





Governance of Mandatory Health Insurance and Access to Healthcare: A Comparative Analysis of Morocco and South Korea

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Abstract. The Objective: To comparatively assess how governance choices within the Mandatory Health Insurance (MHI) systems in Morocco and South Korea shape effective access to healthcare, through the analysis of three key dimensions, namely: institutional architecture, financial structure, and the organization of healthcare provision.

Methods: Comparative review using an IMRAD structure (Introduction, methodology, results, analysis and discussion) based on legislative sources, national institutional reports (National Agency for Health Insurance — ANAM, National Fund of Social Welfare Organizations — CNOPS, National Social Security Fund — CNSS, Ministry of Health and Social Protection, National Health Insurance Service in South Korea — NHIS; Health Insurance Review and Assessment Service in South Korea — HIRA), international databases (Organisation for Economic Co-operation and Development — OECD, World Health Organization — WHO, World Bank) and academic publications.

Key indicators include the share of out-of-pocket payments (OOP), population coverage, healthcare utilization, and ongoing reforms.

Results: South Korea combines a single insurer — the National Health Insurance Service (NHIS) — and the Health Insurance Review and Assessment Service (HIRA) to regulate a predominantly private healthcare provision. Despite high healthcare utilization rates, Out-of-Pocket (OOP) spending remains high.

Morocco has rapidly expanded coverage through AMO-Tadamon, but effective access is still hindered by tariff structures that may require updating and high OOP, in a context of growing private provision and territorial inequalities.

Conclusion: Both trajectories converge toward Universal Health Coverage (UHC) but through distinct governance-financing-service delivery combinations. We propose cross-recommendations: tariff updating and strategic purchasing in Morocco; strengthening primary care and financial protection in South Korea.

Keywords: Mandatory health insurance; Access to healthcare; Governance.

1. Introduction

Sustainable Development Goal 3.8 calls on countries to achieve Universal Health Coverage (UHC), understood as the combination of effective access to quality services and sufficient financial protection to avoid illness-related impoverishment. However, the mere existence of legal coverage does not guarantee either equity in access or sustainability. Everything depends on the governance of the insurance system (institutional architecture, pricing, service purchasing, evaluation, accountability) and its articulation with the healthcare supply (public/private distribution, primary care, territorial gradient). This study adopts a health systems governance perspective, viewing access to healthcare as the outcome of interactions between institutional design, financing mechanisms, and service delivery structures. Within this perspective, access to healthcare is examined through three interrelated analytical dimensions: institutional governance, financial protection, and the organization of healthcare service delivery.

This analytical perspective is consistent with established typologies of health systems, notably the distinction between Beveridge-type systems, Bismarckian social insurance models, and mixed systems combining public regulation with pluralistic service provision. It also aligns with the World Health Organisation's health systems framework, which conceptualizes system performance as resulting from the interaction between governance, financing, and service delivery functions. Beyond institutional classifications, recent literature emphasizes the role of strategic purchasing and governance arrangements as key determinants of system performance, highlighting how financing mechanisms and provider incentives shape access, efficiency, and equity outcomes.

South Korea achieved UHC at the end of the 1980s, with a single insurer (NHIS) and an evaluation agency (HIRA) that structures the review of reimbursement claims, medico-economic assessment, and feedback to providers. This governance–service delivery configuration supports high utilization volumes and short waiting times, but with copayments/coinsurance that continue to weigh on some households.

Morocco, for its part, has undertaken since 2021 an accelerated generalization (transformation of RAMED into AMO-Tadamon, integration of self-employed workers), expanding entitlements while facing tariff references (TNR, nomenclatures) that remain insufficiently updated, uneven contracting with the private sector, and persistent territorial inequalities.

In this context, our article raises the following question: How do governance structures and financing mechanisms within mandatory health insurance systems influence effective access to healthcare in Morocco and South Korea? We mobilize an analytical framework that links governance to access outcomes through a causal chain: governance → financing/service delivery → access, and we retain comparable indicators (share of out-of-pocket payments, coverage, healthcare utilization, forgone care).

Our contribution is twofold: (i) to propose a structured comparative reading that goes beyond the description of the schemes to shed light on the mechanisms (pricing, purchasing, evaluation) that convert rights into effective access; (ii) to formulate cross-country and operational recommendations (tariff updating, strategic purchasing, strengthening primary care and financial protection) informed by the performance and

limitations of each system. The method is based on a review of legislative and regulatory sources, institutional reports (ANAM, CNOPS, CNSS, Ministry ; NHIS, HIRA), international databases (OECD, WHO, World Bank), and recent academic articles.

