Mixed Provider Payment System in Morocco

Challenges of alignment

(work in progress)

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Morocco: What is in the mix?

Purchasers

Ministry of Health

Ministry of Finance

Medical Assistance Regime (RAMED)

National Health Insurance (NHIs)

Private Health Insurance

Payment methods

Line Item budgets

Budget allocation

National conventions (combining Case-Based Payment + Fee-For-Service)

Case-based (PPP)

Cost sharing (OOPs)

Providers

Primary Health Centres (ESSB)

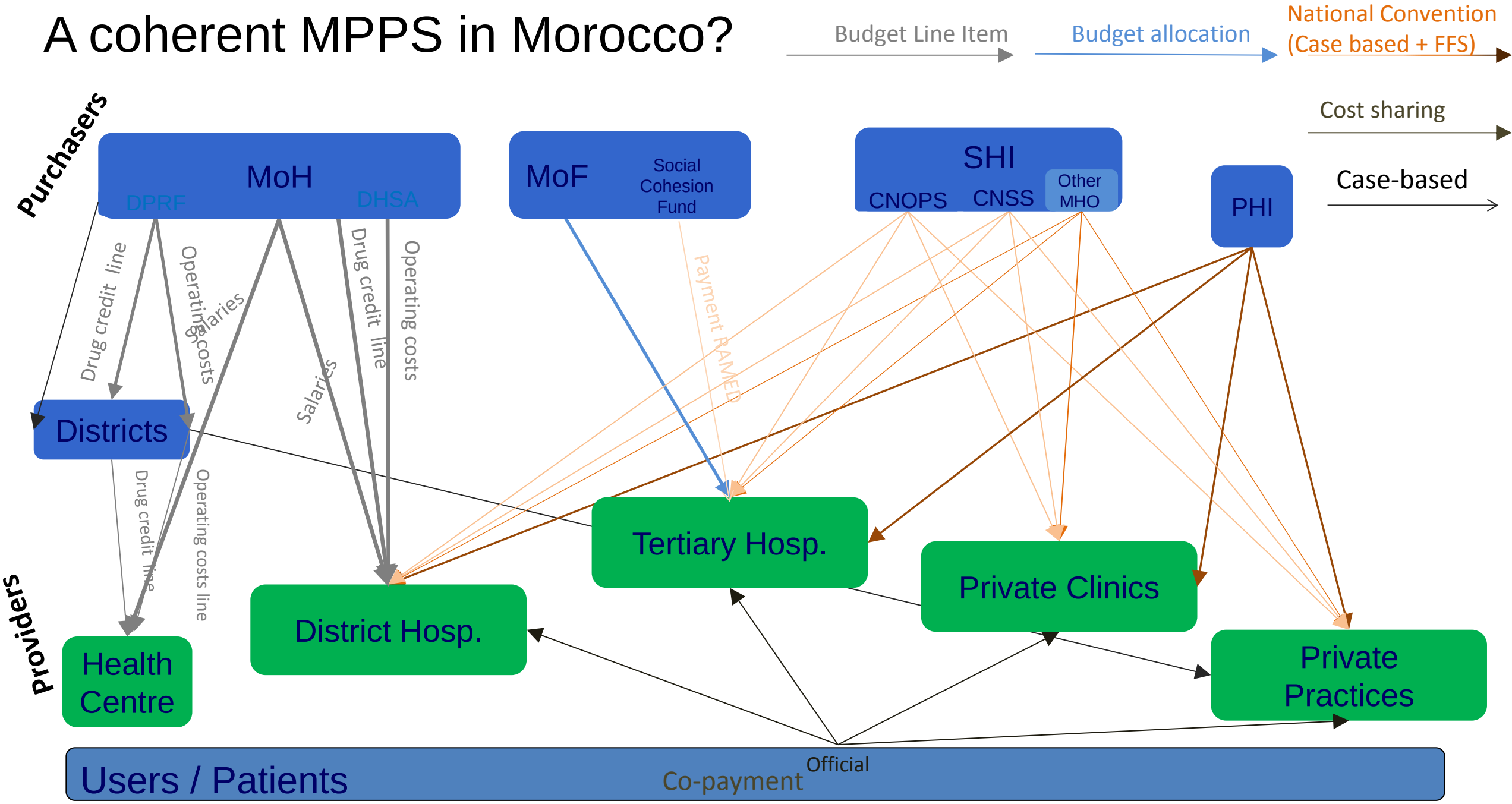
District Hospitals (SEGMA)

Teaching / University Hospitals (CHU)

Private practices (GPs and Specialists)

