JMSR
Journal of Medical and Surgical Research

Research Article

ISSN: 2351-8200

JMSR 2024 Vol XI, n 2: 1377- 1389

BENCHMARKING OF GOVERNANCE MODELS FOR BASIC HEALTH COVERAGE: RESEARCH OF GOOD PRACTICES FOR MOROCCO

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doi: ……---
Published in January 2025

Abstract

Background: The benchmarking is a concept with multiple aims. The reflection on improving the governance of Basic Health Coverage (BHC) in Morocco leads us to analyze successful solutions that have been implemented in other countries. Objectives: This study aimed to make an international benchmark of BHC's governance models and look for good practices in other countries in order to study the possibility of their implementation at the Moroccan level. **Methods:** We benchmarked BHC's governance models by determining the criteria for selecting the benchmark countries. We have selected five countries, namely: Turkey, Malaysia, France, Chile, Rwanda. We analyzed governance models based on the five dimensions of the World Bank study "Governing Mandatory Health Insurance: Learning from Experience", which are: Coherence of the decision-making structure, stakeholder involvement, transparency and access to information, supervision and regulation, coherence and stability. **Results**: Our analysis based on the five dimensions showed that there are relative common factors with the governance model between the benchmark countries that allowed them to achieve universal health coverage, however, each country has introduced innovative rules and solutions adapted to its context and constraints. There are several good governance practices that we have drawn from this benchmark. Morocco can use these good practices to improve its governance model for BHC. An adaptation effort is necessary, taking into consideration the existing situation. **Discussion**: There is not a governance model suitable for all countries. Each country is trying to find a formula that will allow it to overcome its challenges. Morocco can draw inspiration from these models to instaure good practices to adopt, but this cannot happen without repositioning the governance of health coverage in the government's strategic vision in relation to the social protection agenda and the objectives of the health system. **Conclusion**: Improved governance has a direct impact on the performance of the basic health coverage system. In this sense, Morocco must take this aspect into consideration in the process of achieving universal health coverage as many other countries that have made this great step forward.

Keywords : Benchmarking**,** Governance, Social Security, Health Insurance, Morocco.

Introduction

Health insurance is an interesting context in which governance is at the intersection of several actors: public service, private sector in all their dimensions and social/political environment. Basic health coverage (BHC) is a fundamental element of any social protection model. Its governance varies from country to country depending on the available ressources, the political system and the legal framework(1). Governance in the public service inherits the common aspects of corporate governance, however, other elements related to the purpose of public affairs management are added. Health insurance is a fundamental element of any social protection policy. Its governance model varies from country to country depending on the means available, the political system and the legal framework it governs. To this end, our study aims to answer the following question: How do the different governance models of health insurance systems influence the effectiveness of social protection coverage and equitable access to healthcare in various national contexts?

In Morocco, the health system is characterized by a dual structure that includes both public and private sectors. The public health system is managed by the Ministry of Health and provides services through a network of hospitals and primary healthcare centers. The private sector complements the public system by offering additional services, often with higher perceived quality and shorter waiting times. The Moroccan health insurance system includes both compulsory and voluntary schemes. The compulsory schemes are

managed by public institutions such as the National Social Security Fund (CNSS) for private sector employees and the National Fund of Social Welfare Organizations (CNOPS) for public sector employees. These schemes cover a significant portion of the population, but there remain gaps in coverage, particularly for informal sector workers and the self-employed.

A major step towards achieving universal health coverage (UHC) in Morocco was the introduction of the Medical Assistance Plan (RAMED) in 2012, which aimed to provide health coverage to the economically disadvantaged population. RAMED was based on a means-tested system and was funded by both the government and local authorities. However, despite the progress made, challenges remain in achieving comprehensive coverage and ensuring equitable access to healthcare services. In response to these challenges, Morocco has embarked on a significant reform of its health insurance system, aiming to expand UHC. The enactment of Law 06-22 marks a new era in Moroccan healthcare, transitioning from the National Agency for Health Insurance (ANAM) to the High Authority for Health (HAS). This reform was designed to enhance the efficiency, transparency, and accountability of the health insurance system, and to ensure that all citizens have access to essential health services without financial barriers.

By analyzing these developments, this study aimed to provide insights into the governance models of health insurance systems and their impact on achieving UHC in Morocco. It highlights the importance of effective governance in ensuring the success of health reforms and the realization of universal health coverage. The international benchmark will complete our perception based on the diagnosis made in a comparative analysis approach. Universal Health Coverage has been extensively studied by various international organizations, highlighting the importance of an integrated and well-structured approach. For instance, in 2010, the World Health Organization (WHO) has provided a comprehensive analysis of strategies to achieve UHC, highlighting the challenges and successes observed in different national contexts (3). Similarly, in 2019, the Organisation for Economic Co-operation and Development (OECD) has conducted a comparative analysis of UHC among its member countries, identifying best practices and areas needing improvement(6). Additionally, in 2017, the World Bank has published several reports detailing global progress towards UHC, emphasizing the links between health coverage, economic development, and poverty reduction.(2)

Objectives

Our study aimed to answer the following questions: can we find innovative solutions related to the problems of BHC useful for the Moroccan model? How can we select the good practices to implement in Moroccan BHC's governance?

