 18% in urban areas [4]. Education also plays a critical role in healthcare access. Limited awareness of health rights, insurance mechanisms, and disease symptoms reduces timely healthcare utilization and participation in preventive programs, often leading to self-medication or alternative treatments. These patterns are especially common in rural and underserved populations [4, 19]. Gender-based inequalities persist, particularly for rural women, who face mobility constraints, financial dependence, restrictive social norms, and limited access to reproductive health services. Studies by the WHO and UNFPA highlight gaps in prenatal, postnatal, and family planning services [1]. Morocco has expanded medical coverage through programs such as RAMED, improving access for vulnerable groups [3]. However, challenges remain, including overcrowded hospitals, quality-of-care issues, administrative delays, and insufficient services [9, 14]. While AMO coverage has expanded among formal-sector workers, many individuals—especially in the informal sector—remain uninsured [14]. The 2020 reform aiming for universal AMO coverage by 2025 represents a major policy shift [14], yet its success depends on overcoming technical, financial, and organizational constraints, particularly in rural service delivery [3, 10]. Empirical evidence from the HCP, ONDH, and World Bank confirms substantial regional disparities in healthcare access, medical supervision rates, and patient satisfaction [6, 4, 5, 9]. The COVID-19 pandemic further exposed inequalities in testing, vaccination, and equipment availability, as well as financial barriers discouraging care among uninsured populations [1, 20]. Overall, these findings reveal multidimensional inequalities rooted in social, economic, geographic, and institutional determinants, underscoring the need for integrated and equitable governance reforms within Morocco's healthcare system [8, 12, 3, 11].

4 Structural determinants of inequalities of access

In Morocco, there are significant inequalities in terms of individuals' access to health services and overall health care. These inequities stem from an under-developed health system both in infrastructure and in terms of human and material resources.

Health facilities are not equitably spread across the nation and are disproportionately located in urban areas; there are many rural and isolated communities that are adversely affected by this distribution of facilities [7]. Many health facilities located in many provinces do not provide adequate access to basic health care services, do not provide specialty services, nor do they have functional Emergency Rooms.

The inadequate number of medical personnel also compounds the structural limitations of the health system; in 2022 Morocco had approximately 1 Doctor for every 1,800 people; this ratio is considerably lower than that recommended by the World Health Organization (WHO), which recommends that every 1,000 people have access to at least one Doctor [1,3].

The concentration of qualified health care professionals is primarily in urban areas where employment conditions are better, there are more career development opportunities, and the quality of life is better than in rural areas. This leads to a shortage of health care providers in some regions, especially in interior provinces, leaving many areas "medically barren" [10,7]. The continued reluctance of young, inexperienced doctors to accept positions in rural areas contributes to the problems with access to ongoing, high-quality care in those regions. The inability to find specialists (such as Gynaecologists, Paediatricians, and Anesthesiologists) seriously compromises local capabilities to adequately address the needs of specific populations in those regions [3].

Improving the governance of health systems is an important element. The lack of effective coordination among different levels of management (i.e., central, regional and local) reduces the effectiveness of managing the health plan. Regions, generally speaking, do not have the degree of autonomy required to modify health policies in response to local needs, even though the regionalization model recommended in the Constitution of 2011 has been implemented to a great extent throughout the country [7]. In addition, there are several areas of weakness within the national programs, including: insufficient transparency regarding resource allocation; a lack of systematic evaluation and assessment of existing public policies; and the inability to execute reforms on time [9, 11].

Although the funding of the health care system is limited (averaging approximately six percent of GDP, lower than the global average for middle-income countries) [5, 18], it continues to encounter funding issues that have resulted in an increasing number of deteriorating health care/hospitals, limited equipment availability, and decreased capacity in the hospitals [3]. In addition, the percentage of out-of-pocket expenditures continues to increase (over 50 percent of health care expenditures are borne by users), perpetuating inequality, especially among the poor [4, 5].

The distribution of health services across geographic areas is not uniform. Many rural residents have to travel long distances to access health care and have limited means of transportation. The absence of local health services, coupled with long travel time to the clinic, results in delays in receiving necessary care or no care at all, and increased use of traditional medicine. Mobile health programs or travelling clinics exist but are uncoordinated and inadequate to resolve these health disparities [3].

Health services provided at public health facilities are not of the same quality across all facilities; for example, Facilities in urban areas have modern technology and well-trained staff compared to Facilities located in rural areas where staff may be less experienced and do not have access to continuing education [10]. These differences create a distrust of public health facilities which drives many rural patients to seek consultation from private facilities even though they might incur higher costs [4, 9].

