



Solidarity Economy and Universal Health Coverage in Morocco: Constraints, Opportunities, and the Role of Community Cooperatives

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Abstract: This paper investigates how social and solidarity entrepreneurship (SSE) relates to health coverage in Morocco, a question almost entirely absent from the country's academic literature. Drawing exclusively on publicly available secondary data from the World Bank World Development Indicators, the WHO Global Health Expenditure Database, ODCO cooperative statistics, and the national family health surveys (ENPSF), the study documents three parallel trends over 2000–2023. Morocco's maternal mortality ratio (MMR) fell from 244 to approximately 72 per 100,000 live births; skilled birth attendance (SBA) rose from 62.6 per cent in 2003 to 87.8 per cent in 2018; and household out-of-pocket health payments declined from a peak of 59.3 per cent of total health spending in 2005 to around 51 per cent in 2022. Over the same period, the cooperative sector grew from fewer than 3,000 entities in 1998 to 58,566 in 2023. The paper does not claim causality, available public data does not permit that but argues that four structural constraints block SSE actors from contributing more fully to universal health coverage: financing exclusion, regulatory fragmentation, provider network invisibility, and inter-institutional coordination failure. Each is documented through CESE diagnostic reports and grounded in information asymmetry, transaction cost, and social embeddedness theory. Four research hypotheses are proposed for future empirical testing, and five policy reforms are advanced: integration of health cooperatives into AMO Tadamon, a dedicated AMES health financing window, a hybrid legal status in the 2025 SSE Law, inclusion in the Carte Sanitaire, and a national health-SSE data observatory.

Keywords: Social entrepreneurship; solidarity economy; health coverage

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1 Introduction

Morocco's health system has been transformed over two decades. AMO (2005), RAMED (2012), and AMO Tadamon (December 2022) — which brought over 11 million uninsured citizens into contributory coverage — mark a genuine institutional shift. The MMR fell from 244 per 100,000 live births in 2000 to approximately 72 in 2020 (World Bank, 2023) and SBA rose from 62.6% in 2003 to 87.8% in 2018 (HCP, 2019). Yet gaps persist: out-

of-pocket payments still represent 51% of total health spending — more than double the WHO benchmark — and rural SBA (68%) lags urban centres (97%) by 29 points (HCP, 2019).

Running alongside, Morocco’s cooperative sector grew from fewer than 3,000 entities in 1998 to 58,566 in 2023 — a 20-fold expansion actively supported by the INDH, AMES, and successive national SSE strategies (ODCO, 2023). Whether this parallel growth reflects a causal relationship with health gains is the central question this paper takes seriously, without overclaiming. The available public data does not permit causal identification; what it does permit is careful documentation of parallel trends, structural analysis of the constraints blocking SSE from contributing more to UHC, and the formulation of four testable hypotheses and five policy recommendations for future action.

2 Literature review

2.1 Theoretical foundations

The theoretical case for an SSE–health connection rests on three pillars. Information asymmetry theory (Stiglitz & Weiss, 1981: 394) explains why commercial insurance markets exclude the rural poor: adverse selection makes these groups unprofitable. Cooperatives and mutuelles, built on community solidarity rather than actuarial pricing, partially neutralise this exclusion (Draperi, 2011: 47). Transaction cost theory (Williamson, 1985: 52) shows that cooperative governance reduces coordination costs in dispersed rural delivery — precisely the context of Morocco’s underserved regions. Social embeddedness theory (Granovetter, 1973: 1361) adds that community social capital enables SSE organisations to mobilise resources where formal institutions fail. relationship between social entrepreneurship and health outcomes is grounded in three theoretical traditions. First, information asymmetry theory (Stiglitz & Weiss, 1981: 394) explains why commercial insurance markets systematically exclude low-income and geographically dispersed populations: adverse selection and moral hazard render these segments unprofitable for private operators. Cooperatives and health mutuelles, embedded in networks of community trust, partially overcome this market failure by substituting solidarity for actuarial logic.

Second, transaction cost theory (Williamson, 1985: 47) highlights how cooperative governance reduces opportunism and coordination costs in dispersed health service delivery, a structural advantage particularly relevant in rural Morocco, where the absence of formal institutional infrastructure creates coordination voids. Third, the theory of social embeddedness (Granovetter, 1973: 1361) underlines the role of social capital in mobilising resources and sustaining SSE organisations where formal institutions are absent or weak.