Methods

We have benchmarked BHC's governance models using the following methodology:

1. Determining the criteria for selecting the countries in the benchmark (Table 1):
2. Setting the number of countries in the benchmark: we have selected 5 countries, namely: Turkey, Malaysia, France, Chile, Rwanda. The table 2 is showing the selection criteria and their relevance to the moroccan context.
3. Searching documents and reports dealing with BHC governance in the benchmark countries: We accomplished a global research in all Google Scholar articles. A search strategy was prepared using the keywords shown in Table 3. Related publications were reviewed by title and abstract to acquire information relevant to governance in BHC. Relevant articles were accessed in full text and further investigated for information related to the topic of interest.
4. Analyzing governance models based on five dimensions from the World Bank study "Governing Mandatory Health Insurance: Learning from Experience" (2): Coherence of the decision-making structure, stakeholder involvement, transparency and access to information, supervision and regulation, coherence and stability;
5. Making a global synthesis of the good practices resulting from the benchmark for the Moroccan model.

Table 1: Determining the criteria for selecting the countries in the benchmark

Critère	Description
Nature of the system	We have selected countries that have several types of medical coverage system (national system and insurance system)
Coverage rate	We have chosen countries that have achieved Universal Health Coverage (UHC), which means coverage of more than 90% of the population
Out-of-the Pocket	We have opted for countries that have a lower rate of patient care than Morocco, which is 59.7% of total health expenditure

Table 2: Benchmark of CMB governance models in six countries

	Morocco	France	Türkiye	Malaysia	Rwanda
Nature of the system	Old Mixed model: (AMO/RAMED) New model: Assuranciel AMO	Insurance	Mixed (Health insurance/green card)	National/Private Insurance	Public/Private/Community
Coverage	84%	99.9%	99%	90%	90%
The patient remains responsible for total health expenses (WHO)	59.7%	7%	17%	36%	8%

Table 3: Keywords and search terms used

Governance	Basic health coverage	Health insurance	Country
Governance AND Corporate governance AND	Basic health coverage OR Basic health coverage OR	Health insurance OR Health system OR	Turkey, Malaysia, France, Chile, Rwanda

Results

We will present the results of our benchmarking by describing each country's WCD system and analysing its governance model according to the five dimensions mentioned above.

Turkey

System description

Turkey, with a population of 79 million and a per capita Gross National Income (GNI) of 18.760 USD, is an upper-middle income country in the Europe and Central Asia region. In 2014, total health expenditure per capita amounted to 1.036 USD, or 5.4% of the country's Gross Domestic Product(GDP)(3). Turkey has a long history of providing health care to its citizens. Prior to 2008, funding sources were fragmented, with multiple insurance programmes covering specific population groups. In 2008, all insurance programs were merged. The unified general health insurance program is administered by the SGK (SOSYAL GUVENLIK KURUMU BASKANLIGI). In 2017, about 99% of the population was covered by the programme. SGK's spending on hospitals exceeded US$9.7 billion and 13 million hospitalizations (average spending per hospitalized patient: US$750). The rest to be paid for by the patient is 17% of total health expenses (4).

The worker must be a Turkish national and reside in Turkey or be a permanent resident.

Social security reform was made up of four main and complementary elements:

1. Universal Health Insurance ensuring the provision of a good quality health service, guaranteeing equity and protection for the entire population;
2. A system of assistance accessible by the needy, on the basis of the objective profit criterion, by collecting non-contributory benefits and social assistance;
3. The single pension insurance scheme including non-health insurance branches, in the short and long terms.
4. Institutional reform to provide services in a contemporary, active way that facilitates the daily lives of citizens (5).

In this respect, the Social Security Institution was established in 2006 and with the Law of 2006/No. 5510, the three institutions (the Social Insurance Institution, the Turkish Republic Pension Funds and the Social Security Institution of Corporation, Craftsman and Other Independent Workers) were merged under the same roof.

In 2013, life expectancy at birth in Turkey was 77 years, 5.5 years lower than the OECD average of 80.2 years, but the gap was narrowing(6).

Consistency of the decision-making structure

The health insurance system in Turkey has been in existence since the law on health insurance and maternity insurance was passed in 1951(7). Subsequently, there were several attempts to upgrade this regime as part of a comprehensive reflection on social protection. The real reform of social security was implemented as soon as Law No. 5510 cames into force in 2008.

Health services prices are determined by a committee composed of representatives of government agencies (e. g. Ministry of Labour and Social Security, Ministry of Finance, Ministry of Health, Ministry of Development, Treasury and SGK) and private hospitals. The benefits package for hospitalization are defined. SGK, however, has a long list of exclusions that are not covered by the program, such as orthodontic procedures for cosmetic purposes, health care services that are not accredited or accepted as health care services by the Ministry of Health, and, in some cases, chronic conditions for foreigners.