Private Clinics

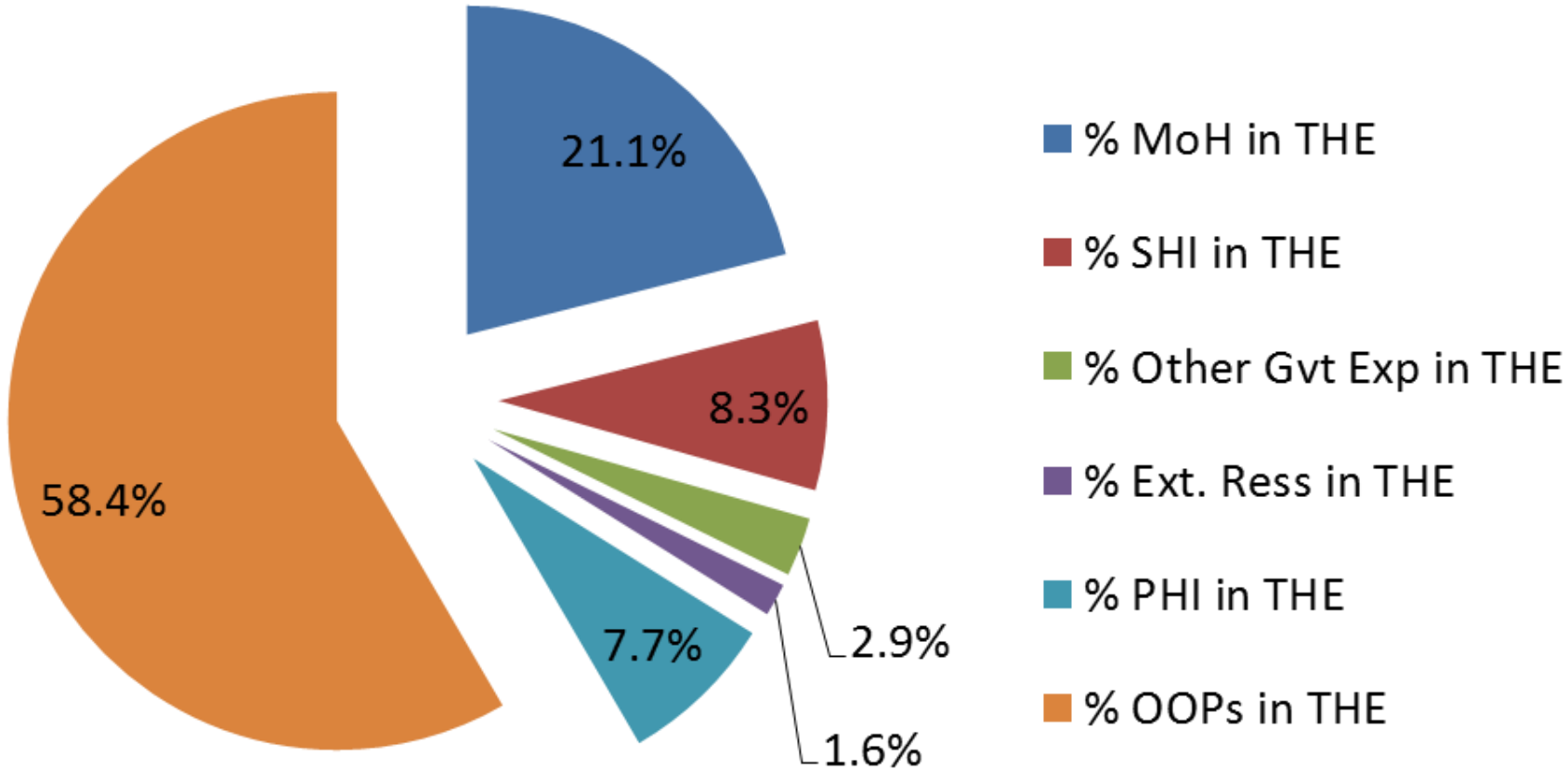
A coherent MPPS in Morocco?



Breakdown of Total Health Expenditure (THE)

NHA 2014

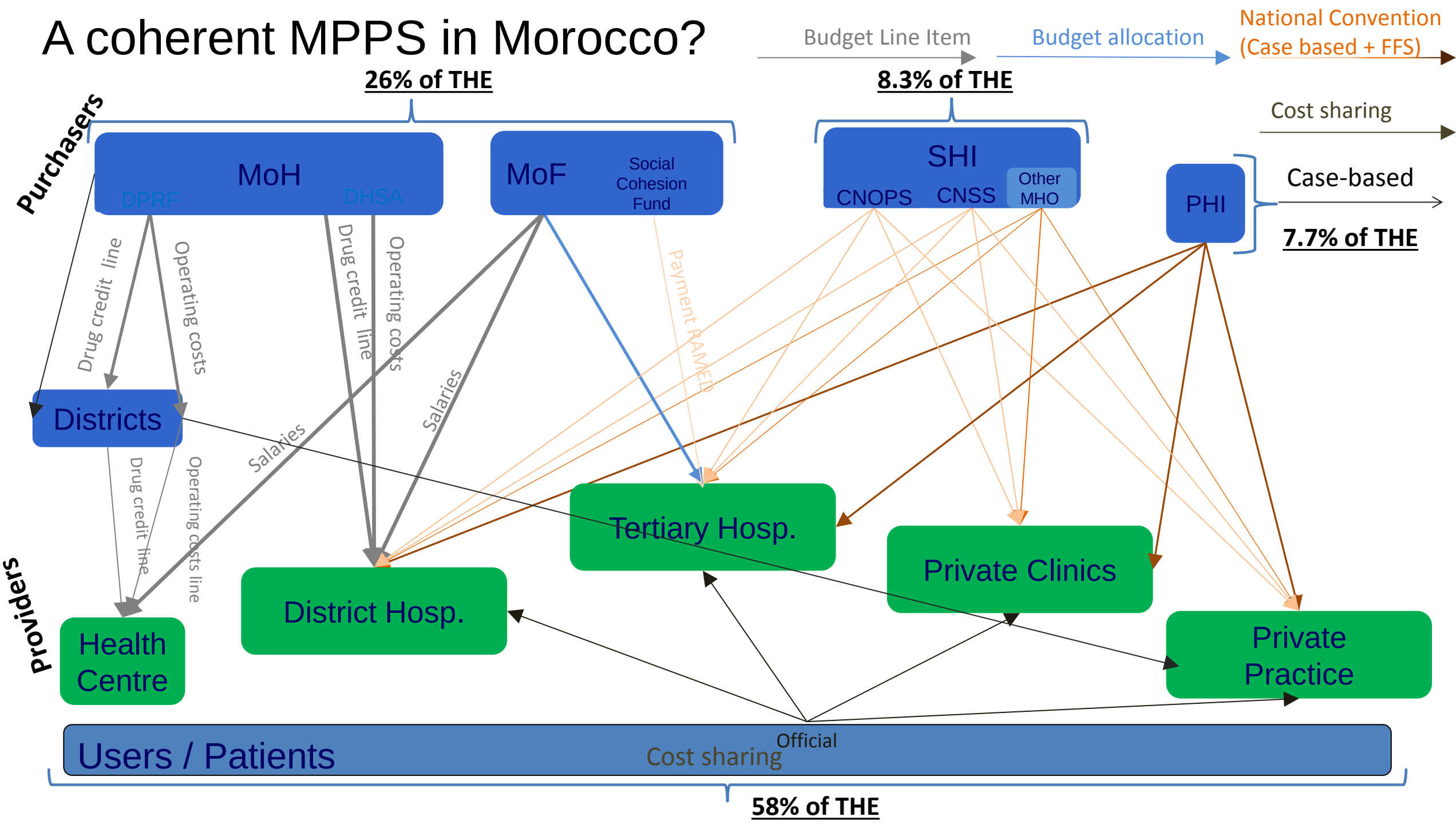
Source: http://apps.who.int/nha/database/ViewData/Indicators/en



