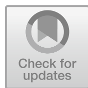

Health Technology Assessment: What Lessons from the South Korean Model for Medicalized Cost Containment in Morocco?

Aazelarab BOUGHALEB*[1] and Mounir JERRY[1]

[1] Laboratory of Economic Sciences and Public Policy, Ibn Tofail University. Kenitra, Morocco
boughaleb.aazelarab@uit.ac.ma

Abstract. This article presents a comparative analysis of health economic evaluation (HEE) systems in South Korea and Morocco, amid ongoing healthcare reforms. Based on a documentary review, it highlights shared objectives—sustainability and access to innovation—while revealing institutional and methodological divergences. The study identifies four strategic levers from the Korean model: formalization, institutional specialization, technology reassessment, and real-world data. Policy recommendations are proposed to adapt these lessons to the Moroccan context. This work contributes to strengthening HEE policies as tools for spending control and healthcare system regulation.

Keywords:HTA, health technology innovation, health expenditure control, Morocco, South Korea

1 Introduction:

The sustainability of health systems represents a major global challenge. The convergence of structural factors—such as demographic aging, the increasing prevalence of chronic diseases, and the rising cost of technological innovations—is placing unprecedented financial pressure on health budgets [1]. In the face of this issue, traditional budget-cutting approaches are showing their limits, risking both the quality and equity of access to healthcare. It is in this context that Health Technology Assessment (HTA), or medico-economic evaluation, has emerged as a strategic regulatory tool—aimed not at spending less, but at spending better by maximizing the value of delivered care [2].

This medicalized cost containment approach lies at the heart of ongoing reforms in many countries, but its implementation modalities vary considerably across national contexts. This article aims to shed light on the challenges of a system in the midst of structuring—Morocco—through the lens of a model recognized for its maturity: South Korea. This comparative choice is not based on contextual similarity, but rather on the relevance of their trajectories. On the one hand, Morocco finds itself at a historical inflection point with the generalization of social protection, enshrined in Framework Law No. 09-21. This ambitious reform raises the pressing issue of recon-

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ciling expanded access to healthcare with financial sustainability, making the establishment of an HTA system both urgent and indispensable [3].

On the other hand, South Korea provides a particularly instructive benchmark. Having achieved universal health coverage as early as 1989, the country was quickly confronted with a funding crisis in its National Health Insurance (NHI), which became the primary driver of the institutionalization of its HTA system in the early 2000s [4]. Today, the South Korean system, led by agencies such as HIRA and NECA, has reached a high level of maturity—even tackling the complex task of reassessing technologies already in use (Health Technology Reassessment – HTR) [5]. Studying its evolution, successes, and weaknesses offers valuable insight into the challenges and potential solutions for a country like Morocco.

The central question of this article is therefore: What strategic lessons can Morocco draw from South Korea's HTA trajectory and model to strengthen its own medicalized cost containment policy, while taking into account the specificities of their institutional, economic, and healthcare contexts?

To address this, this chapter adopts a comparative institutional analysis perspective to examine how Health Technology Assessment (HTA) systems evolve under different political economy constraints. By doing so, the study anchors its reflection within the broader fields of comparative public policy, institutional economics, and health governance. The general objective is to conduct a comparative analysis of these two systems in order to formulate analytical implications and strategic insights tailored to the Moroccan context. To achieve this, the study aims to:

1) Describe and compare the structuring contexts (political, economic, epidemiological) of both countries;
2) Analyze the institutional and methodological frameworks of HTA (governance, processes, criteria);
3) Conduct a strategic diagnosis (SWOT) of each system to synthesize strengths and weaknesses;
4) Identify transferable lessons and institutional learning for strengthening the Moroccan system.

2 Methodology:

As the objective of this article is to comparatively analyze the health technology assessment (HTA) systems of Morocco and South Korea in order to derive strategic insights, the study adopts a qualitative and comparative approach based on a case study analysis. The methodology was structured into three key steps: case justification, data collection, and analytical framework.