Stakeholder involvement

The SGK has a Board of Directors and a General Assembly composed of all actors involved in social

protection. For better coordination between social risk schemes, a Higher Advisory Council on Social Security has been created to ensure harmonisation between the different schemes including basic medical coverage. The General Directorate of Universal Health Insurance(UHI), which manages and monitors the UHI system and provides input to the Board of Directors for strategic decision-making.

Transparency and access to information
According to the third chapter of the Turkish Constitution entitled "Social Law and Responsibilities: "Everyone has the right to social security. "(Turkish Constitution, Article 60). As can be seen from the Constitution, social security is the "right" for every Turkish citizen and it is the responsibility of the state to provide these services, in other words, the Turkish citizen has the right to request social security services while the state has to suggest them. The article 3 of Act No. 5502 describes the missions of the Social Security Institution, which has a central role in the implementation of social security policy in the country. All legal documents related to BHC are accessible to the general public via the website at the following address: https://www.kaysis.gov.tr/
SGK uses an integrated information system called MEDULA for the electronic collection of billing information from health care providers and payments to health services. It also offers an online service for access to statistics and publications related to basic medical coverage and other social risks.

Supervision and regulation
The health care financing and delivery system was fragmented and included four separate social insurance schemes and the green card for the poor, each with different rights and access rules. The management and governance of the system by the Ministry of Health was inadequate, there was little coordination between the Ministry of Health and the Ministry of Labour and Social Security, which were both providers and financiers of the health system(4). Today, the plan is managed by the (SGK), which has local offices, regional medical offices and health facilities that coordinate with health facilities. The SGK is a financially autonomous public body responsible for collecting contributions, managing risks and providing benefits, under the supervision of the Ministry of Labour and Social Security (8). SGK handles complaints internally. It is a separate agency from the Ministry of Health. The Ministry of Health is the gendarme of the health system and is responsible for policy development, regulation, monitoring and evaluation. On the other hand, SGK is the sole purchaser of the services and responsible for the day-to-day activities of the health insurance programme. SGK currently employs 26,000 people and about 16 people monitor health insurance activities (9).

Consistency and stability
In 2003, Turkey launched a comprehensive health system reform programme called the "Health Transformation Programme", which reflects political will, with the main objective of increasing access to services and eliminating funding fragmentation by merging the five existing health insurance schemes (including the Green Card Programme) into a universal health insurance scheme to be managed by the new social security institution (10).

Malaysia

System description
Malaysia, with a population of 31 million and a per capita Gross National Income (GNI) of 22.460 USD, is an upper-middle income country in Asia. In 2014, total health expenditure per capita amounted to 1040 USD, or 4.2% of the country's GDP. The rest to be paid for by the patient was 36% of total health expenses (3). Health coverage and outcomes in Malaysia are now approaching the country levels of the United Nations Development Cooperation and Development Organization. Malaysia's results are achieved through a combination of public services (financed by general revenues) and parallel private services (mainly financed by personal expenses) (11).

Consistency of the decision-making structure
Private sector employers may choose to offer health and social benefits and generally negotiate packages with managed care organizations and private insurance companies to provide medical insurance coverage for their employees.
Public health services are financed by general taxation, with annual health budgets allocated by the Ministry of Finance to the Ministry of Health. The proportion of general revenue allocated to the functions of the Ministry of Health in the national budget is decided each year (12).

Stakeholder involvement
The Ministry of Health provides public health care according to a strategy validated by its Board of Directors. Several areas of reform have been identified in the partnership between the Malaysian government and WHO according to clear strategic priorities. As for private health insurance, there are several types and each insurance company sets up its own board of directors according to the Malaysian Corporate Governance Code.

Transparency and access to information
All statistics on the national health system are published on the website of the Ministry of Health: www.moh.gov.my . The government has also launched the mygov portal: www.malaysia.gov.my , which provides central access to all online services, particularly in relation to medical coverage.

Supervision and regulation

Malaysia is a mixed health care financing system. In the private sector, enrolment in private health insurance is voluntary, and the type of insurance and level of coverage is based on the individual's state of health. On the one hand, private sector employers can negotiate medical insurance with private insurance companies. On the other hand, a public health service is available with funding from the Ministry of Health (13).

The Malaysian case indicates that the focus on reducing the ratio of dependency to GDP may be more effective in improving financial protection than the focus on reducing the ratio of unpaid expenditure to total health expenditure(14). However, Malaysia demonstrated that it is possible for a health system to achieve high levels of protection against financial risks despite having higher shares of the rest to be borne by households according to WHO estimates, which recommends a threshold between 15 and 20%.

Consistency and stability

Observation of Malaysia's health coverage system has shown that it has been effective for several decades in equalizing health care and protecting against financial risks, despite modest incomes. With regard to government spending, it should be noted that a high cost per share of total funding is not a consistent indicator of financial protection, more attention is needed on the absolute level of personal spending.

France

System description

France, with a population of 64.7 million and a per capita GNI of USD 37,580, is a high-income country located in Europe. In 2014, total health expenditure per capita amounted to USD 4,508, or 11.5% of the country's GDP. The rest to be paid for by the patient is 7% of total health expenses (3).

