# The Politics of Social Action in Morocco

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This paper analyses the attitudes of public sector professionals toward work in order to understand how a neoliberal policy orientation in Morocco has affected the relationship between social identity and political practice. The paper suggests that policy reforms have undermined the association between social identity and the nation-based social and political purpose of public institutions and instigated new dependence in self-identification and political practice on relations with low-income service users. Professionals no longer act to preserve a conceptual identification like the *middle class*, instead finding political and social meaning through demonstrating the capacity to defy institutional rules and policy expectations of behaviour.

*Keywords*: Morocco; Middle Class; Social Action

## Introduction

About a year before she resigned, the head of a paediatric unit at a public teaching hospital in Rabat told me, "I recognise my limits. I can't do budget management or accounting. I am a clinician. I have a way of working that doesn't function here. They want me to leave, so I st bay. I am not good value for money. It's true—I am a very bad money manager." She then explained that with her specialisation, Type A Diabetes, it was very difficult to practice quality medicine and be cost effective, so she chose the former over the wishes of hospital administrators to pursue the latter.

> It costs a lot for each consultation for Diabetes. I tell them [the administration] that my meetings with patients are around preventative care and not consultations, which aren't free [60 MAD at the time of the research in 2009]. Therefore, I don't bring any money to the hospital. Moreover, people who were seeking treatment in the private sector come to me instead, and the hospital pays for them too.

A paediatrician at another hospital echoed the unit head's comments, stating:

> We hear [from the hospital administrators] that we are not here to practice social work [*faire le social*]. Sometimes, they want us to charge for consultations. But when I see that patients can't pay, I don't ask for the fee. They, the administrators, want the money but that isn't my profession, it is not the way I see things.

She added, "We see cases that are dramatic. The family has given everything for the patient to come here."

Drawing on qualitative research conducted since 2000,[1] this paper analyses the attitudes of professionals in the public sector toward their work in order to understand how a neoliberal policy orientation in Morocco has affected the relationship between social identity and political practice.[2] Specifically, the paper suggests that policy reforms since the eighties[3] have undermined the association between individual social identity and the nation-based social and political purpose of public institutions[4] that characterised pre-market reform in Morocco. Instead, re-structuring and priorities based on now internationalised principles of institutional reform[5] have instigated new dependence in self-identification and political practice on relations with largely low-income service users.

Under reforms, particularly over the past decade, public institutions have arguably changed from signifying national progress

to serving the "poor."[6] Reflecting on the national education policy of 2009-2012,[7] labelled "Programme d'Urgence," one teacher that I interviewed remarked, "They [the Ministry] haven't talked about the fact that most of the students in state schools are poor."

This change in institutional purpose has in turn altered the intertwined political meaning and socio-spatial framework (see Badiou) of working as a professional in public services from affirmation of social status to the combined marginalisation of professionals and service users. Teachers, doctors, and nurses no longer situate their work in relation to a conceptual identification like *middle class* within a nation-state but rather pursue their own individual material security and, for some, existential meaning in their immediate and tangible support to patients and students subjected to poverty and discrimination. These professionals identify themselves through their ability to succeed, often in collaboration with colleagues, in spite of institutional rules and policy expectations of behaviour.[8]

This paper first draws on ethnographic research to examine the current relation between social identity and political practice amongst professionals working in public education and health in Morocco. In the second section, the paper suggests how studying public services has implications not only for understanding political and social change under neoliberalism and in Morocco specifically but also for linking academic research with improving the effectiveness of services. The attitudes and behaviour of the professionals interviewed indicate that policy and programmes should move beyond universalised concepts and related methods like "participation" and "empowerment" that tend to segregate service users from those delivering the services, ignoring the reality of the front line. Rather, new policy and programmes could more accurately reframe public services as combined social and political opportunities situated in relations between the two groups.