THE = 5.91% of GDP

GGHE = 6.03 % of GGHE

A coherent MPPS in Morocco?



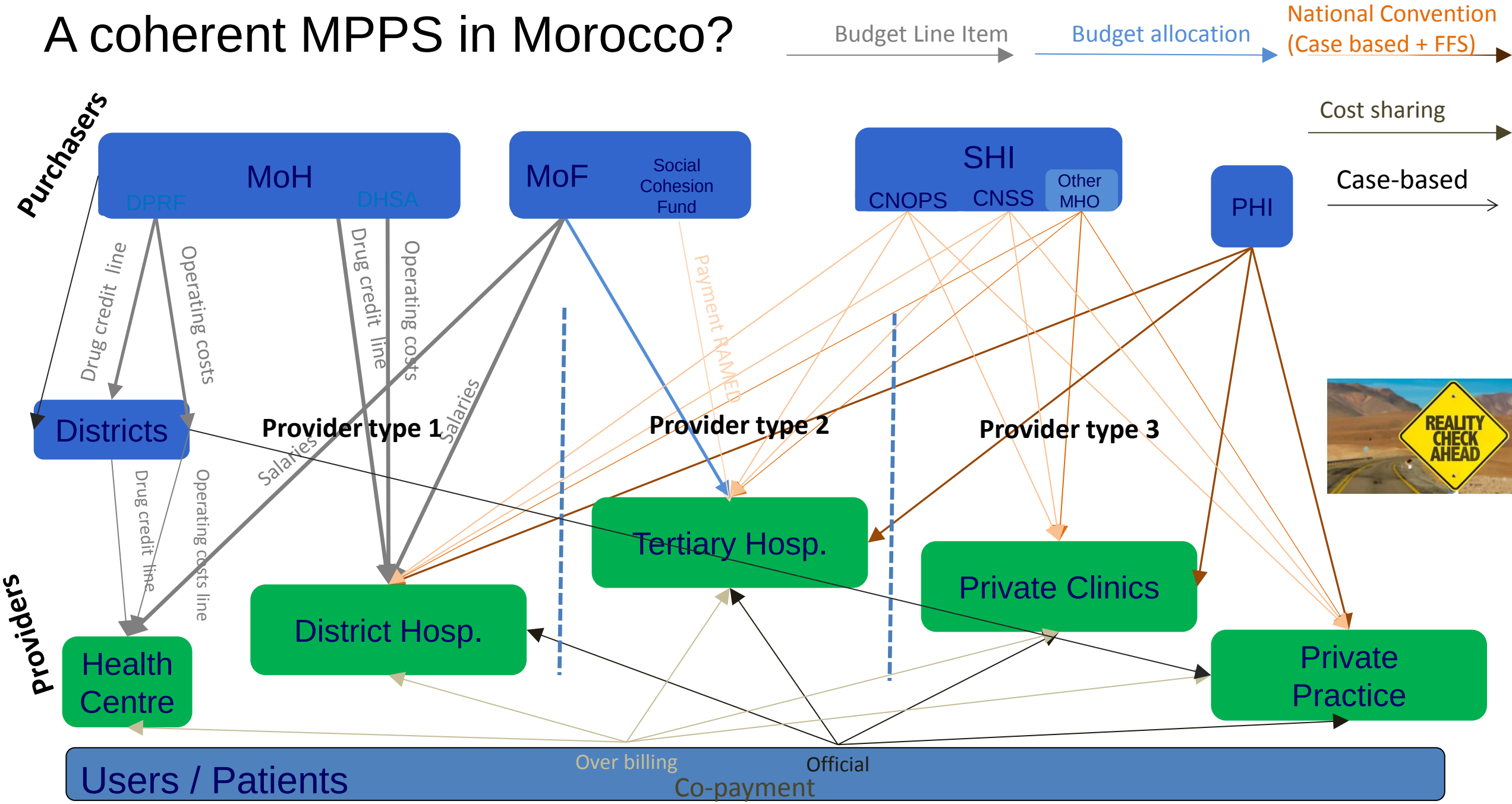
Analysis


REALITY
CHECK
AHEAD


Incentive Systems
incentive
incentives
people
money
terms
economics
Categories
example
certain
structures
choice
differences
exist
moral
physical
acting
person
act
admiration
Incentives
community
within
financial
action
study
even
expect
particular
way
course
pain
sense
incentive
different
failure


Efficiency
Quality
Speed
Cost

A coherent MPPS in Morocco?