On January 1st, 2016, Universal Health Coverage (UHCP) came into effect. This reform, which was provided for by Article 59 of the Social Security Financing Act for 2016, continues in the same way as the introduction of basic universal health coverage (UHI) in 1999. The CMU aimed to give rights to health insurance to all persons who were deprived of it. In turn, the PUM has offered every person who works or resides in France a right to health risk coverage, without any specific procedure to follow(15). The CMU Act provides for persons insured under the personal insurance scheme, which was abolished, to be insured under the general scheme on the basis of residence criteria. Only insured persons whose tax income exceeds a threshold will pay a contribution, calculated on the basis of income above that threshold. The creation of free complementary coverage, as part of national solidarity, is in addition to the coverage of health care by health insurance. UHCP reform affects the most disadvantaged 10% of the population, meeting criteria of resources and residence (16).

Social Security includes two essential schemes and special schemes, each covering one or more specific socio-professional categories and characterised by different management and care arrangements:

- The general scheme: which covers the majority of the population: salaried workers and self-employed workers since 1 January 2018 as well as any person benefiting from a right of residence, managed by the Caisse nationale de l'assurance maladie des travailleurs salariés (CNAMTS) ;
- The agricultural regimen: which covers farmers and agricultural workers. This scheme is managed by the Mutualité sociale agricole (MSA);
- Many special schemes, such as that of seafarers, mines, the French National Railway Company (SNCF), the Régie Autonome des Transports Parisiens (RATP), Electricité De la France (EDF)-Gaz De la France (GDF), the National Assembly, the Senate, clerks and notaries' employees.

Consistency of the decision-making structure

In countries with a decentralized political organization such as France, the distribution of decision-making powers between the different levels of government is not constant, and reforms change it at regular intervals (18).

In a somewhat paradoxical way, while governance refers to more horizontal relations between state and non-state actors, French reforms, particularly since the Juppé plan on pensions and social security in France, have contributed to the affirmation of the role of state actors to the detriment of the funds(19). The August 2004 law further extends the powers of the director of the CNAMTS, who negotiates with trade unions of doctors and other health professionals practising in the city and signs medical agreements to ensure that the health insurance expenditure targets voted by Parliament are met (20). The basic reimbursement rates are set in the national agreements concluded between health professionals and health insurance organisations. Agreements are published in orders and amendments when there is an update (21).

The introduction of new drugs and medical devices into the reimbursable lists follows an evaluation process by the High Authority on Health (HAS), which is an independent public authority of a scientific nature, the HAS aims to develop quality in the health, social and medico-social field, for the benefit of individuals (22).

Stakeholder involvement

The representativeness of the actors in the boards of directors of health insurance organisations is determined by regulation.

All commissions related to health insurance include representatives of health professionals, health product manufacturers and civil society.
The French model is characterized by the multiplicity of organizations and institutions that participate in the health insurance system. It should also be noted that any reform of the existing system would lead to the creation of new committees and the abolition of others.

Transparency and access to information
The objectives of the health insurance system in France are detailed in the Social Security Code and these implementing regulations(23).
The National Interregime Information System for Health Insurance (SNIIRAM) contains individual information on the socio-demographic and medical characteristics of the insured and all reimbursements for hospital care and town medicine, coded according to different standards. The SNIIRAM has continued to evolve to become, in 2016, the foundation of the future National Health Data System (NHDS), which will gradually integrate new information (causes of death, medical and social data and supplementary health insurance)(24).

Supervision and regulation
In France, several models of supervision and regulation have been tested, which has led to the creation of several bodies and institutions for the regulation and supervision of the health insurance system. Health insurance is managed within the framework of a national social security programme.
The Ministry of Solidarity and Health implements government policies on health protection and social security in partnership with other ministries such as the Ministry of Labour(25).
With regard to monitoring financial equilibrium, a health insurance expenditure alert committee has been set up to alert Parliament, the Government, the national health insurance funds and the national union of supplementary health insurance bodies in the event of changes in health insurance expenditure that are incompatible with compliance with the national objective voted by Parliament(26).
There is also the High Council for the Future of Health Insurance (HCAAM), which is a forum for reflection and proposals that has contributed, since 2003, to a better understanding of the challenges, functioning and possible developments of health insurance policies (27).

Consistency and stability
The French social security system is one of the most successful experiences in the world despite the problems of the financial deficit. Social Security funds are expected to return to balance in 2019 after 18 years in deficit. Health insurance contributed the most to the rebalancing of the accounts despite a small deficit(28).

Chile

System description
Chile, with a population of 17.9 million and a per capita GNI (Gross National Income) of USD 21,030, is a middle-income country located in South America. In 2014, total health expenditure per capita amounted to USD 1,749, or 7.8% of the country's GDP. The rest to be paid for by the patient is 32%(3).
Chile has a long-standing commitment to public health and has implemented mandatory programmes in this area, initiating health insurance for workers in the formal sector in 1924. As part of a major health reform in the early 1980s, only one national public insurer was created: The National Health Fund (FONASA). Individuals could choose between FONASA and the private health insurance funds called: the Provisional Health Establishments (ISAPREs)(29). The private health insurance market was largely unregulated in its first ten years of existence, and grew fast enough to reach about a quarter of the population, but had high administrative costs and very diverse benefit packages.