## The Political Significance of Social Action in Morocco

Judith Butler writes of subject-formation:

> Indeed, if it is precisely by virtue of its [the subject's] relations to others that it is opaque to itself, and if those relations to others are precisely the venue for its ethical responsibility, then it may well follow that it is precisely by virtue of the subject's opacity to itself that it sustains some of its most important ethical bonds. (22)

In the past, professions like teaching or medicine offered the promise of economic security and the status of possessing a skill needed to advance the "nation" (Cohen), or the bases for a coherent social identity vis-à-vis other social groups.

Inversely, the "opacity" of self-identity amongst these professional groups today is the consequence of a decline in public regard for state institutions like hospitals or schools.[9] Self-identification is instead derived from personal insecurity and work increasingly encompassing the complex needs of low-income service users, setting up the possibility for Butler's *ethical bonds*. For instance, one teacher spoke of two of her students who obviously did not have enough to eat before coming to school. "I can't expect the same level from them, when they haven't eaten—or a student who is being hit at home—from other students." However, dependence on lower-income groups for signifying social identity does not necessarily mean responding ethically to their needs. It means that individuals, sometimes influenced by their peers or directors, have to make a choice to respond ethically or to refuse, which is manifested at its worst in corruption and absenteeism. The teacher who observed that the Ministry had "forgotten" about the poverty of students said, "Some teachers are very motivated in their craft. They participate in clubs after school. I give free supplementary courses for motivated students dur-

ing a free period." She then added, "Others are not motivated at all. They expect rote learning, they don't show up, they insult the students."[10]

The obligation to make a decision makes the individual practice of their profession political, in that this decision acknowledges or rejects personal responsibility to challenge the poverty and exclusion of others. Likewise, it is a choice whether to maintain the integrity of their profession, even if policymakers and administrators are undermining this integrity through lack of investment and respect.

One project manager working with state schools asked:

> Why were teachers so motivated before versus now? There used to be just one manual, no materials, to teach with. And they didn't have a good salary. Now, they want to add to their salary and that is where they are motivated. And I say, why have you chosen this profession? No one imposed this path on you. You have to recognise the sacred value of this profession, that children are like play dough in your hands and when the door of the classroom closes, it is just you with the students and no one from the Ministry.

On the other hand, a doctor working in a gastroenterology unit stated, "I am happy to do a service for patients who don't have money. It is true that it is medicine at a basic level. There aren't enough nurses, technicians or equipment." Another gastroenterologist, working in a teaching hospital, commented, "I like the social side of the public hospital […]. I could earn three times more in the private sector but the mentality is more commercial." At the end of the conversation, she summed up with: "We aren't here for the conditions [of the hospital]. We have chairs that are twenty years old, not luxury. We take care of our patients." Her unit head also emphasised his humanistic regard of the profession, claiming:

> Me, I could not work in the private sector. When I practice medicine, I see a patient who has need of me to cure him. I cannot profit from that. He does everything to come to see me—he gathers money from his family, friends to come to be treated. I cannot profit from that; I have to practice my trade […]. I have done some replacement work but I was not at ease with it. In the private sector, they view a patient as a client who pays. When they see a patient, they see how much this person can pay them. If the person can pay everything, then the patient receives good treatment until the end. If he doesn't have the means, he pays what he can and then the doctor sends him to the public sector.

Amongst the interviewees, responding to the demands of patients or students was associated explicitly with transcendent values—whether universal human rights or the recognition of human dignity inherent in Islam, rather than nation-based notions of citizenship. For example, a nurse who worked in the same gastroenterology unit at the teaching hospital remarked, "It is only humanity as a motivation here. It is only the humane side and our religion that pushes us to do the work that we have here."

The most prominent practical effect of adopting an ethical position in the research was to mobilise resources through social networks, the assistance of former patients, and contact with international NGOs able to offer equipment. The unit head of the gastroenterology unit had built up a bank of medicine through monetary donations from former patients and others to bring medicine via friends in Europe while several nurses in his unit worked around restrictions on equipment usage to offer patients tests out of hours. The now retired paediatrician relied upon a former patient to help run a support programme for families of children with Type A Diabetes and the retired head of another paediatric unit had

worked with an American NGO to bring equipment to his unit. Likewise, several teachers mobilised clothing and school materials for low-income students and a senior teacher had set up classes for deaf students through an NGO supported by Handicap International. The teacher had been posted to another school so rushed from his new position every afternoon to oversee the project.