Incentives and effects of MMPS
Provider perspective – public sector

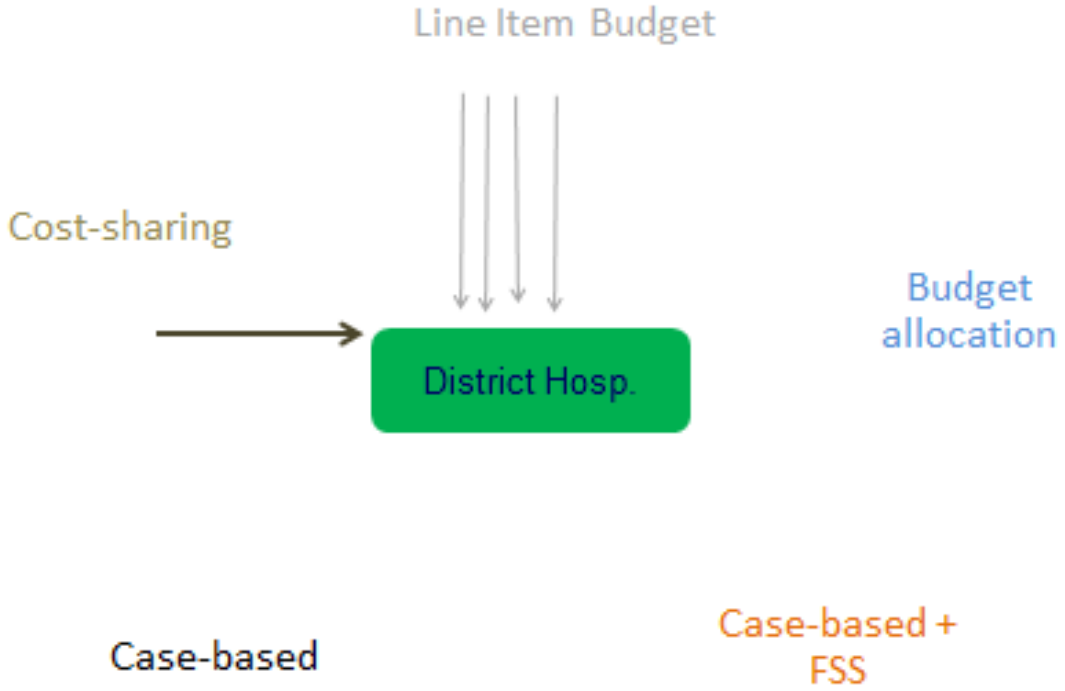
Health centres and District / Provincial hospitals

- 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

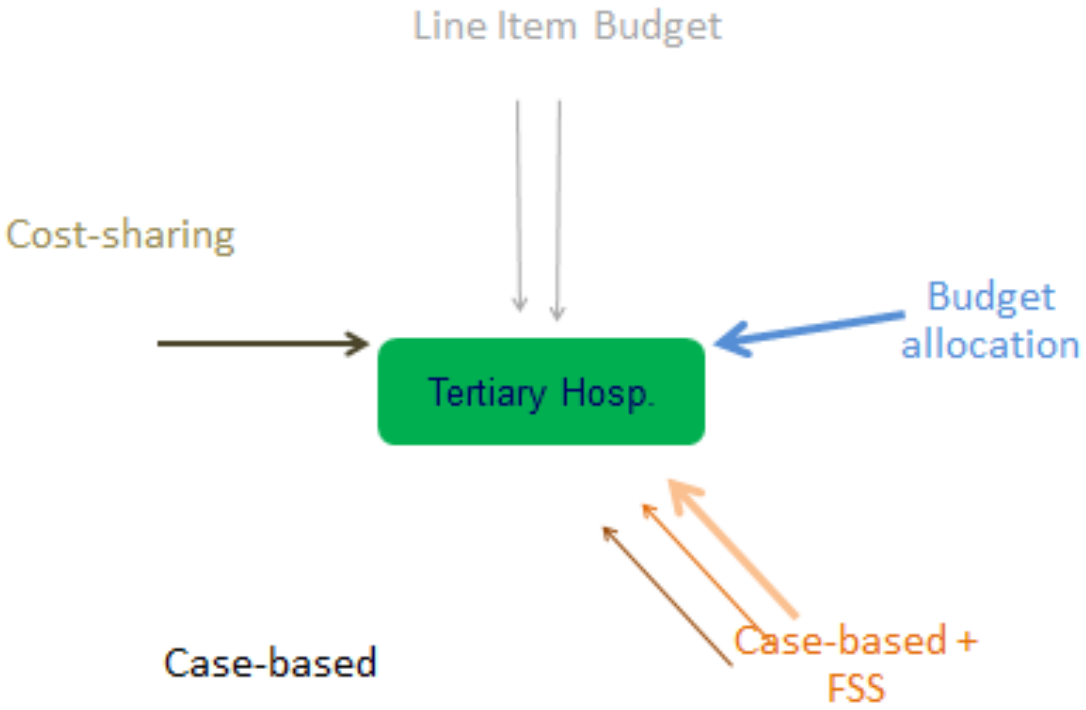
- Incentives of line-item budget coupled with lack of autonomy dominate