Households' attitudes toward using health care also affect the use of health care services as do many other factors. The way a household perceives the service being provided and/or receives services is impacted heavily by the service's perceived quality and access issues: is it "affordable"? (i.e., not too expensive), geographically accessible, and does it respect the household's cultural beliefs? Households may be reluctant to seek medical attention for several reasons including complicated paperwork, a crowded emergency room, or poor treatment at the hospital. In rural areas where households rely upon informal economic activity as their main source of income, health insurance enrollment is limited and therefore more likely to rely on the use of informal or home treatments [14, 19].

While RAMED has been introduced, financial costs to access health care still pose a significant challenge for many households. Medications, tests, specialist physicians, and hospitalizations generally impose high financial burdens on low-income household(s) [4]. Out-of-pocket expenses remain high in Morocco; out-of-pocket expenditures usually represent an outsized share of total expenditures for approximately half of the individuals living in Morocco; this means many do not have equitable surgery care and therefore may not receive proper treatment or care, and therefore lose the right to receive all health care benefits [5, 8]. The slow expansion of the AMO program reinforces this social divide [14].

Additionally, the ongoing problems with the health system are compounded by challenges faced by the health supply chain including inadequate drug supply distribution, broken hospital relationships, and procurement of technological supplies and equipment [3, 20]. The lack of a functioning national health policy with respect to managing the healthcare supply chain restricts the efficiency of the healthcare system and perpetuates disparities throughout the country [7].

To conclude, the culpability of structural determinants is a driving factor in inequities in health services across the country. The effects of financing, organisation and governing the health system has contributed to these disparities as they relate to geographic and economic viability, and consumer's (the patients) expectations regarding services provided via Morocco's health system [8, 12]. To effectively reduce these disparities, the model on which the health service is based will have to be reconsidered [16, 11].

5 Public policies and reforms to reduce inequalities in access to care

Morocco has made a number of changes to its health system over the last 20 years to improve the ability of all citizens, especially those who find it difficult to use the system, to obtain care. One of the more significant efforts has been the implementation of the Medical Assistance Scheme (RAMED), which began in 2012, giving people in financially vulnerable situations free and/or low-cost hospital care [3]. While millions of Moroccans are currently benefiting from basic medical coverage through RAMED, several issues related to governance, funding, and high demand on public healthcare facilities continue to limit the effective implementation of RAMED [9, 14].

The recent gradual generalization of Mandatory Health Insurance (AMO), particularly through its extension to self-employed workers and populations in the informal sector, represents an important step towards universal coverage [14]. This initiative is part of the royal project on social protection launched in 2021. However, the success of this reform will depend on the State's ability to expand healthcare provision and improve the quality of services, in order to avoid a simple increase in demand without an adequate response [3, 10].

As part of advanced regionalization, efforts have been made to strengthen the role of regions in health planning and management. The transfer of certain health responsibilities to regional councils aims to adapt public policies to local specificities [7]. However, the

lack of technical capacity, sufficient financial resources, and coordination with the Ministry of Health still limits the impact of this approach [11]. Clarification of institutional roles and training of regional managers appear essential.

The strategy of Digitalizing Morocco's Healthcare Sector through an EHRs /EMRs, Telemedicine, and Online Appointment Booking can help ensure access to healthcare, particularly in rural areas. Digital technology can also support the decongesting of healthcare facilities, ensuring continuity of care, and facilitating preventive health. However, currently there are still significant gaps in digital access specifically for rural areas and subsequent investment is needed into infrastructure and training [9, 7].

One focus of recent Public Policies in Morocco is providing sufficient training and equitable distribution of healthcare personnel. To this end, Morocco has embarked on a University Reform programme designed to increase the annual number of Physicians, including through the reduction of training time for new Physicians. Also being promoted are Contractual Recruitment and Financial Incentives targeting Rural Areas [3, 10]; however, in addition to these incentives, significant effort needs to be placed on providing an attractive Work Environment, housing, and logistical support, so as to keep Health Staff in Rural Areas [7].

In addition, the government has expanded targeted programs for specific at-risk populations such as people with disabilities and people suffering from chronic diseases (e.g., diabetes, hypertension) through the provision of medical caravans and mobile health clinics based in rural or mountainous communities [3]. While these initiatives can be viewed as having a positive impact upon delivery, the extent of their success will be limited unless they are incorporated into a more comprehensive, long-term, territorial health system [12].

