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The Health Coverage and the Social Inequity for Kidney Failure Patients in Morocco: A Glance at Haemodialysis Centres, Fez/Morocco

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Abstract

Introduction: *This study aims to reveal to which extend the health coverage new regime (AMO) is crucial for kidneys failure patients and for any other patient, it covers the majority of their medical activities like the haemodialysis sessions (3 times a week), the different injections, the symptomatic treatment, etc. the new regime was established by the government to reduce disparities between citizens and to allow their easy access to health services even in public or private sector.*

Methods: *This study analyzed 60 patients with kidney failure disease after surveying them. We used Google Forms for collecting Data and Microsoft Excel for creating Graphs.*

Results: *Of the total participants, 56.6% of patients were females, while 43.3% of them were males. All the respondents had chronic kidney failure (100%. There were 72.9% unemployed, 13.6% working, 3.4% students, and 1.7% retired. More than 74% belong to Compulsory health insurance (AMO), which allows patients to benefit free of charge from the panel offered to kidney failure patients, replacing the ancient regime RAMED. When the rights to health care ended, 53.6% of cases went to court, and only 33.9% could pay temporarily.*

Discussion: *This study indicates that patients are enormously satisfied and feel dignity in their lives; that is to say, that health coverage reduces disparities between Moroccan citizens, in this case, kidney failure patients, by allowing them to have access to all health services, either in the public sector or in the private one. Nevertheless, when the rights of health coverage end, they are kicked out of private hemodialysis centers to the public ones, which impose billing as well.*

Keywords: Haemodialysis, patients, vulnerability, health coverage, society, inequity

Introduction

Social disparities are a complex, multidimensional issue because they involve multiple aspects (health, education, social class, housing, individual income, etc.). They create a sort of discrimination between categories in the same society, leading to a sort of segregation. They permit some favourable categories to have easy access to services, whereas others find it difficult to benefit from their simple rights.

Social equity is based on the increase in the quality of life; its importance is shown in the policy adopted by the State in facing the vulnerability of people, at least by providing the essential services (accommodation, good education, easy access to health services) to achieve peace, stability, social justice, and sustainable development (Aguenane, 2020).

The consequences of social inequality in the field of Health include negative repercussions on the level of health, quality, durability, and safety of individuals and communities. Social inequalities in health increase the likelihood of chronic diseases, disability, and premature death, and social inequalities in health can also increase the burden on the health system and affect the overall economic development and stability of society (Asada et al., 2013).

Health policies should focus their intervention programs on vulnerable and at-risk groups, such as those suffering from chronic diseases (Siqueira et al., 2017) that require continuous and high-quality medical intervention, such as renal insufficiency.

Morocco has recently promulgated Law No. 09-21 related to the generalisation of social protection, which permits indigent people to have access to healthcare services easily, either in the public sector or in the private one (Sanaa et al., 2025).

Nevertheless, to what extent the legislator has respected the recommendations of the WHO in terms of accessibility to healthcare services, which is characterised by 4 conditions: non-discrimination, possibility of physical access, ability to shoulder the expenses, and possibility to attain the information easily (Boughaleb & Jerry, 2024).

This study will focus on the question of health coverage for patients with kidney insufficiency and its impact on reducing social disparities. To what extent has the introduction of AMO reduced the social disparities between citizens of the same country? Have they reached the level of dignity of the privileged category?

Research Hypothesis

- It is assumed that the quality of health coverage is mainly hostage to the social, professional, and economic status of the patient.
- It is assumed that different health coverage systems make it easier for one group of patients to access treatment without another.
- It is assumed that the difference in health coverage systems leads to an impact on the material situation of one group and not others.

Methodology

Quantitative and qualitative approaches were adopted to be able to describe the collected data from patients we had contacted, to analyse and interpret the different variables of the issue, and to deduce the feasibility of the Moroccan new strategy towards renal insufficiency patients.