= > 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 attractice

=> 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

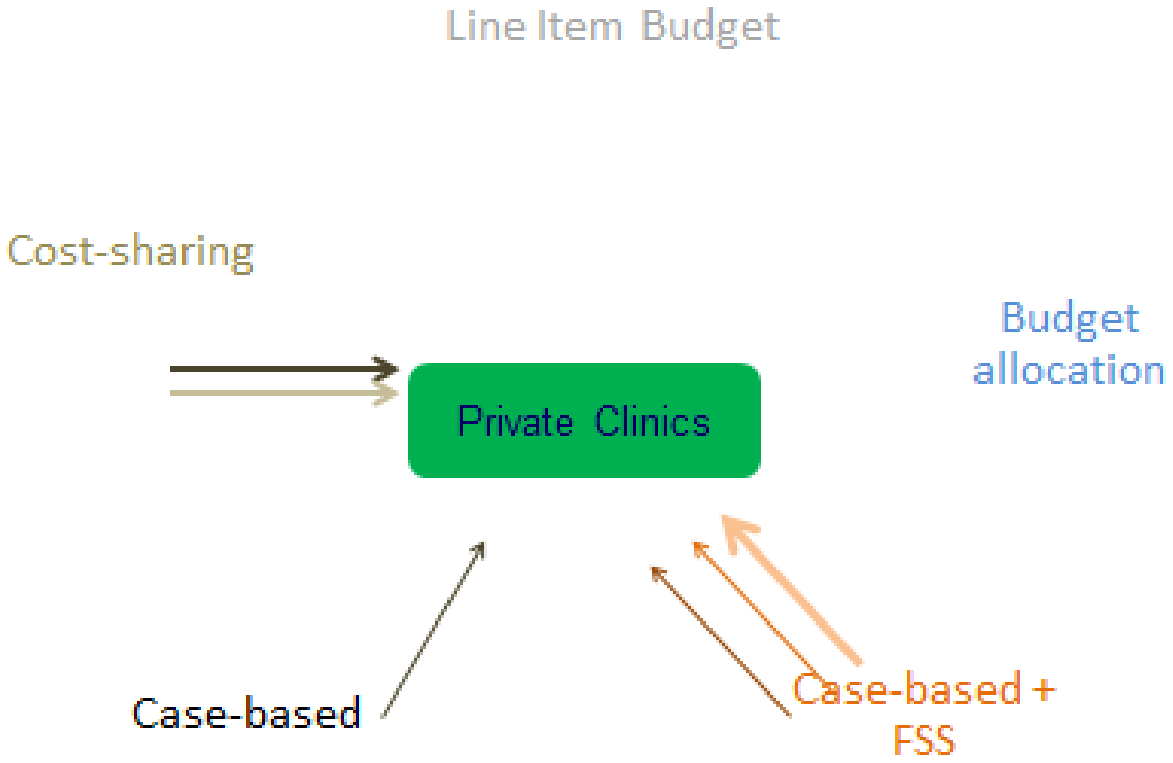
=> Over-provision

=> 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?

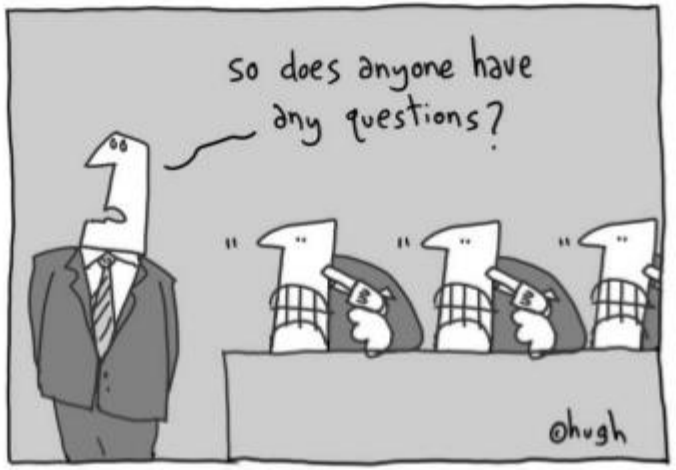
- Harmonise payment methods
  - Provider payment for RAMED patients should be similar to that of patients affiliated to CNOPS, or with a specific budget with explicit funding
  - Reduce tariff differences in the national conventions between RAMED, SHI and VHI
- Introduce a P4P in the public sector

