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**MOROCCO
PRIVATE HEALTH
SECTOR STUDY:**

**FINDINGS
AND PROJECT DESIGN
RECOMMENDATIONS**

**JOHN SNOW, INC.
Arlington, Virginia, USA**

with

**INGENIERIE ET CONSEIL EN ECONOMIE
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LIST OF ACRONYMS

CHU	Centre Hospitalier Universitaire
CJP	Crédit Jeunes Promoteurs
CNOPS	Caisse National des Oeuvres de Prévoyance Sociale
CNSS	Caisse National de la Sécurité Sociale
FP/MCH	Family Planning and Maternal and Child Health
GP	General Practitioner
JSI	John Snow, Inc.
ICONE	Ingenierie et Conseil en Economie
IQC	USAID Indefinite Quantity Contract
MS_t	Ministère de la Santé Publique
SGG	Secrétariat Général du Gouvernement
SMSM	Société Marocaine des Sciences Médicales

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I. EXECUTIVE SUMMARY

This is a propitious time for USAID and the Government of Morocco to work together to devise a strategy in support of the growth of private health services. Because of their increasing numbers, physicians are becoming more sensitive to market conditions, while other key actors and decision makers have likewise become aware of health organization and financing issues. In addition, several initiatives are already underway to explore changes in the tax structure and examine other economic factors which influence how health services are produced and distributed throughout Morocco.

USAID and the Government of Morocco recognize the inherent limitations of public resources to meet the growing health needs of the Moroccan population (as reflected in the latest USAID Health Financing Project Implementation Document). This problem has become more evident in recent years due to an decrease, in real terms, in public sector health budgets. In response, the GOM has decided to support greater private sector involvement in the production and distribution of health services, while at the same time designing a strategy for refocusing public resources on high priority services for target groups.

An earlier document prepared for the USAID Mission suggested a "dual litmus test" for evaluating possible activities.¹ This dual litmus test included determining whether proposed activities were (a) potentially profitable for the private sector and (b) in the public good. Profitability is a *sine qua non* if the private sector is going to involve itself in the directed growth process. Serving the public good is accomplished when recommended activities are judged against the criteria of quality, equity, efficiency, cost containment, and complementing overall GOM and USAID goals.

The present document has two main objectives. The first is to provide an assessment of the prevailing conditions affecting private health service providers and the nature of health services resulting from those conditions. The assessment is based on findings from in-depth interviews with key service providers, with professional and trade associations, and in industries linked to the health sector (such as employers who purchase services, insurance companies, and banks), and from the considerable body of supplementary information existing in Morocco. The discussion will focus on problem areas, constraints, and opportunities. The second objective is to develop a set of activities which are based on the findings and which will stimulate the desired expansion in the private sector. These activities will prompt private sector growth which is resource efficient, beneficial to the public at large, and likely to help the public sector concentrate its resources on appropriate or priority activities.

¹ Opportunités pour une Expansion du Secteur Privé de la Santé au Maroc. (Translation of Nancy Harris et al. consultant report to USAID, November). 1990: JSI/The Enterprise Program.

The issues studied herein were chosen by USAID to provide background information for an upcoming Mission Project Paper. The decision to exclude an in-depth consideration of insurance activities, pharmaceutical sector activities, and specific managed care initiatives reflects the terms of reference prescribed by the Mission and direction given during the course of the study. This omission notwithstanding, the present document lays out a framework against which other initiatives can be considered, arguing that it is essential to judge initiatives by their ability (i) to foster growth which leads to improved equity, (2) to contain macrolevel costs, (3) to strengthen the ability of the private sector to respond positively, and (4) to make efficient use of both public and private resources.



The recommended activities are organized into three groups:

GROUP 1 ACTIVITIES are designed to help remove constraints (official and unofficial) and send appropriate market signals throughout the private sector. (the term "market signals" is explained in more detail in the text of the paper.) These activities include:

- Implementation of a demonstration project to stimulate innovative, alternative ways of producing and delivering services.
- Introduction of tax and regulatory specific incentives to stimulate desirable private sector responses.
- Strengthening the availability and dissemination of information.
- Promotion of quality of care in private sector services.
- Implementation of a consumer education campaign.

GROUP 2 ACTIVITIES are designed to enable the private sector at large to respond to market signals by making financial and technical resources more available. These activities include:

- Implementation of loan guarantee and technical assistance programs to support improved lending practices.
- Support for the development of an in-country capacity and market for management consulting activities in the health sector.
- Development of a set of training manuals and/or workshops for practitioners on marketing services to new groups, on investment choices, and on management.
- Formal training in health management for Moroccans planning to work in the private medical sector.
- Awarding of mini-contracts to develop case studies and manuals of successful organizational models in the private health sector.

GROUP 3 ACTIVITIES are designed to remove conditions which encourage use of public services by patients who would normally be using the private sector if comparable services were available at competitive prices, which increases government burden and stifles competition. This group of activities is intended to in effect "protect" public resources from unnecessary subsidization and to expand the opportunities for private sector provision of currently subsidized services, i.e.:

- Implementation of public production cost-based pricing: update of prices charged for curative services provided by the public and the semi-private sector to private and/or insured patients; review and possible improvement of eligibility/waiver systems.



Taken together, this set of activities should enable USAID to focus its resources to assist the private sector in producing and delivering quality health services. While the activities are presented in distinct modules to make it easier for USAID to choose those it wishes to fund, as a set they comprise a carefully integrated structure for introducing changes in market signals and enabling market response. The estimated cost of implementing these activities is on the order of US \$ 8.3 million.

As we will argue repeatedly in this document, *it is critical for USAID to direct its efforts toward the clearly identified end of efficient and equitable growth.* In and of itself, growth of the private sector may not be a desirable outcome — if that growth is inefficient, for example, or if it makes health care too expensive, if it doesn't create more access for more people, or if by its very nature it increases the drain on public resources. The goal, in short, is appropriate growth, the kind that will lead to a private sector that is at once more innovative, more competitive, and more widely distributed — thereby ensuring that more and better health services are more readily available to all the citizens of Morocco.

II. STUDY OBJECTIVES

As outlined in several documents prepared by the GOM and USAID, efforts in the private sector are broadly intended to make more services available to more people while recognizing the need to reduce the public sector's share of the burden.² Naturally, identifying a strategy to carry out these efforts in the most rational and effective manner falls within the domain of the government and its collaborating international agencies.

The following discussion is intended to provide information to the GOM and USAID as they work together to develop a blueprint for promoting expansion of the private health sector in Morocco. The information and recommendations herein are consistent with existing policies and strategies.³ They are designed to send appropriate signals to the private health market and to enable the market to respond to those signals. (examples of market signals are provided in Exhibit 1). Particular attention is paid to developing activities which will yield a maximum return on USAID's investment in private sector initiatives.

The issues selected for study and action were chosen by USAID to provide background information for an upcoming Mission Project Paper. The decision to exclude an in-depth consideration of insurance activities, pharmaceutical sector activities, and specific managed care initiatives reflects the terms of reference prescribed by the Mission (see Appendix I for study questions) and direction given during the course of the study. This omission notwithstanding, the present document lays out a framework against which other initiatives can be considered, arguing that it is essential to judge initiatives by their ability (1) to foster growth which leads to improved equity, (2) to contain microlevel costs, (3) to strengthen the ability of the private sector to respond positively, and (4) to make efficient use of both public and private resources.

This paper has two major objectives: The first is to identify and analyze constraints on the private sector's ability to respond to market signals; and the second is to present a set of project design recommendations aimed at removing those constraints. The identification and analysis will emphasize the private sector perspective by taking the point of view of providers, lenders, insurers, and any others who watch for and respond to changes in the private health market — the targets, in other words, of the proposed changes.

² "Project Identification Document", USAID/Rabat, 1990; "USAID Health Finance Strategy for Morocco", USAID/Rabat (draft version dated 7/25/90); "Discussion with Mr. Mechbal, Director of Preventive Health and Health Education, Ministry of Health, July 19, 1990 (Interview notes of unknown authorship, 1990); additional interviews and private discussions with Ministry of Health and USAID officials.

³ As outlined in "USAID Health Finance Strategy for Morocco", *op. cit.*

EXHIBIT 1

MARKET SIGNALS

Market signals are, simply put, signals which affect the economic behavior of investors, providers, and other actors. Market signals can be sent by users, institutions, the tax code, competition, lenders, legislatures, or government ministries, and they can be received by any of these actors. They can encourage or discourage actions. Desirable market signals would encourage behavior that is in the public interest and discourage behavior that is not, while undesirable market signals would have the opposite effect. Following are a few examples of market signals:

Source of Signals	Desirable Market Signals	Undesirable Market Signals
Government and regulations	Tax exemptions for preventive health services; tax holidays for practicing in underserved areas; access to subsidized vaccines, contraceptives, etc.	Taxes on preventive services; unclear regulations regarding allowable practice settings; specific prohibitions against delivery settings which are efficient and beneficial
Lenders	Credit access for innovative kinds of organization and expansion or for incorporating certain services	Credit terms which favor expensive equipment; unwillingness to lend to innovative medical practices
Insurers	Full payments for preventive services; inducements for preventive care	Copayment structure which discourages use of preventive services

The following section presents the technical framework within which the analytic and design activities have been carried out. Then follows a brief descriptive overview which identifies the major actors in the private sector, to provide some sense of their importance, their geographic distribution, and the extent to which they interact. This is followed by an analysis (or "diagnosis") of factors which limit the ability of the private sector to perform more efficiently. From this diagnosis, the report presents a strategy (or "prescription") for stimulating changes in the private sector and finally, based on the strategic direction suggested, outlines a set activities which can be undertaken by the government and by USAID.

III. TECHNICAL FRAMEWORK

The approach used to conduct this study was specifically developed for assessing and designing private sector initiatives. It involves (in this instance) reviewing existing information on the health care system in Morocco, supplementing it with information obtained through extensive interviews with sample groups, and analyzing the resulting information to pinpoint key constraints to the growth of the private health sector and the likely impact of any recommended changes.

The analysis of the Moroccan private health sector is presented here in four stages; Description, Diagnosis, Prescription, and Implementation.⁴ Each stage builds on the former and provides a clear basis for recommendations. The Description section identifies and categorizes the major actors in the private sector. These actors include groups working totally within the health sector, such as physicians, and those whose work involves other spheres of economic activity (such as banks and insurance companies). This section provides a basis for assessing both the magnitude and distribution of resources and also relates general quantitative information to the critical resource constraints already identified by USAID and the GOM.

The Diagnosis section focuses directly on the way private sector behavior is shaped and influenced by the existing rules, practices, and conditions in the health care market. We consider a number of key questions concerning growth constraints in the private sector as well as a number of other questions specific to the health sector. These two sets of questions, which reflect a number of expectations about influences on private sector activities, were built into the interviews with the sample groups.

The approach used in this study asked three fundamental questions:

1. Does the market generate the *appropriate signals* to stimulate the most effective private sector participation?

That is, the desired result is that the private sector receive appropriate signals about the economics of the marketplace (where the demand is, how it responds to changes in quality, what the potential income is, what the tax structure is, and so forth) and discount inappropriate signals (e.g., confusion about practice settings, inhibitions to its ability to organize and produce services efficiently, limitations on use of credit, etc.).

2. If the "correct" signals were generated, *can the private sector respond?*

That is, the desired result is to make sure that the private health sector has the resources, both technical and financial, to respond to market signals. This may

⁴ The steps of describing, diagnosing, prescribing, and implementing are loosely based on a methodology described in MAPS: Manual for Action in the Private Sector (Washington, 1990: Austin and Associates/Ernst and Young).

involve improving access to credit (for different geographic areas or for expenses other than capital/equipment purchases) and introducing standard technical approaches to organizing and producing services (such as market studies, operations research, utilization monitoring, cost analysis and so forth).

3. If the signals were correct and the private sector responded, *would this change lead to the desired result of decreasing government burden and protecting public resources?*

Protecting public resources means preventing a situation in which growth in a limited set of private sector services leads simultaneously to demand for other services (because of referrals, etc.) which are only produced in the public or quasi public sector. Underlying the desire to protect public resources is the desire to make more public resources available for preventive health services and to limit the use of public services by those who could and would use the private sector instead of the public sector, if this were a reasonable alternative.

To the extent that current conditions create negative answers to these questions, the policy issue becomes "What actions can we take to make the answers to the above questions positive?"

These technical questions provide us with an organizational approach by which we can identify problems as well as opportunities in the private sector, and develop an approach for applying USAID resources to ameliorating constraints and stimulating the kinds of growth which are in the best interest of the public.

The first two questions were asked at length in the interviews. We asked respondents about obstacles to entering the market, why their practices were organized as they were, and how they might respond to certain changes in the market. And we then used their responses as a basis for developing the implementation strategies in this report.

Based on observations made in the Description and Diagnosis sections, the Prescription stage (Part IV) identifies the major areas of needed change and outlines a number of strategies to move the system in the right direction. These strategies address each of the three policy questions asked above and are the logic behind the specific activities presented in the Implementation section (Part VII).

The Implementation section, as noted, presents recommendations for achieving each of the prescriptive themes. Each recommended action is assessed against a set of attributes designed to focus the activity and anticipate conditions in which it is most likely to be effective. Taken together, the set of implementation recommendations, linked to the basic policy questions they derive from, form a coherent strategy for strengthening the role of the private sector in meeting the health care needs of Moroccans.

