

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

Fahdi Dkhimi, WHO HQ

Inke Mathauer, WHO HQ

Olivier Appaix, Independant Consultant

Houcine El Akhnif, MoH Morocco



# Morocco: What is in the mix?



## **Purchasers**

Ministry of Health  
Ministry of Finance  
Medical Assistance Regime  
(RAMED)  
National Health Insurance  
(NHIs)  
Private Health Insurance

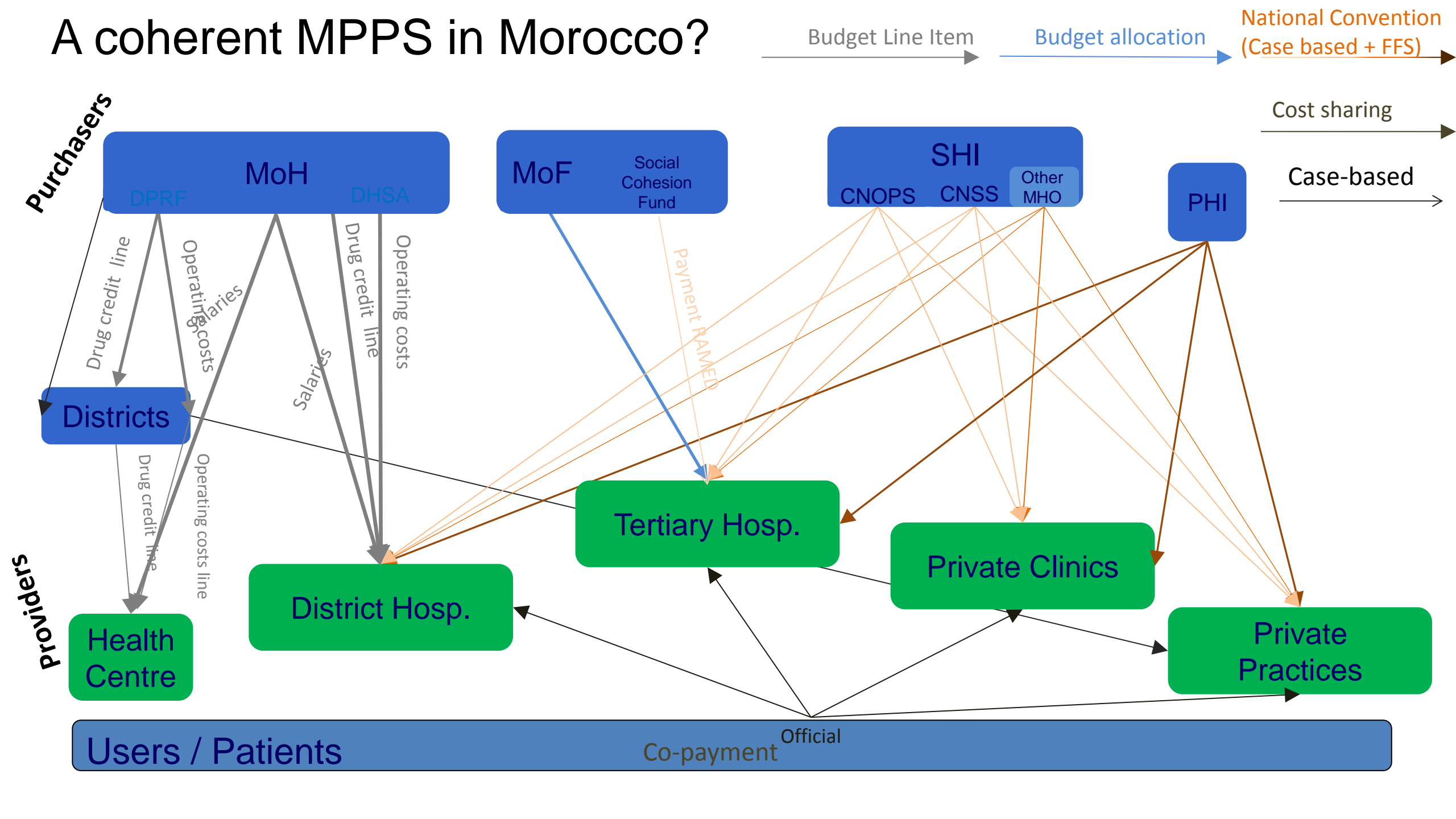
## **Payment methods**

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

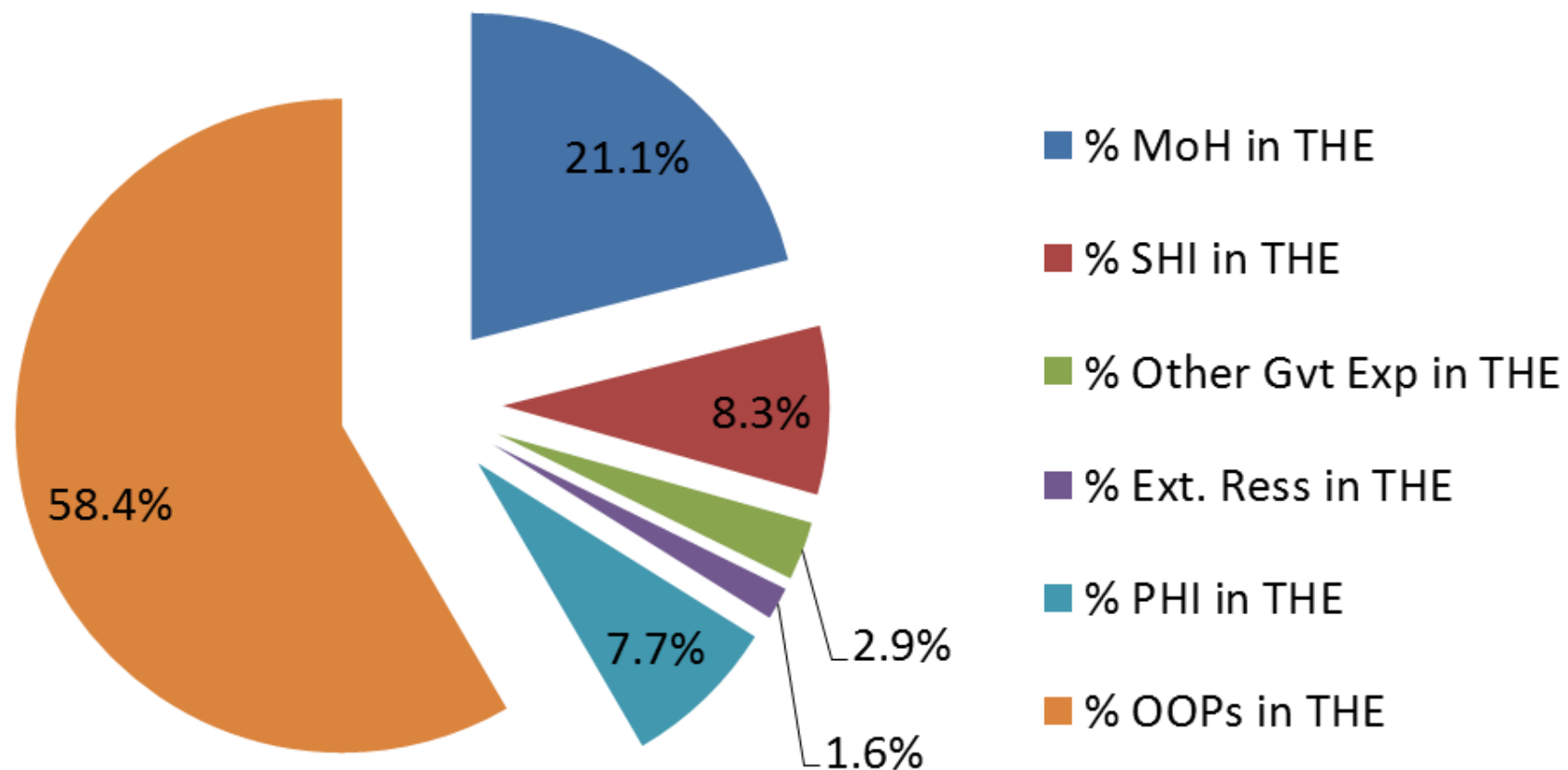
# A coherent MPPS in Morocco?



# Breakdown of Total Health Expenditure (THE)

NHA 2014

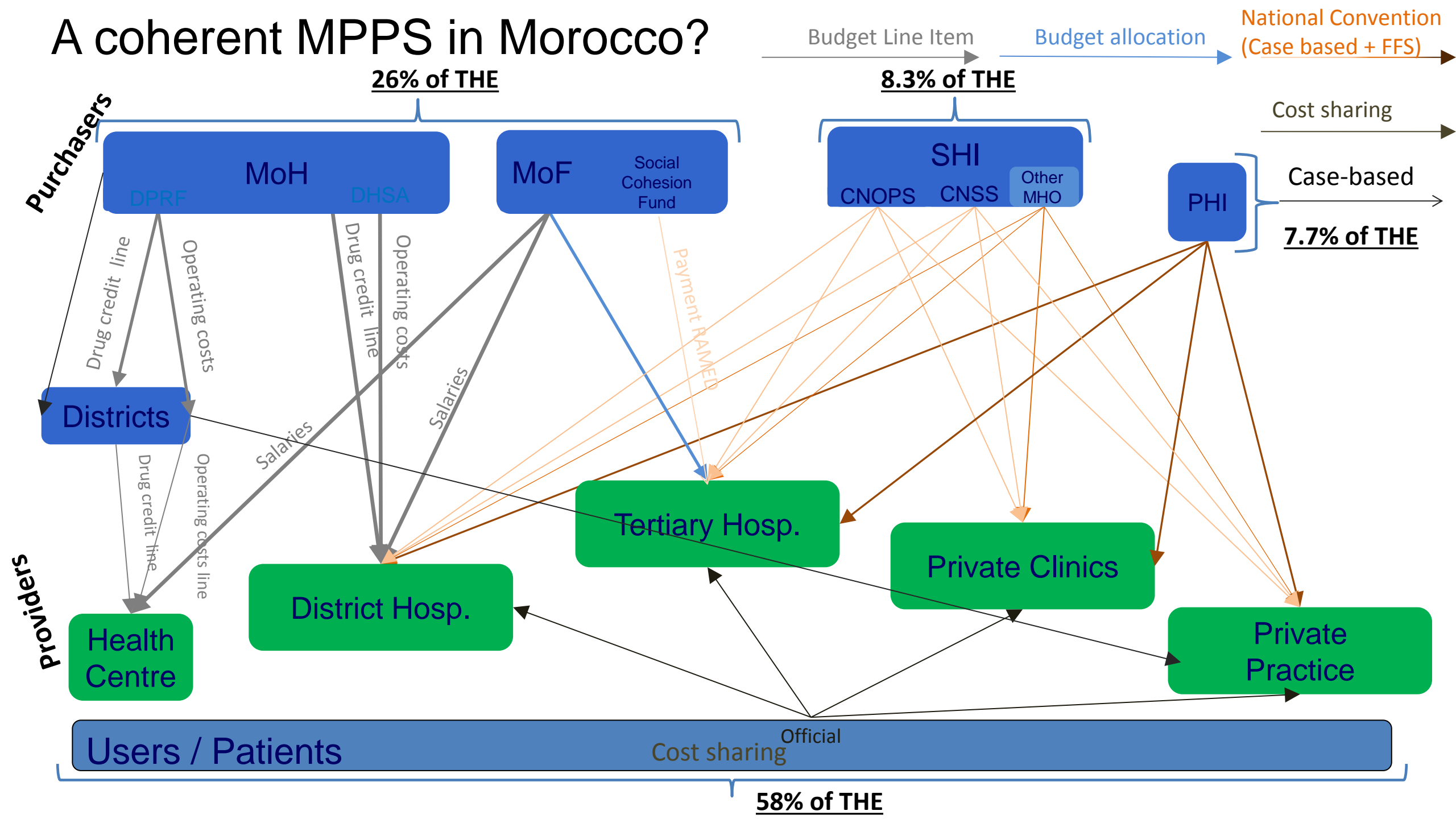
Source: <http://apps.who.int/nha/database/ViewData/Indicators/en>