2.1 Study Design and Case Justification:

The study is based on a comparative case study between Morocco and South Korea. This approach is particularly relevant for understanding how distinct national contexts shape seemingly similar public policies. The selection of these two countries is not incidental but follows a "contrast and trajectory" logic:

→ Morocco represents a healthcare system at a critical turning point, engaged in a large-scale reform (the generalization of social protection), where the implementation of a robust HTA mechanism is a condition for sustainability. Its evaluation system is still in a nascent stage, making it an ideal case for analyzing the challenges of structuring and institutionalizing HTA.

→ South Korea constitutes a reference model for its accelerated development trajectory. Its HTA system, born out of necessity following a funding crisis in its National Health Insurance (NHI) [4], has reached an advanced stage of maturity, even including the reassessment of existing technologies [5]. It provides a case rich in insights into the evolution, governance, and tools of a well-established evaluation system.

The comparison between these two trajectories (one under construction, the other mature) allows us to go beyond mere description to identify governance principles and actionable levers that may be adapted elsewhere.

2.2 Data Collection and Sources :

The research is based on an exhaustive documentary analysis combining scientific literature and grey literature in order to obtain a comprehensive view of both systems and their respective contexts. Sources were systematically collected between 2010 and 2025.

→ Scientific literature: A literature review was conducted using academic databases (PubMed, Scopus, Cairn.info, Google Scholar), with keywords such as “Health Technology Assessment,” “évaluationmédico-économique,” “cost containment,” “drug pricing,” “reimbursement policy,” combined with country-specific terms (“Morocco,” “Maroc,” “South Korea,” “Corée du Sud”).

→ Grey literature and official documents: This source constitutes the core of the institutional analysis and includes:

  - For Morocco: Annual reports and publications from governmental bodies and public agencies (MSPS, ANAM, HAS, AMMPS); legislative and regulatory texts (notably Framework Laws No. 09-21 and 06-22); as well as relevant publications by national experts [3].
  - For South Korea: Activity reports, methodological guides, and publications from regulatory agencies such as the Health Insurance Review and Assessment Service (HIRA) and the National Evidence-based Healthcare Collaborating Agency (NECA).
  - International reports: Analyses and databases from the World Health Organization (WHO), the Organisation for Economic Co-operation and Development (OECD), and the World Bank were used to contextualize the performance and challenges of the two systems on an international scale.

2.3 Analytical Framework:

To operationalize the comparative institutional analysis, the study employs an explicit analytical framework to evaluate the collected data. Specifically, the comparison is structured around four analytical dimensions: (i) drivers of HTA emergence, (ii) institutional governance, (iii) methodological formalization, and (iv) strategic use of HTA for cost containment. This structured approach guides the synthesis of the results and

ensures that the extracted insights are both systematically derived and theoretically grounded.

3 RESULTS :

This section presents the findings of the comparative documentary analysis. It first describes the national contexts and the factors that led to the emergence of Health Technology Assessment (HTA) in each country, before detailing and comparing their institutional architectures and processes.

3.1 National Contexts and the Emergence of HTA:

The analysis reveals that while Morocco and South Korea share the common objective of controlling health expenditures, the trajectories and motivations behind the implementation of Health Technology Assessment (HTA) are fundamentally different.

- Morocco: HTA as a Pillar of Societal Reform

In Morocco, the institutionalization of HTA is a direct consequence and a key pillar of the country's historic social protection reform, initiated under the Royal High Directives and formalized by Framework Law No. 09-21 [18]. The 2020–2024 strategy of the National Health Insurance Agency (ANAM) explicitly positions medicalized cost control as a lever to "ensure the sustainability" of the system in light of the generalization of Mandatory Health Insurance (AMO) [19]. This approach is justified by the structure of health expenditures: in 2022, total health expenditure reached 81.7 billion dirhams, equivalent to 6.1% of GDP, and although the share of out-of-pocket (OOP) payments by households has declined, it remained high at 38% [6]. Furthermore, long-term illnesses (Affections de Longue Durée – ALD) are the primary cost driver, accounting for 52.6% of expenses under the AMO-Salaried scheme in 2021 [21].