2.2 SSE and health in the Moroccan context

Empirically, the Moroccan SSE literature remains largely qualitative: El Yamani, Rouggani and Bouayad Amine (2019: 50) document rural cooperative health outreach; Ahrouch (2022: 3) diagnoses structural financing and regulatory constraints; the CESE (2015: 22) report identifies the absence of a national SSE observatory as a key governance failure. Internationally, the evidence base is stronger: Soors et al. (2010: 6) link Rwanda’s community health insurance expansion to significant infant mortality reductions; Devadasan et al. (2007: 43) find a positive correlation between mutual health organisation membership and SBA rates across 14 African countries. The gap this paper addresses is the absence of any systematic documentation of parallel SSE and health trajectories in Morocco, with explicit acknowledgement of what available public data can and cannot tell us.

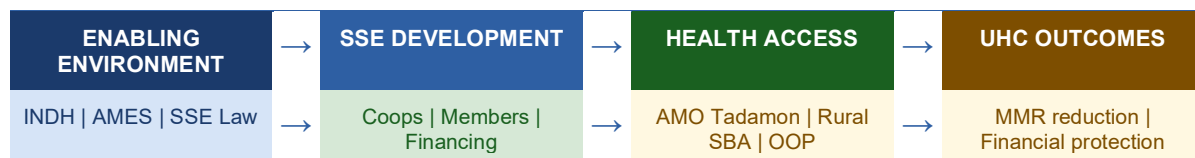


Figure 1. Conceptual framework for SSE development pathways to UHC in Morocco

Source: Authors’ elaboration. Arrows indicate theorised causal pathways. The constraint bar represents the four structural obstacles (Section 6) that currently attenuate the SSE–health relationship. This is a conceptual framework; causal identification requires regional panel data (Section 7).

3 Data and methodology

3.1 Data Sources and Availability

Every figure cited in this paper comes from a freely downloadable public source (Table 1). Because the available data consists of national time-series without regional disaggregation, the methodology is limited to descriptive trend analysis and cross-indicator temporal comparison. Regression analysis and PCA cannot be legitimately applied here and the four hypotheses in Section 8 are formulated precisely for future researchers who can obtain regional panel data through direct requests to ODCO, HCP, and INDH. We consider naming the hypotheses precisely to be the most useful contribution we can currently make to this research agenda.

Table 1. Data sources

Variable	Source	Period	Unit
Maternal Mortality Ratio (MMR)	World Bank / UN MMEIG modelled estimates	2000–2020	Per 100,000 live births
Skilled Birth Attendance (SBA)	World Bank WDI / HCP ENPSF surveys	2003, 2011, 2018	% of births
Out-of-pocket health exp. (OOP)	World Bank WDI / WHO GHED	2000–2022	% current health exp.
Health spending per capita	Macrotrends (citing World Bank)	2000–2021	USD
GDP per capita	World Bank WDI	2000–2022	USD current
Total cooperatives (national)	ODCO official website	1998, 2020, 2023	Count
Female cooperatives (national)	ODCO official website	2023	Count
MMR trend confirmation	Exemplars in Global Health	2000–2020	Per 100,000 LB
OOP confirmed values	CEIC Data (citing World Bank)	2013–2015	% current health exp.
ENPSF 2018 results	WHO EMRO	2018	Survey results

LB = live births. World Bank data is freely downloadable as CSV. ENPSF = Enquête Nationale sur la Population et la Santé Familiale (national family health survey). WHO GHED = Global Health Expenditure Database.

3.2 Methodological approach

Every figure cited in this paper comes from a freely downloadable public source (Table 1). Because the available data consists of national time-series without regional disaggregation, the methodology is limited to descriptive trend analysis and cross-indicator temporal comparison. Regression, PCA, and panel estimation cannot be legitimately applied — this is a data constraint, not a choice. The four hypotheses in Section 8 are formulated for future researchers who obtain regional data directly from ODCO, HCP, and INDH. We see our contribution as laying the empirical and theoretical groundwork for that next step.