IV. DESCRIPTION: ACTORS IN THE MOROCCAN PRIVATE HEALTH SECTOR

We begin by identifying what the private sector is currently doing, who the main actors are, how big it is, and where it operates. We can then consider what makes it operate the way it does and then look for opportunities for desirable change and growth.

In addition to existing data sources, legal texts, etc., information in this and the following section was obtained through in-depth interviews with major actors in the private sector, such as health providers, financiers, and insurers. (Summary Transcripts of interviews are provided in the Annex to this paper). The sample was chosen to cover the widest possible range of experience within the private health sector, thereby allowing us to identify the distribution, market niche, and roles of each set of actors.

PUBLIC AND QUASI-PUBLIC: THE GOVERNMENT AS SUPPLIER AND FINANCIER OF HEALTH SERVICES

Despite the growth in the private health sector in the past few years, the public sector remains a major player in the Moroccan health care market. The Ministry of Public Health (MSP) employs over 2,600 physicians and 22,000 paramedical staff in a variety of hospitals, health centers, and dispensaries throughout the seven regions of Morocco (See Table 1). The level of services ranges from basic primary health care through sophisticated tertiary care to the Centres Hospitaliers Universitaires (CHU) in Rabat and Casablanca.

Table 1

Distribution of Public Sector Health Providers and Facilities in Morocco, 1989

	Para-Physicians	Hospital Medicals	Hospital Beds	Health Centers	Dispensaries	Total Population
South	8.6%	10.7%	10.4%	16.4%	18.7%	11.9%
Tensift	7.4%	12.4%	13.4%	9.8%	13.9%	13.9%
Center	26.1%	22.7%	24.9%	26.3%	19.7%	27.7%
Northwest	39.4%	27.2%	27.5%	19.6%	15.3%	20.6%
Center-North	8.0%	10.4%	9.3%	10.9%	14.8%	11.4%
Eastern	3.9%	6.6%	5.3%	6.4%	6.1%	7.3%
Center-South	6.6%	10.0%	9.2%	10.6%	11.4%	7.2%
Total Number	2,619	22,227	24,054	377	1,243	24.6 mill.

It was estimated that in 1987 the public and quasi-public sector provided about two-thirds of the hospital care and nearly half of the outpatient care in the country, and roughly 60% of the value

of hospital and ambulatory care combined.⁵ It was also estimated that the growth of private ambulatory care for the three preceding years was about equal for the two systems (public and private), though the fastest growth overall was in private hospitals/clinics.

Between 1982 and 1990, increasing budgetary constraints faced by the MSP resulted in a decline in real per capita recurrent expenditures of over 30%.⁶ Moreover, these declining resources were being spent increasingly on curative care in urban areas, so that resources available for rural areas and preventive care became even more scarce.

According to many of those interviewed during the course of this study, decreasing real resources have resulted in notable declines in both the quality of care in public health facilities and the working conditions of health practitioners assigned to these facilities. As a result, an increasing number of people have been seeking care from the private and quasi-public sectors. Indeed, the fastest growing segment of the health market has been private practitioners.⁷

Table 2
Distribution of
Public and Private Physicians in Morocco
1985 and 1989

	1985		1989		% Change 1985-1989	
	Private	Public	Private	Public	Private	Public
South	73	191	101	224	38.4%	17.3%
Tensift	137	146	163	195	19.0%	33.6%
Center	745	378	972	683	30.5%	80.7%
Northwest	460	753	586	1,032	27.4%	37.1%
Center-north	142	154	190	209	33.8%	35.7%
Eastern	123	69	132	103	7.3%	49.3%
Center-south	83	125	99	173	19.3%	38.4%
TOTAL	1,763	1,816	2,243	2,619	27.2%	44.2%

⁵ Derived from Ottmani and Tibouti (1991), p. 83.

⁶ Vogel and Stinson (1989), p. 17.

⁷ Ottmani and Tibouti (1991), p. 83.

PRIVATE PROVIDERS OF HEALTH PRODUCTS AND SERVICES⁸

A wide range of health providers operate in the private sector in Morocco. These include general practitioners (GPs) and specialist physicians in individual practice, group practices, private clinics with inpatient facilities, dentists, paramedical personnel, laboratories, and pharmacies.

Physicians in private practice in 1989 numbered 2,243 — up 27% from 1985, as shown in Table 2. During this same four year time period, however, the number of public sector physicians (not including CHU employees) increased by over 44%, from 1,816 to 2,619, despite the shortage of funds in the Ministry of Public Health during this period. Nearly 75% of private physicians were GPs, compared to less than 50% of public sector doctors (not including CHU personnel). In fact, more GPs were practicing in the private sector in Morocco in 1989 than in the public sector (1,681 vs. 1,250, respectively). (See Tables 3-6 for detailed data.)

Private Practice Physicians - General Practitioners

In 1989, 1,681 private GP physicians were practicing in Morocco. Over 70% of these were practicing in the Center and Northwest regions (containing Casablanca and Rabat), where only 48% of the population lives. The vast majority of GPs practice in individual offices rather than in group settings. GPs indicated that they tend to locate their offices in "quartiers populaires" and near arrival points of travelers because these locations have lower rents and provide easier access to patients. The types of services provided by GPs are largely curative, although many physicians also provide health education and vaccinations.

Private Practice Physicians - Specialists

Of the 562 private sector specialist physicians practicing in Morocco in 1989, 67% were operating in the Center and Northwest regions. While group practices of specialists have become more common in recent years, most specialists continue to operate out of individual offices. Specialists tend to open offices in downtown areas (where their signs can be seen by the largest number of people) and in well-to-do suburbs (near their potential clients, who may be more well-off than the average patient of a GP). In addition, specialists may be more able to afford the higher rents in these areas.

⁸ Information in this subsection was gathered largely from the Annuaire Statistique du Maroc 1990, Direction de la Statistique, Ministère du Plan, Royaume du Maroc. Unless otherwise indicated, all tables are drawn from data in this source. Descriptive information from the survey interviews is also summarized where appropriate.

Table 3
Distribution of Public Sector Doctors
As of December 31, 1989
by Region

	Gen.	Specialists			Total
		All	OB/GYN	Ped.	
South	13.4%	4.2%	4.7%	3.3%	8.6%
Tensift	10.1%	5.0%	5.4%	6.7%	7.4%
Center	23.3%	28.6%	22.8%	30.8%	26.1%
Northwest	27.2%	50.5%	51.0%	51.7%	39.4%
Center-North	11.1%	5.1%	8.1%	3.3%	8.0%
Eastern	5.4%	2.6%	3.4%	2.5%	3.9%
Center-South	9.5%	3.9%	4.7%	1.7%	6.6%
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%
Total number	1,250	1,369	149	120	2,619

Table 4
Distribution of Public Sector Doctors
As of December 31, 1989
by Specialty

	Gen.	Specialists			Total	Number
		All	OB/GYN	Ped.		
South	74.6%	25.4%	3.1%	1.8%	100.0%	224
Tensift	64.6%	35.4%	4.1%	4.1%	100.0%	195
Center	42.6%	57.4%	5.0%	5.4%	100.0%	683
Northwest	32.9%	67.1%	7.4%	6.0%	100.0%	1,032
Center-North	66.5%	33.5%	5.7%	1.9%	100.0%	209
Eastern	66.0%	34.0%	4.9%	2.9%	100.0%	103
Center-South	68.8%	31.2%	4.0%	1.2%	100.0%	173
Spec. Dist.	47.7%	52.3%	5.7%	4.6%	100.0%	2,619

Table 5
Distribution of Private Doctors in Morocco
As of December 31, 1989
by Region

	Gen.	Specialists			Total
		All	OB/GYN	Ped.	
South	4.3%	5.2%	4.6%	6.3%	4.5%
Tensift	7.1%	7.7%	4.6%	4.7%	7.3%
Center	47.5%	30.8%	29.2%	20.3%	43.3%
Northwest	22.7%	36.3%	43.1%	42.2%	26.1%
Center-North	7.8%	10.5%	9.2%	9.4%	8.5%
Eastern	5.9%	5.9%	4.6%	10.9%	5.9%
Center-South	4.6%	3.7%	4.6%	6.3%	4.4%
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%
Total number	1,631	562	65	64	2,243

Table 6
Distribution of Private Doctors in Morocco
As of December 31, 1989
by Specialty

	Gen.	Specialists			Total	Number
		All	OB/GYN	Ped.		
South	71.3%	28.7%	3.0%	4.0%	100.0%	101
Tensift	73.6%	26.4%	1.8%	1.8%	100.0%	163
Center	82.2%	17.8%	2.0%	1.3%	100.0%	972
Northwest	65.2%	34.8%	4.8%	4.6%	100.0%	586
Center-North	68.9%	31.1%	3.2%	3.2%	100.0%	190
Eastern	75.0%	25.0%	2.3%	5.3%	100.0%	132
Center-South	78.8%	21.2%	3.0%	4.0%	100.0%	99
Spec. Dist.	74.9%	25.1%	2.9%	2.9%	100.0%	2,243

Group Practices/Partnerships

The geographic distribution and total numbers of physicians involved in group practice are not known. There are signs, however, of a growing tendency toward the formation of group practices in recent years, particularly among specialist physicians. The interviews indicated that doctors chose group practices for two main reasons: to share equipment costs and to benefit from close working relationships with other physicians. Most of the group practices interviewed involved partnerships of specialists of the same type (for example, radiologists), since it is this type of partnership that can best take advantage of shared equipment costs. Clinics owned by groups of physicians may group together a variety of specialties — for example, Clinique El Hakim in Casablanca.

Private Clinics

Given that private physicians have difficulty following their patients if they are referred to public hospitals, individual physicians or groups of physicians often open clinics (private inpatient facilities). Surgeons in particular are drawn toward opening clinics since access to inpatient facilities is important given the requirements of their profession.

Current information on the number and geographic distribution of private clinics is not available. A study published in 1989 reported that there were 83 private inpatient facilities at that time. Half of these clinics were in the two cities of Rabat and Casablanca, and over two-thirds were in the Center and Northwest regions encompassing these cities.⁹ A recent study by the Ministry of Public Health should provide more current data on these private inpatient facilities.¹⁰

In Rabat and Casablanca, many private clinics find themselves in competition with CHU services. The university hospitals, for example, offering tertiary care for low fees, attract a high percentage of the potential clients of private inpatient facilities. CNSS polyclinics and mutualist clinics also compete for patients with purely private sector clinics.

Paraprofessionals/Midwives

In 1989, over 22,000 nurses and midwives were working in the public sector in Morocco (see Table 7). These paramedicals were distributed among the seven regions of Morocco in a way that matched the distribution of the population as a whole much more closely than does the distribution of physicians. In contrast, the 735 nurses and midwives authorized to practice in the private sector worked almost exclusively in the Center and Northwest regions (81% total, and nearly 60% in the Center region alone — see Table 8). It is unclear whether these include only nurses and midwives operating independently in the private sector or also those working for private clinics and physician's offices, though their distribution certainly reflects the distribution of private physicians. The services provided by these individual paramedical practitioners include injections, dressings, and other basic medical care.

⁹ Waji Maazouzi, Les Elements d'une Nouvelle Politique de Santé au Maroc (Rabat: Editions Okad, 1989), p. 195.

¹⁰ Results of this study are not available at the time of this writing.

Table 7
Distribution of Paramedical Personnel in Morocco, 1989
Public Sector

	ASDES	ASDE	ASB (1)	Total	% Dist.
South	110	600	1,672	2,382	10.7%
Tensift	89	780	1,881	2,750	12.4%
Center	150	1,331	3,558	5,039	22.7%
Northwest	436	2,053	3,560	6,049	27.2%
Center-North	85	693	1,541	2,319	10.4%
Eastern	52	440	965	1,457	6.6%
Center-South	81	751	1,399	2,231	10.0%
TOTAL	1,003	6,648	14,576	22,227	100.0%

ASDES Adjoints de Santé Diplômés d'Etat Spécialisés (including midwives)
ASDE Adjoints de Santé Diplômés d'Etat
ASB Adjoints de Santé Brevetés

(1) Aides sanitaires not included

Table 8
Distribution of Paramedical Personnel in Morocco, 1989
Private Sector
(number authorized to operate in private sector)

	Midwives	Nurses	Total	% Dist.
South	1	13	14	1.9%
Tensift	6	39	45	6.1%
Center	33	401	434	59.0%
Northwest	32	126	158	21.5%
Center-North	5	23	28	3.8%
Eastern	5	21	26	3.5%
Center-South	3	27	30	4.1%
TOTAL	85	650	735	100.0%

Dentists

In 1989, less than 10% of dentists in Morocco were working in the public sector; the vast majority were practicing in the private sector, either individually or at mutualist clinics. Seventy-six percent of private dentists were practicing in the Center and Northwest regions, approximately the same percentage found two years earlier (see Table 9). Curiously, the total number of private sector dentists more than doubled from 1987 to 1989; it is not known what caused this increase, or whether it may be a result in changes in the reporting system itself.

There is competition for patients between the surgeon-dentists trained in modern methods and traditional "mechanist-dentists" operating out of marketplaces and in villages. No information is available on the size or market share of this traditional sector.

Employment-based clinics

The provision and financing of health services by employers in Morocco currently consists of a complicated mix of legal obligations, contractual agreements, and social assistance given to improve employee relations. While many employers are obligated by law to provide insurance for work-related accidents, only some enter into contractual agreements to provide overall medical insurance (usually splitting the premiums with employees). Some enterprises hire a physician to supervise work-related medicine ("médecine du travail"), such as overseeing safety. Several interviewees pointed out providing curative care (other than for work related injuries) at the workplace was forbidden by law, presumably because such arrangements run counter to the code of medical ethics, which stipulate that there must be a direct payment relationship between physician and patient.