In this context, the emergence of HTA is the result of a strategic and proactive state-led initiative. It is not a reaction to a past crisis, but rather a forward-looking measure aimed at anticipating and managing future costs to ensure the sustainability of social reform. The establishment of a High Authority for Health (HAS) and a Moroccan Agency for Medicines and Health Products (AMMPS) are intended to become the operational arms of this value-based regulation policy [7,19].

- South Korea: HTA as a Response to a Financial Crisis

In South Korea, the trajectory is the opposite. The HTA system did not emerge to support an expansion of coverage—universal health coverage had already been achieved in 1989—but rather as a pragmatic response to a major financial crisis in its National Health Insurance (NHI) in the early 2000s [4]. The South Korean health system, although funded by a single payer, is dominated by a highly competitive private sector that accounts for more than 80% of services [4]. This has led to a rapid proliferation of costly technologies and a more than tenfold increase in NHI expenditures between 1990 and 2006 [8]. The epidemiological burden, marked by rapid aging and a predominance of non-communicable diseases, has further intensified cost pressures [1].

The response was both legislative and institutional. The amendment of the NHI Act in 2000 required agencies—particularly the Health Insurance Review and Assessment Service (HIRA)—to systematically evaluate technologies prior to reimbursement, initially as a cost-control mechanism [4]. It was only later, with the 2006 Health Care Act, that the system was supplemented by a more independent agency, the National Evidence-based Healthcare Collaborating Agency (NECA), tasked with in-depth clinical evaluations and reassessments [5].

Ultimately, this institutional configuration reflects a broader distinction between anticipatory regulation in Morocco and crisis-driven regulation in South Korea.

3.2 Institutional Architecture and Governance:

The comparative analysis of the institutional frameworks in Morocco and South Korea reveals systems at very different stages of development, reflecting their distinct trajectories of emergence. While Morocco is in the process of consolidating a new legal framework, South Korea has optimized a structure established nearly two decades ago.

In Morocco, regulatory architecture is currently centralized within the National Health Insurance Agency (ANAM), which provides technical oversight of the AMO system [18]. To do so, it operates via two specialized commissions inspired by the French model: the Transparency Commission (CT) for clinical value (SMR), and the Economic and Financial Evaluation Commission for Health Products (CEEFPS). ANAM's governance relies on a tripartite Board of Directors. However, recent legal overhauls led to the creation of the High Authority for Health (HAS)—a new entity expected to assume and strengthen these evaluation missions with greater autonomy [7].

In South Korea, the more mature system is characterized by a clear functional division between two main agencies. HIRA is historically linked to the National Health Insurance (NHI) and serves as the main entry point for reimbursement, managing prices and economic evaluations [4]. In parallel, NECA—a more academically oriented and independent agency—was established in 2006 to conduct comparative research, develop guidelines, and crucially, conduct Health Technology Reassessments (HTR) [5].

The table below summarizes and compares the main governance characteristics of the two HTA systems.

Table 1: Comparative Analysis of HTA Governance Frameworks

Characteristic	Morocco (Emerging System)	South Korea (Mature System)
Key Agencies	• ANAM (National Health Insurance Agency): current central actor. • HAS (High Authority for Health), created by Law No. 07-22, expected to take over and expand missions [7].	• HIRA (Health Insurance Review and Assessment Service): evaluates for reimbursement. • NECA (National Evidence-based Healthcare Collaborating Agency): clinical and HTR evaluation [4,5].
Primary Mandate	• ANAM: Technical oversight of AMO, reimbursement admission via	• HIRA: Cost-effectiveness evaluation of new technologies for NHI.

