Mixed Provider Payment System in Morocco
Challenges of alignment (work in progress)

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Morocco: What is in the mix?

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A coherent MPPS in Morocco?

Budget allocation

District Hosp.

PHI

Districts

MoH

MoF

Social Cohesion Fund

SHI

CNOPS

CNSS

Other MHO

National Convention (Case based + FFS)

Cost sharing

District Hosp.

Private Clinics

Private Practices

Districts

DPRF

DHSA

Salaries

Drug credit line

Operating costs

District Hosp.

Health Centre

Operating costs line

Tertiary Hosp.

MoH

MoF

SHI

CNOPS

CNSS

Other MHO

Cost sharing

Official

Co-payment

Users / Patients

Budget Line Item

Case-based
Breakdown of Total Health Expenditure (THE)

NHA 2014

Source: http://apps.who.int/nha/database/ViewData/Indicators/en

THE = 5.91% of GDP
GGHE = 6.03% of GGHE

- % MoH in THE: 58.4%
- % SHI in THE: 21.1%
- % Other Gvt Exp in THE: 8.3%
- % Ext. Ress in THE: 7.7%
- % PHI in THE: 2.9%
- % OOPs in THE: 1.6%

THE = 5.91% of GDP
GGHE = 6.03% of GGHE
A coherent MPPS in Morocco?

**Budget allocation**

- **8.3% of THE**
  - SHI
  - CNOPS
  - CNSS
  - Other MHO

- **26% of THE**
  - MoH
  - DPRF
  - DHSA

- **58% of THE**
  - PHI

**Cost sharing**

- **8.3% of THE**
- **58% of THE**

**Users / Patients**
Analysis
A coherent MPPS in Morocco?

Budget allocation

National Convention (Case based + FFS)

Cost sharing

Case-based

Purchasers

MoH

DPRF

DHSA

MoF

Social Cohesion Fund

SHI

CNOPS

CNSS

Other MHO

PHI

Districts

Provider type 1

Operating costs

Drug credit line

Salaries

Provider type 2

Tertiary Hosp.

Provider type 3

Private Clinics

Private Practice

District Hosp.

Health Centre

Users / Patients

Operating costs

Drug credit line

Over billing

Official Co-payment

Official

Co-payment

Over billing
Health centres and District / Provincial hospitals

- Mostly line-item budget allocations
- Low autonomy and under-funding
- No incentive for hospitals to bill for SHI nor for RAMED, as this would affect budget allocations
- Incentives of line-item budget coupled with lack of autonomy dominate

= > Under-provision (= low activity)
Incentives and effects of MMPS
Provider perspective – public sector

Autonomous University Hospitals

- Budget allocation and FFS and case payment from SHI/PHI
- Active billing for the SHI patients, virtual billing for documentation for RAMED patients

=> Higher activity

- Difference in payment rates of tarification between Ramedists, SHI members, and PHI clients makes the latter two groups more attractive

=> Cream-skimming (?), with potential inequitable access
Incentives and effects of MMPS
Provider perspective – Private sector

Private Providers
• Mostly paid per activity (cased-based + FFS)
  – In certain instances, combination of FFS and case payment is possible

• Lack of control of billing practice
  => Over-provision
  => Cost-shifting, over-billing
  => Inefficiencies, cost increase

Evidence:
  – 92% of the SHI expenditure flows to the private sector
System perspective
Effects at the system level

Current MPPS provides:
• More activity oriented incentives for private providers and tertiary hospitals
• More cost-containment incentives for public, primary health care providers

⇒ Imbalance in financial flows: private sector is more attractive for both patient and health staff
⇒ Contributes to the growth of the private sector
⇒ Health workers shift to the private sector

• Reinforces the segmentation of the health system and hospital-centrism
• Issues also rooted in the overall fragmented health financing architecture, as well as in governance issues
• How can the differences in supplies, human resources and (perceived) quality be reduced between the public and private sector?
Options: how to align the MPPS for coherent incentives?

• Do we need to add new payment methods? If so with what sequence?

• Difficult task which requires intensive work
  – Illustration of the new PPP agreement

• Will reforming the existing mix suffice? If so in what sense?

No magic bullet
Options: how to align the MPPS for coherent incentives?

• Harmonise payment methods
  – Provider payment for RAMED patients should be similar to that of patients affiliated to CNOPS, or with a specific budget with explicit funding
  – Reduce tariff differences in the national conventions between RAMED, SHI and VHI
• Introduce a P4P in the public sector

Accompanying governance related measures

• Provide effective financial autonomy to District/Provincial Hospitals
  – to enable them to respond to output oriented payment methods
• Introduce cost-containment measure and quality control for private sector; more rigorous review of claims + strengthen the accreditation process
Thanks for your attention

(more to come soon)
System perspective
Effects at the system level

• There is no P4P:
  – Would P4P be a useful component of the payment system in the public sector?
District Hosp.

FSS

Budget allocation

Cost-sharing

Line Item Budget

Case-based

Case-based + FSS

Line Item Budget

Budget allocation

Case-based

Cost-sharing

District Hosp.
Tertiary Hosp.

Budget allocation

Cost-sharing

Line Item Budget

Case-based

Case-based + FSS
Private Clinics

Cost-sharing

Case-based

Line Item Budget

Budget allocation

Case-based + FSS
Tertiary Hosp.

Case-based + FSS

Budget allocation

Cost-sharing

Line Item Budget
Private Clinics

Cost-sharing

Case-based

Budget allocation

Case-based + FSS

Line Item Budget