The sample was randomly chosen among renal insufficiency patients, notably those who quit the public sector to join the private one, thanks to the new social protection (AMO). Nearly 60 patients kindly and generously accepted to participate in this survey.

To collect data, a physical meeting with patients and some healthcare professionals was opted for to construct a real study founded on direct reception of information (mouth-to-mouth). Moreover, our choice of direct interviews is explained by: First, the patients of the sample were generally illiterate. Second, the direct interview allowed us to feel the state of the patient and his/her grief.

The informed consent procedure for illiterate participants, unable to read a written consent, consisted essentially of witnessing verbal consent. The interviewer read the question to the participant, explained it until he/she showed full understanding, and then received the answer and entered it anonymously on Google Forms.

In this optic, could the Moroccan government, by the generalisation of social protection, reduce the social disparities, or will it reproduce the same inequity by increasing only the number of inhabitants subscribed under the health coverage regime without convenient healthcare services?

Results

The economic situation of the vulnerable groups is severely affected, which makes them in need of receiving assistance within the framework of solidarity developed by civil societies. The foundation of the study rested on a survey answered by 60 patients, and as illustrated in Figure 1, the largest category of the sample exists between the ages of 20 and 60, by 71%, which means the economically active part of the society, and there is a slight difference between the sexes; they are about 57% of women and 44% of men. However, we noticed that the whole sample belongs to the haemodialysis (HD) type by 100%, and we do not understand why peritoneal dialysis (PD) is marginalised, even if it offers a better quality of life for patients. Moreover, it confers a large space of independency comparing to haemodialysis (HD), whose patients should make regular visits (3 times/ week at least) to dialysis centres (Shrestha, 2018). This resort to blood ultrafiltration is explained by the desire of nephrologists to continue encouraging their patient to constantly and regularly come to their centres, and there is also a group of involved people in the trade of kidney filtration: medicines' companies, filtering devices companies, filtering materials companies, etc.

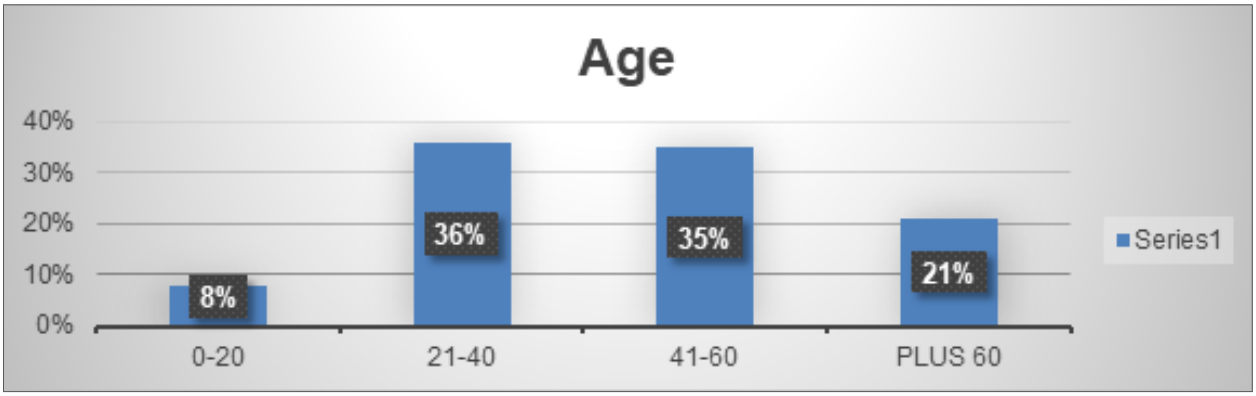

Figure 1: More than 75% of the sample are between the ages of 20 and 60 years, which means ¾ of the economically active people.

As it is mentioned in Figure 2, more than 70% of the sample are jobless, and only 13% work, which means that the patients of kidney failure belong to the vulnerable class of society. Nevertheless, the good thing is that more than 75% of them have health coverage, and that is thanks to the new social protection regime (CHI=AMO) set up by the Moroccan government.