Pharmacies

While pharmacies were not included in the survey, some information on this component of the private sector is important for understanding the sector as a whole. The overwhelming majority of pharmacists operate in the private sector — a total of 1,546 in 1989 (see Table 10), and 65% of these are located in the Center and Northwest regions.

Like most businesses, pharmacies tend to be located in downtown areas and commercial districts where they are readily accessible to consumers. CNOPS (see below) and private insurers reimburse their beneficiaries for a fixed percentage of pharmaceutical expenditures in the same way that medical services are reimbursed.

Table 9
Distribution of Dentists in Morocco
1987-1989

	1987		1989		% Change 1987-1989		% Dist. of Dentists in 1989	
	Priv.	Pub.	Priv.	Pub.	Priv.	Pub.	Private	Public
South	10	2	15	2	50.0%	0.0%	3.2%	5.6%
Tensift	12	5	29	7	141.7%	40.0%	6.1%	19.4%
Center	120	3	227	6	89.2%	100.0%	48.0%	16.7%
Northwest	60	11	132	10	120.0%	-9.1%	27.9%	27.8%
Center-North	16	4	27	7	68.8%	75.0%	5.7%	19.4%
Eastern	7	1	21	2	200.0%	100.0%	4.4%	5.6%
Center-South	10	--	22	2	120.0%		4.7%	5.6%
TOTAL	235	26	473	36	101.3%	38.5%	100.0%	100.0%

Table 10
Distribution of Private Sector Pharmacists
1989

Region	Number	Percent
South	108	7.0%
Tensift	127	8.2%
Center	631	40.8%
Northwest	69	23.9%
Center-North	124	8.0%
Eastern	99	6.4%
Center-South	88	5.7%
TOTAL	1,546	100.0%

CNSS/CNOPS – quasi-public/mutualist sector

The Caisse Nationale des Oeuvres de Prévoyance Sociale (CNOPS) is an umbrella organization of mutual insurance companies providing medical coverage for 80% of public servants. In 1987, 2.1 million beneficiaries (9% of the total population) were covered by CNOPS mutuels (694,077 members and 1.4 million dependents).¹¹ In addition to reimbursing beneficiaries for a fixed percentage of medical expenditures, a number of mutuels operate clinics to provide services to their beneficiaries. Membership in CNOPS is concentrated in the Northeast (38%) and Center (32%) regions.¹²

CNOPS and its member mutuels play a role in both the financing and provision of health services. Clinics directly operated by CNOPS and its member mutuels have not been required to conform to the same rules as purely private sector clinics (including ownership rules, authorization requirements, restrictions on salaried physicians, and tax laws).

The Caisse Nationale de la Sécurité Sociale (CNSS) is the national social protection program for private sector employees. Its funds are obtained from a 10% levy on the wages of private sector employees. Benefits include family benefits, indemnity benefits, and retirement pensions. From 1979 to 1988, CNSS used a portion of its funds to build a network of 13 polyclinics: four in Casablanca and one each in Mohammadia, El Jadida, Marrakech, Tanger, Agadir, Kenitra, Oujda, and Settat. Over half the beds in this system are in the four clinics in Casablanca.

Services at these clinics are provided to those who can pay its fees or who have insurance coverage. CNSS polyclinics do not cover all of their costs through revenues from these fees; in the past, deficits have been covered from other CNSS funds. This subsidization implies that private sector employees who contribute to CNSS but whose companies do not provide medical coverage, are in fact subsidizing the users of the clinics (i.e., individuals insured by CNOPS or a private insurance plan and those who can afford to pay the fees out of pocket).

The high average cost of care at these clinics (due to a combination of high total costs and low occupancy rates) has brought the CNSS management of these clinics into question. Efforts at reforming CNSS polyclinic management have already been undertaken, but many issues remain unresolved. In recent months, this issue has entered into the realm of public debate.

As part of an agreement between CNOPS and CNSS, CNOPS beneficiaries who visit CNSS-operated polyclinics are reimbursed 100% of the costs of their care, making these polyclinics popular among mutual members.

¹¹ Annuaire Statistique du Maroc 1990, p. 343.

¹² Vogel and Stinson (1989), p. 59.

SUPPLIERS OF ALLIED GOODS AND SERVICES

Laboratories

A 1989 study reported that 50 private laboratories were in operation in Morocco. The distribution of these laboratories closely parallels that of private sector physicians.¹³

Medical Equipment Suppliers

According to the interviews, there are over 50 importers of medical equipment and supplies in Morocco — approximately 15 in Rabat, at least 30 in Casablanca, and at least one in each other major cities. Many of these companies have exclusive contracts with suppliers, reducing the ability of purchasers (who often require a very specific type of equipment available from only one supplier) to negotiate among importers to obtain the most favorable commissions.

Import firms may specialize in a particular type of equipment; for example, only the larger import firms deal in expensive radiological equipment. Maintenance contracts are often purchased from the import company, but purchasers receive no assurance that these contracts will be honored if the company goes out of business. Purchasers usually obtain credit directly from the bank rather than from the supplier. Import companies reported giving advice to doctors about where to obtain bank credit. In some cases, special credit terms may be written into the purchase contract. Because medical equipment is often highly specialized and difficult to market, physicians who place an order for a particular piece of equipment are usually required to pay 20 to 50% in advance.

CONSUMERS

While this study did not focus on consumer demand for services, some information on the changing nature of demand is evident. In the past few years, many private practitioners and other private sector actors have perceived a market saturation, particularly in the larger cities. While this does not necessarily indicate that supply is in excess of needs — Morocco in fact has a lower physician to population ratio than many other countries — it may indicate that the supply has reached the limit of the population's ability to pay. Interviews with physicians practicing in smaller towns suggest that even in these areas the supply of private health services is sometimes excessive given the actual demand.

Meanwhile, the traditional medical sector remains the first choice of many rural inhabitants.¹⁴ However, cash expenditures on traditional care appear to be small — only 1.51 DH per year per capita. In-kind payments may play an important role for traditional practitioners. However, information on the traditional health care market remains extremely limited.

¹³ Maazouzi (1989), p. 198. It is unclear whether the market signals at play cause laboratories to follow physicians or physicians to follow laboratories, or whether both following paying patients.

¹⁴ Vogel and Stinson (1989), p. 21.

THIRD PARTY PURCHASERS

Private Insurance

The private for-profit medical insurance sector is relatively small in Morocco. Approximately 4-5% of the population is covered by private health insurance, mostly by policies obtained through contracts at the workplace. According to the insurance companies interviewed, medical insurance has become a "loss leader" for insurers, used to attract clients to purchase a package of insurance coverage (life, fire, disability, etc.), a pattern often seen in health insurance in other countries.

Most medical insurance contracts provide for reimbursement of a fixed percent of medical expenditures (usually 75-85%). Ceilings, either on reimbursements for each service or on total reimbursements, are usually included in the contracts. Once these ceilings are exceeded, additional expenditures are the sole responsibility of the patient, often forcing the patient then to seek care in the public sector.

Employment-based Purchasers

Some employers have established standard agreements ("conventions") with physicians and/or clinics to treat their employees (for work-related accidents or other problems). Such agreements appear to be relatively common. The attitude of providers toward these agreements varies depending on the promptness and level of payment offered by the company. When the company pays acceptable fees in a timely manner, the agreements are well received; when the company pays low fees and delayed payment for long periods, providers are less enthusiastic.

CNOPS

CNOPS and the mutual insurance societies make up the single largest sector of medical coverage in Morocco; together, this group insures 9% of the population. In addition to reimbursing beneficiaries for a percentage of medical care expenditures and providing services at their own clinics, CNOPS and the mutuels have some standard agreements with private providers and CNSS polyclinics to treat their beneficiaries. This group thus makes up an important element of organized demand in the health sector and is key to policymaking in the country.

V. DIAGNOSIS: FACTORS AFFECTING PERFORMANCE IN AND EXPANSION OF THE PRIVATE SECTOR

This information about the private sector comes from over 60 in-depth interviews with key informants and from reviews of existing data and other sources. This approach does not generate a body of statistics but rather relies upon identifying significant areas of agreement in the observations made by the key respondents.

In point of fact, there was considerable agreement — and in some cases, near unanimity — among the interviewees with regard to the experiences they recounted, the problems they identified, and the opinions they expressed. This is all the more striking because the sample was selected specifically to find divergence in practice setting, location and specialization. (This section can only present a brief synthesis of those interviews; for more detailed information, the reader is referred to the summary interview transcripts which are provided as the Annex to this paper.)

This section presents an overview of key problems and the most common responses. It is written primarily from the perspective of the major actors in the private sector, and at times includes vignettes from the interviews as examples of "typical" responses. This material is then supplemented with information from other sources to provide a more comprehensive analysis of the conditions which not only limit the ability of the private sector to expand, but to expand in an efficient and desirable manner. This section ends by recasting conditions into the structure set forth in the Technical Framework (the three questions of Section III) to facilitate the development of a prescription for action and a set of recommendations which are firmly founded in the views, attitudes, and experience of those currently working in the private sector.

One note concerning the sample should be kept in mind when interpreting the findings of the interviews: with two exceptions, the providers interviewed were all practicing in their field and therefore are representatives of *successful* experiences. These are the ones who have found a way to operate, who have been able to make a living in the Moroccan market. The experiences of practitioners who have *not* been able to survive in the private sector, including those who made innovative efforts without success, were outside the scope of the study.



To expand efficiently, the private sector must have the flexibility and the resources to change the ways it produces and delivers services. The decisions made by the private sector players are influenced by the availability of information, certain rules and regulations, financial incentives, such as the tax structure, competition, personal preferences, and perceptions or beliefs about all of the above topics. These decisions determine the way that health service delivery will be organized, what patients are to be attracted, what the pricing structure is to be, influence the what services will be produced, and who will receive those services. These decisions in turn choices patients make about where to go for services and what services to use. Some of the key issues include:

- How will health professionals practice (solo practices, group practices, salaried relationships, etc.)?
- Where will services be made available (urban versus rural areas; city centers versus periphery)?
- What services will be made available?
- What investments will be made (in equipment, buildings, etc.)?
- How will fees and prices be set?
- What payment options will be made available to increase access to services?
- What relationships will be developed with other referral points (such as specialists, inpatient facilities, etc.)?
- What sources of information will be used for decision-making?

A series of ancillary questions help identify factors which influence these issues, whether in a positive way or in a restrictive way. The answers to these ancillary questions provide additional information to enable us tailor activities to promote private sector expansion that will be most beneficial¹⁵ for the country overall:

- What are the problems encountered in gaining financing or access to credit?
- How does the legal and regulatory environment affect operations?
- What difficulties arise from pricing structures?
- How do third party purchasers (e.g., insurers) affect the services produced?
- How do providers manage and administer their day to day operations?
- How do quality of care issues affect private sector production and consumption of services?
- To what extent are private providers already offering preventive services?
- How does continuing education and other technical information reach providers?
- What is the role of paramedicals?

¹⁵ These questions incorporate the questions asked in the original Scope of Work for this study, a copy of which is provided as Appendix I to this paper.

- What is the effect of consumer knowledge on demand?

The rest of this section will take up each of the questions posed above.

PRACTICE SETTING: CHOICE OF INDIVIDUAL OR GROUP PRACTICE

Generalists

The interviews indicate that the typical GP considers few options. A significant portion choose to work in the public sector, others decide to continue their education and seek specialist qualifications, and others establish a private practice — although increasing competition in recent years has led many generalists to choose the public sector rather than risk entering an apparently saturated market for private medical services.

Once they choose a private practice, most generalists state flatly that there is no choice other than solo practice (though some see group associations as a remote possibility). The vast majority open an individual office and gradually develop a practice base. A typical interviewee is the Casablanca physician who says "*Je n'ai pas considéré d'autres options, le cabinet individuel étant la meilleure solution pour une généraliste,*" or his counterpart in Marrakech who can say confidently "*C'est la seule possibilité offerte à un généraliste.*"

Some physicians arrive at the same conclusion even after considering their options with considerable vigor. Such is the case of the GP in Skhirat, who fully explored looked the possibilities:

"L'intégration dans la santé publique a été écartée, la rémunération et les conditions de travail étaient décourageantes...L'opportunité d'un engagement comme médecin salarié auprès d'une grande entreprise s'étant présentée, j'ai commencé par cette expérience. Très vite j'ai été dissuadé de la poursuivre (pour des raisons morales: pas d'autonomie du médecin dans l'exercice de ses fonctions, confusion entre la médecine du travail et la médecine curative, absence d'organisation, etc...)."

Very few generalists choose (or are able to choose) group practices, either with other generalists or with specialists. The low equipment costs of a generalist office, the small number of continuing patients, and the established custom of individual family physicians discourage many generalists from pursuing the idea of group practice.

Specialists

Unlike generalists, drawn increasingly toward the public sector because of the increased risk of private practice as a family physician, specialists seem to be leaving the public sector in growing numbers due to the perceived decline in working conditions and quality of care.