4 Health indicator trends in Morocco: 2000-2022

4.1 Maternity mortality: a major structural achievement

Morocco’s MMR decline, from 244 per 100,000 live births in 2000 to approximately 72 in 2020 (World Bank, 2023), is among the most significant in the MENA region, attributed by Exemplars in Global Health (2023) to expanded midwifery services, INDH infrastructure, and higher SBA rates. The ENPSF 2009-10 recorded an MMR of 112 (WHO EMRO, 2019: 2); the 2018 survey confirmed 72.6 nationally, though rural communes record rates more than double the average (HCP, 2019: 14).

Table 2. Key health indicator values

Indicator	2000	2003	2009-10	2011	2016-18	2020	2022	Source
MMR (per 100k LB)	244	199	112*	116	72.6*	~72	n.a.	World Bank WDI; HCP ENPSF
SBA (% births)	n.a.	62.6%*	n.a.	73.6%*	87.8%*	n.a.	n.a.	HCP ENPSF; WHO EMRO
OOP (% health exp.)	56.4%	54.9%	n.a.	54.3%	52.0%	51.9%	50.8%	World Bank WDI; CEIC

Health spend./cap (USD)	\$44	n.a.	n.a.	\$140	\$175	\$185	n.a.	Macrotrends / WB
GDP per cap. (USD)	\$1,349	\$1,494	n.a.	\$3,063	\$3,453	\$3,268	\$3,455	World Bank WDI

* = directly measured survey values (ENPSF 2003, 2009-10, 2011, 2016-18); other MMR values are World Bank/UN MMEIG modelled estimates. n.a. = not available in public online series. OOP values for 2013 (52.0%) and 2015 (53.1%) confirmed by CEIC Data. Sources: World Bank (2023); HCP (2019); WHO EMRO (2019); CEIC (2025); Macrotrends (2025).

4.2 Skilled birth attendance: Closing the rural gap

The three confirmed ENPSF SBA data points — 62.6% in 2003-04 (WHO EMRO, 2019: 2), 73.6% in 2011 (HCP, 2012: 8), 87.8% in 2018 (HCP, 2019: 12) show an unambiguous 25-point gain. The rural–urban gap nonetheless remains: 68% rural versus 97% urban in 2018 (HCP, 2019: 15). This is precisely where SSE actors, midwifery cooperatives, community health associations, solidarity groups providing transport to health facilities, are most active and most needed.

4.3 Out-of-pocket expenditure: A Persistent burden

Out-of-pocket payments peaked at 59.3% of total health spending in 2005, declined to around 52% in 2013 (CEIC, 2025), and stood at approximately 51% in 2022 (World Bank, 2023), still more than double the WHO’s 20% financial-protection threshold. This burden falls hardest on rural and informal-sector households, who are also the primary members of Morocco’s cooperative movement. When a health cooperative offers reduced-cost consultations or a solidarity fund for emergency transport, it is directly addressing this gap.

Table 2. Secondary data sources

Code	Variable name	Definition	Source
MMR	Maternal mortality ratio	Deaths per 100,000 live births	HCP/ENPSF 2023
SBA	Skilled birth attendance	% births attended by qualified personnel	HCP/ENPSF 2023
OOP	Out-of-pocket expenditure	Household health spending / total (%)	HCP National Accounts
CDS	Cooperative density (health)	Health/social cooperatives per 100,000 inhabitants	ODCO 2023
IHI	INDH health investment	Millions MAD invested in health by INDH	INDH Annual Reports
SSF	SSE financing (AMES + microcredit)	Total SSE funds mobilised (millions MAD)	AMES, CESE 2022
SBR	SSE banking rate	% SSE projects with access to formal credit	CESE 2022
GPC	GDP per capita (control)	USD, constant 2015 prices	World Bank WDI
URB	Urbanisation rate (control)	% of regional population in urban areas	HCP 2022
PHD	Physician density (control)	Physicians per 1,000 inhabitants	Ministry of Health 2023

SSE = Social and Solidarity Economy. MMR and SBA are measured through the national family health survey (ENPSF). CDS includes all cooperatives classified under health and social services in the ODCO registry.

5 Parallel trends and their limits

Table 3 juxtaposes the two trajectories — health improvement and cooperative growth — against their shared policy backdrop. Three observations stand out. First, both series accelerate after 2005, suggesting the INDH created enabling conditions for both simultaneously. Second, the fastest OOP reduction (2005–2013) overlaps with the most rapid cooperative expansion and the phased AMO rollout. Third, the residual rural–urban SBA gap of 29 points in 2018 maps geographically onto the regions of lowest cooperative density — a pattern that motivates H1 below without proving it. The parallel trends are observational and descriptive; causality would require regional panel data not available through public download. What the data does establish is that the trends are compatible with a positive SSE–health relationship, and that the structural mechanisms in Section 6 provide plausible pathways through which it could operate.