It permits them to benefit from the 3 sessions needed in a week, the anti-coagulation syringes, and the erythropoietin injections as well. These are the general panels that kidney failure disease patients are availing; yet, they must do blood analysis, X-ray analysis, and other exams at their own expense. This represents a heavy burden on their shoulders.

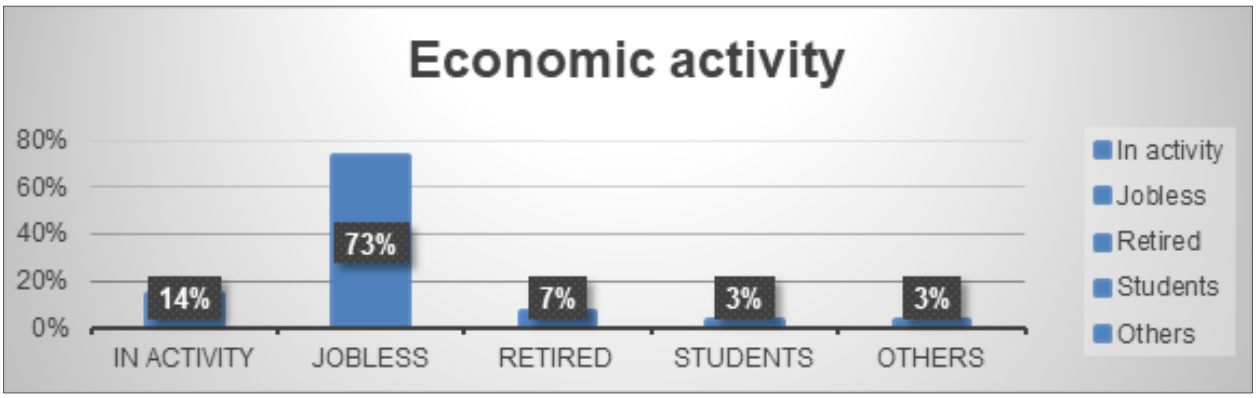

Figure 2: It shows that nearly ¾ of the sample are jobless, which reveals the state of their precariousness and their indigence. Fortunately, as it is shown in Figure 3, most of them are covered by compulsory health insurance (Assurance maladie obligatoire (AMO)), which facilitates their easy access to medical care either in the public or private sector.

For the kidney failure disease patients, Figure 4 reveals that they totally depend on the health coverage to pay for their medical care. They indeed benefit from a panel that contains sessions of haemodialysis, erythropoietin, and anticoagulant injections as well as symptomatic treatment (Figure 5). However, when it comes to biological and X-ray exams, they must pay first and then wait for reimbursement by the fund. The indigent people do not find that what they pay first, they often carry on blood ultrafiltration without supervising their biological state.