While many specialists who move into the private sector set up individual practices, group practice has become more popular in recent years. Group practices offer several advantages: the ability to share often high equipment costs, constant availability of a physician, reduction of competition in the local market, and collegial relationships with fellow physicians (which allows

consultations between doctors and thus may enhance the quality of care). The spiraling cost of medical equipment, particularly high for specialties, such as radiology and ophthalmology, has increased the attractiveness of group practices in recent years. Moreover, the competition for clients with the public sector (CHUs) and quasi-public sector (CNSS polyclinics) makes it imperative for specialists to be well-equipped in order to attract clients away from these sources of subsidized care.

However, a lack of clear regulations and guidance on developing alternative types of organizations discourages many physicians from entering into group practices. One ophthalmologist stated that:

"J'ai voulu m'installer en association pour atténuer la concurrence, pouvoir investir, drainer d'avantage de patients en leur assurant de meilleurs soins...J'ai été confronté à l'absence de réglementation incitant à l'association et permettant d'instituer des liens juridiques durables entre associés."

Interviews established that when group associations are formed, providers usually gain the advantages they had expected, even though such providers often act in the absence of clear regulations governing group practice. As one respondent in a group practice in Rabat noted:

"La forme juridique des cabinets de groupe n'est pas parfaitement réglementée. Le cabinet est sous la forme d'une 'association de fait': deux dossiers indépendants, deux autorisations d'exercer, deux déclarations au fisc."

At least one interviewee found that regulatory problems obliged him to constitute his clinic in three different forms for three different purposes:

"Le statut juridique d'une clinique est confus. Triple statut...: société commerciale auprès de la banque, société de fait devant le Conseil de l'Ordre, société de personnes devant le Secrétariat Général du Gouvernement.... Cette diversité peut être la cause de problèmes de gestion et avec le fisc."

When group practices are formed, they have tended to include only physicians within a single specialty, who can thereby take advantage of the shared equipment costs. Practices grouping together different specialties (with or without generalists) remain rare (except for inpatient facilities) despite the potential advantages in terms of complementary care.

Such multi-specialty arrangements are found at many private clinics. The grouping together of several specialties in a single clinic appears to enhance the ability of the clinic to utilize (and thus amortize) all of the expensive medical equipment required to establish a competitive clinic.

LOCATION OF PRACTICE

Large cities remain the location of choice for most physicians entering into private practice. However, the saturation of the market, first seen in Rabat and Casablanca, has now extended to other cities and even to small towns. One physician practicing in a small town 40 km outside of Meknès noted that he was the fourth physician to open a practice in that town.

From the point of view of most physicians, cities offer three distinct advantages over rural areas or small towns: first, the population with cash income and/or medical insurance is larger, providing a sizeable pool of potential clients; second, pharmacies, laboratories, and referral facilities are available to assure a full range of potential services; and third, physical amenities, such as schools, restaurants, and cinemas are available to attract the family.

Despite this urban preference, a number of physicians have established practices in small towns off the beaten path. Because the number of doctors practicing in the larger cities is increasing while the number of people who can *afford* private health services has not grown significantly, fewer potential patients exist for each new physician entering practice. Accordingly, young physicians see better income potential in areas with few doctors. In one case, a physician had to leave Casablanca because he was unable to repay his loans with the limited income he could generate in that city. He moved his practice to a small town outside of Marrakech, where he has been able to generate sufficient income to continue his practice.

"Je me suis installé antérieurement en cabinet individuel à Casablanca pendant 8 mois. Je recevais rarement des patients dans cette ville. J'ai alors désespéré de pouvoir rembourser le prêt que j'ai obtenu pour m'installer et j'ai décidé de transférer mon cabinet ailleurs (à une ville à 100 km au nord de Marrakech), en accord avec ma banque.... je pense désormais ne plus avoir à affronter de difficultés de remboursement...."

Private practitioners have been limited to towns of at least 20,000 inhabitants in order to ensure sufficient demand for their services. The access of the rural population to these practitioners varies considerably depending on their distance from a town with a private doctor. Among rural inhabitants, many have low incomes and generally only the military and government employees (such as teachers) have any kind of medical insurance. As a result, the rural population's ability to purchase private health services is considerably limited, a fact which is admitted by practitioners operating in these areas.

Due to the nature of demand for specialist services, most specialists continue to establish practices in cities and large towns. Generalists have extended into smaller and smaller towns seeking new markets, despite the difficulties in estimating the income potential of new areas.

Within cities, the offices of generalists tend to be spread throughout residential areas (including lower income neighborhoods), while specialists tend to locate their offices in downtown areas and upper class residential neighborhoods. Almost without exception, however, physicians interviewed noted that it was the availability of affordable real estate (to purchase or rent) that determined the location of their practice. The shortage of affordable real estate in areas appropriate for a medical office may make it impossible for physicians to select a location carefully. None of the physicians interviewed carried out a sophisticated market analysis before choosing a practice location, and few seemed to consider even a rudimentary study necessary. The lack of firms specializing in this type of study also may have contributed to this situation. One bank indicated that loan applicants wishing to establish medical practices did not give sufficient attention to the effect of location on the potential profitability of a practice, relying instead almost exclusively on the level of rent as the deciding factor.

While private clinics remain concentrated in the Rabat and Casablanca areas, during the last two years several private clinic projects have been started in medium-sized cities (El Jadida, Kenitra, Benimellal, Khenifra, Ouarzazate, Sidi Kacem). For the most part these have been initiated by local doctors, particularly surgeons.

SERVICES OFFERED

According to the interviews, the types of services offered by practitioners were chosen on the basis of regulations (services that can be offered by different types of practitioners), training of the practitioner, equipment available, and demand from patients. Some common responses regarding the choice of services offered include:

- *"Les types de soins à dispenser et la nature de la demande (pouvoir d'achat) limitent la gamme de services à offrir."*
- *"Toute amélioration des méthodes d'investigation (échographie par exemple) nécessite une formation spécialisée qui ne peut être financée sur les ressources propres."*
- *"Les services offerts sont ceux prévues par la réglementation de la profession de généraliste."*
- *"[Certains] types d'équipement nécessitent des moyens financiers qui ne peuvent être assumés que par une structure collective (association ou clinique)."*
- *"J'aurai souhaité m'équiper en doppler (radio des vaisseaux), en scanner, et en mammographie (radio des seins). Or le matériel est cher et la demande ne permet pas son amortissement."*

It is clear that within certain limits imposed by their training, equipment, and regulations, most practitioners adjust the services they offer to the demand from patients. Specialists in particular mentioned lack of certain costly pieces of equipment as limiting the types of services they could offer. Clinics and some group practices can offer a wider range of services because of the variety of personnel and equipment to which they have access. One clinic noted that it did not offer services which it deemed unprofitable.

The services offered by generalists include curative care for a variety of common ailments and some preventive care (advice on hygiene, prenatal care, vaccination, etc.). Generalists refer cases to specialists (or specialists to other specialists) when required, often giving the patient several names from which to choose. Specialists provide diagnostic services and treatments within their area of specialization. Patients requiring surgery or other inpatient care may be referred to public facilities (particularly if they have limited financial means) or treated at a private clinic. In rural areas in particular, patients requiring hospitalization prefer to shift to the public sector.

Preventive Medicine and Family Planning Services

Though a majority of physicians interviewed stated that they provide few preventive services. Generalists (particularly those working in rural areas), paramedicals, pediatricians, and gynecologists provide more preventive services, including immunizations, health education, and family planning. Many of the services provided by independent paramedicals in private practice correspond to primary health care: injections, first aid, simple medical treatments, and health education. One paramedical interviewed noted that family planning services played an important role in her practice. Pediatricians interviewed noted that preventive services make up a high percentage of their services. One pediatric group practice stated that preventive activities make up 50 percent of their services, often involving a coordinated set of services beginning at birth, including vaccination, nutrition, and health education. Gynecologists in particular noted that they provide some family planning services, although the level of demand for these services is not clear. Gynecologists also provide preventive services (prenatal care, education of pregnant women on prenatal and postnatal behavior, education on sexually transmitted diseases, etc.).

FEE SETTING

An official fee schedule for medical services in the private sector has been established by MSP regulation. This official fee schedule, which has not been updated since 1984, is universally considered by private practitioners to be too low. None of the interviewees indicated that they used the official schedule as the basis for setting their fees. CNOPS uses these fees as the basis for their reimbursements, however, with the result that CNOPS beneficiaries who are reimbursed 80% of the official price of a given service in fact find that this sum covers only 45% to 55% of the actual price they paid for that service.

Physicians interviewed asserted that the fee-setting process did not constitute a free negotiation between partners. A primary concern in setting the level of fees is the preservation of the financial balance of CNOPS, which is supposed to receive its resources from a combination of contributions from civil servants and their employer (the state). In fact, the state rarely pays its share of the contributions, creating a financial strain on CNOPS and an incentive for the state to fix the level of official fees (and thus CNOPS reimbursements) lower than fair market value.

Most physicians indicated that actual fees are established in informal consultation with other physicians in the same town or region. Price competition is avoided. There is a diversity of opinions of the interviewees on how fees *should* be set varied, as some wanted a liberalization of prices, others a harmonization of prices, while others preferred a system setting a minimum and maximum but allowing variations within this range.

All physicians interviewed stated that their fees were uniform for all patients, although most give free or reduced price services on occasion to indigent patients.

FINANCING AND ACCESS TO CREDIT

Access to credit for medical practitioners does not appear to pose a major obstacle. Difficulties with obtaining credit center around the administrative complications involved and delays in the release of funds, but in the end, most appear to be able to obtain the financing they require.

One important source of financing in recent years for young physicians moving into private practice has been the *Crédit Jeunes Promoteurs (CJP)*, a mechanism funded by the Ministry of Finance in conjunction with private banks. While originally designed to encourage entrepreneurship in all sectors, approximately two-thirds of all loans have gone to private medical practitioners. This may indicate that banks to date have considered loans to medical professionals as relatively "safe" loans. An official at one bank noted that his institution had begun refusing some loan applications from generalists because of declining profit potential for this group. Serious delays in releasing the government's portion of the funds (up to a year, according to those interviewed) have marred the success of the program, although the Ministry of Finance has instituted efforts to reduce these delays to a few weeks.

The *Banque Centrale Populaire (BCP)*, an important lender of CJP funds to young doctors, indicated that from August 1988 through May 1991 it loaned over 187 million dirhams to 565 borrowers in the medical professions through the CJP program. The average size of CJP loans to medical professionals through this bank was 330,000 DH. Additionally, medium-term credits amounting to over 75 million dirhams were offered to radiologists and clinics, with an average loan size of 2 to 3 million dirhams.

Medium-term credits from banks have also been an important source of financing for individual physicians not eligible for CJP loans and for clinics or group practices requiring funds surpassing the ceiling for CJP loans. Over the past two to three years, the number of loan applications from clinics and radiology offices has increased. While the majority of applications continue to be localized in the Casablanca and Rabat areas, banks have noted a trend toward decentralization, as shown by applications for funding of clinics in other towns, such as Beni Mellal, Kenitra, Sidi Kacem, Meknes, and El Jadida.

The amount of money needed to establish a generalist practice is relatively small (50,000 to 100,000 DH) and thus relatively easy to obtain from banks or other sources. Certain specialties, however, require heavy investments in equipment to establish a practice: from 250,000 to 1 million dirhams for pediatric, cardiology, gastroenterology or ophthalmology offices. Radiology offices remain the most expensive, the total amount needed depending upon the type of equipment purchased.

Clinics usually require heavy investments — the average amount lent for a clinic by the BCP was 2.2 million dirhams — which usually includes both construction/refurbishing and equipment costs.

Even while many practitioners place access to finance as low on the list of factors influencing their choice of practice setting and location, information on capital acquisitions on the part of providers and on lending practices on the part of banks show a bias toward the "hardware" of medical practice. This encourages the concentration of health resources on acquisition of land, buildings and medical equipment, rather than on startup costs of developing new "entrepreneurial" delivery within the health market.

REGULATORY AND LEGAL ISSUES

Authorization to Construct and Open Clinics

To construct a private clinic a provider needs the approval of the prefecture (city government) and local health authorities. This approval is required at the planning stage, before construction begins. At the *end* of this process, an "authorization to open" is requested from the Secrétariat Général du Gouvernement (SGG). Only at this late date, when construction is usually nearly complete, does the SGG seek the opinion of the Ministry of Public Health (MSP) on whether the clinic conforms to technical norms. As a result, any problems the MSP has with the construction (e.g., size or shape of surgical areas) may result in the owners of the clinic being required to demolish and rebuild portions of the building. Several clinic owners noted that this regulatory process resulted in significant delays in opening their facilities — and thus a loss of income. The interviews suggest that the regulations regarding equipment requirements, treatment standards, and hygiene remain inadequate. Considerable variations exist among clinics and may undermine the quality of care available from certain facilities.

Ownership of Medical Facilities

Regulations and rules of medical ethics also govern who can own medical facilities. While the physical structure of a clinic or other health facility can be owned by non-physicians, the medical material and equipment are supposed to be the exclusive property of physicians. This excludes non-physicians from participating in the financing of this equipment and material.

In fact, the interviews indicated that a number of facilities have circumvented this rule and included non-physicians in partnerships controlling clinics. One administrator of a clinic even stated that only one percent of the shares of a corporation owning a medical facility had to be held by a physician, implying that the rules governing ownership of medical facilities are anything but clear.