Consistency of the decision-making structure
The government responsible for the financial sustainability of the BHC system can control some of its parameters, as can the scope of all explicit guarantees of basic health benefits. Other parameters are less flexible, such as membership conditions and contribution rates(30).
The Superintendence of Health (SIS) is an organization that calculates reimbursements and co-payments, authorizes health credits for beneficiaries, formally arbitrates between FONASA and its beneficiaries and conducts a satisfaction survey of beneficiaries through opinion surveys.

Stakeholder involvement
The regulatory institution of FONASA, which is the government, does not have representatives of all stakeholders. The government acts through the Ministry of Health, and to a lesser extent through the SIS. FONASA has no representatives of trade unions, employers, beneficiaries or service providers. Despite the existence of 14 user committees within FONASA (participatory bodies of patients' and beneficiaries' associations acting as advisors to the Director of FONASA), beneficiaries are not fully represented because these committees have neither the power to impose decisions nor the power to vote (31).
The SIS has no representatives of trade unions, employers, beneficiaries or suppliers. Within ISAPREs, the structures of the boards of directors are not regulated and are left to be abandoned.

Transparency and access to information
In Chile, the right to health is mentioned in the Constitution, as well as the role of the State, the mixed health insurance system and freedom of

choice between the two. FONASA submits an annual report to Congress, regularly to the Office of the Comptroller General and, more recently, to the General Inspectorate of Finance and SIS. Private insurers are required to report on key financial, operational and performance indicators to the National Health Insurance Supervisory Authority.

Supervision and regulation

The Chilean governments of the 1990s gave FONASA greater financial and political support and established a more coherent regulatory structure for ISAPREs. In 2004, the SIS, as the only regulatory body, was created to supervise both FONASA and ISAPREs.

The BHC system in Chile has several competing insurers. It is supervised by the SIS, which is responsible for controlling public and private health insurers. Its main regulatory functions, the protection of beneficiaries, the financial solvency of ISAPREs and compliance by both organizations (FONASA and ISAPREs) with the payment of benefits required by law (32).

Consistency and stability

The BHC system in Chile has its roots in the constitution, which makes the objectives stable and unchangeable. The legal texts have had changes since the creation of the system that are in the interest of the insured. It must be said that the foundations of BHC remained the same.

This is a structuring problem for the Chilean health system. There is an urgent need to move towards an integrated health system(33).

Rwanda

System description

Rwanda, with a population of 11.9 million and a per capita GNI (Gross National Income) of USD 1,430, located in Africa, the country experienced sustained economic growth from 2003 to 2013 of 6.5%. In 2014, total health expenditure per capita amounted to USD 125, or 7.5% of the country's GDP. The rest to be paid for by the patient is 8%(3).

In recent years, Rwanda has developed a comprehensive financing framework for the health system based on best practices in global health care financing. This framework considers both supply and demand. On the supply side, there is the implementation of fiscal decentralization with increased transfers from central government to local authorities. Governments and peripheral health institutions based on need and performance, as well as a health insurance system including cross-subsidies from the richest to the poorest.

On the demand side, there are direct payments to the population through incentives in kind. Many efforts have been made to reduce the burden of direct payment. Over the past decade, Rwanda has made exceptional progress in protecting households from catastrophic health expenditures.

The Rwandan medical coverage system consists of different complementary schemes, including both the formal sector which covers 7% and the informal sector with 93% of the population.

The formal sector is managed by several institutions:

- Rwandaise d'Assurance Maladie (RAMA): beneficiaries including civil servants, employees in service and pensioners. It is managed by the Rwandan Social Security Office (RSSB). The mission of the RSSB is to ensure the management of resources and contribute to the development of the National Social Security Policy;
- Medical Military Insurance (MMI): with a mandatory membership system. The beneficiaries are Ministry of Defence officials and officials of security bodies. Insured persons benefit from primary care offered in the country's approved public health centres, as well as in district hospitals in the event of a transfer;
- Private health insurance: they have existed in Rwanda since 2006 and often target private companies. All the services are more attractive because they offer transfers outside the country if necessary.

With regard to the informal sector, the government has begun to think about innovative solutions to integrate the rest of the population through the launch of a Community Based Health Insurance (CBHI) scheme, which covers three-quarters of the population and aims to ensure that all the population has access to health services without financial barriers, and this, with a more equitable environment, in a progressive and sustainable manner with a high level of subsidization for poor and vulnerable groups(34).