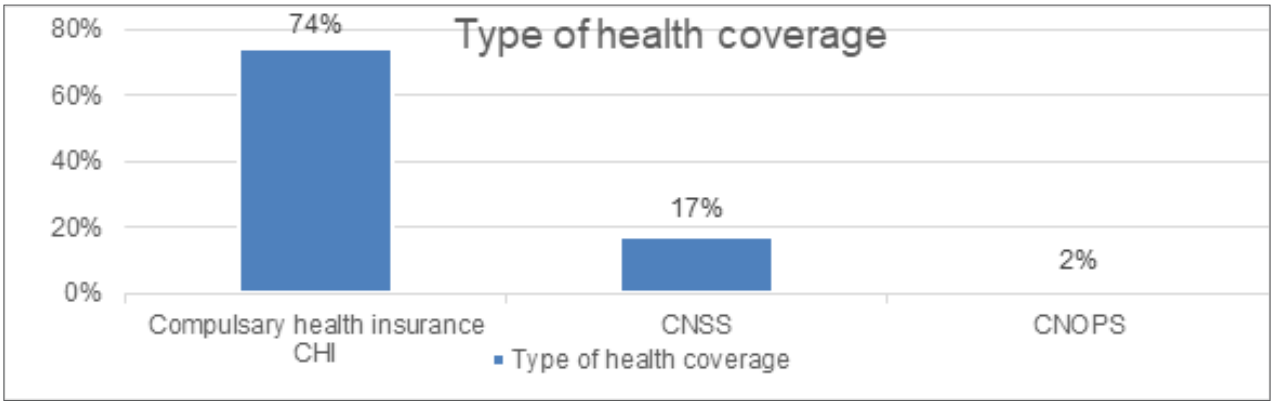

Figure 3: This figure illustrates that the majority of the sample depends on the fund of social solidarity reserved for needy people.

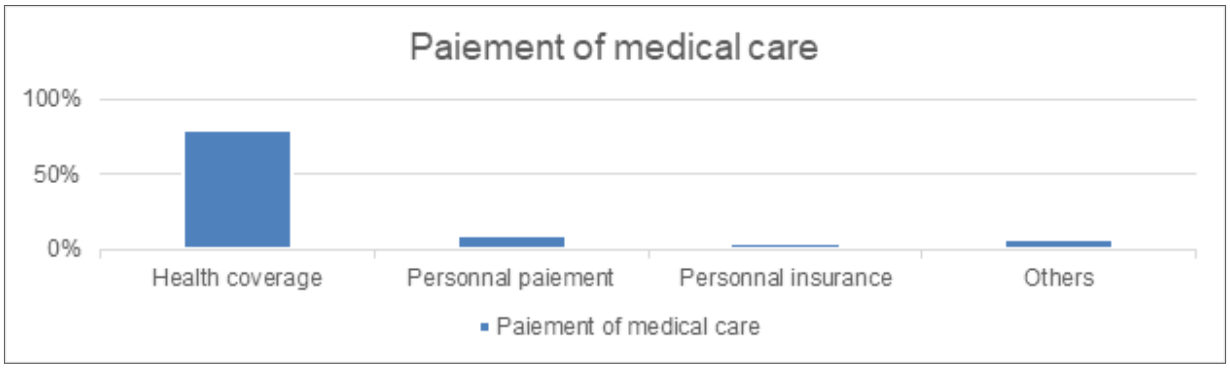

Figure 4: The majority of the sample depends on health coverage to pay for their medical care, including the sessions of haemodialysis.

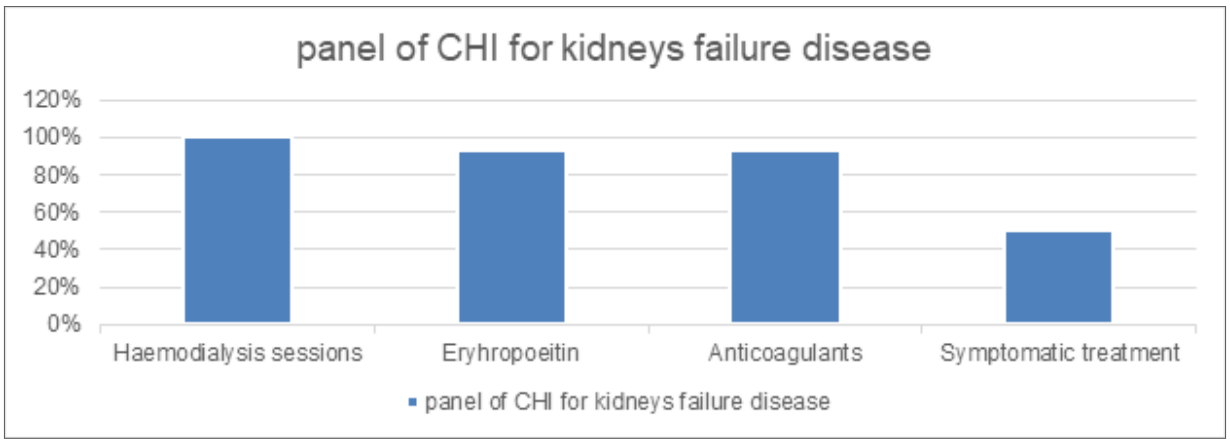

Figure 5: According to the CHI, patients could benefit from all the sessions of dialysis needed, plus the erythropoietin and anticoagulant injections. Besides, they could benefit from symptomatic treatment.