Salaried Medical Practice

Some confusion appears to exist over whether private sector physicians are permitted to work under salary rather than on a fee-for-service basis. A literal interpretation of the code of medical ethics would imply that *any* type of remuneration which does not involve direct payment to the physician by the patient is forbidden. However, the presence of salaried medical practice in the public, university, military, and mutualist sectors demonstrates that this ethic has already been bypassed. Few physicians in the private sector appear to believe that salaried practice in this sector is permissible or desirable. However, at least one clinic indicated that one of its physicians was receiving a salary rather than fees for services.

The clear authorization of salaried medical practice in the private sector would allow the sector to experiment with a wider variety of organizational forms. For example, many types of managed care organizations involve reimbursing some practitioners through a fixed salary, although other practitioners (particularly specialists who are not required on a full-time basis) might be reimbursed on a fee-for-service basis.

Public Sector Personnel

Many private medical facilities and large employers hire MSP personnel to provide services to their clients or employees. These individuals supplement their government income by working in the private sector, despite existing regulations forbidding this practice. This has resulted in considerable dissatisfaction among purely private sector physicians, who see the public sector doctors as being in unfair competition with them.

ORGANIZED DEMAND/INSURANCE

Nearly all of those interviewed said that universalization of medical coverage, whether through a government program or private insurance, was a key to improving the situation of the health sector. Currently, less than 15 percent of the population benefits from medical coverage, either through mutuals or private insurance companies. Respondents said that this low level of coverage was the principal obstacle to access to health care and to the development of the private health sector. The difficulties caused by this lack of coverage, many of which have serious quality of care implications, were detailed by the practitioners themselves:

- inability of certain categories of patients to receive necessary diagnostic exams because of the cost,
- irregular and late visits to a doctor by rural and underprivileged urban populations,
- insistence by patients on receiving reduced treatments (fewer medications required, shorter time periods) in order to reduce their costs,
- attempts by patients to negotiate lower fees or to ask for fixed payments for surgical interventions.

The clientele of the practitioners interviewed differed from the population at large in that coverage of patients by medical insurance ranged from 10% (in rural areas) to 70% (for some specialists), with the average percentage covered by some type of medical insurance at approximately 30%. This is considerably higher than the national average, but not surprising considering the concentration of private practitioners in urban areas and the self-selection of patients (those without coverage preferring to seek care in the public sector).

TRAINING/CONTINUING EDUCATION

Basic Medical Education

While most physicians interviewed stated that their medical education had prepared them adequately for private practice, many generalists found the training did not devote sufficient attention to practical training, the most common epidemiological problems, or the environment and psychology of the patient. Many agreed that the addition of information on medical legislation/regulation and management to the standard curriculum would be helpful to young doctors. Specialists emphasized the need to strengthen education on theory and investigative techniques. Clinics and group practices

expressed a need for courses in health economics and management and a need for more detailed continuing education programs.

Continuing Education

Most private practitioners emphasized the need for continuing medical education in order to keep practitioners up to date on the latest treatment and diagnostic techniques. Most said that they subscribe to one to three medical reviews and occasionally participate in scientific conferences. However, participation in continuing education programs is completely discretionary and not well institutionalized, nor has any systematic national policy been developed on continuing medical education. The Société Marocaine des Sciences Médicales (SMSM) has played the largest role to date in organizing conferences and seminars on medical topics. However, because the leaders of this association are university professors, these conferences have tended to focus on subjects of academic interest rather than those responding to the daily needs of practicing physicians. Moreover, the pedagogical techniques used in the programs (conference-debate) are not especially relevant to the objectives of continuing education programs; presentation of cases and working seminars would be more appropriate. Finally, a lack of sufficient financing has hindered continuing education efforts.

Interviewees proposed several improvements for continuing medical programs:

- decentralization of training to permit trainers better to define the needs of the GP. Regional and local associations could be reinforced to play this role.
- coordination of private and public sector efforts, including formation of a group of interested parties (MSP, medical associations, medical unions, universities, councils of the Ordre des Médecins, etc.) to define training needs, develop objectives, mobilize resources, and evaluate efforts.
- development of incentives to motivate participation: tax exonerations, convenient timing and location of training, increased quality of programs, etc.

Paramedicals

Many paramedical staff working for private practitioners have no formal qualifications and are trained entirely on the job. Some providers hire certified nurses (those with a *breveté* degree), but most noted that these nurses were poorly trained and required significant additional in-service training. Few private facilities hire nurses with state diplomas (*diplômés d'état*) or specialized nurses (*diplômés d'état spécialisé*). Physicians cite lower salaries and the simplicity of the tasks assigned to paramedicals as the reasons for hiring paramedical personnel with few qualifications. Specialists tend to hire more qualified personnel than generalists, while clinics employ a range of paramedical personnel. Some private practitioners employ MSP paramedicals on a part-time basis because of a lack of highly qualified paramedical personnel willing to work solely in the private sector and because the level of need for nurses specialized in certain areas (e.g., ophthalmology, radiology) does not justify having them as full-time employees.

The attractions of public sector employment seem to be strong for paramedical personnel, which may explain the shortage of nurses with state diplomas in the private sector. In fact, several private clinics noted that many of the paramedicals they train on the job leave within a few years to work in the public sector mainly for reasons of job security and benefits.

Over 700 trained paramedicals (nurses and midwives) are authorized to practice independently in the private sector in Morocco. According to the interviews, individual private practice by paramedicals is not particularly lucrative as the services they provide (injections, dressings, blood pressure surveillance, etc.) are not highly valued by the patients. Formally trained midwives face competition from traditional birth attendants, since most Moroccan women do not distinguish between the two groups.

QUALITY OF CARE

Quality of care was a primary concern of the physicians interviewed during the study. As noted above, most believed that their basic medical training was adequate to allow them to provide quality medical services to their clients, but the absence of a systematic program of continuing education limits professional development of medical practitioners.

For most of the physicians interviewed, improving the quality of their services means purchasing state-of-the-art medical equipment; thus, their efforts to improve quality are limited by their financial means. Meanwhile, other elements of improving the quality of care receive less attention. This concentration on medical technology may be leading to the over-equipping of private health facilities relative to the actual need, and it may also encourage overconsumption of services. That is, once expensive equipment is purchased it can only be made profitable if it is used fully, prompting practitioners owning such equipment to order diagnostic exams of dubious utility in order to amortize their investment.

The only deterrents to this potential tendency toward excess reliance on medical equipment are the high cost of equipment (due to the cost of transporting equipment from the point of production, high customs duties, and importer commissions) and the asset tax system ("la patente"), which varies with the value of the assets held by a facility. Curiously, the tax structure penalizes facilities which are well maintained and equipped. The level of asset taxes ("la patente") is determined by an examination of the facilities and increases if the facility is well equipped and in good condition.

The tendency of private physicians to recruit underqualified paramedicals and train them on the job also has implications for the quality of care. But the current shortage of nurses with state diplomas in the private sector makes an improvement of this situation unlikely. While there is a surplus of certified nurses (*brevetés*), most private practitioners, as noted earlier, were not satisfied with the qualifications of those who held this degree.

Poorer patients are especially vulnerable to quality problems, as they tend to access services later in the course of illness and to forego many diagnostic services and treatments owing to their inability to pay.

Currently, the Moroccan private health sector lacks a strong mechanism for establishing and enforcing standards for quality of care. Efforts by the Order of Doctors to oversee rules of medical ethics or close health facilities which do not meet technical standards are hampered by its lack of enforcement capability. The Ministry of Public Health likewise lacks the resources or the will to play a strong regulatory role over the private sector. Without strong mechanisms to regulate ethical and technical standards in the private health sector, continued growth of the sector is likely to be tarnished by wide variations in quality of care and instances of unethical behavior on the part of a few practitioners.

CONSUMER EDUCATION

A number of physicians interviewed indicated that lack of patients' understanding regarding what constitutes quality medical care creates difficulties for practitioners and at times leads them to conduct unnecessary exams (e.g., x-rays) to satisfy the patients' expectations (and thus encourage them to return to the same doctor in the future). Moreover, several practitioners (particularly paramedics and physicians working in rural areas) complained that the population's lack of understanding of health issues led to inappropriate patient behavior, such as:

- delays in seeking health care until a very late stage (when it may be too late for successful medical intervention),
- consultation of traditional practitioners before seeing trained physicians,
- unwillingness to pay for health services (or purchase health insurance) because these services are not valued highly,
- insistence on receiving diagnostic exams or treatments that are not in fact medically necessary,
- inability to choose a provider based on his/her qualifications.

Clearly, the consumer's lack of full information causes distortions in the level and types of medical services demanded and provided. Health providers, faced with distorted demand, are tempted to "bend the rules" of medical ethics in order to keep patients and thus ensure their economic survival. Several physicians indicated that a significant effort to educate consumers on health (including what constitutes quality health care) would be necessary to ensure that consumer demand was appropriate.



We can see from the interviews and supporting information that the private sector has already demonstrated a significant market response — that is, practitioners and banks alike shy away from saturated markets, seek out areas that are underserved as potential markets, and adjust the services they offer to the demands of their clients. This flexibility has made the private sector the fastest growing portion of the health market in recent years.

However, the market responses observed appear to be limited to a very narrow range of alternatives. As a result, as the private sector has expanded along a path of least resistance, a number of gross inefficiencies have been occurred in the way health resources are used. Two of these can be deduced from the information contained in the interviews. First, the growth of the private sector in an environment where subsidized public and quasi-public services are available has caused distorted signals to be sent. This is manifest in the private providers who are unable to compete for certain services, particularly tertiary care, because of the low public sector prices, and also inhibits the range of services which could potentially be produced with private resources.

It is evident that, even though we have only touched upon the most oft repeated problem areas and constraints, the private sector actors see a host of difficulties which influence the way they function within the private health market. Signals sent through the market suggest to private sector actors which possibilities exist and ways in which they can or cannot respond, and their experiences shed some light on how they do respond, on which decisions or actions they take. These conditions need to be incorporated into any broad strategy for change. Based upon our technical and organizational framework, we can organize the problem areas and constraints identified during the fieldwork phase of this study into the categories of (1) problems related to market signals, (2) problems related to the ability of the private sector to respond, and (3) problems related to market differentiation between public and private markets, as shown below.

PROBLEM AREAS AND CONSTRAINTS IDENTIFIED BY INTERVIEW RESPONDENTS

(1) PROBLEMS RELATED TO INAPPROPRIATE MARKET SIGNALS

- There are limited options or alternative models available to, or considered by, GPs.
- The "high risk" (in financial terms) of private practice is pushing GPs into the public sector.
- There is considerable confusion in the interpretation of rules and regulations concerning group practices.
- Fee schedules are out of date and widely disregarded by private practitioners and do not emphasize preventive services.
- The requirements for opening new service delivery sites are burdensome.
- Quality of care is inconsistent among practices.
- There is confusion about restrictions against non-physicians having ownership in health practices.
- There is confusion about restrictions against salaried physicians.
- There is a shortage of state nurses in the private market, leading private practitioners to train their own nurses and paramedicals.

- There is no market for independent paramedicals providing preventive services.
- There is a tendency to equate quality of care with expensive technology and equipment.
- The recurrent tax on medical equipment ("la patente") discourages investments.
- T.V.A. taxes are applied evenly to private health services.
- There are limited (80%) reimbursements from third parties for preventive services.
- There is a lack of information about where demand is present.
- There is an absence of formal quality assurance systems.
- A weak consumer knowledge base leads to inefficient demand patterns.

(2) PROBLEMS RELATED TO THE INABILITY OF THE PRIVATE SECTOR TO RESPOND TO THE MARKET IN AN EFFICIENT WAY

- There are limited options or alternative models available to, or considered by, GPs.
- Practices are normally opened without any application of market analysis or other systematic market review.
- Physicians and other supply side services are concentrated in urban areas.
- Purchasing power is weak in rural areas.
- There is a lack of support facilities in rural areas.
- It is becoming increasingly difficult for generalists to secure private bank loans.
- Fee schedules are out of date and widely disregarded by private practitioners and do not emphasize preventive services; substitute pricing systems are informal "price fixing" agreements.
- There is a generalized lack of training and information on health management techniques.
- Continuing education and training is poorly organized and coordinated.
- There is a shortage of nurses with state diplomas in the private sector.

(3) PROBLEMS RELATED TO THE RELATIONSHIP BETWEEN THE PUBLIC SECTOR AND THE PRIVATE SECTOR

- There is competition from the public sector for services which could be produced and delivered by the private sector, arising from distorted/subsidized pricing structure for use of public services and from overly easy access for access to public services at subsidized prices

These indications from the private sector are symptomatic of the broader problems related to market signals, market response, and public/private overlap and competition.

Respondents also mentioned a number of positive factors in the dynamic private health marketplace which bode well for the potential success of changes and new stimuli. These offer points of opportunity for tailoring new activities. Among these positive signs are the following:

- A significant market response can be observed as practitioners and lenders alike recognize competitive markets and are already beginning to steer toward less competitive markets (i.e., outside of Casablanca and Rabat).
- There is a recent tendency to form into group practices, though this is being done with some difficulty.
- There already exists widespread provision of preventive services, especially among pediatricians (reaching as much as 50% of practice activity) and OB-GYNs, and among paramedicals.
- There is currently widespread provision of reduced price services to the indigent.
- Physicians appear to be able to pay loans back with little problem.
- The private sector has responded with creative, locally generated approaches to organization and ownership despite confusing regulations concerning who can actually own medical practices and clinics.
- The private sector has found ways to hire physicians on salary, which is taking place even though there may be restrictions against this practice.