Consistency of the decision-making structure

In Rwanda, the political settlement can be described as a dominant political settlement. Vertical and horizontal power is concentrated in the hands of the Rwandan Patriotic Front (RPF), which dominates a broader government coalition(35). The Ministry of Health has a very important role in managing the supply of care and setting up a health insurance system. As soon as the genocide ended, Ministry of Health officials discussed how best to make the health sector financially viable through cost recovery, while improving financial access to care. The Ministry of Health has studied several experiences with health insurance in neighbouring countries, but these experiences have yielded disappointing results, prompting the Ministry to look for a new way to finance the health system given that the majority of the population operates in the informal sector(36).

For the other regimes, decisions are taken in the governing bodies of the management institutions with coordination with the Ministry of Health.

Stakeholder involvement

In the 2004 policy, which largely involved the community in the national institutions that manage the CBHI. At the district level (Territorial Administrative Subdivision), the members of the board of directors of the mutual health insurance are all appointed by ministerial decree. Consequently, WHO has noted that "this limited representation of mutual members is not likely to promote a sense of community ownership of the schemes"(37).

The Association of Health Insurers in Rwanda (RHIA) is represented on the boards of directors of the RSSB, MMI and private insurance companies.

The community nature of the scheme was further entrenched in the CBHI Act of 2015, following an attempt to improve the management of the scheme. In 2014, the government leaders' retreat decided that the RSSB would manage the CBHI. This was because, as the body managing the pensions and health insurance of civil servants, the RSSB had better experience in the management of funds than the Ministry of Health(38).

Transparency and access to information

The objectives of the medical coverage system are mentioned in the legal framework. The websites of management bodies such as the RSSB clearly explain its missions and offer several online services and a service for locating regional RSSB centres, but they do not have a statistics section. The website of the Rwandan Ministry of Health offers several information on the health system: statistics, reports and online service.

Supervision and regulation

Medical coverage in the formal sector is governed by the law of 28/02/1967 on the Labour Code in Rwanda, which was amended and supplemented by law No. 51/2001 of 30/12/2001 on the provision of medical care to workers in the formal sector(39).

The decision to make CBHI mandatory was taken by ministerial order in 2006 and subsequently enshrined in the 2007 CBHI Act, which stipulates that "any person residing in Rwanda is required to join the mutual health insurance scheme"(40).

Registration in CBHI was first facilitated by the many awareness channels available to national and local governments. The CBHI Act of 2007 and 2015 authorized the imposition of fines for any person who does not join or induces others to refrain from joining a community health insurance scheme.

In 2015, the contribution of civil servants' and military insurance, as well as private health insurance to the CBHI, was increased from one to five per cent of their income.

Consistency and stability

Health insurance in Rwanda has evolved under the same legal framework as part of the improvement of the existing system, which has guaranteed continuity and stability in the system put in place. The Ministry of Health and other ministries implement identified social protection interventions. However, national authorities recognize the need to strengthen intersectoral cooperation to improve and generate expected results, including the translation of national decisions at the local level(41).

The CBHI initiative in Rwanda was in part the product of specific paradigms. First of all, national autonomy was at the heart of the RPF's ideology. Such a paradigm translates into an unwavering refusal to even partially eliminate user fees, which was seen by leaders as a long-term dependence on the outside world. It is also in line with the desire to involve the entire population in the CBHI financially, either through compulsory enrolment or by subsidising the scheme by the State (41).

Synthesis of the Benchmark

The synthesis of the benchmark analysis includes SWOT analyses for Turkey, Malaysia, France, Chile, and Rwanda. Each country's health insurance system is evaluated for strengths, weaknesses, opportunities, and threats, followed by a discussion on how these criteria can be adapted to the Moroccan context.

SWOT Analysis for Each Country

Turkey

Strengths:

- Universal Health Insurance (UHI) system ensuring wide coverage.
- Significant government investment in healthcare infrastructure.
- High access to primary care services.

Weaknesses:

- Regional disparities in healthcare quality.
- High out-of-pocket expenses despite UHI.

Opportunities:

- Potential for enhancing health IT systems for better management.
- Increasing public-private partnerships to improve service delivery.

Threats:

- Economic instability affecting healthcare funding.
- Growing burden of non-communicable diseases.

Malaysia

Strengths:

- Dual system with both public & private healthcare services.
- Government commitment to healthcare funding.
- Effective public health programs.

Weaknesses:

- Overcrowding in public hospitals.
- Unequal distribution of healthcare resources.

Opportunities:

- Expansion of private health insurance.
- Strengthening primary healthcare services.

Threats:

- Rising healthcare costs.
- Potential shortage of healthcare professionals.

France

Strengths:
- Comprehensive coverage with a strong regulatory framework.
- High quality of healthcare services.
- Extensive use of electronic health records.

Weaknesses:
- High cost of healthcare services.
- Complex and bureaucratic administrative processes.

Opportunities:
- Potential for reducing administrative costs through digitalization.
- Integration of advanced health technologies.

Threats:
- Economic fluctuations impacting healthcare funding.
- Demographic changes leading to higher healthcare demands.

Chile

Strengths:
- Mixed public-private healthcare system.
- Strong focus on preventive care.
- High coverage rates for essential health services.

Weaknesses:
- Inequality in access to healthcare between public and private sectors.
- High out-of-pocket expenses.