**THE = 5.91% of GDP**

**GGHE = 6.03 % of GGHE**

# A coherent MPPS in Morocco?

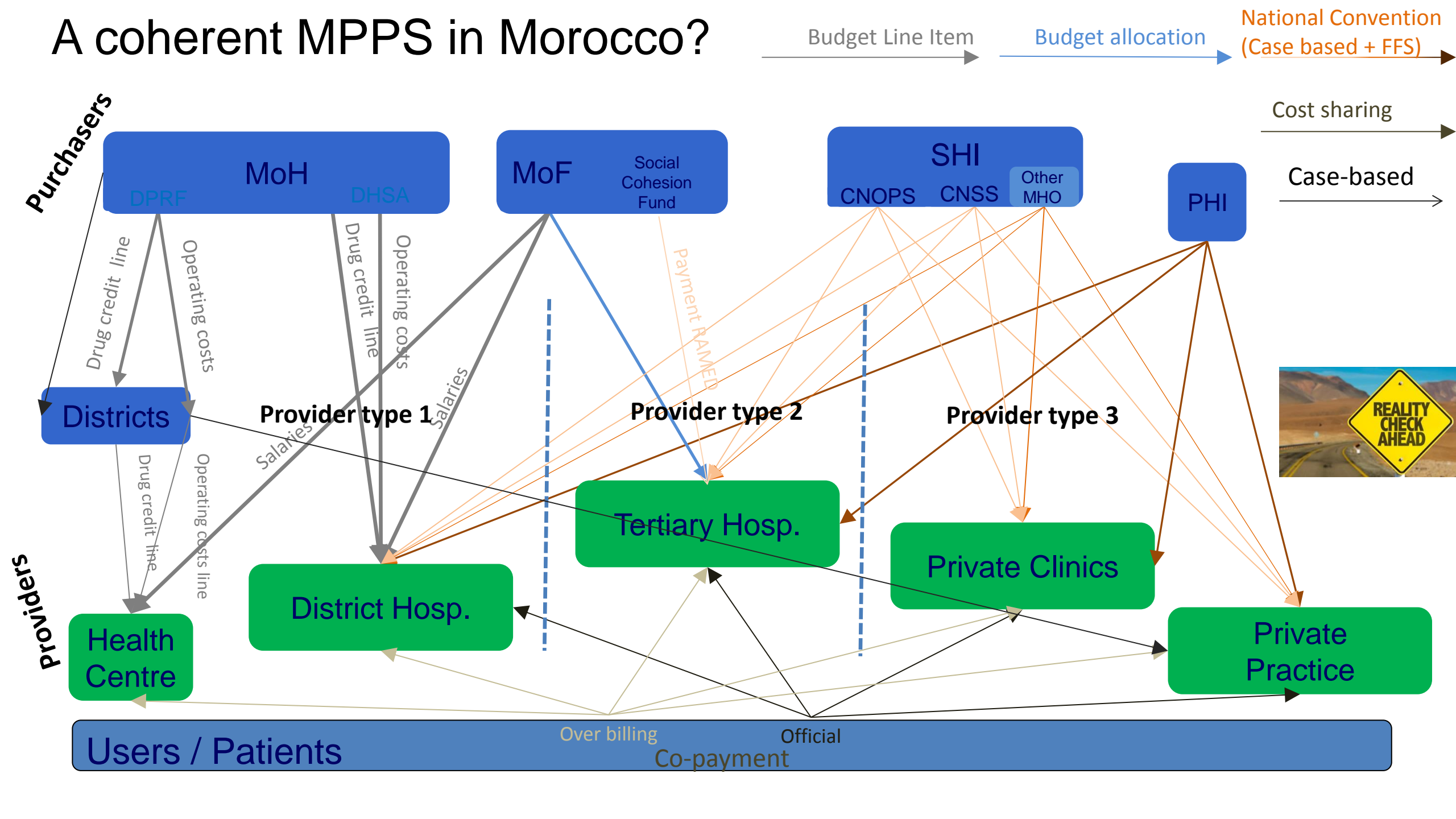




# Analysis



# A coherent MPPS in Morocco?



# Incentives and effects of MMPS

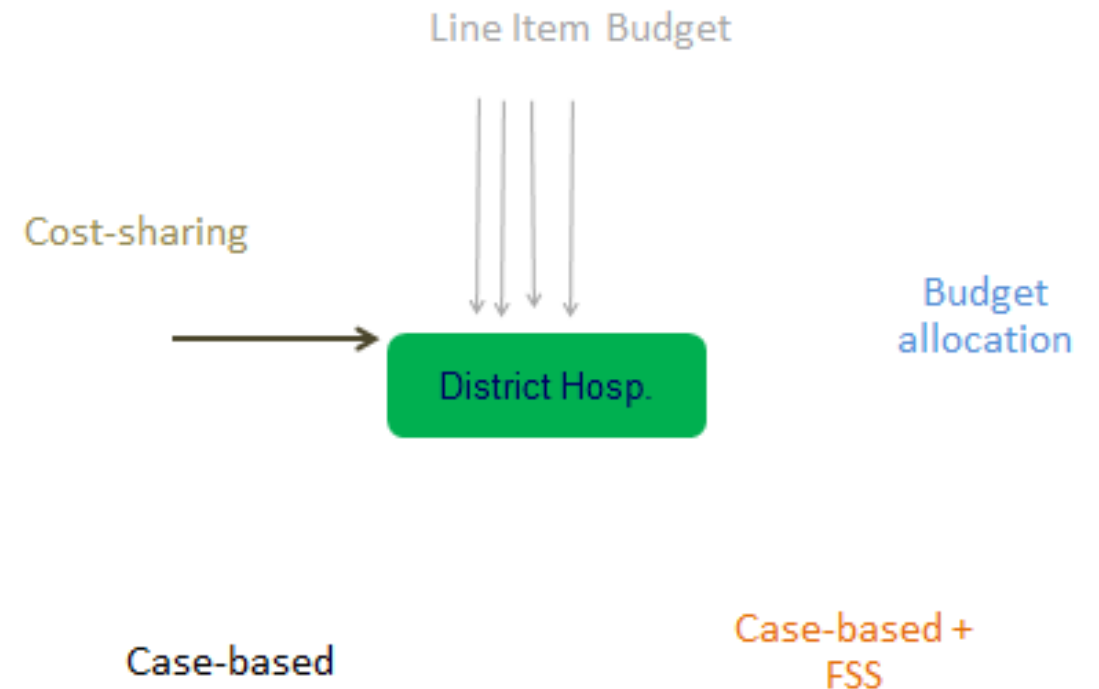
## Provider perspective – public sector



### 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

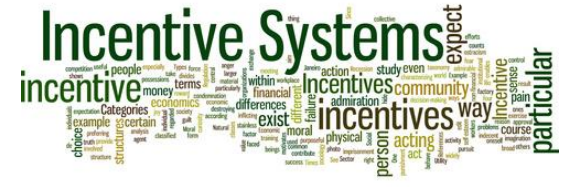
= > Under-provision (= low activity)