	two specialized commissions: CT (clinical evaluation - SMR) & CEEFPS (economic evaluation). • HAS: expected to assume these responsibilities with an enhanced mandate [7,19].	• NECA: Comparative research, clinical guidelines, reassessment of existing technologies [4,5].
Status & Independence	• ANAM: Public institution under state supervision. • HAS: Public legal entity designed to enhance autonomy [7].	• HIRA: Semi-public agency integrated with NHI; faces tension between technical mission and financial dependence on the payer [4]. • NECA: More autonomous, academic in nature.
Technical Committees	• CT & CEEFPS: Appointed experts, representatives from CNSS, CNOPS, and ANAM. • CEEFPS: Uniquely Moroccan, includes experts in pharmacoeconomics and public health [23].	• HTA Committees: Multidisciplinary (physicians, pharmacists, economists, legal experts, institutional reps). • Extensive subcommittee structure [4,5].
Stakeholder Involvement	• Industry: Submission of applications. • Health professionals: Participation in Board via professional orders; role in pricing negotiations [27]. • Patients/citizens: Indirect representation via unions on Board; no participation in technical committees.	• Industry: Submission of applications. • Professionals: Strong involvement of scientific societies in HTA committees [4]. • Patients/citizens: Limited involvement; some consumer group reps as advisors [4].

Source: Prepared by the authors

Analytical interpretation: Table 1 illustrates how differing institutional architectures reflect a broader shift from integrated, state-supervised models to mature, dual-agency frameworks, highlighting the political economy challenge of maintaining regulatory independence from the single payer.

Three key points emerge from this comparison:

1) Institutional division of labor differs significantly. Morocco is transitioning from an integrated model within ANAM (housing both clinical and economic evaluation) to a new structure led by the HAS. South Korea, by contrast, has developed a mature dual-agency model, separating market access evaluation (HIRA) from reassessment and clinical research (NECA).
2) Independence from the payer is a shared challenge. In Morocco, the creation of the HAS is precisely aimed at reinforcing the autonomy of the evaluation function from direct state oversight. In South Korea, although formally independent, agencies—especially HIRA—are structurally and financially dependent on the single payer (NHI), making them "vulnerable to its influence, particularly with regard to financial status" [4].
3) Stakeholder participation reflects different philosophies. In Morocco, social partners are formally included at the highest level of strategic decision-making. In contrast, the Korean system is described as more technocratic, favoring consultation with scientific societies to ensure technical acceptability, but with more limited involvement of civil society [4].

3.3 Evaluation Processes and Methodologies:

The distinct institutional architectures translate into evaluation processes that operate according to different logics. The comparative analysis of these approaches, summarized in Table 2, reveals significant divergences in evaluation criteria, transparency, and the formalization of decision-making.

Table 2: Comparative Analysis of HTA Processes and Methodologies

Characteristic	Morocco (Emerging System)	South Korea (Mature System)
Entry Point / Referral	Mainly by the manufacturer (application for reimbursement listing) [19].	Primarily by the manufacturer for new technologies. Self-referral by agencies (NECA) for the reassessment of existing ones [5].
Evaluation Criteria	Mainly clinical, through the Transparency Commission (SMR, ASMR). Economic evaluation by CEEFPS is planned, but systematic application is still under development [19, 22].	Dual and systematic: assessment of clinical safety and effectiveness, and cost-effectiveness analysis (cost-utility, budget impact) by HIRA [4, 20].
Cost-Effectiveness Threshold	Not explicit nor public. Pricing and reimbursement decisions are made on a case-by-case basis and through negotiation, as outlined in submission guidelines [23].	Explicit but flexible threshold. Generally around 1x GDP per capita per QALY; serves as a reference point but not a rigid cutoff [20].
Methodological Transparency	Submission guidelines available to manufacturers [23, 24]. Internal rules of commissions established. However, there is no detailed and public methodological guide for economic evaluation.	High level of transparency. Public and detailed methodological guidelines, including for cutting-edge areas such as digital health technologies [20]. Processes, criteria, and committee compositions are published.
Types of Data Required	Clinical data (comparative trials), local epidemiological data, price proposals. Economic and budget impact data increasingly requested [23, 24].	Highly formalized dossiers requiring robust clinical trials, full cost-effectiveness analysis as per HIRA guidance, and budget impact analysis for NHI [20].
Decision Timelines	Target timelines defined in internal regulations [22], though actual timelines may be longer and variable.	Legally mandated timelines. Clearly defined process with deadlines for each stage, ensuring predictability (e.g., ≤90 days for selection, max 1 year for final decision) [4].