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

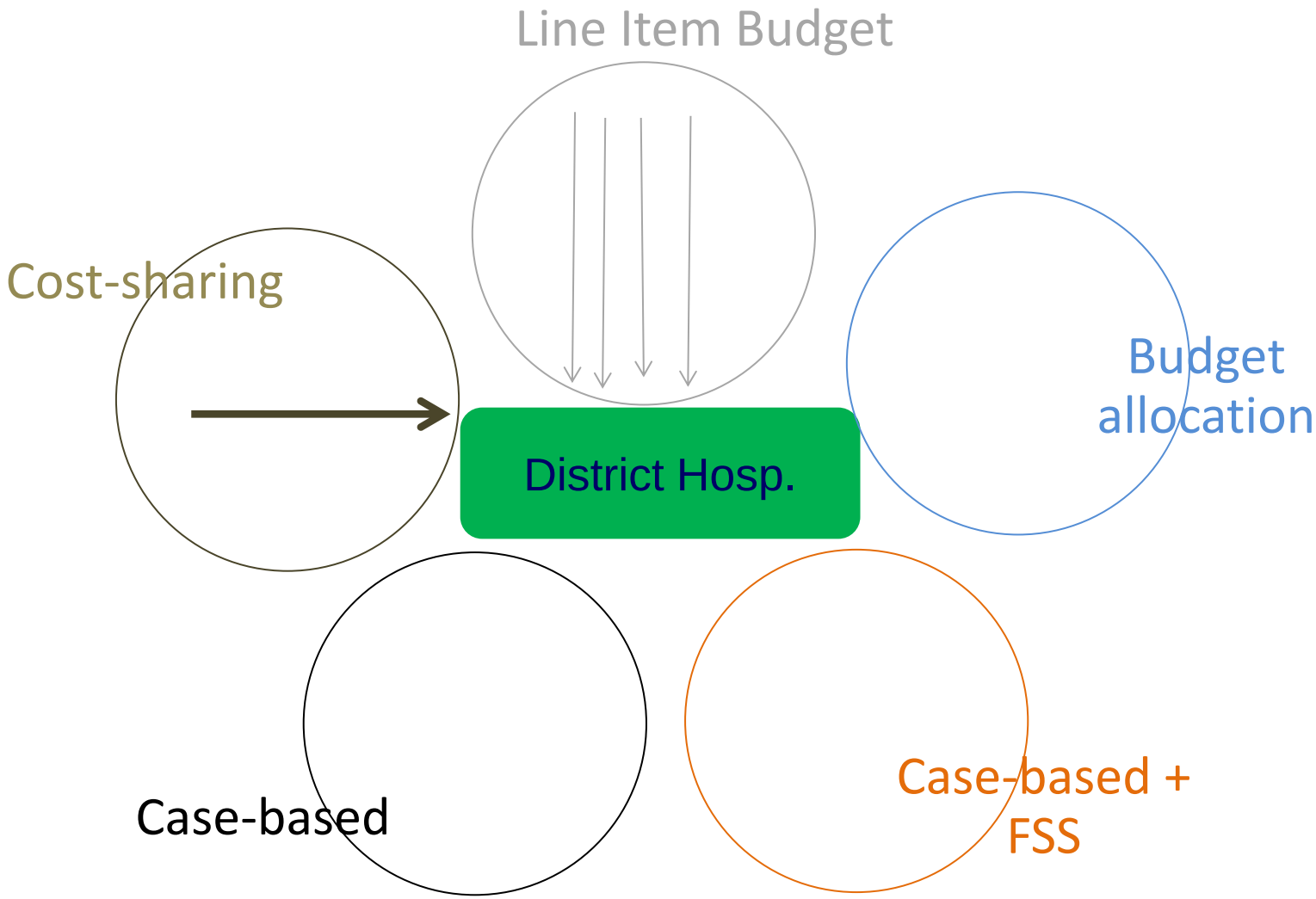
Thanks for your attention

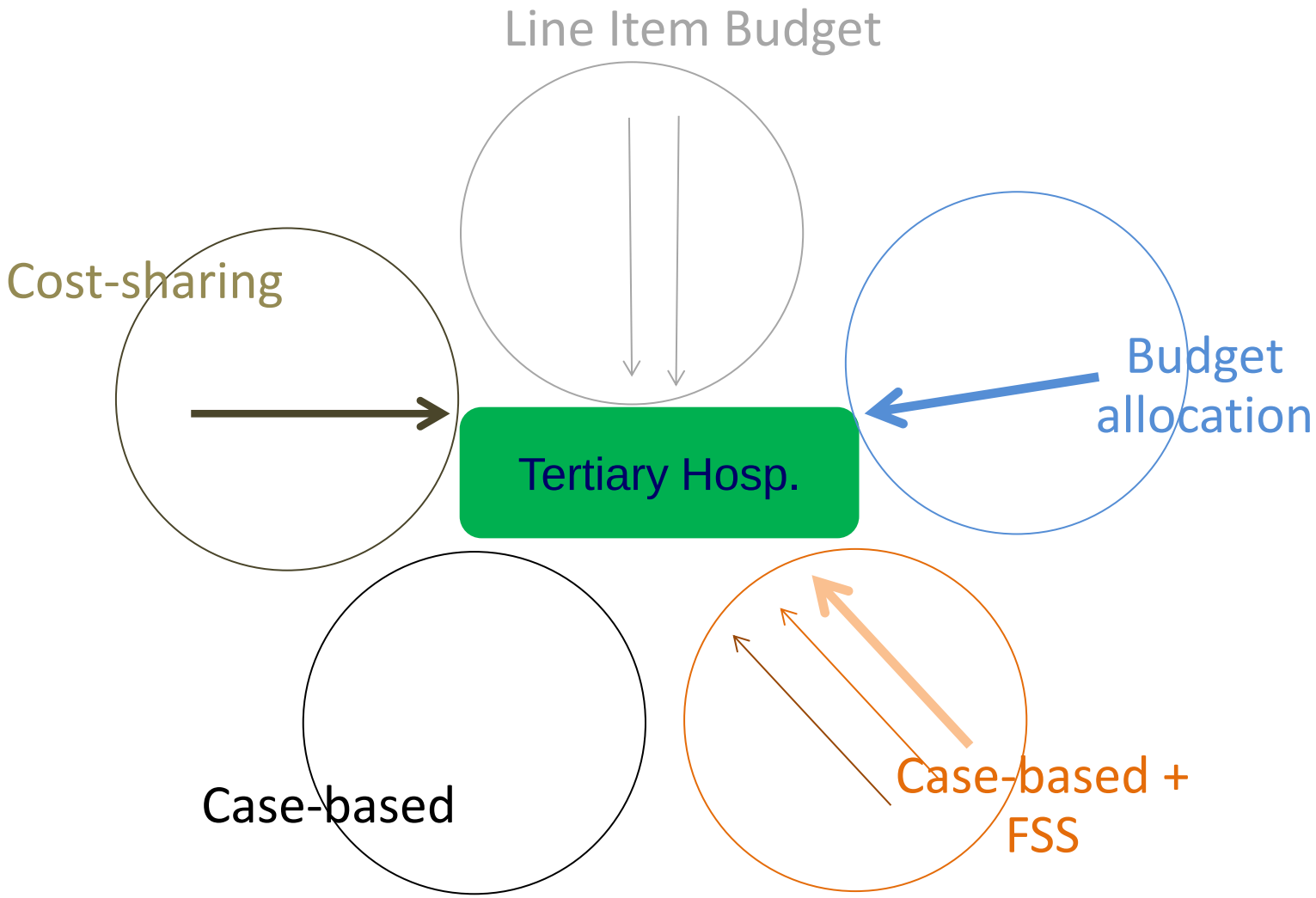
(more to come soon)