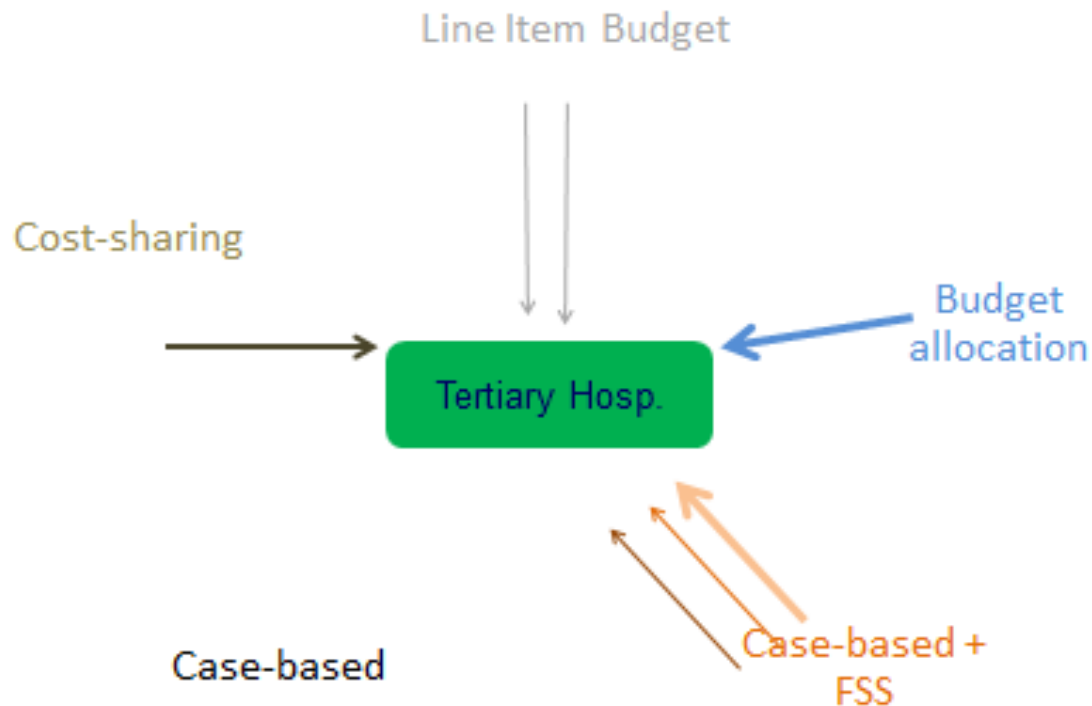


# Incentives and effects of MMPS

## Provider perspective – public sector



### Autonomous University Hospitals

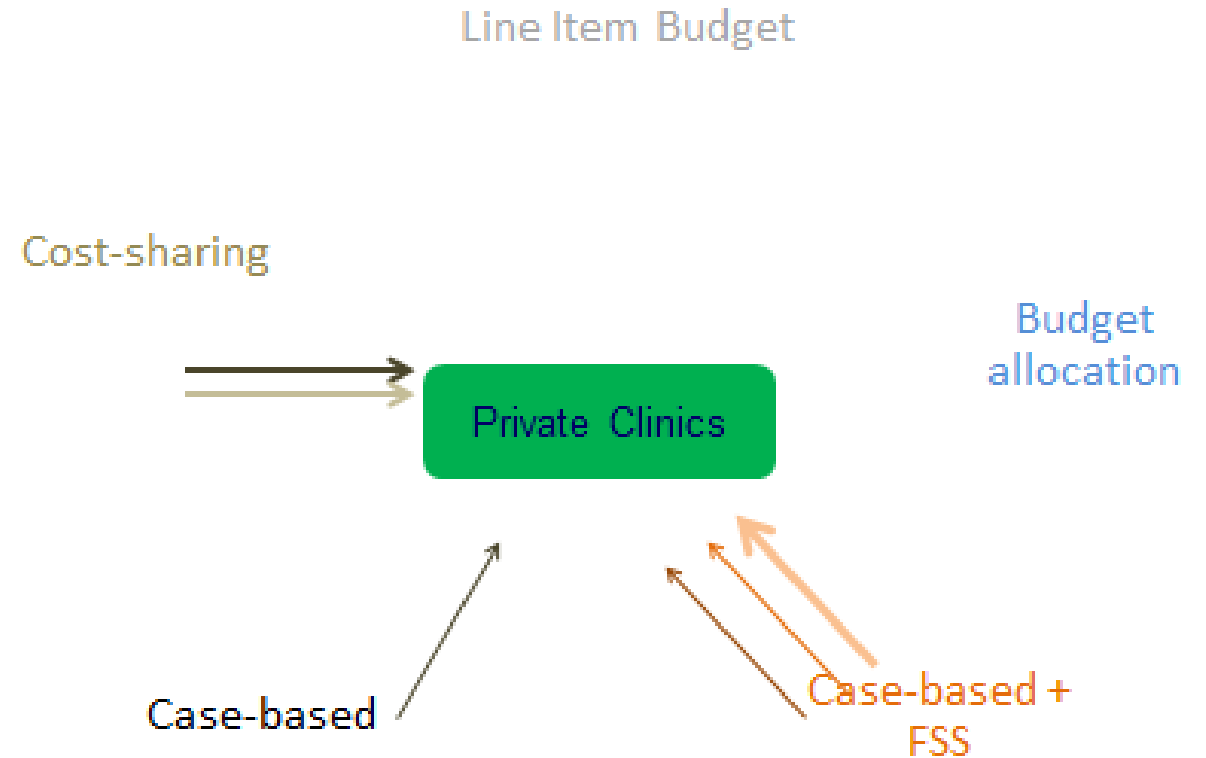


- Budget allocation and FFS and case payment from SHI/PHI
- Active billing for the SHI patients, virtual billing for documentation for RAMED patients

=> Higher activity

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

=> Cream-skimming (?), with potential inequitable access

[illegible]

[illegible]

- More activity oriented incentives for private providers and tertiary hospitals
- More cost-containment incentives for public, primary health care providers

⇒ **Contributes to the growth of 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



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# **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

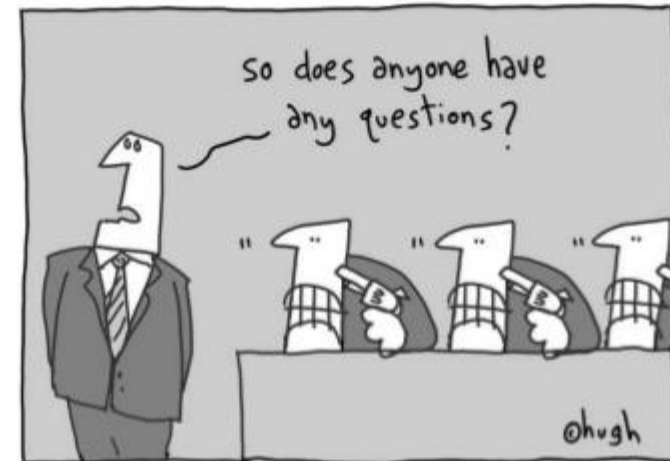
## **Accompanying governance related measures**