Source: Prepared by the authors

Analytical interpretation: Table 2 illustrates how methodological formalization increases predictability and objectifies decision-making, but may concurrently reduce flexibility in managing rapid access to innovation.

The analysis of the above table highlights a fundamental divergence in process philosophy. The South Korean system is characterized by formalism, explicit criteria, and transparency. The systematic use of cost-effectiveness analysis, framed by a public threshold, aims to objectify decision-making and render it predictable and defensi-

ble. The publication of detailed methodological guides reinforces this culture of transparency [4, 20].

The Moroccan system, by contrast, is still in a phase of construction. While inspired by established models for clinical evaluation, the economic approach remains more deliberative and less formalized. The absence of a public methodological guide for economic evaluation and of an explicit cost-effectiveness threshold leaves more room for case-by-case assessments and negotiation [19, 22]. While this approach allows flexibility, it poses challenges in terms of predictability, equity, and transparency.

3.4 Strategic Diagnosis (SWOT) of HTA Systems:

To synthesize the internal and external dynamics of each system and lay the groundwork for discussion, a comparative SWOT analysis (Strengths, Weaknesses, Opportunities, Threats) was conducted for Morocco and South Korea. This analysis highlights two models at very different stages of development, whose contrast provides valuable lessons for Moroccan strategic planning.

The SWOT analysis of the Moroccan system (Figure 1) reveals a striking contrast between strong political momentum and an operational environment still in its formative stages. The main strength lies in the unprecedented political will driving the reform, placing regulation and sustainability at the core of the national agenda. This momentum has enabled the establishment of a renewed institutional framework (HAS, AMMPS).

However, these strengths are counterbalanced by structural weaknesses, primarily the lack of local expertise in health economic evaluation, the absence of formal methodological guidance, and the persistent fragmentation of health data. Nonetheless, significant opportunities are emerging, such as the generalization of AMO and the legal framework for digitalization (Shared Medical Record - DMP). The system remains exposed to serious threats: pressure from industry for rapid market access and potential delays in implementing new structures.

Figure 1: SWOT Analysis of the Moroccan HTA System

Source: Prepared by the authors

In contrast, the SWOT analysis of the South Korean system (Figure 2) depicts a model that is institutionally robust and methodologically formalized, yet confronted with the challenges of regulating a highly innovative market and the pressures of an aging population.

The main strength of this system lies in its maturity. The clear division of roles between HIRA and NECA, coupled with transparent processes and access to massive Real-World Data (RWD), constitutes a proven regulatory model. The most notable opportunity is its ability to innovate through Health Technology Reassessment (HTR), enabling disinvestment from low-value care.

Its weaknesses are the flip side of its maturity: a certain administrative rigidity, a process perceived as technocratic, and the limited independence of HIRA due to its organic link to the single payer (NHI). The threats are structural: constant demographic pressure and industry lobbying to relax cost-effectiveness criteria.

Figure 2: SWOT Analysis of the South Korean HTA System

Source: Prepared by the authors

The comparison of the two diagnostic frameworks reveals a fundamental difference in paradigms. Morocco is in a phase of institutional construction and political legitimization of HTA, where the challenge is to build tools and develop competencies. South Korea, by contrast, is in a phase of continuous optimization, managing the complexity of a mature system in the face of rapid innovation.

This divergence in trajectories—between a system that is "building while walking" and another that is "optimizing while running"—will be central to the discussion on strategic lessons to be drawn.