These positive factors lend momentum to activities to stimulate desirable growth. In the following section, we will develop a broad approach to modifying conditions in the marketplace to improve the signals which the market sends and to support the ability of the private health sector to respond appropriately.

VI. PRESCRIPTION: STRATEGIC OBJECTIVES IN THE PRIVATE SECTOR

We asked three questions as part of our technical framework:

1. Does the market generate the *appropriate market signals* to stimulate the most effective private sector participation?
2. If the "correct" signals were generated, *is the private sector able to respond?*
3. If the signals were correct and the private sector responded, *would this circumstance contribute to the desired result of alleviating government burden and protecting public resources?*

The previous section illuminated a host of factors which influence the experience of, and actions taken by, providers and others involved in the Moroccan health sector (such as financiers, insurers, etc); these are indeed symptomatic of needed modifications to help the private health sector grow in a desirable way. It is not surprising that this study identifies and highlights many of the same problems noted in the voluminous body of work produced on the Moroccan private health sector over the past five years. These include weak demand, regulations limiting the settings in which physicians can organize and operate, competition from public and quasi-public providers, and so forth. It is also significant that certain subjects, such as use of market analysis and other information, were not mentioned by the respondents. (By inference, we can anticipate the influence those factors may have upon other potential actors, such as providers and investors yet to enter the market.)

Certain steps have already been taken to introduce change. The health sector investment code currently being prepared and the recent efforts to introduce mandatory health insurance are examples of significant efforts to support expansion of the private sector, as are all of the studies conducted by the GOM, USAID and the World Bank. A prescription for change in the private sector must incorporate the momentum already begun by these efforts, and promote approaches which will complement recent initiatives while introducing new stimuli into the market.

Increasing the role of the private sector to meet the growing demand for health care services in Morocco requires action on several fronts. The interviews carried out for this study and other studies in Morocco have made it clear that current structures, rules, and practices serve to limit both the supply of private sector services and the potential demand for these services. Without changes which affect both of these dimensions, the potential of the private sector to help meet the health care needs of Moroccans will not be realized.

Our prescription addresses the three categories of problem areas and identifies strategies for positive change.

PRESCRIPTION FOR PROBLEMS RELATED TO THE SENDING OF MARKET SIGNALS

Under the first problem area, we have seen that the information, regulations, and policies at times inhibit the sending of appropriate market signals, and that at other times appropriate signals simply do not exist. Sources of these difficulties include official regulations and laws, private lending practices, and an artificial competitive environment for certain curative services (expressed in perceptions of unrealistically low pricing, abuse of the "carte d'indigence", etc.). And there is a widely perceived lack of information because of unclear signals (about the legality of certain practice or employment settings, for example). Recommendations in this area must specifically address factors which encourage the private sector to organize and invest in inefficient ways, and encourage efficient growth which is in the public interest. Recommended activities seek to promote more effective market awareness through improved information and support systems, to create opportunities to test more cost-effective structures for producing services, and to change inefficient legal and regulatory controls which artificially limit private sector response.

Prescription 1: Generate appropriate, positive market signals to stimulate effective private sector participation through a revision of existing policies and regulations, by introducing new signals into the market, and by facilitating the flow of information. This will address problem areas in such a way that desirable changes can lead to efficient market responses, such as the following:

SYMPTOMATIC MARKET SIGNAL PROBLEMS

Limited options available to, or considered by, GPs

The high risk of private practice pushes GPs into the public sector

Confusion in the interpretation of rules and regulations concerning group practices

The requirements for opening new service delivery sites is burdensome

Quality of care is inconsistent among providers

There is a tendency to equate quality of care with expensive technology and equipment

DESIRABLE MARKET SIGNALS

Availability and encouragement of efficient alternative practice or employment settings

Flexibility for GPs to have choices other than solo practice or public sector

Demonstration and support of efficient group practice settings, especially in desirable (underserved) areas

Streamlined requirements and availability of information and technical and financial support for desirable practice models

Emergence of quality of care as an important factor in the private market

Introduction of cost effective quality of care techniques into the private markets, with mechanisms to train and encourage quality services

Confusion about restrictions against non-physicians having ownership in health practices

Presence of, and communication concerning, expanded possibilities and investment opportunities

Confusion about restrictions against salaried physicians

Clear possibilities and support for alternative practice or physician payment models

The recurrent tax on medical equipment ("la patente") discourages investments

Tax structures which encourage appropriate investments (cost effective or appropriate technology or locally produced equipment), especially those designed for priority health services.

T.V.A. taxes are applied evenly to private health services

Tax structure which encourages delivery of health services which are in the public interest

Limited (80%) reimbursements from third parties for preventive services

Insurers which encourage preventive care by applying higher rates of reimbursement

There is a lack of demand for certain services in certain market areas, and a general shortage of information about where demand is present

Growth in demand for certain services in broader market areas, accompanied by a flow of information about changes in demand

There is an absence of formal quality assurance systems

Presence of quality of care systems which function as a signal to attract demand and to cause competitors to improve quality

A weak consumer knowledge base leading to inefficient demand patterns

An informed consumer base which seeks care in appropriate patterns



PRESCRIPTION FOR ENHANCING THE ABILITY OF THE PRIVATE SECTOR TO RESPOND TO SIGNALS

Under the second problem area, our diagnosis found that the private sector is not able to respond effectively to market signals due to technical and resource constraints. Important needs include a variety of technical resources (market analysis, business development, pricing and payment structuring, organizational development, etc.) and the ability to mobilize financial resources. Our prescription specifically addresses the absence of opportunity for the private sector to participate in the growing market for health care services. Our recommendations seek to open markets by changing current insurance provisions, promoting more equitable pricing and access policies on the part of subsidized competitors, and utilizing cost-reducing strategies (e.g. subsidies of tax forgiveness) to "level the playing field."

Prescription 2: Carry out activities to help the private sector respond to market signals by providing technical assistance and making more resources available.

SYMPTOMATIC MARKET RESPONSE PROBLEMS

There are limited options or alternative models available to, or considered by, GPs

Practices are normally opened without any application of market analysis or other systematic market review

Physicians and other supply side services are concentrated in urban areas

Purchasing power is weak in rural areas

There is a lack of support facilities in rural areas

It is becoming increasingly difficult for generalists to secure private bank loans

Fee schedules are out of date and widely disregarded by private practitioners, and do not emphasize preventive services; substitute pricing systems are informal "price fixing" agreements

There is a generalized lack of training and information on health management techniques

DESIRABLE MARKET RESPONSES

Technical and financial resources to enable the development and implementation of new practice, employment, payment, or service delivery settings

Systematic application of market analysis techniques to match supply with demand

Demand for private health care in rural areas and response through increased supply in rural areas, through improved availability of financing, information, etc.

Strengthened purchasing power through a diversification of payment and coverage opportunities

Availability of financial and technical resources for support facilities as well as health providers to expand geographically

Improved access to credit for different practice settings or services, and in geographic areas, which are most desirable

Ability to modify pricing structure to stimulate access to services

Availability of health management techniques to provide sector providers, investors, and others to enable them to expand competitively and efficiently

Continuing education and training is poorly organized and coordinated

Widespread use of continuing education which advance priorities of the health system, such as quality of care, preventive services, etc.

Shortage of nurses with state diplomas in the private sector

Increased opportunities for trained nurses and paramedicals



PRESCRIPTION FOR IMPROVING THE RELATIONSHIPS IN PRODUCTION AND CONSUMPTION OF SERVICES BETWEEN THE PUBLIC SECTOR AND THE PRIVATE SECTOR

Under the third problem area, we saw that the private sector has been growing in the recent past both as a source of health services and a preferred source of care for some sectors of the population. Under the current conditions this growth, while responding to real demand, has placed even greater pressures on available public resources. The pressure occurs because the current organization of health care services encourages the use of some public services by private or insured patients at fees which amount to significant public subsidy. This means that increased private provision of health services may place even greater pressures on public resources, in particular, by drawing on public resources disproportionately for curative care for those who are able to pay.

The public and the semi-private sector produces services which could be produced and distributed by the private sector, a problem which manifests in two main ways. First, the public sector provides hidden subsidization of private curative care used by the insured population and by people otherwise able to afford the costs of care, leading to a distortion of prices and other market signals (such as utilization). As more people use more of these services, the level of these hidden subsidies will also increase, leading to a long term and increasing drain on public resources. The second way this problem is manifested is in what private actors see as "unfair competition" from the public sector. This shows up both in the artificially low prices charged for services which discourages the private providers from entering the market for those services, and diverts to the public sector patients who are eligible for public services but who would otherwise be able to pay for those same services from private providers.

Prescription 3: Carry out specific program and/or project interventions to reduce hidden public expenditures on privately insured services and to protect public resources from risk of unnecessary drain by consumers otherwise able to afford care. This can be done by both reducing the public sector production and hidden subsidization of those curative services which could and should be produced by the private sector, and by enabling private providers to gain more of the market for patients who have the ability to pay for services (individually or through third parties).

SYMPTOMATIC MARKET DIFFERENTIATION PROBLEMS

Competition from the public sector for services which could be produced and delivered by the private sector; arising from distorted/subsidized pricing structure for use of public services and from overly easy access for private patient access to public services

DESIRABLE DIFFERENTIATION

Use of public resources for those services and those patients which are public sector priorities; remaining services produced and provided by the private sector



It is important to consider these prescriptions and the following activities as a group, as many of them are designed to be mutually supportive. Activities to send new signals, to enhance the ability of the private sector to mobilize technical and financial resources, and to protect public resources will have maximum impact if implemented in such a way as to motivate or mobilize the private sector in general. This is particularly important when planning demonstration projects, as these will have limited impact if they have too narrow a focus. It is also important when considering demand side activities, as increases in demand may not have the desired results — or may even have undesirable results — if they are not linked to broader supply side changes.

In implementing activities, we must keep in mind that the goal here is not simply to foster expansion. Rather, it is to increase the degree to which private health care providers — in lieu of public providers — can meet the expanding demand for services and thereby free up an increasing proportion of the public budget for preventive and primary care, in particular for populations who cannot afford to obtain such care from other sources. An overriding imperative in developing strategies and activities, therefore, is to recognize that *increasing the size of the private sector, in and of itself, is not necessarily a desirable outcome*. It is essential that growth and expansion follow an effective and affordable course; one which leads to more *appropriate* services, produced *efficiently*, and made more accessible to *more people*.

It is important at this point to state once again that this and the following section do not propose a policy or strategy for the GOM. Rather, they are intended to assist the government and USAID in their ongoing development of policies and strategies by presenting some fundamental principles which should be included in all such strategies, and suggesting ways to approach the private sector in pursuit of those principles.

VII. IMPLEMENTATION: ACTIVITIES IN SUPPORT OF POSITIVE GROWTH IN THE PRIVATE HEALTH SECTOR

An earlier document prepared for the USAID Mission suggested a "dual litmus test" for evaluating possible activities.¹⁶ This dual litmus test included determining whether proposed activities were (a) potentially profitable for the private sector and (b) in the public good. Profitability is a *sine qua non* if the private sector is going to involve itself in the directed growth process. Serving the public good is accomplished when recommended activities are judged against the criteria of quality, equity, efficiency, cost containment, and complementing overall GOM and USAID goals.

This section presents a number of recommended activities to implement the prescription outlined in Section VI. As a set, these activities can be expected to stimulate the changes that would result in positive answers to each of our three guiding questions: (1) Are market signals appropriate?, (2) Can the private sector respond in a profitable way?, and (3) Are public resources protected? Furthermore, each of these questions must be answered in the overall context of serving the country's public health goals.

It is evident that there is already a trend toward increases (in absolute terms) in both the supply of, and the demand for, health services in Morocco. Most of this total increase is a simple result of growth in the number of physicians and in the overall size of the population; in many areas, individuals are unable to pay out of pocket. As we have noted, there are significant constraints and distortions in market signals, both of which limit the ability of the private sector to grow in such a way as to make efficient use of private resources and protect public resources.

Many recommendations have previously been made to USAID and the GOM.¹⁷ These are useful and valid, all have been taken into consideration for the purpose at hand, and most have been incorporated in some form into the present recommendations. However, in light of the underlying intent of this paper to assist the Mission in identifying actual implementation steps, this section goes beyond simply making topical recommendations; it also offers a priority list of recommended activities, an evaluation of each recommended activity, an estimation of resource and time requirements for those priorities, and concrete steps to carry out recommended activities.

¹⁶ Opportunités pour une Expansion du Secteur Privé de la Santé au Maroc. (Translation of Nancy Harris et al. consultant report to USAID, November). 1990: JSI/The Enterprise Program.

¹⁷ For example, those found in "An Indicative Survey of Health Services Development in the Kingdom of Morocco: A Report to the Minister of Public Health" (The PRITECH Project, 1986); and "Opportunités pour une Expansion du Secteur Privé de la Santé au Maroc" (JSI/The Enterprise Program, 1991).

SELECTION CRITERIA

Possible activities can be assessed against a rigorous set of criteria, the satisfaction of which will help further GOM and USAID goals. Each activity which is proposed herein is considered against the following criteria: (1) alleviating government burden, (2) macrolevel cost containment, (3) individual service/product cost containment, (4) linkages to other initiatives, (5) feasibility, (6) profitability, (7) stimulating/generating more resources for health, (8) leveraging resources with USAID investment, (9) enhancing equity and access, (10) enhancing quality, and (11) promoting efficient models of resource use. (See Exhibit 2 two pages below for an explanation of each criterion). These criteria are interrelated and not all are applicable to each possible activity, though as a set they represent important considerations for tailoring USAID-supported activities.