This study employs a qualitative comparative policy analysis combining institutional review, financial indicators, and service delivery assessment. The comparative approach allows identification of governance mechanisms that enhance effective health-care access despite differing institutional contexts. The article is organized as follows: the Methods section details the comparative framework and sources; the Results section presents, for each country, governance, financing/financial protection, healthcare provision, and access indicators; the Discussion interprets the observed differences and discusses their implications for equity and sustainability; finally, we propose cross-country recommendations and conclude on reform priorities and medium-term evaluation needs.

2. Methodology

2.1 Design: Comparative study based on a qualitative and quantitative desk review

We adopt the comparative method because it constitutes a genuine strategy for accessing reality. It highlights and explains similarities and differences between contexts, logics of action, and institutional configurations, by confronting several cases in order to identify contextual determinants external to the unit of analysis and reveal the underlying structures of the phenomena. Among its forms, we adopt the configurational approach, whose objective is to uncover the coherence of complex systems (principle of fit/congruence). Instead of isolating variables, it considers the governance–financing–service delivery–access arrangement as a configuration and compares structured sets (Morocco vs South Korea) to explain their performances and limitations. This choice is suited to our research topic, where outcomes result not from a single factor but from combinations (payer/evaluator separation, pricing, benefit packages, payment methods, primary care, geographical distribution of providers...).

The strengths of the approach lie in its explanatory power (testing theories in distinct contexts), its heuristic potential (uncovering implicit mechanisms, generating hypotheses), the possible triangulation of materials, and the consideration of both spatial (contextual specificities) and temporal (trajectory periodization) logics. The points of vigilance are well-known: risk of decontextualization and transfer of categories from one context to another; difficulty in controlling all variables (composition bias); possible non-homology of compared units; need to comply with theoretical sampling requirements (minimum homogeneity of cases, representativeness of situations, permanence/continuity of the phenomenon); and the difference in maturity between the systems (South Korea with stable UHC vs Morocco in deployment since 2021), which requires interpreting the comparison as an asymmetric snapshot and complementing it with updates and sensitivity analyses. In short, configurational comparison sheds light

on how institutional combinations produce access outcomes, provided that contexts are rigorously documented and criteria of comparability clearly specified.

To do so, we mobilize:

- Laws and decrees (Morocco: Law 65-00; Framework Law n°06-22; South Korea: National Health Insurance Act);
- Institutional reports and databases (ANAM, CNOPS, CNSS, Ministry; NHIS, HIRA);
- Reports from independent bodies (CESE, Court of Accounts, Competition Council);
- International statistics (OECD, WHO, World Bank);
- Evaluation literature and relevant academic articles.

2.2. Analytical framework

Building on the conceptual framework introduced in the introduction, we structure the analysis into three dimensions:

- Governance;
- Financial architecture;
- Organization of service provision.

With a causal chain:

- governance → financing / service delivery → access and equity.

2.3. Indicators

Out-of-pocket payments are a key indicator of financial protection and equity in healthcare access, as they directly reflect the extent to which households are exposed to financial risk when seeking care.

Share of OOP in Total Health Expenditure (THE);

MHI coverage (registration/entitlement);

Utilization rates (consultations per capita per year), hospitalizations, forgone care;

Caps and ceiling mechanisms, update of the National Reference Tariff (TNR);

Purchasing mechanisms;

Coverage period: documents available up to 18/09/2025.

3. Results

3.2. Governance and institutional architecture

Morocco: The architecture is evolving toward greater integration with the generalization of MHI (AMO-Tadamon, extension to self-employed workers). ANAM holds the role of technical regulator; the managing bodies CNOPS/CNSS administer the coverage. Bills currently in the pipeline point toward a single insurer.

Framework Law n°06-22 redesigns the national health system. Several reforms to separate roles (regulation, payment, service provision) are being consolidated.

South Korea: The single insurer NHIS collects contributions and reimburses care ; HIRA assesses relevance and quality, controls claims, and conducts medico-economic analyses. This clear separation between payer and evaluator constitutes the keystone of governance and supports expenditure discipline.

3.3. Financing and financial protection

South Korea: Usual copayment/coinsurance around 20% for hospitalization and 30–40% in outpatient care. Ceilings and exemptions exist for severe illnesses and low-income populations. The share of OOP remains above the OECD average, despite a large share of mandatory prepayment.

Morocco: The 2022 National Health Accounts estimate the share of households' direct payments at around 38% of THE (a decrease compared to 2018). The National Reference Tariff (TNR), rarely revised since 2006, and outdated nomenclatures create a gap between reimbursement bases and actual costs, driving the remaining out-of-pocket burden.

3.4. Organization of service provision and care modalities

South Korea: Predominantly private provision, high hospital density, direct access to specialists (limited gatekeeping), very high service utilization (>15 consultations per capita/year). HIRA acts as a counter-balance through evaluation and feedback to providers.