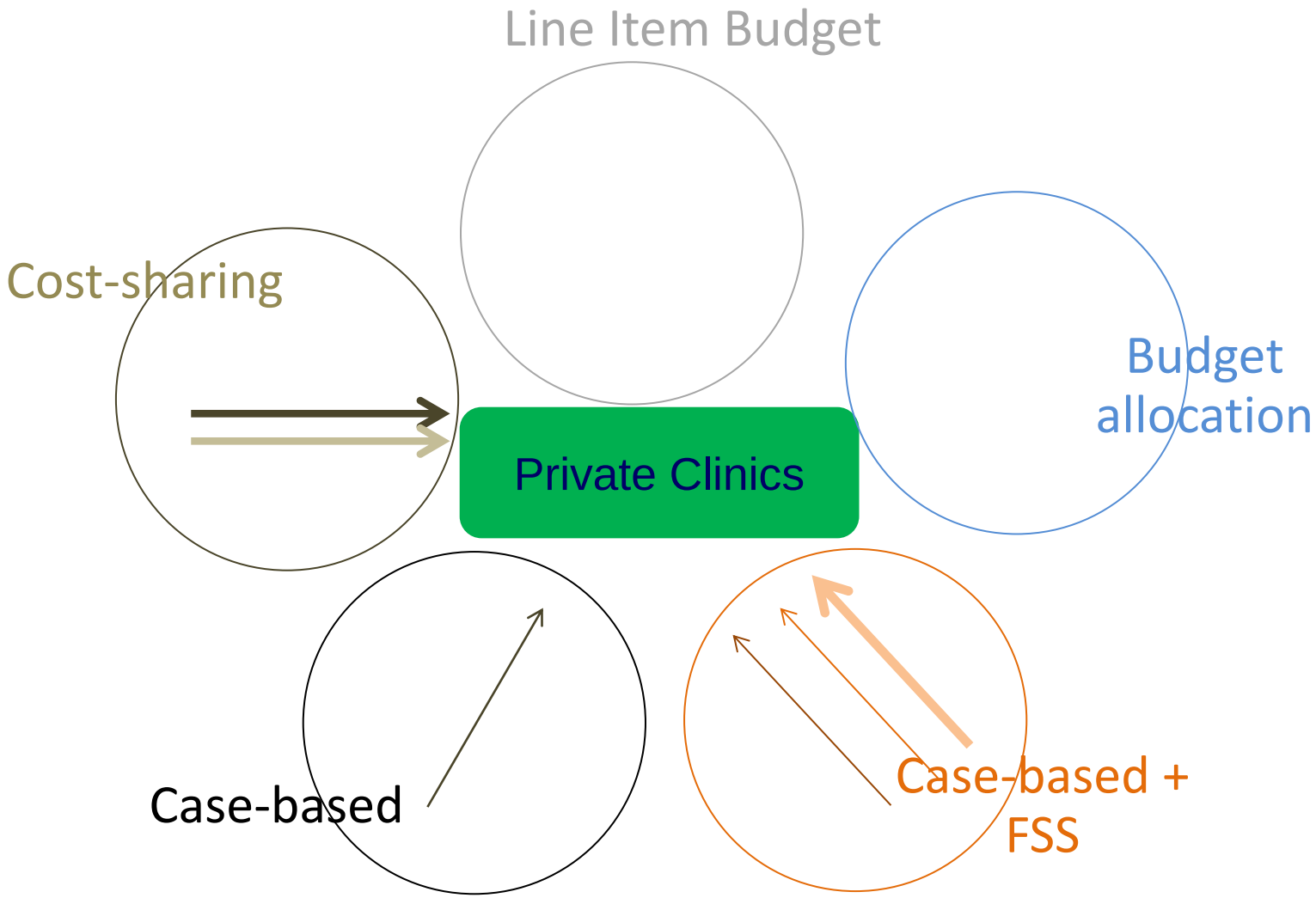


System perspective
Effects at the system level

- There is no P4P:
  - Would P4P be a useful component of the payment system in the public sector?


Line Item Budget
Cost-sharing
Budget allocation
District Hosp.
Case-based
Case-based + FSS