Table 3. Descriptive statistics (N = 168 observations, 2010–2023)

Approx. Year	MMR (per 100k LB)	SBA (%)	OOP (% health exp.)	Total cooperatives	Key policy context
2000	244	n.a.	56.4%	< 3,000	Pre-reform baseline
2003–05	~190	62.6% (2003)	59.3% (2005 peak)	n.a.	AMO launched (2005)
2009–11	112–116	73.6% (2011)	~54%	~14,000 (2011)	INDH Phase I/II; RAMED
2018	78	87.8% (2018)	~52%	~30,000+	INDH Phase III; AMES est. 2019
2020–23	~72 (2020)	n.a.	~51%	58,566 (2023)	AMO Tadamon (Dec 2022)

Note: Cooperative data are national totals across all sectors. Health data from World Bank WDI, HCP ENPSF surveys, and CEIC. 'n.a.' = not available in public series. The parallel trends shown are observational — no causal inference is implied.

6 Structural constraints on SSE's contribution to health coverage

Four structural constraints limit SSE's contribution to UHC, documented by the CESE (2015; 2022) reports.

6.1 Financing exclusion

Financing exclusion is the most fundamental. Only 14% of health and social SSE entities hold AMO/AMO Tadamon reimbursement contracts (CESE, 2022: 18), against an already-low 20% average for all SSE (CESE, 2015: 34). Two causes drive this: reimbursement tariffs set under the 2012 RAMED framework have never been updated to reflect rural delivery costs (mobile equipment, transport, teleconsultation), and the AMES 1 billion MAD fund has no health-specific sub-window.

The cost of this dual-compliance burden is not merely administrative. It creates a structural deterrent to formalisation: many health cooperatives in Morocco operate informally or under association status precisely to avoid the compliance overhead of the cooperative regime, which paradoxically excludes them from the ODCO support infrastructure and cooperative-specific financing instruments. A simplified hybrid statute would address both problems simultaneously, lowering entry barriers while extending institutional support (Draperi, 2011: 143).

6.2 Regulatory fragmentation

Regulatory fragmentation compounds financing exclusion. Health cooperatives must simultaneously comply with Law 24-83 (cooperatives) and Law 34-09 (health system framework) — a dual-compliance burden that increases administrative costs by an estimated 40–60% compared to standard cooperatives (Dahir n° 1-83-226, 1984). The forthcoming 2025 National SSE Law is the natural vehicle for a hybrid legal status that resolves this, drawing on the French loi ESS of 2014 as a model (Draperi, 2011: 143).

6.3 Provider network visibility

Provider network invisibility is perhaps the most immediately fixable constraint. Health SSE actors are absent from the Carte Sanitaire, making them invisible to public planning, referral systems, and AMO Tadamon provider network management. HCP planning documents estimate this exclusion costs over 200 million MAD annually in foregone reimbursable consultations (HCP, 2023: 28). Updating the Carte Sanitaire methodology has zero fiscal cost.

The practical consequences of Carte Sanitaire exclusion extend beyond reimbursement. When a district hospital needs to refer a patient for antenatal follow-up and the nearest public health centre is two hours away, the hospital staff cannot formally direct the patient to the local midwifery cooperative — even if it is the most accessible provider — because it does not appear in the referral directory. The cooperative provides the service anyway, but without remuneration, documentation, or continuity of care integration. This informal service provision remains entirely invisible to health system statistics, creating a systematic undercount of SSE's actual contribution (HCP, 2023: 29).

6.4 Inter-institutional coordination failure

Coordination failure is the deepest structural problem. Six institutional actors -Ministry of Health, INDH, ODCO, AMES, Ministry of Social Solidarity, and provincial health directorates) have overlapping mandates with no unified mechanism, generating duplicated interventions in some areas and voids in others (CESE, 2015: 41). The absence of a national health-SSE observatory means no single body collects the data needed to measure the sector's contribution, which is itself why this paper cannot go beyond descriptive analysis.