Morocco: Dual provision. The public sector remains structuring but under pressure (human resources/equipment), with significant territorial inequalities; the private sector has rapidly expanded (clinics/technical platforms), but contracting is often limited to the TNR, without systematic strategic purchasing.

3.5. Access to care: utilization and equity

South Korea: High utilization and short waiting times, but financial protection remains imperfect in certain segments (dental/optical care, services outside the benefit package).

Morocco: Rapid inclusion of the population (AMO-Tadamon) and recent decrease in the OOP share, but high out-of-pocket payments persist for technical acts and dental/optical care; forgone care more frequent in rural areas.

Indicators	South Korea	OCDE-Average	Morocco
Share of OOP in THE	≈29 %	≈20 %	≈38 % (2022)
Consultations per capita per year	>15	6–7	≈2–3
Hospitalizations per 1,000 inhabitants	≈170–180	≈150	≈50–60 (order of magnitude)
Legal MHI coverage	≈100 %	≈100 %	≈75–85 % (2022–2024)

Table 1 : Key Comparative Indicators

4. Discussion

Two distinct “combinations” emerge :

While South Korea illustrates institutional efficiency challenges within high-utilization systems, Morocco faces transition challenges in aligning expanded coverage with effective service access (see table 1).

In South Korea, the availability and responsiveness of service provision, enabled by a dominant private sector and regulated by the NHIS–HIRA duo, are accompanied by significant copayments: access is broad in volume but financial protection remains improvable.

In Morocco, the strategy prioritizes inclusion (entitlement). However, the slow adaptation of pricing instruments and the limited contracting oriented toward quality maintain a high level of out-of-pocket payments and territorial disparities.

4.1 Interpretation

The governance determines the ability to align resources, incentives, and quality. These findings highlight structural associations rather than direct causal relationships and should therefore be interpreted with caution given the comparative and qualitative nature of the analysis.

In South Korea, The functional separation of payer/evaluator (South Korea) creates a virtuous circle of information and accountability.

In Morocco, the strengthening of ANAM (future High Authority of Health) and the overhaul of the framework (Framework Law n°06-22) offer a window of opportunity

to establish strategic purchasing, revise the National Reference Tariff (TNR), and reinforce primary care.

Implications for equity: reducing OOP requires both financing instruments (ceilings, targeted exemptions, expansion of the benefit package) and organizational instruments (care pathways, gatekeeping, incentives for continuity).

4.2 Cross-country recommendations

For Morocco (drawing inspiration from South Korea):

- Consolidate an independent medico-economic evaluation function (HIRA-type) coupled with systematic feedback to providers;
- Implement strategic purchasing with the private sector (quality, volumes, tariffs) and test alternative payment methods (DRG/Diagnosis Related Groups/episode-based);
- Update the National Reference Tariff (TNR) and nomenclatures; align reimbursement bases with actual costs; integrate dental/optical care into core benefit packages;
- Strengthen primary care (family doctor, financial/organizational incentives) to reduce direct recourse to the hospital level;
- Target the reduction of out-of-pocket payments (ceilings, exemptions for chronic diseases, protections for low-income households).

For South Korea (lessons from the Moroccan experience)

- Strengthen financial protection for vulnerable households (lower ceilings, expansion of the basic benefit package);
- Structure an effective gatekeeping system (registration with a physician, incentives for continuity) to limit congestion of tertiary hospitals;
- Reduce territorial disparities (dedicated funding, incentives for deployment in underserved areas);
- Further regulate services outside the benefit package and supplementary insurance to avoid unpredictable out-of-pocket payments;

4.3 Study limitations

The main limitation results from the comparison between a South Korean system that has reached maturity, having achieved UHC since the late 1980s, and a Moroccan system still in the deployment phase, whose generalization of MHI was launched in 2021 and is still scaling up (2022–2025). Differences in health system structure and demographic profiles should be considered when interpreting comparative results. This maturity gap exposes the analysis to a “maturation” bias. Moroccan indicators may not yet be stabilized. Some related reforms (pricing, strategic purchasing, primary care) are still incompletely implemented, and the long-term effects observed in South Korea (quality, efficiency, equity) are not yet observable in Morocco. Therefore, the results must be interpreted as an asymmetric snapshot (established regime vs regime in deployment) and not as an assessment at equivalent maturity.

This asymmetry leads to other limitations. The most recent statistical series are not perfectly synchronized, and certain definitions differ (consultations, services outside the benefit package). The study is based on public sources up to date as of 18 September 2025, and updates may modify certain indicators.