- 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**

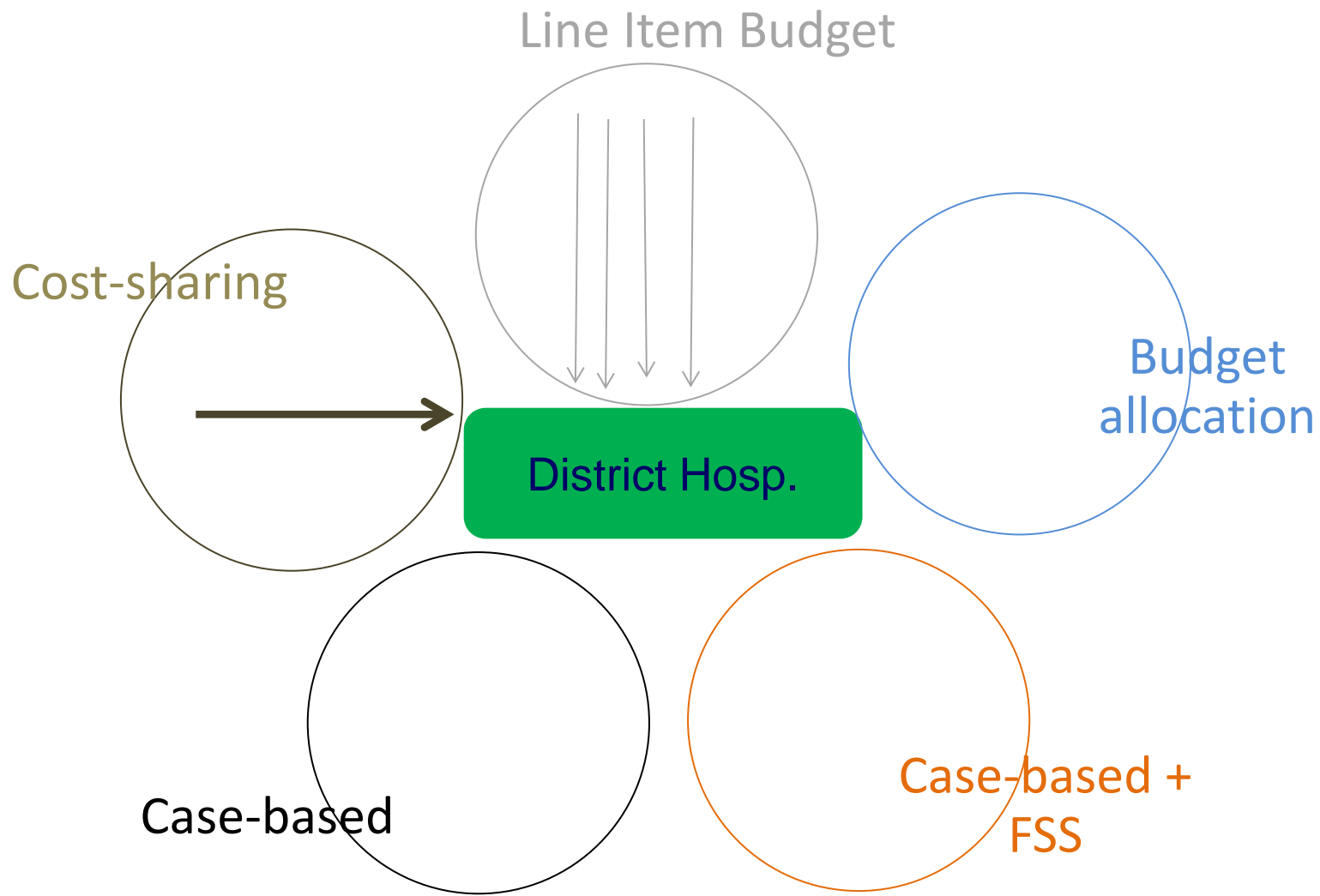
**(more to come soon)**