The two extremes of material responses to the decline of public services, social action and absenteeism/corruption, evoke the need for new policy strategies that address how institutional cultures can provoke such different kinds of individual behaviour. Writing about managing shared resources, Elinor Ostrom states:

> We posit three layers that affect the decisions of an individual to cooperate in a common-pool situation: their own identity, the group context in which decisions are being made, and whether the situation is repeated and it is possible to use reciprocity and gain a reputation for trustworthiness […]. Individual values are not sufficient, however, to solve all common-pool resource problems. Without institutions that facilitate the building of reciprocity, trust, and trustworthiness, citizens face a real challenge. (2)[11]

**Should Policy Account for Motivation?**

Tendler and Freedheim, in a study of community nurses working in Ceara, Brazil, challenge what still remains mainstream thinking that poor performance in the public sector, whether related to corruption, weak training, or otherwise, requires turning to private sector options and laying off workers. They write:

> When agents talked about why they liked their jobs, the subject of respect from clients and from 'my community' often dominated their conversation—much more, interestingly, than the subject of respect from supervisors or other superiors. The trust that was central to the workings of the health programme was inspired by quite mundane activities […]. 'She is a true friend,' a mother said of the health agent working in her community. 'She's done more for us than she'll ever realise.' (1784)

In fact, the authors found that the trust cultivated with clients and the larger community was so significant in inspiring quality performance that it was hard to differentiate its effects from external performance monitoring (1785).

Yet, in Morocco, reform of public services has focused on structural reform rather than social relations or support,[12] highlighting now universal themes of cultivating private investment, subcontracting, introducing fee payments and expanding health insurance coverage, encouraging competition, improving training and education, and so on.[13] Protests against marketisation of services by staff have, nonetheless, been rejected as in other countries,[14] denigrating the motivation of professionals. For example, an article in *Le Matin*, the newspaper representing the viewpoint of the Palace, dismissed protests from medical staff in the public sector about encouraging private investment:

> It is not a secret to anyone that the health sector is among the most corrupt in Morocco (without stigmatising those who are honest). Isn't the preponderance of corruption and bribery in the sector proof that a good number of staff in the public sector (once more, not to generalise) already do 'commerce' with the health of our citizens?

The author argues that this behaviour is the result of monopoly, as doctors or nurses can charge what they like because they know patients have no other choice. Yet, if some of the hospital staff members remain honest, is it appropriate to justify privatisation because monopoly encourages exploitative behaviour? I suggest that the research on professionals in Morocco shows that approaches to reform should consider how policies affect the social role of institutions, and thus the so-

cial identity of staff. For example, critiquing teacher unions and administrators together, a teacher in her early fifties from a family of leftist politicians longed for the state to raise the level of professionalism and restore respect to the institution. She attributed the absenteeism and inadequate performance of her colleagues not only to the lure of profit in extra private work but also to low morale brought on by issues largely unaddressed by national policymakers, from innovations in pedagogy to greater learning support for students. She explained:

> The problem in teaching is not just material. I stopped going on strike because the unions only talk about money. There is no mention of pedagogy. We must take more interest in our craft. For sure, the conditions in schools are not good. There are too many students per class. But we need to improve our image and that can be done through demonstrating that we care about teaching.