The situation becomes worse when the rights of health coverage end up for one reason or another (lay-off of workers, long-term illness, etc.). Figure 6 illustrates that kidney failure patients are in an awkward situation and only 1/3 could pay for a temporary period, while more than half of them are kicked out to courts for judicial trial, which is disgraceful and abominable.

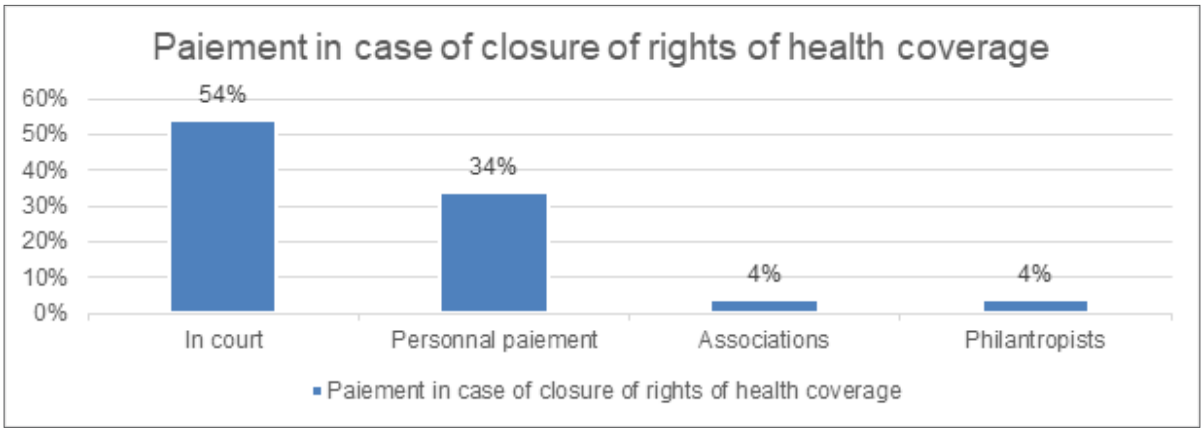

Figure 6: In the case of closure of rights of health coverage, patients have two choices: to pay, which represents more than 30%, or the case goes to judicial trial in more than 50%.

Discussion

Health coverage constitutes the protection that individuals and communities receive to maintain their health and treat diseases and injuries that confront them throughout their lives. Health coverage includes access to basic medical services such as hospitals, clinics, specialised consultations, reimbursement of medicines, and medical test bills (Ozawa et al., 2020). Health coverage may be provided through the public health system, such as government health insurance, or through private health insurance. The main goal of health coverage is to improve public health and reduce the financial burden on individuals who require health services, which is why Morocco made this transition from the RAMED system to the AMO system.

Transition from the system of medical assistance (RAMED) to compulsory health insurance (CHI=AMO)

The system of medical assistance is used to allow people to have access only to the public health sector. However, the new system of compulsory health insurance (CHI=AMO) allows people who are unable to afford the subscription obligations to benefit from all the advantages of the old RAMED system, in addition to the same basket of treatments in private sector procedures.

"The compulsory health insurance system" enables the insured to access health services without discrimination in terms of belongings or the nature of the activity. The CHI is therefore a measure aimed at achieving social justice and equality among all Moroccan citizens by ensuring the availability of basic healthcare for all and reducing the financial burden on individuals and families in cases of necessary medical and surgical treatment. It also aims to overcome the shortcomings of basic health coverage.