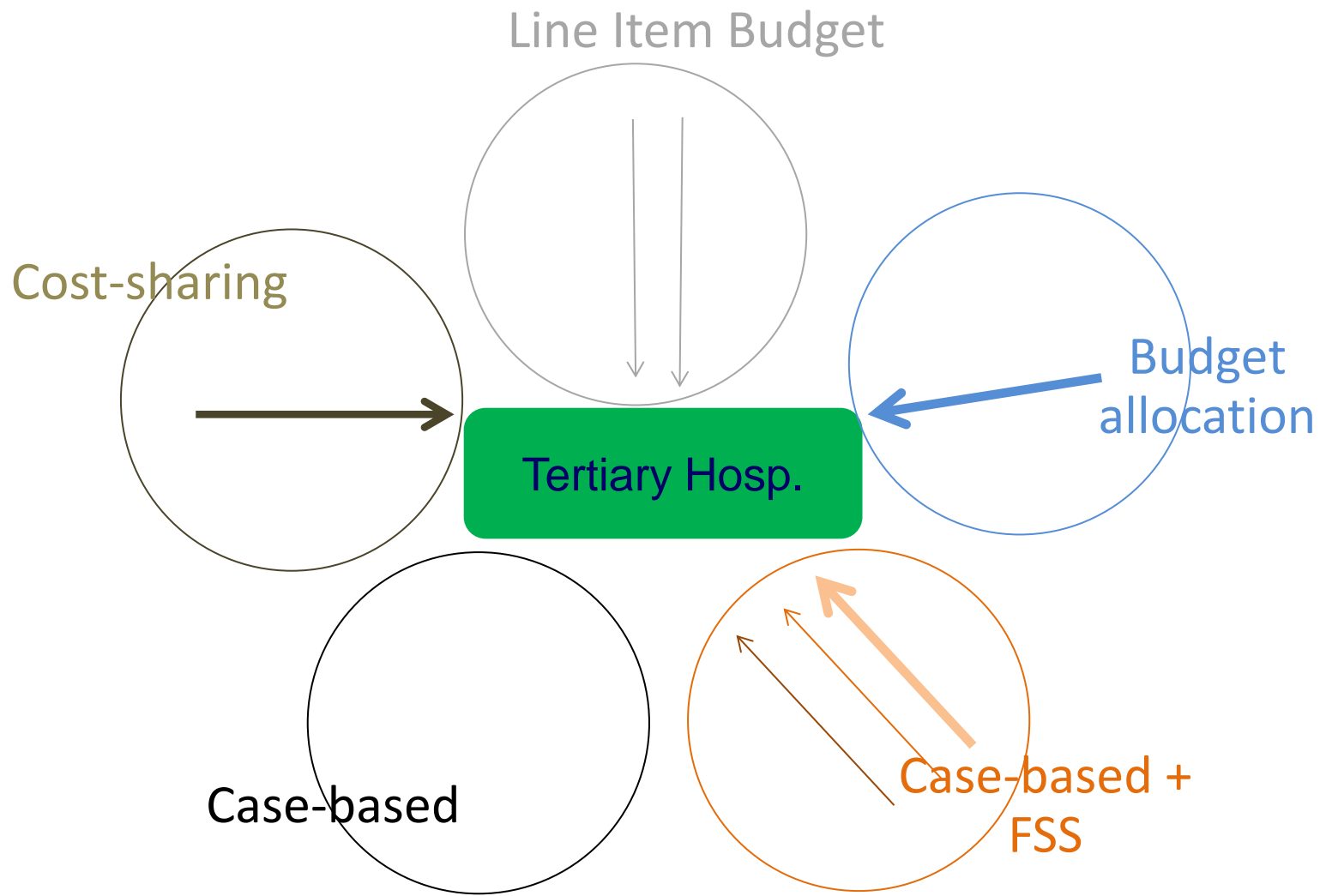


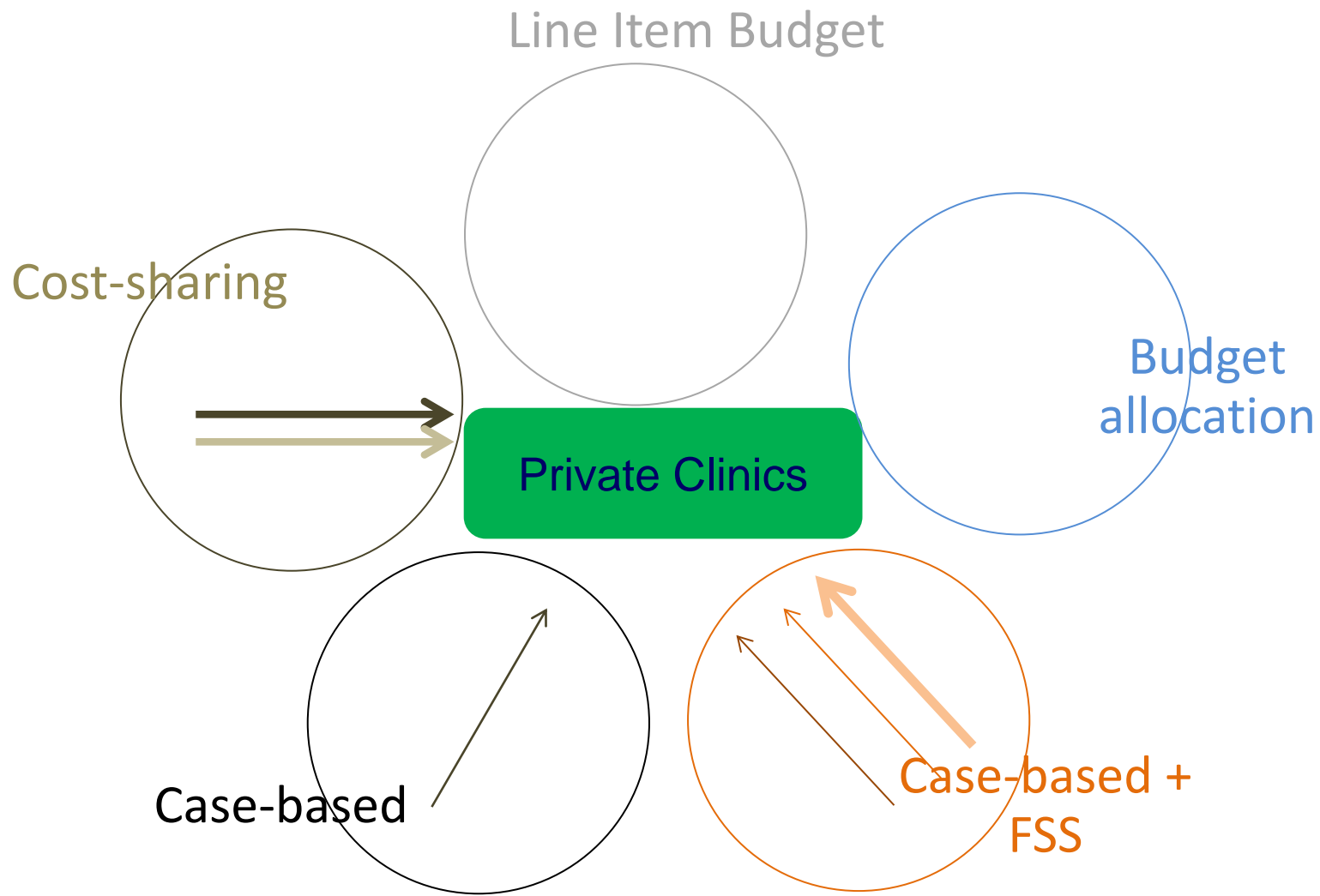
# System perspective

## Effects at the system level