Moreover, for a few of the professionals interviewed the focus on budget management only heightened a sense of resistance. The (now retired) head of the paediatric unit at the teaching hospital thought that public health reform meant getting rid of doctors while adding managers and clerical staff "who spend their time on computer games and painting their nails. Doctors never meet except to talk about money, which is all the administrators care about." She openly despised her administrative supervisors, whom she claimed "want to increase the number of patients for the budget without reflecting on the quality of work. How are we going to treat all of these people? Do we have the means to treat them?" She also commented that she and her colleagues

> did their job in spite of increasingly difficult working conditions, where human and material resources are reduced to the extreme […]. It is always satisfying when we can note positive results in an adverse context. Sometimes these results even seem miraculous.[15]

Discussion of the social dimension of public services has overwhelmingly focused both within development studies and amongst international aid agencies on input from service users. Academics have argued for greater attention to "participation" in governance and designing programmes (Evans; Wright; Hicky and Mohan) in order to democratise decision-making.[16] Perhaps the most holistic approach to supporting service user input has been that of "empowerment," derived from Amartya Sen's human capabilities approach, which attempts to match agency with opportunities. International agencies like the World Bank, NGOs, and a number of national governments, particularly India, have integrated rights-based legislation[17] with widening opportunities for jobs, health, education, among others. The principle is that building "assets" amongst marginalised groups will—for instance, specific training, matched by opportunities—lead not only to greater material resources but also, as Deepa Narayan puts it in a World Bank report, the ability "to make choices and then to transform those choices into desired actions and outcomes" (10).[18]

As with the *Le Matin* article, the failure to deliver "empowerment" is blamed in good part on public sector staff. Remedies for this failure include methods like scorecards on service delivery. Cited in an Asian Development Bank study on empowerment, a center in Hyderabad collected "the views and perceptions of users about the ability of health services and the perspectives of the staff of the health centers" (29). Once collected, the scorecards revealed "dissatisfaction with staff behaviour and working style, hours of operation and availability of medical personnel, and overall weak responsiveness" (29).

Though the scorecards' leading to better attitudes and service quality should certainly be regarded as positive, the problem of dissatisfaction with staff points to a

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more profound issue of neglecting constructive social relations between service users and professional staff.[19] Scorecards segregate, labelling one group as problematic and giving the other power to "reform" it.

If social relations between professional staff and service users are important to delivering quality services, then how should they be addressed in policy? More fundamentally, how can the services of public institutions be conceptualised so as to encourage constructive behaviour and discourage practices like corruption and absenteeism? I suggest three ways of rethinking public institutions and improving service quality. First, the language of "public services" should be revised to reflect the mutual participation and benefit of different social and economic groups. Rather than one social group, i.e. professionals, providing services to another primarily low-income group, a hospital or school would be reframed as a means for all stakeholders to achieve social meaning and political significance as well as better health and education.

Secondly, the conceptual and practical focus on social relations means shifting away from a vertically-oriented dynamic whereby policymakers and staff respond to feedback, like scorecards, from low-income service users, to cooperation and collaboration on the front line, similar to the mobilisation of resources by doctors, teachers, and sometimes service users. Finally, the emphasis on the front line implies recognising practical constraints on delivering quality services and acting upon them. As one nurse in the gastroenterology unit in the teaching hospital commented:

> You do the work even with the constraints in front of you. The patient has nothing to do with the salary. You are obliged to do the work necessary. This is a patient who perhaps came from far away. He is far from his family. You have to make up for that. And you have to be responsible at the same time for the material side of things, sterilisation, and so on […]. The social services here are negligible. We need a social worker for each ward. But there aren't any.[20]

The recognition of these constraints would logically entail granting more decision-making power to professionals, like the nurse, and service users over the allocation of resources. More profoundly, this shift would make cooperation and raising the authority of the different front line actors a primary objective of institutions in order to improve service quality and "efficiency," for example, greater attention in the front line leading to better after care at home and less chance of regression. Institutions would then be represented less by their modes of governance than by collective action for shared benefit.

## Conclusion

This paper has analysed social action amongst professional staff in public health and education and makes the argument that both constructive and negative behaviour are due to institutions no longer linking vocation with collective social purpose. The paper suggests that policy should respond by reframing the social role of institutions as bringing together different social groups for shared benefit. This reframing not only addresses the social consequences of neoliberalism as a policy approach; it also means offering an alternative.