The rest of this section will present a variety of recommended activities grouped under our three main themes (which in turn correspond to the three questions at the heart of this study):

- GROUP 1 Activities to generate appropriate market signals to stimulate effective private sector participation. (Addresses the question: Does the market generate appropriate signals to stimulate the most effective private sector participation?)

- GROUP 2: Activities to help the private sector respond to market signals. (Addresses the question: If the correct signals were generated, can the private sector respond?)

- GROUP 3: Specific programs or projects to reduce hidden public expenditures on privately provided services. (Addresses the question: If the signals were correct and the private sector responded, would this change lead to the desired result of reducing the burden on public resources?)

After a brief overview of the theme or group, each activity under that group will be presented and analyzed according to a consistent format which includes the following headings:

Discussion: How does this activity contribute to the desired changes laid out in the prescription?

Problem areas/ constraints addressed: What specific problem areas or constraints, identified through the interviews and through other sources, will be ameliorated by this activity?

Implementation steps: What specific steps can be taken to carry out the activity?

Relationship to selection criteria: Does the activity respond to or meet most or all of the 11 selection criteria (in Exhibit 2 below)?

Pros/strengths: What characteristics of the proposed activity make it especially likely to achieve the desired outcomes?

Cons/weaknesses: What are the limitations of the activity?

Potential USAID constraints: What critical factors are clearly beyond the practical ability of USAID to control or change?

Milestones: What products or accomplishments along the way will indicate that the implementation is progressing?

Benchmark indicators: What results (statistical or otherwise) can be monitored to evaluate progress?

Red flags: What changes or indications should we be especially attentive to, as signs that the private sector is responding negatively? The appearance of a red flag should automatically lead to a review and revision of the activity and/or the way it is being carried out.

Expected overall impact: What changes are anticipated as a result of the activity?

Estimated activity cost: How much can the activity be expected to cost, as a very rough estimate, including not only technical time but overall personnel, administrative, and other direct and indirect costs?

The last item in the standard format, activity cost, is of course difficult to estimate. Estimates are presented with an anticipated duration for each step, person months required, and special skills required for the person responsible. A discussion of the method used for estimating activity costs is provided as Appendix II, along with explanations for making changes (based on different blends of consultant time, person months, and so forth) using a simple spreadsheet which is provided to USAID along with this report.

EXHIBIT 2

CRITERIA FOR PRIVATE HEALTH SECTOR ACTIVITIES

Alleviates government burden	Will the recommended activity actually lead to a reduction in the government's burden <i>vis à vis</i> services and their distribution and in terms of both geography and market segmentation?
Macrolevel cost containment	Keeping in mind that no expansion is going to <i>lower</i> macrolevel costs, does the activity contribute to <i>containing the increase of costs</i> at the macro level, such that the total (national) costs of health care do not outpace the ability of the sector and the overall economy to pay for expansion?
Individual service/product affordability	Does the activity contribute to the delivery of economical services and products at the individual level?
Linkages to broader impact	Does the activity relate to other recommended activities? Is it likely to have a "ripple effect" across other problem areas?
Feasibility	Is the activity relatively simple in its technical, managerial, and political aspects, such that its implementation can be carried out with a minimum of complication from any of these sources?
Profitability	To meet an all important need to be feasible in the private sector, can it meet most of the other 10 criteria and still be profitable?
Stimulating or generating more resources for health	Will the activity actually bring more resources into desirable kinds of services and products or merely encourage a shifting of resources from one kind of service to another (recognizing of course that some shifts, such as from the public sector to the private sector, are desirable)?
Leveraging resources with USAID investment	Will the resources of the planned activity have maximum leverage by combining resources, building upon or encouraging initiatives already undertaken by the private sector, or sharing costs with efforts by other agencies such as the GOM or World Bank?
Enhancing equity and access for target groups	Will the activity make services more accessible to those who otherwise would not have access, or will it enhance the public sector's ability to provide services to the indigent?
Enhancing quality	What impact can the activity be expected to have on quality improvement?
Promoting efficient use of resources	Does the activity encourage the efficient use of resources in the long term, such as appropriate use of low cost technology, the increased use of essential drugs, or provision of preventive services?

GROUP 1: ACTIVITIES TO GENERATE APPROPRIATE MARKET SIGNALS TO STIMULATE EFFECTIVE PRIVATE SECTOR PARTICIPATION

OVERALL OBJECTIVES OF GROUP 1 ACTIVITIES: The objectives of this activity are to remove or modify signals in the market place which discourage or fail to attract investors and practitioners into desirable and efficient activities, and to send appropriate market signals to stimulate desirable private sector investment and activity. There are three main factors which serve as impediments to the diffusion of appropriate signals (as discussed above in Section V): (1) official regulations and policies and private institutional practices which limit the organizational and operating options available to the private sector, (2) inadequate flow of information concerning those market opportunities which do exist, and (3) subsidized competition which generates distorted signals. This last group is linked to the greater problem of public resource allocation and is treated separately (under Group 3 Activities). The objectives, therefore, are to revise constraining market signals, to send new signals to stimulate efficient production of services, and to facilitate the flow of information so that those signals can reach the private sector.

ACTIVITY 1.A: Implement a demonstration project, to test and display innovative, alternative ways of producing and delivering services.

Discussion: The interviews and other information strongly suggest that the expansion of the sector is restricted by many of the policies and regulations which affect health sector organization and operations. These include rules against hiring of physicians, rules against marketing medical services to users, rules inhibiting group practice, rules restricting access to credit, etc.

Because many market influences interact, it cannot be known whether removal or modification of any specific characteristic or factor will generate an appropriate market response. Furthermore, an across the board revision of tax codes, regulations, and laws is a very difficult and time-consuming undertaking, even when there is widespread consensus on the need for, and nature of, desired changes (and such a consensus does not yet exist). A different approach to making changes in the regulatory environment is to experiment with selected changes and note how the market responds, all in the context of a limited controllable environment. Such an approach would make *ad hoc* modifications in market conditions on a "waiver" basis (i.e., suspension of rules for a pilot activity) as part of a demonstration project. A fundamental goal of this activity is to determine the degree to which changes in market supply conditions can support an expanded role for private services on a profitable and efficient basis.

This activity would involve implementing a demonstration project using both development funds (grants) and guaranteed loans. A waiver authority would be incorporated to allow innovations not incorporated into current legislation and regulation.

Demonstration projects send market signals to potential investors and providers. Perhaps more important, demonstration projects provide planners and managers with experience and information about how the market responds, what unforeseen difficulties can arise, and what new opportunities are created out of the changing market. It may well be that the responses

observed after a few years are very different from what is predicted at this point, or from responses in the first couple of years, as programs do evolve on their own. A flexible approach to demonstration projects permits the cycle of (a) introducing new signals and stimuli, (b) monitoring and evaluating market response, and (c) modifying and redirecting scarce government or donor resources.

Managed care may be one kind of organizational setting selected as a demonstration project but other modifications in structure, organization, capitalization, and reimbursement should also be considered. It must be kept in mind that as a demonstration project a managed care entity may very well be less valuable as an end in itself than as a vehicle for sending signals to other potential investors, practitioners, and consumers about the efficiencies and quality which can be attained in a managed care setting.

Problem areas/constraints addressed by activity: Most significantly, limited knowledge of alternative models; can also include many constraints arising from market conditions, capital availability, or laws and regulations, including those identified during the course of this study and others not yet identified. The full set is to be determined during demonstration.

Implementation steps:

1. Establish a demonstration project oversight committee, to include representatives from USAID, the government, and private associations.
2. Identify priority target population/geographic area (based on explicitly defined points of selection).¹⁸ A demonstration project should not duplicate services or compete for existing market share, which is an important consideration since most candidates will be in urban areas. Important criteria for points of selection would, include at a minimum:
 - a. Serving a target population or market segment (e.g. lower income) not currently receiving private health care, but with minimal disposable income to be able to participate; employed persons should normally qualify
 - b. Ability to produce services at a price affordable for targeted population.
 - c. Ability to achieve full financial self-sufficiency
3. Determine total startup budget and share to be covered under demonstration project grants.

¹⁸ The emphasis upon a demonstration project in a highly populated area (e.g., Rabat or Casablanca) would only be reasonable if the intervention were predicated upon a demonstrated oversupply or surplus of physicians who could be recruited for alternative financing activities. The counter-argument is that the true oversupply of physicians is going to be found among new entrants into the health market, namely those coming from medical schools or shifting from the public sector to the private sector. If this is the case, then it is not desirable to attract these physicians to Rabat or Casablanca, but rather to make a specific effort to attract them to less served areas.

4. Prepare detailed implementation and monitoring plan.
5. Identify and secure any specific government waivers required.
6. Select implementing agency. This can include a local firm or a joint venture with a foreign firm. Qualification requirements include existing health systems capabilities and sufficient track record in the technical area of the demonstration project.
7. Solicit and fund demonstration projects. These can include elements of a managed care setting, other forms of prepayment, a trial insurance experiment, group practices, or a locally adapted entity incorporating several of these elements. There may be several smaller demonstration projects or one or two larger ones. Substantive technical assistance will be needed at the project development stage.
8. Implementation, monitoring, and technical assistance.
9. Dissemination of results and experiences (carried out through activity 1.C.).

Specific assessment in relation to selection criteria:

Alleviating government burden	Demonstrations will be selected which specifically provide needed services to groups not currently receiving significant private services, thus providing an alternative to government services in those areas.
Macrolevel cost containment	By incorporating long-term macrolevel cost considerations into the review and selection process, activity can have a positive impact in this area.
Individual service/product cost containment	If startup costs are amortized, the average unit costs of individual services should reflect the effect of competition on production costs. Initial (startup) can be high on a per capita basis due to existing health conditions related to poverty (i.e., accumulated need).
Linkages	Demonstration project shows advantages of innovative private sector initiatives at the same time that the out-of-pocket costs of public services become higher and access is controlled more stringently (c.f. Activity 3.A), making the public sector a less desirable alternative for those who have access to private sector services.
Feasibility	Technically and managerially feasible; need for specialized managerial skills increases commensurate with complexity and size of demonstration project. May depend to some extent on obtaining waivers.
Profitability	Profitability must be included as part of the business plan workup required of selecting grantee.

Leveraging resources with USAID investment	Grants may be awarded based on a proportion of costs (e.g., matching grants, 90% startup grants) or as 100% of startup costs. Private replication of demonstration elements represent ongoing leveraging of investment.
Enhancing equity and access for target groups	Needs to be established as part of the selection of target areas and target groups. Subsidies for demonstration efforts could be restricted based on need, or choice of project could be based on criteria (geographic, socio-economic status, etc.) favoring those in need.
Enhancing quality	Needs to be assessed for each proposal. Should be built into program priorities as specific requirements or evaluation points as part of the grant-making process, and through technical input at the planning stage and during all monitoring and evaluation. Quality assessments need to focus on both provider perspectives and on health status indicators.
Promotion of efficient models of resource use	By removing institutional constraints to efficient production (such as group practices, HMOs, franchises, etc.), program would demonstrate more cost-effective service production strategies. This can be enhanced by technical assistance at the application and review stage.

Pros/strengths: Major strength is that it permits domestically generated ("grassroots") models grounded in the realities of the Moroccan system. A second strength is in the creation of an additional vehicle for input into the policy dialogue process (such as through the Board of Directors).

Cons/weaknesses: Weakness in the amount of attention required for the program, as it involves diverse sub-project level activity.

Potential USAID constraints: limitations on the ability to obtain legal and regulatory waivers.

Milestones: Establishment of oversight committee; award of first grant; full grant portfolio awarded.

Benchmark indicators: Amount of grants committed (e.g., 50% and 100% of available grant money); numbers served by demonstration project; comparative utilization statistics (e.g. service mix, patient profiles).

Red flags: Inappropriate solicitations (based on technical evaluation, cost of services, geographic location, etc.); unacceptable utilization curve; increases in use of public services in demonstration areas.

Expected overall impact: demonstration of significant private market potential to provide needed health services when market constraints are appropriately modified. Establishment of several viable (i.e. self-financing) activities in targeted areas, covering target groups.

Estimated activity cost: Costs for this activity are based on the following technical inputs:

1. **Technical Resource Requirements:**

Step	Duration (Months)	Person Months	Special Skill Areas
1	2	2	Economist or management specialist with extensive knowledge of Moroccan health sector
2	1	1	Health management and planning
3	1	1	Health management/finance/planning
4	4	1	Management and planning
5	4	2	Economist or management specialist with extensive knowledge of Moroccan health sector
6	3	2	Health management
7	4	9	Health management and health economics (more than one individual)
8	36	51	Health management, finance, MIS
		70	

2. **Additional Resource requirements:** Pass through money for demonstration project startup operations of approximately one million dollars.

3. **Total estimated activity cost (in US\$ * 1,000):**

TOTAL PERSON MONTHS	TECH. PERS.	TRAVEL+ PER DIEM	OTHER DIR. & INDIRECT	PASS- THROUGH	TOTAL ACTIVITY COST
70	256	71	447	1,000	1,774

ACTIVITY 1.B: Introduce specific incentives (tax related and modifications in official and nongovernmental rules and regulations) to stimulate desirable private sector responses.