4 Discussion: Lessons for Morocco

The comparison of health technology assessment (HTA) systems in Morocco and South Korea, while rooted in very different contexts, yields valuable insights. This discussion aims to synthesize their divergences and convergences to extract strategic lessons and formulate analytical implications tailored to the Moroccan context.

4.1 Synthesis of Divergences and Convergences:

Viewed through the lens of comparative public policy, the divergences between the two systems can be understood through distinct developmental trajectories. The Korean experience illustrates a path-dependent HTA trajectory, where institutional responses were heavily shaped by an early financial crisis and an urgent need for cost containment. Conversely, Morocco follows a reform-driven learning path, where

HTA emergence is anticipatory and linked to a broader societal project of universalizing social protection. This highlights the dynamics of institutional learning and the complexities of policy transfer when adapting mature regulatory tools to emerging healthcare contexts.

Beyond these theoretical trajectories, the analysis highlights a fundamental convergence in objectives: both Morocco and South Korea strive to reconcile access to innovation with the financial sustainability of their health systems, amid increasing pressure from chronic diseases and high-cost technologies. However, the operational paths taken to achieve this goal reveal significant divergences:

→ Institutionally, Morocco is in a phase of proactive construction, with the creation of the High Authority for Health (HAS) and the Moroccan Agency for Medicines and Health Products (AMMPS) as forward-looking pillars of social reform. In contrast, South Korea has developed a mature, dualistic model (HIRA/NECA) in response to a financial crisis, gradually optimizing a structure established over two decades ago.

→ Methodologically, Morocco's current system relies on deliberative flexibility, inspired by proven models but lacking a formal economic framework (guidelines, thresholds), favoring negotiation over predictability. The South Korean system is characterized by strict formalism, where transparency of guidelines and explicit cost-effectiveness criteria structure and objectify decision-making.

→ In terms of governance, both countries face challenges related to independence. Morocco seeks to enshrine this statutorily through HAS, whereas Korea manages the structural tension between HIRA and its single payer (NHI). Regarding stakeholder participation, Morocco formally integrates social partners at the strategic level, while the more technocratic Korean model privileges academic expertise, with limited citizen engagement in both cases.

This contrast between a "developing" and a "mature" approach serves as the foundation for extracting the most relevant lessons.

4.2 Strategic Lessons from the South Korean Model:

The South Korean experience offers four key lessons for any country aiming to institutionalize HTA:

→ Formalizing processes strengthens legitimacy:

The publication of detailed methodological guidelines and the use of a cost-effectiveness threshold—even a flexible one—are more than just technical tools. They establish a transparent and predictable framework that objectifies decisions, makes them scientifically defensible, and limits arbitrariness.

→ Institutional specialization enhances efficiency:

The functional division between HIRA (market access evaluation) and NECA (research and reassessment) avoids mission conflicts and enables the development of specialized expertise, particularly in the complex domain of Health Technology Reassessment (HTR).

→ HTR is a critical efficiency lever:

A mature HTA policy does not merely filter new technologies; it actively manages the existing care portfolio by identifying and disinvesting from obsolete or low-value technologies, thereby freeing up resources to finance true innovations.

→ Real-world data (RWD) are the fuel for evaluation:

The strength of the Korean system lies in its ability to leverage massive data from its national health insurance. These data are essential for budget impact assessments, practice analysis, and real-world outcome measurements—beyond clinical trials.

4.3 From Lessons to Adaptation: Recommendations for Morocco

Drawing lessons from the Korean model does not imply advocating for a direct "copy-paste" policy transfer, but rather adapting these insights to the Moroccan context to accelerate its own institutional learning curve:

→ A key implication of the Korean experience is the necessity for a progressive and contextual approach to formalization. Morocco cannot immediately replicate Korea's rigid framework. It should instead embark on a stepwise formalization process. A crucial first step is to accelerate the production and publication of national methodological guidelines for economic evaluation. Subsequently, the establishment of a flexible, indicative cost-effectiveness threshold, rather than a strict cutoff, would serve as a decision-support tool to structure debates and objectify negotiations.