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## → Notes

[1] The research consisted of several parts: First, I have worked extensively with non-governmental organisations since 2000, and a number of these are run either by former or current public sector staff or their purpose is to support education or health. Thus, I have been exposed to some of the challenges facing public services in Morocco. Secondly, I received three grants (Leverhulme Trust, University of Sheffield Internal Grant, and American Institute of Maghrib Studies) to conduct research over a six-month period in 2009, during which I ended up focusing on the transformation of public services under neoliberalism in Morocco. The third is ongoing research into how policy affects the social role of institutions and how, inversely, front line service delivery can inform policy.

[2] See Koenraad Bogaert for a more general analysis of the relationship between neoliberalism and political transformation in the region.

[3] Structural adjustment and market liberalisation began in Morocco in 1983.

[4] A study by Haut-Commissariat au Plan in Morocco on the attitudes of youth ("Les jeunes en chiffres") found that for young men and women (ages 15-24), household was by far the most important area (46.2%), followed by religion (23.9%), work (11.4%), and then national progress (10%) (66).

[5] Writing about the universalisation of higher education policy in a comparison of reform in Morocco and Egypt, Kohstall remarks, "It is remarkable how the discourse on higher education has changed and is now jam-packed [with] wording from the international agenda for higher education reform, from accreditation to benchmarking and quality assurance to ranking. A common language has emerged that shapes university administrators and faculty members alike when they apply for international funding. This is probably the most important side-product of a type of reform that otherwise has not yet lead to tangible results in the improvement of teaching and research." (107)

[6] See a White Paper by Dr. Alaoui, the Secretary-General of the Ministry of Health in Morocco for a summary of the direction and purpose of health sector reforms, which focus largely on governance, decentralisation, insurance coverage, and recruitment and training. The overriding orientation of his paper, as well as reforms in education and social development, is to ensure greater access by low-income populations, particularly in rural areas. This orientation follows the World Bank Millennium Development Goals, as well as aid agency priorities, but regardless of the merit of this objective, it leaves out completely the notion of public schools and hospitals as serving all of the population.

[7] See "Programme d'Urgence 2009-2012" of Ministère de l'Enseignement Supérieur.

[8] Despite his focus on the motivation of protesters across the globe, Zygmunt Bauman's identification of desire for tangible and immediate change as the inspiration for action could refer both to doctors manipulating administrators to avoid low-income patients paying fees or teachers pursuing extra income. They both embrace "the locality and press[ing] it close to one's breast" (16) and are spurred on by the "knowledge that the governments in the form in which they have been squeezed by the 'global forces' are not the protection against instability but instability's principal cause" (16).

[9] Describing the decline of public education in Morocco, Rim Battal writes in the online magazine *Yabiladi*, "The absenteeism of teachers is only a symptom. You have to go further than that. What can we expect from a teacher who earns a miserable wage? Most skip their classes between four and six in the afternoon to tutor individual students or to teach in the private sector. The teachers diagnose a number of problems like lack of resources, ramshackle infrastructure and dirty and dilapidated buildings, lack of furniture and equipment, classrooms that are overcrowded at many levels, undisciplined, indeed aggressive students."

An article on interns ("Médicin au Maroc") in the public health system, who were striking at the time for medical insurance, echoed the pervasive demoralisation indicated amongst teachers, quoting Ayoub Halfya, the then president of the association of medical interns as saying: "We work ninety hours a week, sometimes we do forty-eight hours on call that are not paid, all for a pathetic salary, that doesn't match the rise in the cost of living." An anonymously quoted intern was more direct, stating: "Our salaries are […] largely insufficient […]. Over time, I have come to see that you have to be rich to study medicine. I earn 3,500 MAD a month and my parents still have to help me. I can't pay for my rent, a car, and all of the daily expenses with so little. At twenty-eight years old, one becomes very angry. One starts to want to

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→ set up in the private sector, where, with my specialisation, I can earn much better than in the public sector. But the set up costs a lot, and there too, the assumption is you have the means to do this."