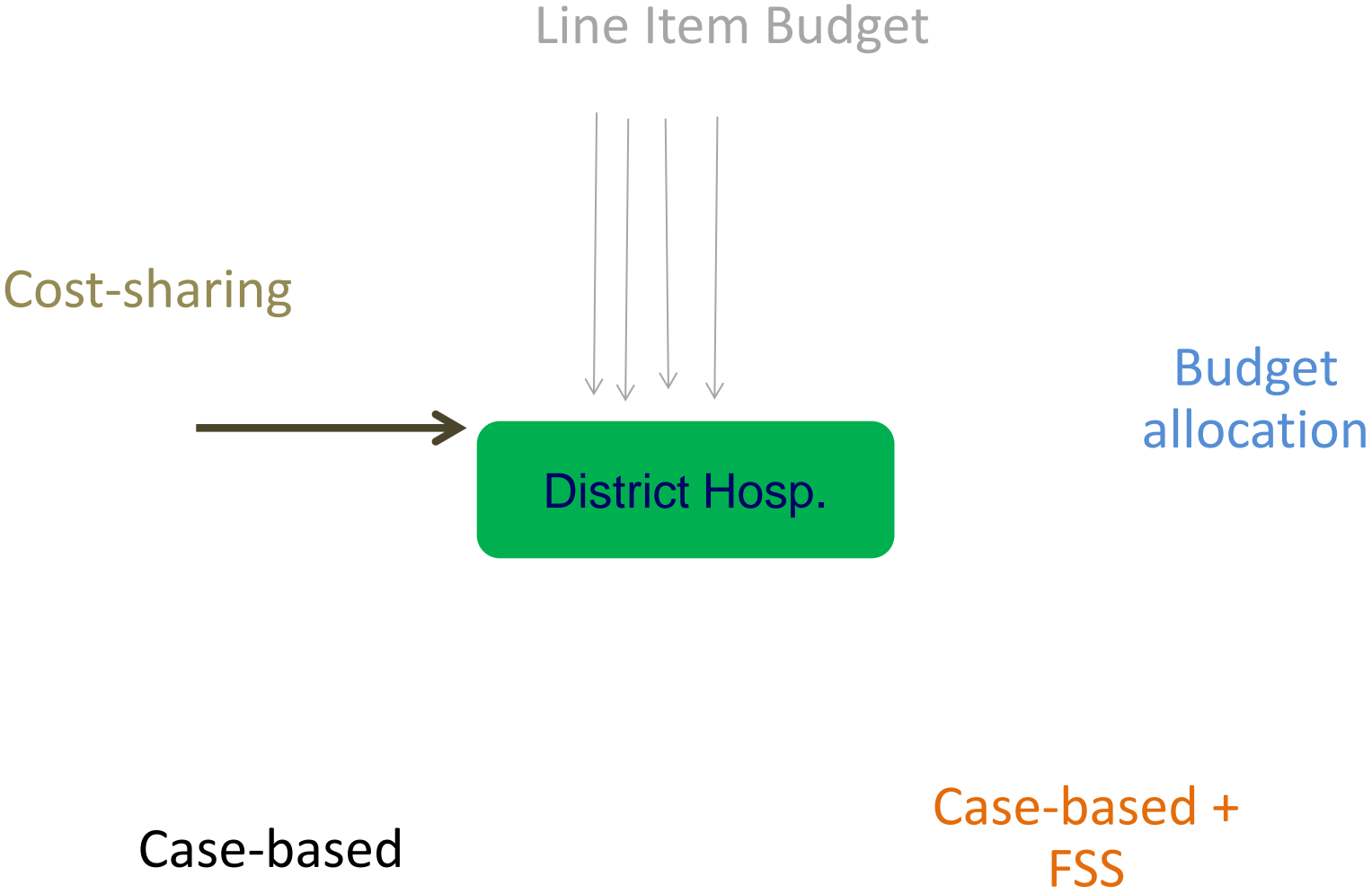
- There is no P4P:
  - Would P4P be a useful component of the payment system in the public sector?