There has been an increase in international cooperation focused on financing and providing technical support for health reform throughout Morocco. Many different organizations, including WHO, WB, and EU, support various programs (e.g., RH, communicable disease control, capacity building) and this has led to a growing number of projects currently being implemented in country [1, 5]. However, improved coordination of these initiatives with the respective national priorities would help reduce the potential for duplication, enhance sustained program outcomes, and ultimately result in a more integrated approach [18].

In addition to improved programme coordination, there is also a critical need for enhanced data-driven program management. The establishment of a comprehensive, readily available, current state of a health information system is a critical barrier to strategic planning [6, 4]. The further development of a regionalised-based database combined with health equity indicators will help the government target its public health policy actions more effectively, and to evaluate their results as defined by various health equity indicators. Strengthening the National Health Observatory is needed in this regard [20].

To summarize, citizen engagement is critical for the success of any reform. In Morocco, community involvement in identifying needs, assessing services and monitoring health policy is still too limited [19]. Strengthening the capacity of civil society, creating mechanisms for an open dialogue at a territorial level and creating a culture of accountability would be powerful tools in establishing health equity as a national priority [15, 16].

6 Recommendations and future prospects

Given persistent inequalities in healthcare access across Morocco, a comprehensive, territorial, and multi-dimensional approach is required. First, access to local healthcare should be strengthened through the expansion of Community Health Centres, improved equipment in existing facilities, and the deployment of mobile health units integrated into local care networks.

Second, a more equitable distribution of healthcare professionals is essential. This requires financial incentives, residency bonuses, and stable working conditions for assignments in underserved areas, alongside training modules—both initial and continuous—focused on social determinants of health and health vulnerabilities. Third, healthcare financing must be reinforced to ensure fairness and sustainability. The implementation of Universal Health Insurance should incorporate inter-category solidarity, compensation mechanisms for vulnerable populations, and hospital pricing reform. A strategic shift from hospital-centered curative care toward community-based preventive care is also necessary. Improving governance remains a central priority. Stronger coordination between central and local authorities through advanced regionalization is needed, with future Regional Health Agencies playing a key role in planning, contracting objectives, and monitoring resources. Digitalization offers major opportunities to enhance access, continuity, and monitoring of care, but full system integration is still required, including electronic medical records, inclusive telemedicine platforms, and improved digital literacy while addressing regional digital divides. Health equity considerations must be embedded across all public policies, recognizing that access to care depends on broader living conditions beyond healthcare infrastructure alone. To strengthen policy impact and data use, Morocco should establish a national health equity observatory supported by regional observatories, producing publicly accessible indicators by gender, geography, and income to better assess policy effects on vulnerable groups. Community participation should be central to health policy design and implementation through local consultation mechanisms, strengthened patient organizations, and social audits of healthcare services. This bottom-up approach would improve responsiveness to local needs.

Finally, interdisciplinary and mixed-methods research is urgently needed to better understand healthcare inequities and inform evidence-based solutions. Achieving equitable access to healthcare aligns with Morocco's New Development Model and the Sustainable Development Goals and requires strong political commitment, cross-sectoral collaboration, and collective national engagement to ensure healthcare as a right for all Moroccans, regardless of location or income.

7 Conclusion

An extensive study on unequal access to healthcare in Morocco identifies geographic, socioeconomic, and labor-related factors as major drivers of persistent inequities. These disparities limit citizens' access to quality healthcare, weaken national health planning efforts, and hinder the fulfillment of the constitutional right to health (Article 31) as well as progress toward the Sustainable Development Goals. The study highlights significant inequalities across both urban and rural populations, as well as disparities linked to gender, education, and income levels. While expanding health insurance coverage is necessary, it remains insufficient to guarantee equitable and adequate access to healthcare. Geographic and socioeconomic conditions, combined with labor market constraints, generate additional barriers, including the unequal distribution of healthcare providers, weak political governance, and inadequate public financing. These structural determinants underscore the need for a comprehensive evaluation of Morocco's healthcare system. Addressing these challenges requires stronger policy development at regional and local levels, along with decentralization of funding and resource allocation based on population size, demographic structure, and healthcare needs. Special attention must be given to low-income and financially vulnerable groups. The ongoing healthcare reform under Royal Decree No. 01-2010-3 represents a unique opportunity to advance these objectives. Its success depends on strong political commitment, decentralized and participatory governance, and the adoption

of an integrated public health approach involving local authorities, health professionals, researchers, and communities. Finally, the study emphasizes the importance of further research on social determinants of health in Morocco. Generating evidence-based policies will require qualitative, quantitative, and empirical data. Reducing healthcare access disparities will not only promote social equity but also strengthen national cohesion and support long-term community empowerment.

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