Opportunities:
- Expansion of preventive health programs.
- Increasing investment in public healthcare infrastructure.

Threats:
- Economic volatility affecting healthcare spending.
- Rising incidence of chronic diseases.

Rwanda

Strengths:
- High UHC coverage through community-based health insurance.
- Strong government commitment to healthcare.
- Significant improvements in health outcomes over the past decade.

Weaknesses:
- Limited healthcare infrastructure in rural areas.
- Dependency on external funding.

Opportunities:
- Expansion of healthcare infrastructure.
- Strengthening health workforce capacity.

Threats:
- External funding cuts.
- Political and economic instability.

Adaptability of Criteria to the Moroccan Context

Nature of the System

- Turkey and Malaysia: Morocco can adopt a dual system that incorporates both public and private healthcare services, ensuring a balance between accessibility and quality.
- France: Implement a strong regulatory framework and use electronic health records to improve the quality and efficiency of healthcare services.
- Chile and Rwanda: Focus on preventive care and community-based health insurance to ensure comprehensive coverage and improved health outcomes.

Coverage Rate

- France and Rwanda: Utilize strategies from these countries to improve coverage rates, such as comprehensive health insurance schemes and strong government commitment to UHC.
- Turkey and Chile: Address regional disparities and ensure equitable access to healthcare services across all regions.

Out-of-Pocket Expenses

- France and Chile: Implement cost management practices to reduce out-of-pocket expenses for citizens, ensuring financial protection.
- Turkey and Malaysia: Enhance public-private partnerships to provide high-quality healthcare services while managing costs effectively.

Discussion

We have learned several lessons and good practices in BHC governance that can be taken into consideration to improve the Moroccan model, including:

-A public health insurance system can work well if it is directly accountable to the government (2).

In Chile, the public health insurance system, Fondo Nacional de Salud (FONASA), is directly accountable to the Ministry of Health. This accountability ensures that FONASA operates under strict guidelines and standards set by the government, which helps maintain transparency and accountability in its operations. (30).

Morocco can establish a similar framework where the public health insurance system is directly accountable to the Ministry of Health. This would involve setting up a regulatory body within the Ministry to oversee the operations of the public health insurance system.

- In multi-insurer systems, common regulations and a single regulation can facilitate equal treatment of beneficiaries, protect consumers, reduce emissions from underwriting and increase transparency(6).
- At the level of supervision and regulation in Turkey, there is the merger of management bodies into a single management fund and the creation of a higher social security advisory body to ensure harmonisation between the various schemes including basic medical coverage(4);
- Malaysia has introduced several levels of

private medical coverage that Morocco can take and adapt to achieve complementary health insurance in harmony with basic medical coverage (example).

Example : Premium Private Insurance:

Description: Provides comprehensive coverage with additional benefits such as international medical care, dental and vision coverage, and access to private rooms in hospitals. This level is aimed at high-income individuals and expatriates.
Adaptation for Morocco: Morocco can introduce a premium private insurance tier offering comprehensive benefits, including access to international healthcare providers, dental and vision care, and luxury inpatient services. This would attract high-income individuals and expatriates, ensuring that they receive top-tier medical services.

- -The implementation of a national health information system in France has indeed improved the circulation and traceability of information, enhancing transparency in the health insurance services circuit for insured persons. However, the main assets of the French social security system, which includes health insurance, are its principles of equity and accessibility. (21).
- In terms of integrating the informal sector into medical coverage, we noted the innovative solution by launching a community health insurance scheme in Rwanda, which is based on partial foreign donations and aims to ensure that the uncovered population has access to health services without financial barriers. However, the government's vision is to always be financially self-sufficient and the non-dependence on the outside world is a philosophy that gives sustainability to the system. Morocco can use this practice as a model for covering the population operating in the informal sector (41).

The results showed that there is not a suitable governance model for all countries. Each country is trying to find a formula that will allow it to overcome its challenges. The analysis of governance models based on the five dimensions allowed us to better understand the scope of governance. Morocco can draw inspiration from these models to draw good practices to adopt, but this cannot happen without repositioning the governance of health coverage in the government's strategic vision in relation to the social protection agenda and the objectives of the health system.

Proposed Governance Model by Morocco

Morocco's governance model for health insurance, particularly the reform efforts including the transition to the High Authority for Health (HAS), is characterized by the following elements:

Coherence of the Decision-Making Structure

The governance of health insurance is centrally managed by the Ministry of Health and other relevant government bodies, ensuring alignment with national health policies and strategies.

Stakeholder Involvement

Encouraging collaboration between public institutions and private entities to leverage resources and expertise for better healthcare delivery.

Transparency and Access to Information

Developing and implementing integrated health information systems to enhance transparency, accountability, and efficiency in service delivery.

Supervision and Regulation

Establishing robust regulatory frameworks to oversee health insurance operations and ensure compliance with standards.

Coherence and Stability

Ensuring that health insurance policies and practices are stable and coherent with the overall social protection agenda and health system objectives.