[10] Boutieri views the dichotomies and hierarchies in public education, exemplified in language skills (French and Arabic primarily), as a precursor to the disaffection expressed across North Africa during the Arab Spring, because the school is an original source of limiting opportunities and establishing socio-economic difference. She writes that in Morocco today, "educational anxiety emerges as socio-cultural critique. The circumvention of public education through privatisation, parallel schooling, corruption, or charity—all responses to this anxiety—is telling of a radical uncertainty about how to plan the future of the next generation" (445). She adds that this anxiety cannot be remedied through conventional reforms, stating: "By claiming that what appears as a sudden move to the streets [the Arab Spring] may in part be a gradual result of a collective disengagement from the public school as a space of empowerment and integration, I emphatically reorient our attention away from the technical diagnostics of international policymakers and toward the political nature of all learning." (445)

[11] For more information see Ostrom.

[12] A World Bank article on educational reform in Morocco lists as the priorities governance, decentralisation, and infrastructure. Management of human resources are regarded as key to 'effectiveness' "because they exercise a considerable influence on the performance overall of schools. The minister has launched a massive strategy to promote the career plans and mobility of teachers with the aim of directing them to where their competence will be the most useful." The language is notably and not surprisingly utilitarian and individualist, again obscuring the necessarily social dimension of teaching.

[13] See Royaume du Maroc, "Stratégie Sectorielle de Santé 2012-2016."

[14] For example, teacher strikes in 2011 in the UK over pensions were criticised by Michael Gove, the Minister for Education. He said of the strikers (which included, unusually, head teachers): "They want mothers to give up a day's work, or pay for expensive childcare, because schools will be closed. They want teachers and other public sector workers to lose a day's pay in the run-up to Christmas. They want scenes of industrial strife on our TV screens. They want to make economic recovery harder—they want to provide a platform for confrontation just when we all need to pull together" ("Gove Appeals to Teachers"). The heads of the teaching unions responded to government criticism by remarking how much they would prefer to be practising their profession. The head of the university lecturers union (UCU) remarked, "Our members are unlikely militants and would much rather be in the classroom than on the picket line" ("UK Schools Disrupted by Pension Strikes").

[15] She eventually retired in frustration in 2012.

[16] *Participation* has also been criticised within development studies for only superficially acknowledging service users while carrying on with pre-determined policies and specific projects (Cooke and Kothari).

[17] The Asian Development Bank report provides more detail on the practice of empowerment: "A common form of empowerment is through *rights-based entitlements,* which are enforceable rights enshrined in the legal framework or national constitutions with specific roles and responsibilities of implementing authorities as well as criteria for beneficiary eligibility and procedures for identification. There are two types of rights-based entitlements: First, the right of eligible citizens to specific services; and second, the right to information, which is an instrument to ensure that citizens can influence the fulfillment of their rights to services. In both cases, it is the binding obligation of the state to ensure that eligible citizens receive the specific entitlement being guaranteed." (22)

[18] Citing Sen and others, the Asian Development Bank study on empowerment defines the approach as: "People should be free to choose what they want to do, have the functional ability to put those choices into action, and have an enabling environment that allows them to actually perform those actions." (20)

[19] For more information see *Oxfam Briefing Paper* 125.

[20] The same anonymous intern quoted in the article ("Médicin au Maroc") about the interns' strike in Morocco made similar comments: "The public hospital in Morocco lacks resources. Like myself, many of my intern or resident colleagues are obligated to do the tasks of the nurse or nurse's aide because of a lack of personnel. It is up to us to change the sheets, clean the sick who are immobile, push the guerneys. In some services, there is a nurse for ten sick people, which is [simply] not enough, and suddenly it is the doctors who have to contribute to remedying the situation, and this isn't OK. Above all, it tires us out and takes over the time when we are supposed to be curing patients."

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