The new system provides a wide basket of treatments, including general and specific medicine, preventive medicine, and hospitalisation for childbirth, etc (Bentaleb & Aba, 2024). The framework law n°09-21 related to the generalisation of social protection, namely, indicates the field of its intervention, which includes:

- The protection against the risks of illness;
- The protection against risks related to childhood and the granting of lump-sum benefits to families not covered by this protection;
- Protection against risks related to aging;
- Protection against the risk of job loss.

That is to say that the transition from the RAMED system to the CHI (AMO) system is one of the steps that seek to achieve parity in the field of healthcare in Morocco. There are several ways in which this equality can be achieved:

- Access to high-quality health services,
- Expanding inclusivity in the way that CHI (AMO) aims to cover all citizens and residents of Morocco who commit to participating in Social Security,
- Promoting social justice,

Health coverage falls within the social protection policies developed by the State in several areas of health, especially for the benefit of individuals, most of whom belong to the vulnerable and needy category, who cannot secure these needs. Social Protection has become a "basic human right, and an primordial factor in achieving major social and economic goals, so its topics occupy an important area of public policy concerns, especially in light of the evolution of the roles of the State and its concept from a protective state to a social state responsible for ensuring the provision of a range of social services such as health, education, employment, social insurance, redistribution of resources, social justice and other socio-economic determinants contributing to sustainable development", which is the mechanism that the State has worked on through its social policies, which aims, first of all, to provide health services to all community groups, despite their socio-professional, ethnic or community differences (Ikram & Abahmaoui, 2025). It is a policy based on the elimination of social inequality and disparities in health by ensuring access to this sector by the community without preferences.

Law n°. 65.00 represents the code of basic health coverage, which refers to six structured principles that are not fully respected: compulsory, universality, equity, solidarity, Prevention of all forms of discrimination, and Prevention of risk selection. This system has two levels: compulsory basic health coverage (Couverture médicale de base) and supplementary coverage (couverture médicale complémentaire). Basic coverage has been assigned to two institutions based on criteria related to the professional status of the public sector versus the private sector, on the rights acquired before the entry into force of the basic coverage code, and on criteria related to income levels. This division, which was initially carried out as a transitional stage before the establishment of a universal basic system, resulted in a compulsory health insurance system, based on contributions, financed by deductions from the wages and incomes of people engaged in income - generating activity, beneficiaries of pensions, veterans of the Resistance, members of the Liberation Army and students, as well as a system of medical assistance (RAMED based on the principles of social assistance and national solidarity for the needy population). Complementary health coverage is provided by cooperatives and private insurance companies.

Impact of health coverage on the reduction of social inequality
The transition that we have mentioned from the RAMED system to the compulsory health insurance system (AMO) has provided many privileges for its insurers (Belhassani, 2023).

Thanks to this system, this category of needy people can secure ultrafiltration sessions for free, as it was demonstrated by patients in Figure 5, with the possibility of undergoing them either in the public or private sector, and some medicines are provided to them for free, while others are highly costly, estimated at 2700 dirhams (around 270 dollars). Also, it tries to compensate as much as possible for the financial difficulties associated with chronic diseases. On the other side, patients expressed with sorrow their frustration because they lost their jobs as their health condition deteriorated. They must carry on paying, though. Otherwise, they are kicked off to courts for judicial regulation, as it is highlighted in Figure 6.

Furthermore, some of the medicines required by this disease are not compensable and therefore difficult to acquire.

Considering that chronic illness requires a set of expensive costs and expenses, which are represented by medicines and tests that are not compensable, and therefore it is difficult for patients to acquire, this affects their economic situation. In the case of patients with renal insufficiency, it should be noted that they do not only suffer from this disease, but also from diabetes, high blood pressure, and heart disease (Verma et al., 2016). Hence, the financial expenses burden the patients and affect their daily economic life, especially since most of them who used to practice professions that generate income are no longer able to do so because of the deterioration of their health condition (Kim et al., 2023) and because they are associated with ultrafiltration 3 times a week at a rate of 3 to 4 hours per session, depending on each case.