Challenging and Adapting the Governance Model

Based on the insights from other countries, Morocco's governance model can be challenged and adapted as follows:

Coherence of the Decision-Making Structure

- **Current Model:** Centralized oversight by the Ministry of Health.
- **Challenge and Adaptation:** Introduce independent regulatory bodies to oversee health insurance schemes, similar to Chile's FONASA, which is directly accountable to the government but operates with a degree of autonomy. This can enhance accountability and reduce bureaucratic delays.

Stakeholder Involvement

- **Current Model:** Encouraging collaboration between public institutions and private entities.
- **Challenge and Adaptation:** Increase stakeholder involvement by establishing formal mechanisms for stakeholder consultation and participation in decision-making processes. Malaysia's multi-level private medical coverage system, which involves various stakeholders, can provide insights into effective stakeholder engagement.

Transparency and Access to Information

- **Current Model:** Use of integrated health information systems.
- **Challenge and Adaptation:** Strengthen transparency mechanisms by ensuring that all health insurance data is publicly accessible and regularly audited. France's extensive use of electronic health records and public reporting can serve as a model.

Supervision and Regulation

- **Current Model:** Establishing regulatory frameworks to oversee health insurance operations.
- **Challenge and Adaptation:** Enhance supervision and regulation by adopting best practices from Rwanda's community-based health insurance, which has robust oversight mechanisms ensuring compliance and quality service delivery.

Coherence and Stability

- **Current Model:** Aligning health insurance policies with the overall social protection agenda.
- **Challenge and Adaptation:** Ensure coherence and stability by continuously monitoring and evaluating health insurance policies to align them with evolving health needs and economic conditions. Turkey's approach to public-private partnerships provides a model for maintaining coherence and stability through flexible yet consistent policy frameworks.

The study has a limitation in terms of information sources. Since we have relied only on publications and scientific work and institutional reports. Direct interviews with BHC systems managers in the benchmark countries would have added more detail to our results.

Conclusion

It is to be concluded from our study that benchmarking remains one of the most relevant methods for seeking good practices in any field. The use of the dimensions proposed by the World Bank has helped us to define the concept of Basic Health Coverage (BHC) governance and to draw comprehensive insights. The benchmarking results must be analyzed in addition to the diagnosis of the BHC governance model in Morocco to derive maximum benefits. The importance of governance in achieving Universal Health Coverage (UHC) cannot be overstated. Effective governance ensures that health systems are equitable, efficient, transparent, and sustainable. This study highlights several critical aspects of governance in UHC, including the roles of health professionals, financing, and policy coherence.

Health professionals are key actors at the forefront of delivering healthcare services. Their involvement in governance is crucial for ensuring that health policies and practices are practical and patient-centered. Effective governance structures should include mechanisms for the continuous training and development of health professionals to maintain high standards of care. Additionally, involving health professionals in decision-making processes ensures that their insights and experiences inform health policies, leading to more effective and feasible solutions.

Adequate and sustainable financing is fundamental to the success of UHC. Governance structures must ensure that health financing mechanisms are transparent and efficient, minimizing wastage and ensuring that resources are directed where they are most needed. Equitable distribution of financial resources is essential to ensure that all population segments, especially the vulnerable, have access to essential health services. Exploring and implementing innovative financing models, such as public-private partnerships and health insurance schemes, can provide additional resources and improve financial sustainability.

Policy coherence and stability are also crucial. Governance structures should ensure that health policies are aligned with broader national social protection and development goals, supporting a unified approach to health and social welfare. Effective governance requires a balance between policy stability and the ability to adapt to emerging health challenges and changing economic conditions. Continuous monitoring and evaluation are essential for maintaining this balance. Implementing integrated health information systems enhances transparency, accountability, and efficiency in health service delivery, contributing to better governance.

Based on the benchmarking analysis and the identified governance dimensions, several recommendations are proposed for Morocco:

- Strengthening stakeholder involvement by enhancing mechanisms for involving health professionals, patients, and other stakeholders in governance processes ensures that policies are well-informed and widely accepted.
- Enhancing transparency and access to information through robust health information systems that provide real-time data for decision-making and are accessible to all stakeholders fosters transparency and accountability.
- Improving supervision and regulation by establishing independent regulatory bodies to oversee the implementation of health policies and ensure compliance with standards reduces bureaucratic delays and enhances accountability.
- Ensuring coherence and stability by aligning health policies with national social protection goals and ensuring that they are stable yet adaptable to changing health and economic conditions is essential.

- Optimizing financing mechanisms by exploring innovative models to increase resource availability and ensure the equitable distribution of financial resources is crucial for achieving sustainable UHC.

Governance plays a pivotal role in the successful implementation of Universal Health Coverage. By adopting best practices from international benchmarks and focusing on key governance dimensions, Morocco can enhance its health system's equity, efficiency, and sustainability. These efforts will ensure that all citizens have access to high-quality healthcare services, thereby improving overall health outcomes and contributing to the country's social and economic development.

Conflicts of interest

The authors declare no conflict of interest.

Funding

"The authors confirm that no specific funding or financial resources were allocated for the preparation or publication of this article."

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