Ramed medical assistance regimen essay sample

Despite the countless advanced in technology and the abundance of health care organization popping up all over the place, whether they are free standing clinics, hospitals, urgent cares or etc, many people still lack the ability to receive health care. This has become a concern throughout the world, but especially a more vocal concern for the Moroccan people in the past few years.

For this reason in 2012 Moroccan government creates RAMED Medical Assistance Regimen which is a healthcare system based on the principle of social assistance and national solidarity in favor of low income individuals to benefit from treatment dispensed in public medical centers as well as state-provided health services. (Minstry of health , 2013).

Regardless of the effort made by the government to facilitate health access for all Moroccans population is still a group having no social safety yet, because of the lack of financial resources to finance the RAMED according to the World Bank data, 2016 showed that Moroccan public health spending accounted for 6. 5 percent of all public spending, compared with 8. 12 percent in Algeria and 6. 2 percent in Tunisia. Those figures include recurrent and capital spending from central and local government budgets as well as other sources like international agencies. In addition to other obstacle that reduce the effectiveness of this system . The writer chooses this topic because health care system plays a significant role both in economy of country and in demographic structure .

If people are healthy , they work more efficiency(they have more power , they are less ill) Also it is very important for the age structure of the

population which can affect the output too, focusing on the RAMED system we will discuss the reasons that preventing the entire Moroccan population to benefit from this type of health coverage, what are the suitable solution for that and how we can overcome obstacles that stand in the system s way to provide free health care to many who lack it today. T he government of morocco legislated two reforms in 2005 to expand health insurance coverage.

The first is a payroll-based mandatory health insurance plan, l'Assurance Maladie Obligatoire (AMO) for public-and formal private–sector employees, which seeks to extend coverage from the current 16 percent to 30 percent of the population. The second, Regime d'Assistance Medicale (RAMED), creates a publicly financed fund to cover services for the poor. 1 The Moroccan government is now implementing these reforms. Both measures aim to improve access to high-quality care and reduce disparities in access and financing between income groups and between rural and urban areas

RAMED was first launched as a pilot project in 2009 in the region of Beni Mellal, before being expanded in 2012 to the rest of the country. The scheme, which targets the low-income population, took off with the aim of bringing health care coverage to 8. 5m people, or 28% of Morocco's inhabitants. As of December 2015, the number of RAMED beneficiaries was 9. 2m people, exceeding its initial target. While this suggests that more people than originally planned are able to access health services at affordable rates, it also means that more financing will need to be sourced in order to fund the scheme.

Moroccan Ministry of Health ,(2016) There are a wide range of care is covered by RAMED system and accessible to the beneficiaries : Preventive care: vaccinations, pregnancy care, mother and baby care, family planning; General medical consultations (including emergency) in medical centers; Medical and surgical hospitalization, including hospitalization for childbirth; Available radiology and medical imaging; Available functional exploration (endoscopy, neurological exploration, etc.)

Medicine and pharmaceutical products administered during care; Available medical devices and implants necessary for various medical and surgical procedures; Available oro-dental care; Functional rehabilitation and physical therapy;(etc.) Notably Morocco (via the RAMED) have opted for programs that specifically target poor and vulnerable populations (also like the Social Pension Health Care Programme in Egypt), while others have adopted a universal approach, that is to say a national program whose aim is to enrol the whole population, including the poor (like the National Health Insurance Scheme in Ghana and PhilHealth in the Philippines).

In the case of Aarogyasri Community Health Insurance Scheme in the Indian state of Andrah Pradesh, the state’s poverty line determines the scheme’s eligibility criteria, thus making the 70% of the population living below the poverty line the target. (Joel. A, etal. 2015) RAMED is largely funded by the Ministry of Health, which in 2016 allocated Dh1bn (€91. 7m) to the programme. Beneficiaries are also subjected to an annual contribution of Dh120 (€11) per person or Dh600 (€55) per household.

However, failing to supply these funds, an estimated 700, 000 existing members are struggling to contribute their share, according to recent local media reports, threatening the expansion of the scheme and straining financing capacities. To improve this, a number of proposals are currently being examined to bring about better financial management. Suggestions include the possibility of shifting the management of the scheme from the National Agency of Health Insurance to another governing body.

Another challenge is ensuring that health services covered by RAMED are accessible, particularly in rural areas where infrastructure and medical personnel may be lacking. “ Medical coverage has progressed positively in recent years. The issue now though is the additional workload expanded coverage has brought with it, considering the shortage of medical professionals, and its risks and impact on the quality of services being delivered,” Mohammed Hamouiyi, former head of the emergency department at the MS, told OBG.

An estimated 45% of doctors operate in either Rabat or Casablanca, while the proportion of doctors working in the rural parts of the country accounts for just 24%. Adding to that the unbalanced distribution of medical public facilities between cities: Rabat and Casablanca have the highest rate of bed and physician per 1 000 people and some medical services are available only in those two cities. Well, RAMED is not of a high interest if a poor has to bare the travel and stay expenses to get cured, the lack of financial resources to finance the RAMED.

Hence, access to medical care provided by public hospitals and university hospitals remains dependent on the contribution of the beneficiaries. The Minister also pointed out " long wait times in some services, a lack of medicine which was handled by the government, who in 2013 allotted 2 billion dirhams (179 million euros) to this mission, against 675 million dirhams (approximately 60 million euros) at the launching of the project.

Additionally, the process of identifying the poor remains problematic: the lack of coherence between the scoring system and the decision of the Local Permanent Commission (CPL) means that some people in vulnerable situations are not properly identified; furthermore the administrative complexity of the documentation that has to be submitted in order to be eligible for RAMED undoubtedly excludes the more vulnerable populations such as the illiterate and those in more remote areas.

Moreover, the scoring system used to target vulnerable people is not yet able to precisely identify the eligible population. Errors of exclusion and inclusion persist and the motivation to join RAMED appears limited. Morocco is implementing reforms to improve the efficiency and quality of care provided in selected hospitals, decentralize service provision, improve information systems, and rationalize future hospital investments and management.

Reforms seek to rectify key problems by allocating more resources to essential preventive and curative care for the poor and those in rural areas, and strengthening the safe motherhood and priority public health programs. For financing, the government of Morocco must be able to greatly increase

the amount of public resources devoted to health care to expand coverage, meet the population’s health demands, and broaden the scope of the benefit package.

The government will also need to change the distribution of public resources among regions, populations, and providers and provide a guarantee for financial commitments to local authorities, especially in rural areas. Policymakers will need to overcome vested and inequitable allocation patterns, especially among providers, which now leave the MOH with only 27 percent of the resources raised by the health system, despite its role as the major provider of services.

Current insurance spending focuses primarily on pharmaceuticals, medical goods and devices, and services provided in private offices and clinics. For reforms to succeed, especially RAMED, resources for MOH facilities and personnel—especially expansion to rural areas—must be sufficient. According to the World Bank data published in 2015 showed that Moroccan public health spending accounted for 6. 5 percent of all public spending, compared with 8. 12 percent in Algeria and 6. 2 percent in Tunisia.

Those figures include recurrent and capital spending from central and local government budgets as well as other sources like international agencies. To conclude, while enabling an access to a larger proportion of population to health care services; RAMED is creating, in terms of pure economics, an additional demand for healthcare. The system will be obsolete if the equilibrium demand/offer is not reached. The equilibrium will be reached

through building additional infrastructure and training the manpower to meet the international standards or at least requirements of the population.