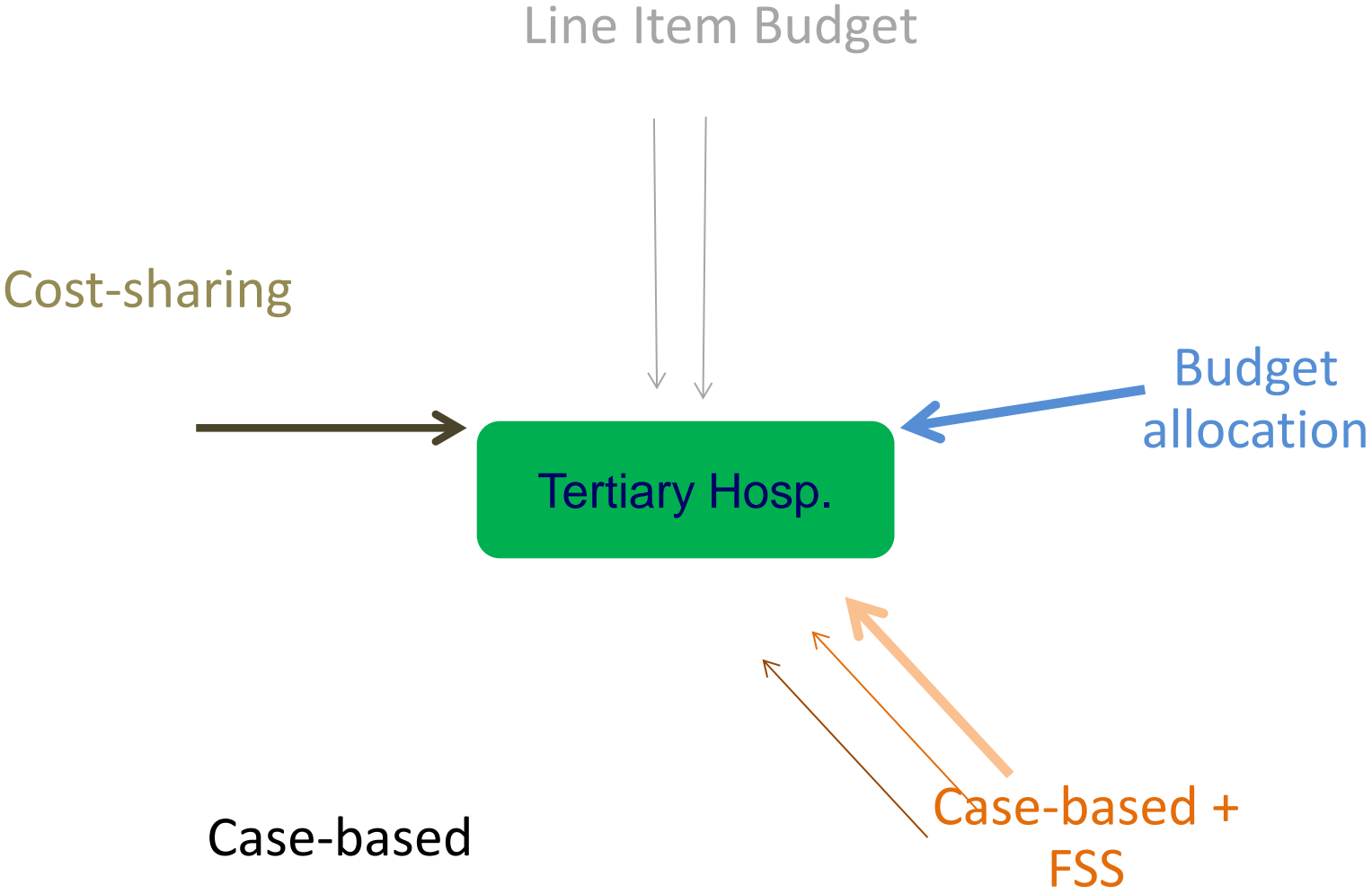












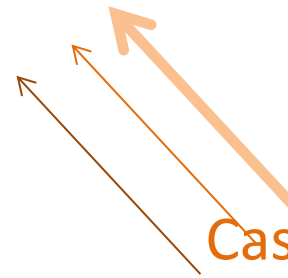
Line Item Budget

Cost-sharing



Budget  
allocation

Case-based



Case-based +  
FSS