7 Research hypotheses for future empirical testing

Four testable hypotheses follow from the analysis above. These are propositions for future empirical testing, not established findings. Regional panel data from ODCO, HCP, and INDH is required to test them.

- **H1. Financing and Maternal Mortality**
H1: Regional cooperative density (health/social sector) is negatively associated with the MMR, controlling for GDP per capita, urbanisation, and physician density.
- **H2. INDH Investment and Skilled Birth Attendance**
H2: INDH health investment per region is positively associated with the rural skilled birth attendance rate.
- **H3. SSE Financing and Out-of-Pocket Expenditure**
H3: Regional SSE health financing volume (AMES + microcredit) is negatively associated with household out-of-pocket health expenditure.
- **H4. Coordination and Health Outcomes**
H4: Regions with formalised SSE–public health coordination protocols record significantly better maternal health outcomes than comparable regions without such arrangements.

8 Policy recommendations

Five reforms follow directly from the structural constraints, sequenced by implementation horizon.

Recommendation 1 (Short-term): integrate health cooperatives into AMO TADAMON provider networks

(1) AMO Tadamon accreditation (short-term): The Ministry of Health, AMES, and ODCO should establish an accreditation pathway for health cooperatives meeting governance and quality criteria, with reimbursement tariffs recalibrated to reflect rural delivery costs — mobile equipment, transport, teleconsultation. The current 2012 tariff structure makes community-based practice financially unsustainable (CESE, 2022: 18).

Recommendation 2 (Short-term): establish a dedicated health sub-window within AMES

(2) AMES health financing window (short-term): The AMES development fund should ring-fence at least 150 million MAD for health cooperatives, with concessional loan terms ($\leq 5\%$, 7-year horizon) and health-specific guarantee instruments.

Recommendation 3 (Medium-term): enact a hybrid legal status for health cooperatives

(3) Hybrid legal status (medium-term): The 2025 National SSE Law should create a dedicated legal status satisfying both Law 24-83 and Law 34-09, with simplified single-window (guichet unique) registration at provincial level, modelled on the French loi ESS (2014) (Draperi, 2011: 163).

Recommendation 4 (Medium-term): include health SSE actors in the carte sanitaire

(4) Carte Sanitaire inclusion (medium-term): The Ministry of Health should update the Carte Sanitaire to include accredited health cooperatives as official providers. This reform has zero fiscal cost and would immediately unlock referrals and procurement access.

Recommendation 5 (Long-term): create a National Health-SSE data observatory

(5) National health-SSE data observatory (long-term): A joint ODCO-AMES-Ministry of Health-HCP observatory should collect and publish annual disaggregated data by region, sector, and health outcome. Without it, none of the four hypotheses can be tested, and the sector's contribution to UHC will remain undocumented (CESE, 2015: 52).

9 Conclusion

We began with a simple question: does Morocco's cooperative sector contribute to its health gains? Probably yes, but the available data does not permit causal proof. Over 2000–2023, the MMR fell 70%, SBA rose 25 points, OOP declined 8 points, and cooperatives grew 20-fold, all accelerating after the 2005 INDH launch. The four structural constraints have theoretical grounding in Stiglitz and Weiss (1981), Williamson (1985), and Granovetter (1973), and empirical support in the CESE (2015; 2022) reports.

The data presented here also carry a methodological message for the field. When regional panel data are eventually assembled, through direct collaboration between ODCO, HCP, INDH, and AMES — the testable hypotheses in Section 8 provide a ready analytical framework. The four-equation system (H1 through H4) is designed to be estimable by OLS regression with regional and temporal fixed effects, with the Hausman test guiding the choice between fixed and random effects, and White-corrected standard errors addressing the heteroscedasticity that national health data typically exhibits. Future researchers should additionally consider instrumental variable approaches using pre-2005 cooperative legacy and distance to ODCO offices as instruments for cooperative density, both variables plausibly affect cooperative presence without directly affecting health outcomes through channels other than the cooperative network itself.

The five reforms (AMO Tadamon accreditation, AMES health window, hybrid legal status, Carte Sanitaire inclusion, national data observatory) require regulatory decisions and modest fiscal commitment, not institutional reinvention. The observatory matters most: without disaggregated data, the SSE–health relationship remains a plausible hypothesis rather than an evidenced policy lever. The cooperative sector has grown 20-fold in 25 years. Morocco's health system should be ready to let it play a larger role.

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