Most of the respondents, especially those who are from the fragile class and belong to the CHI (AMO) system, expressed a deterioration in their physical condition compared to their condition before the disease, which clearly expresses the negative impact of kidney failure on the ordinary life of individuals (Bennett et al., 2017). In this situation, the issue of social solidarity emerged, which formed the initial groups such as the family, and how it helps patients to afford the expenses of treatment and living, especially since most of them do not work since their health has worsened and their ability to withstand the hardships of work has diminished, especially since fragile professions often require physical effort (Francis et al., 2024).

Kidney failure patients subject to the survey express their deep grief towards their new undesirable state; they conveyed from strength to weakness, from autonomy to dependency, from freedom to coupling with the cursed ultra-filtering device. The signs of depression and deception are connotated in their sorrowful tone; their psychology is generally broken to the ground (De Sousa, 2008).

Regardless of their physical and psychological state, we positively noticed deep satisfaction coming from inside the patients as they experienced bitterly the ancient regime (RAMED) where they had only the right to have access to miserable public services. Nowadays, they feel free to knock on

the door of any haemodialysis centre; moreover, all the patients with the CHI AMO regime are welcomed in the private sector. What is more, some nephrologists of the private sector seduce patients venally to come for ultrafiltration by providing them with a sum of money, which is new in the Moroccan context. At least, the patients are now kings and satisfied. Nonetheless, some hindrances are still annoying them.

Constraints

Kidney failure patients are suffering from many hindrances that vex their daily lives. We will reveal some of them briefly:

First, in the public sector, there are no means of transportation for patients who face many difficulties from and to the centre of haemodialysis,

Second, no meals are offered to patients during the session of haemodialysis in the public sector, in contrast to the private sector.

Third, patients find hinders to do some essential medical analyses because they must pay first and wait for partial reimbursement later.

Fourth, the public haemodialysis centre is far away from the main headquarters hospital; that is to say that for any needs (medicines, ambulance, equipment, intensive care, etc.), the health professionals must make many phone calls to different people in charge to benefit from some services that must obviously exist in any health service.

Fifth, some patients lose their right to benefit from the haemodialysis session as soon as they lose their health coverage. However, the centre continues to provide its services and offer only two sessions instead of three, and with billing that the patient ought to pay; otherwise, he/she will not benefit from further services.

Conclusions

This study aimed to examine the impact of health coverage on vulnerable people and its role in reducing disparities and discrimination between citizens of the same country (Emanuel et al., 2020), in this case kidneys failure patients as they suffer from a chronic disease that requires a set of material costs that require the intervention of the state with its health policies to help this category of patients to access health services easily (Wang et al., 2019), without complications and with high quality, as this category will not be able to pay for treatment because it is very expensive, and in front of this situation it becomes necessary for the state to provide a health system that helps to absorb these difficulties. In this scope, the issue of health coverage, which was developed in the framework of protecting individuals from health risks, has been an entry point to confront diseases in general and chronic diseases in particular.

From this point of view, this research is based on the approach of how to reveal the most important measures adopted by the State in the face of chronic disease and the most crucial determinants controlling the direction of its interventions related to health coverage.

We have reached a set of results, the most important of which are:

The State, through its policies, has worked to find solutions for the needy group affected by this disease, which could not access to health services, through the transition from the RAMED system which allows to its adherents to have access only to public health services to the AMO system, which has become easier for them to benefit from the health services in both sectors (public and private) because the government has taken charge of expenses related to expensive medicines and haemodialysis sessions, and it should be noted that this system has created competition between the public and the private sector in the issue of seeking to provide quality services to patients. Hence, the issue that the quality of Health Services is related to social and professional affiliation has been bypassed since all groups have covered expenses by up to 100%.

The State, through this interventionist policy, facilitated the access of all groups to health services related to renal insufficiency, including haemodialysis sessions and expensive medicines. However, some medicines are incompatible with the disease and are not reimbursed, as they burden the needy group. Consequently, there is no ease in obtaining them.

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