→ Strategic insights suggest that operationalizing the new institutional architecture requires targeted capacity building. While the creation of HAS and AMMPS is a major advance, the current challenge lies in clarifying their complementarities and building local evaluation capacity. This requires significant investment in specialized training programs and academic partnerships to bridge the expertise gap and ensure the sustainability of the new structures.

→ From a health governance perspective, embedding HTA at the heart of other health reforms is essential. HTA policy must not operate in a silo. It should be a strategic lever for other major initiatives. On one hand, investment decisions within Territorial Health Groups (GSTs) should be informed by health economic analyses to optimize regional resource allocation. On the other hand, the deployment of the Shared Medical Record (DMP) should be designed from the outset to generate real-world data that will feed future evaluations by HAS.

→ Analytical findings highlight that strengthening participatory governance and transparency is crucial for social acceptability. To ensure social acceptability of decisions—which can sometimes be difficult—it is crucial to go beyond current representation mechanisms. This includes enhancing the transparency of HAS processes by publishing its decisions and decision-making criteria, and institutionalizing the participation of patient associations and insured representatives directly within technical committees, not just at the strategic level of the Board of Directors.

5 CONCLUSION :

At the end of this comparative analysis, it becomes clear that the institutionalization of a rigorous health technology assessment (HTA) policy is a critical condition for the success of Morocco’s social protection reform. Although South Korea's health system followed a different developmental path, it offers strategic lessons of fundamental importance. The viability of the Moroccan model will depend on its ability to transform political ambition into an effective regulatory architecture. The convergence of objectives between the two countries—namely, ensuring access to innovation while maintaining financial sustainability in the face of similar epidemiological and technological challenges—validates the relevance of this comparison and underscores the necessity for Morocco to draw inspiration from good governance principles, without transplanting a model that may not suit its specific context.

The success of this transition in Morocco rests on four interdependent strategic pillars:

First, the transformation of the National Health Insurance Agency (ANAM) into a High Authority for Health (HAS) must translate into functional independence and technical capacity commensurate with its expanded mandate.

Second, it is essential to formalize assessment processes by developing and publishing national methodological guidelines, and by defining explicit cost-effectiveness criteria, to ensure that reimbursement decisions are more transparent, predictable, and equitable.

Third, the effective deployment of the national health information system and the Shared Medical Record (DMP), as provided by the legal framework, is a prerequisite for equipping HAS with the real-world data necessary to fulfill its mission.

Finally, the adoption of a dynamic vision of efficiency, integrating the periodic reassessment of existing technologies, will make it possible to release resources by disinvesting from low-value care in order to fund high-value innovations.

This study, being qualitative and document-based, naturally carries certain inherent limitations related to its approach. The analysis is grounded in official sources and academic literature which, although robust, cannot fully capture the informal dynamics, stakeholder interactions, and negotiation processes that influence the implementation of public policies. Moreover, due to the recent nature of Moroccan reforms, this analysis represents an assessment of an evolving institutional framework, whose operational impact and tangible effects on the health system can only be fully measured in the medium to long term.

As a result, this work opens up promising avenues for further research. Future empirical studies will be necessary to quantitatively evaluate the impact of HAS decisions on drug pricing, prescribing practices, and patient access to new technologies. Social science research could also explore the organizational challenges related to the ongoing institutional transformation, as well as the perception and uptake of these new regulatory tools by healthcare professionals and the pharmaceutical industry. Lastly, more targeted comparative analyses, focusing on specific mechanisms such as patient involvement or disinvestment strategies, could yield even more nuanced recommendations to sustainably support the consolidation of Morocco’s health system.

Ultimately, this chapter contributes to the comparative HTA literature by highlighting how institutional maturity and political economy conditions shape the regulatory role of HTA beyond its technical dimension.

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