Line Item Budget
Cost-sharing
Budget allocation
Tertiary Hosp.
Case-based
Case-based + FSS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Private Clinics
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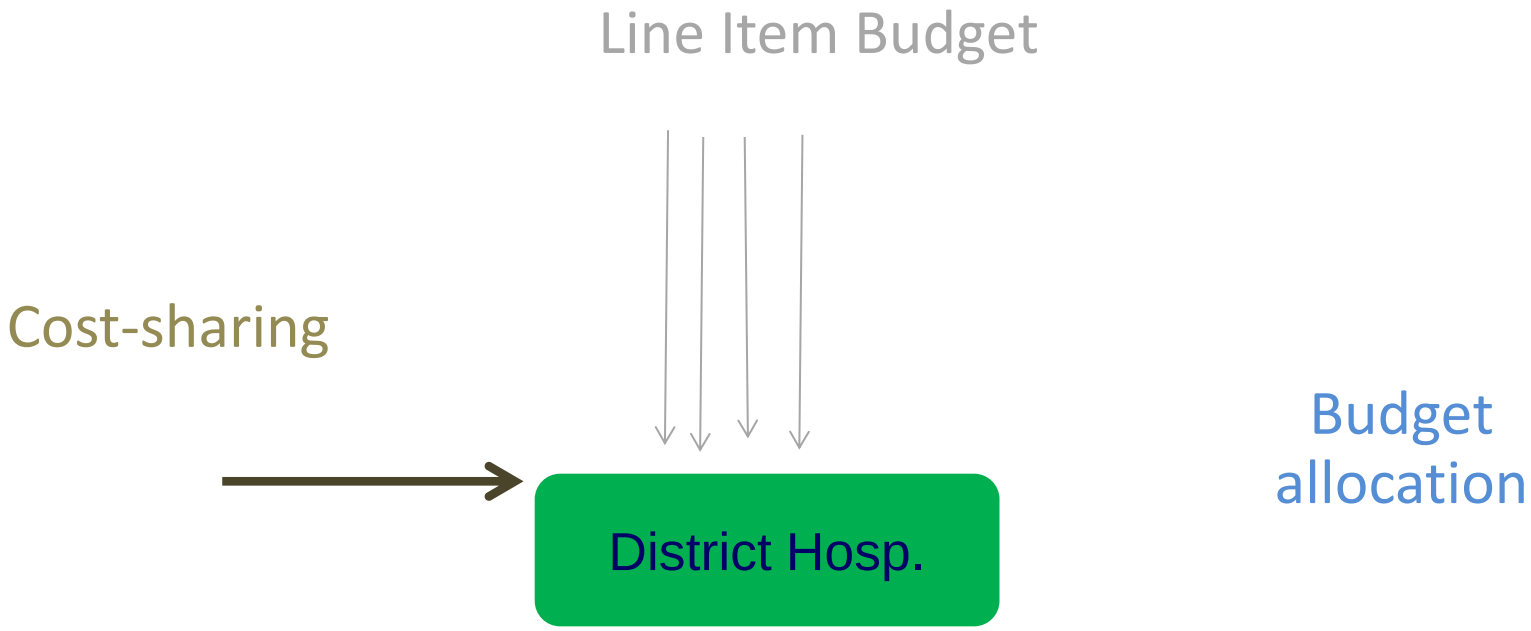
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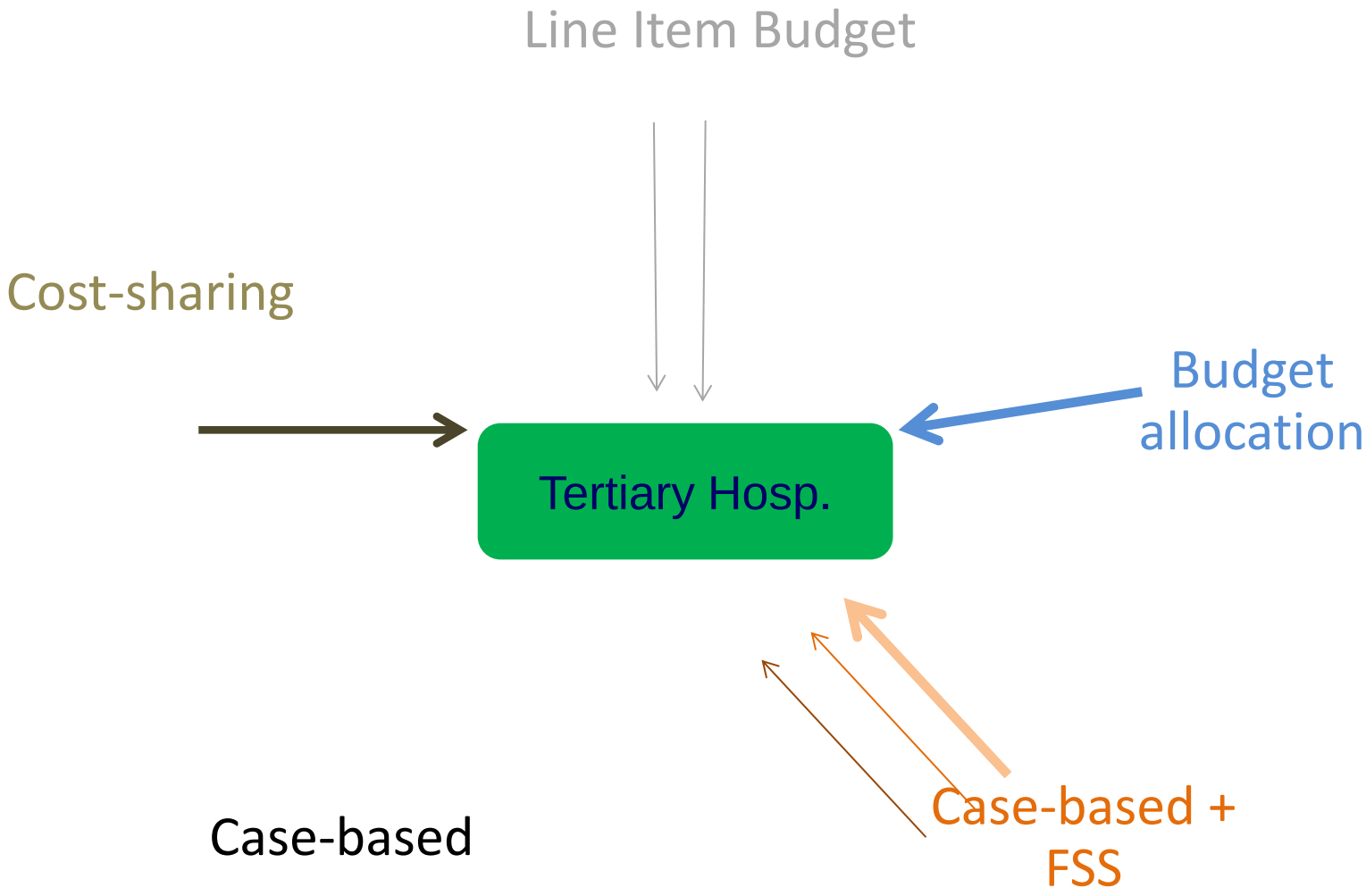
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Line Item Budget