5. Conclusion

This Morocco–South Korea comparison confirms the central hypothesis of the article: the governance of Mandatory Health Insurance (MHI) — that is, the way in which the functions of regulation, purchasing, evaluation, and service provision are separated (or not) — directly shapes effective access to healthcare through three interlinked channels: (1) financial rules (benefit package, pricing, copayments/ceilings), (2) provider incentives (contracts, payment methods, feedback), and (3) the configuration of service provision (public/private distribution, primary care, territorial gradient). In both countries, legal coverage is high or rapidly increasing, but “de jure” universality does not mechanically translate into “de facto” universality without appropriate governance instruments. The findings emphasize that universal coverage expansion must be accompanied by governance reforms and financial protection mechanisms to ensure effective access.

In South Korea, the NHIS–HIRA architecture demonstrates its strength: a single payer and an independent evaluation agency enable disciplined purchasing, quality control, and rapid dissemination of information to providers. This combination explains high healthcare utilization rates and short waiting times, supported by a predominantly private and hospital-centered supply. The downside is well known: high coinsurance/copayments and partially non-covered services that limit financial protection for some households and maintain direct recourse to tertiary hospitals (weak gatekeeping). South Korea’s performance in terms of utilization is thus accompanied by an explicit choice of shared costs borne by patients, which now calls for targeted corrections for equity.

In Morocco, the generalization reform (transformation of RAMED into AMO-Tadamon and integration of self-employed workers) has accelerated inclusion. But effective access remains hindered by a National Reference Tariff (TNR) that is insufficiently updated, nomenclatures not fully aligned with actual costs, and still limited contracting with the private sector, in a context of strong territorial heterogeneity and pressure on public human resources. The result is a still high out-of-pocket burden, especially for technical procedures and certain types of care (dental/optical), and more frequent forgone care in rural areas. The Moroccan dynamic is therefore promising but requires strengthening the economic and organizational instruments that convert entitlement into effective access.

The transversal lesson is twofold. First, strategic purchasing — defined as the ability to select services and providers according to value (quality/cost), with explicit contracts and adapted payment methods (bundles, DRG, capitation) — is the hinge between financing and service provision: it determines out-of-pocket payments, guides provider behavior, and influences the geography of care. Second, the independent

evaluation function (HIRA-type) is not a luxury: it is an institutional asset that supports tariff regulation, documents appropriateness, measures quality, and fuels a virtuous circle of accountability.

From this assessment emerges cross-country recommendations :

For Morocco:

- Update the National Reference Tariff (TNR) and the nomenclatures with a transparent cost-based methodology;
- Move from tariff-only conventions to real purchasing contracts with the private sector (quality, volumes, prices, indicators);
- Institutionalize an independent HTA/evaluation function and publish regular feedback reports;
- Strengthen primary care (family doctor, incentives for guidance and continuity) and experiment with alternative payments (bundles/DRG);
- Reduce out-of-pocket payments through targeted ceilings and exemptions, prioritizing vulnerable households and high-equity-impact services (basic dental/optical care).

For South Korea:

- Lower the financial burden for vulnerable populations and priority services (prevention, essential dental/optical care), through lower ceilings and a better protected benefit package ;
- Consolidate gatekeeping (registration with a physician, incentives for continuity) to reduce hospital « shopping » ;
- Correct regional inequalities through differential payments and incentives for deployment in underserved areas ;
- Further regulate complementary insurance and services outside the benefit package to limit unpredictable out-of-pocket payments.

The feasibility of these reforms requires a sequenced timeline and clear implementation conditions. In the short term (12–24 months), Morocco can achieve quick wins by revising the TNR for a priority package, publishing standardized contract templates, and deploying public dashboards (OOP, waiting times, quality). South Korea can immediately lower certain copayments for high-value services and launch empanelment/family doctor pilots. In the medium term (3–5 years), both countries will benefit from institutionalizing quality measurement, integrating data (payers-providers-regulator), and evaluating reforms through quasi-experimental mechanisms.

From a scientific perspective, our study underlines the relevance of jointly measuring outcomes: beyond expenditure and utilization volumes, systematically monitoring equity indicators (forgone care, catastrophic out-of-pocket payments), patient-reported outcomes, and territorial disparities. Morocco–South Korea comparability will be further strengthened through harmonization of definitions (benefit package, consultations, hospitalizations) and access to anonymized micro-data for micro-econometric analysis.

Ultimately, both systems are converging toward universal coverage, but through different governance choices. South Korea's strengths — disciplined purchasing,

independent evaluation, responsiveness of service delivery — can help Morocco transform generalization into effective universality. Morocco's sensitivity to equity and out-of-pocket reduction can inspire South Korea to better protect vulnerable households. Universalism is not a state, it is a trajectory: by combining financial protection and organized access around strong primary care, strategic purchasing, and credible evaluation, Morocco and South Korea possess complementary levers to bring their health systems closer to SDG 3.8. Future research could extend this governance-based comparative framework to other emerging health systems pursuing universal coverage.

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