Discussion: The complaint most widely expressed by private providers during the interviews was the structure of taxes, primarily T.V.A. but also customs duties (e.g. taxes on imported medical equipment) and asset taxes ("la patente"). Many physicians noted that regulations regarding how they can organize themselves in group practices and clinics (société anonyme, société professionnelle civile, etc.) were unclear or contradicted bank requirements for obtaining capital. Rules regarding the use of borrowed funds also create incentives for certain types of practice settings while actively discouraging others.

Taxes, including the T.V.A., are a major concern of private sector providers, and investors are always sensitive to changes in the tax structure. The work on preparing an investment code (code d'investissement) has attempted to address modifying signals through the tax structure, but difficulties in achieving consensus have presented obstacles to defining, much less implementing, a tax reform package. This activity will introduce targeted signals through tax holidays in order to stimulate the movement of physicians into underserved areas and other desirable trends. These activities are less ambitious and far-reaching than the work already completed or underway in developing an investment code for the health sector, and are meant to facilitate or complement that activity.¹⁹ Should a specific investment code for the health sector be abandoned in favor of an overall investment code for all sectors, this activity would complement this new code as well.

Under the current distribution of private health services, providers are concentrated in urban areas. Physicians have begun to respond to this glut in a limited way by moving into rural and low income urban areas where they have been able to establish practices, despite what is widely believed to be a low level of solvent demand in those same areas; indeed, many rural physicians have done quite well, and some have only been able to meet loan payments after leaving the cities. This activity seeks to encourage this incipient market response by providing specific incentives to physicians willing to work in underserved areas.

The interviews show that borrowed funds are used almost exclusively for startup capital investment purposes (buildings and equipment) and not for operating costs, which ties credit to capital-intensive investment. This in turn makes it more difficult, if not impossible, for providers to finance certain types of practice settings which might be more cost-effective and desirable (for example, group practices of generalist physicians in low income areas). The availability of credit to finance operating costs would encourage physicians to experiment with ventures which might require more time to build up a reliable client base. By reducing constraints on the uses of borrowed funds, this activity will support the opening up of funds for more competitive operations.

¹⁹

As described by Housni (1990).

Problem areas/constraints addressed by activity: Lack of well-developed tax incentives, such as those which encourage priority health services for target groups; confusion over rules and regulations; credit bias toward capital-intensive structures.

Implementation steps:

1. Identify pattern of incentives or disincentives, which are created (1) the current tax structure, (2) restrictions on use of borrowed funds, (3) current regulations, or (4) through confusion or misunderstandings of the above. Sources of constraints can be either governmental or nongovernmental.²⁰
2. Develop specific recommendations for changes in legal, regulatory, and tax structure which would re-align the incentives for the private sector. (Changes governing permitted practice settings should be acceptable to MSP, Ordre des Médecins, and other key actors. Changes in tax structure will need to be negotiated with the Ministry of Finance.) Identify areas where demonstrations are needed to achieve consensus before permanent changes can be approved. Develop a waiver mechanism to provide more flexibility in demonstration projects. (An alternative would be tax credits based on key interventions such as credits for verifiable performance against targets of numbers of children immunized, number of continuing family planning acceptors, etc.)
3. Identify priority changes which can be addressed through nonproject assistance or performance based programming, with specific benchmarks for each.
4. Assess and evaluate initial efforts to modify, expand, or abandon changes which have not had the desired effect on private sector behavior.
5. Continue monitoring and dialogue.
6. Where regulatory/tax waivers or changes have been effected, disseminate information to private sector actors to clarify permissible practice settings, banking changes, and tax changes.

Specific assessment in relation to selection criteria:

Alleviating government burden	This activity should have indirect effects on alleviating the government burden of providing services by expanding the capability of the private sector to perform this role.
Macrolevel cost containment	May reduce macrolevel costs by promoting more cost-effective delivery modes.

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Nongovernmental constraints include those imposed by the Code de Déontologie.

Individual service/product cost containment	Reducing tax costs and enabling efficient service delivery models should reduce unit costs of service delivery.
Linkages	Links to demonstration project under activity 1.A in that waivers to modify existing rules may be necessary for any demonstration project; links to information dissemination activities (under Activity 1.C)
Feasibility	May be difficult to achieve consensus between key actors for permanent regulatory changes and changes in tax structure. Must be prepared to identify advantages of changes to each party involved and demonstrate their effectiveness on a small-scale before large-scale changes are approved.
Profitability	Profitability is the specific incentive involved in this activity.
Leveraging resources with USAID investment	Increased profit potential likely to lead to increased private sector investment in health sector
Enhancing equity and access for target groups	By expanding the variety of service delivery settings which are permissible and profitable for physicians, this activity should enhance the distribution and availability of services.
Promotion of efficient models of resource use	This activity will allow private sector actors to experiment with alternative service delivery models in order to identify those which provide the best return on investment. In addition, incentives can be built into new regulatory and tax structure to promote economically efficient types of services (e.g. preventive care, family planning services).

Pros/strengths: Directly addresses the specific constraints on the ability of the private sector to effectively respond; not capital intensive; may serve to clarify confusion about some rules and regulations without need for extensive modifications; builds upon efforts already under way in the development of a tax investment code; can be followed by nonproject assistance after strategy is fully developed.

Cons/weaknesses: Decision making in some areas lies with the Ministry of Finance and other regulatory bodies and is outside the range of USAID or, to a large part, the Ministry of Health.

Potential USAID constraints: USAID is limited by the willingness of regulatory bodies to make changes. This problem can be offset by a priority based approach which avoids the difficulty of a comprehensive legal reform, such as that necessitated by an investment code.

Milestones: Written plan with organized targets for modifications and plans to achieve change; observed revisions based on items in written plan; dissemination (carried out under Activity 1.C).

Red flags: Inability to achieve consensus on desirable changes; inability to obtain approval for waiver authority.

Expected overall impact: Re-alignment of incentives to permit greater flexibility in organization and service delivery, leading to cost-effective service delivery models and private sector involvement in providing services for underserved populations.

Estimated activity cost: Costs for this activity are based on the following technical inputs:

1. Technical Resource Requirements:

Step	Duration (Months)	Person Months	Special Skill Areas
1	1	2	Economist; taxation/legal expert
2	2	3	Economist; taxation/legal expert
3	6	4	Economist; health mgt. specialist
4	Ongoing	2	Economist; health mgt. specialist
5	12	4	Economist; health mgt. specialist
6	Ongoing	--	(covered under Activity 1.C)

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2. Additional Resource requirements: Any nonproject assistance funds to be used to encourage changes; \$250,000 used as a temporary planning figure.

3. Total estimated activity cost (in US\$ * 1,000):

TOTAL PERSON MONTHS	TECH. PERS.	TRAVEL+ PER DIEM	OTHER DIR. & INDIRECT	PASS- THROUGH	TOTAL ACTIVITY COST
15	50	8	87	750	895

ACTIVITY 1.C: Increase the availability and dissemination of information.

Discussion: It is clear from the interviews that private sector physicians have very limited sources of information on where to set up practices, what procedures to follow, where to get economic support for those practices, and what kind of technical assistance may be available (for example in selecting a practice location, potential employers or partners, performing market analysis, or projecting income). An array of market signals arising from the demand side of the market or from changes, such as tax holidays, needs to be disseminated throughout the private sector, not only to physicians but to allied personnel, potential investors, suppliers, and others. Important areas of information to be included in a dissemination strategy include:

- existing levels and types of competition in different markets
- sources of information and technical assistance for market analysis, marketing, management, etc.
- modifications in taxation, tax holidays, etc.
- modifications in loan requirements
- modifications in regulations
- upcoming seminars
- physician partner matching
- access to referral networks for laboratory exams and tertiary/specialty care

A clearinghouse can also serve as a likely on-going market research center, gathering information on practice characteristics, pricing, services offered and so forth, to supplement government statistics.

Problem areas/constraints addressed by activity: concentration of physicians in Rabat-Casablanca corridor; absence of application of market analysis and other management techniques; lack of information on alternative ways of providing services; absence of channels of communication for new market signals resulting from other expected reforms and initiatives.

Implementation steps:

1. Identify collaborators/implementors for establishing a database-run clearinghouse and for other sources of information. Candidates for implementation may include medical associations, commercial information services, or local consulting firms, each of which has advantages and disadvantages.
2. Organize a study tour for collaborators and/or representatives from key organizations to at least one other country with a successful public health clearinghouse.
3. Develop a portfolio of priority topic areas to be included in information portfolio.
4. Identify target audience.
5. Establish sustainability plan based on fees for information services or subsidization by member fees, or by linking data collection to the government's normal licensing, taxation or regulatory processes.

6. Establish mechanisms for monitoring levels of use and impact.
7. Implement and evaluate regularly, with technical assistance.

Specific assessment in relation to selection criteria:

Alleviating government burden	To the extent that improved information stimulates interest in underserved areas, in experimenting with a broader array of practice settings, and in offering different mixes of services, use of government services can be relieved on both a geographic and a service-mix basis.
Macrolevel cost containment	Only indirectly, through stimulation of competition; does not encourage any activities expected to lead to cost increases.
Individual service/product cost containment	Only indirectly, through stimulation of competition.
Feasibility	Relatively simple on technical and managerial levels; more difficult in terms of effective dissemination.
Profitability	Access to information translates into profit for the entrepreneur, making available information an attractive entity. If clearinghouse becomes firmly established and develops a client base, it can itself become a profitable venture.
Leveraging resources with USAID investment	Amount of resources leveraged is directly related to the amount of private resources attracted to investments as a result of the market signals disseminated through this activity.
Enhancing quality	Provides a mechanism for introducing quality issues through private providers, and a vehicle for initiating dialogue between providers and consumers (especially organized purchasers).
Promotion of efficient models of resource use	Full information assists choice of most efficient models of service delivery.

Pros/strengths: Information is the fuel by which market signals travel, but any one mechanism will be limited by the portion of the market reached. Each potential implementing agency has limitations and conflicts.

Cons/weaknesses: The clearinghouse can become complicated and costly if not controlled; USAID involvement should be limited to startup money and technical assistance in early period. If

seen as a government maintained clearinghouse, it could be interpreted as a controlling mechanism.

Potential USAID constraints: None anticipated if caveats under "pros and cons" above are considered.

Benchmark indicators: Proportion of physicians receiving information from new source; number and types of other parties brought into information loop.

Milestones: Collaborators/implementors identified; specification of priority topics to be disseminated; target audience identified; monitoring mechanisms established; financial independence (breakeven) analysis completed.

Red flags: Lack of response from physicians; lack of response from other actors in market; breakeven beyond desired or estimated timeframe (e.g. three years).

Expected activity cost: Costs for this activity are based on the following technical inputs:

1. Technical Resource Requirements:

Step	Duration (Months)	Person Months	Special Skill Areas
1	1	2	Marketing and communications
2	1	2	Communications
3	1	2	Marketing and communications
4	1	1	Marketing, health planning
5	1	1	Management
6	.5	1	Marketing and communications
7	Ongoing	15	Marketing and communications, MIS

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2. Additional Resource requirements: materials and set up costs and broadcasting costs totalling \$225,000; study tour costs of \$25,000.

3. Total estimated activity cost:

TOTAL PERSON MONTHS	TECH. PERS.	TRAVEL+ PER DIEM	OTHER DIR. & INDIRECT	PASS- THROUGH	TOTAL ACTIVITY COST
24	80	12	140	250	482

ACTIVITY 1.D.: Promote quality enhancement in private sector services.

Discussion: In addition to promoting efficient models of production and equitable distribution of services, another major consideration in private sector expansion is improvement of quality. Quality improvement takes on both ethical and practical dimensions; practical considerations include the need to produce services which actually contribute to the health of individual patients, but also recognizes the need to introduce quality into the competitive marketplace to attract users to private sector services.

The lack of a structured system of quality assurance in the Moroccan health sector is a problem which is likely to grow in importance both for the public and for practitioners in the coming years. While the *Ordre des Médecins* is charged with guarding medical ethics and the *Société Marocaine des Sciences Médicales (SMSM)* supports the dissemination of scientific knowledge in the medical field, neither organization has been provided with the means to enforce standards of quality of care. An assessment of possible mechanisms to reinforce the training of health professionals and ensure the quality of services and products should be a priority for the health sector in Morocco. One possible change which was suggested in the interviews was for physicians (and perhaps other medical professionals) to be licensed only for a two-year period, renewable only upon completion of a specific set of continuing education requirements. A similar system is in effect in the U.S. and elsewhere in the world.

Interviews show that most providers think of quality in terms of sophisticated equipment rather than appropriateness of diagnostic and therapeutic procedures, follow up, continuing education, or other essential elements of quality care. They in turn complain of the constraints to acquiring more costly equipment (i.e., taxes), though purchase of new equipment may not be a cost effective way to improve quality of care. Insurance companies, as large-scale purchasers of health services, are in a strong position to demand certain standards of quality. Though few interviews were carried out with insurance companies during the course of this study, it was stated by at least one major insurer that quality is not their concern.

While the preceding three Group 1 activities focused on sending new signals to the private supply side, this activity concentrates primarily on sending signals to the consumer. All other considerations (e.g. price and availability) being equal, higher quality services should attract more clients to a given provider or a given provider setting (group practice, HMO, etc.). Third party insurers, as large-scale purchasers, can be instrumental in demanding improved quality of services. In turn, a responsive supply side will see quality improvement as a necessary part of a strategy of attracting clients.

Problem areas/constraints addressed by activity: Inconsistent quality of care at private facilities; absence of formal system of quality assurance; equation of quality of care with availability of expensive equipment.

Implementation steps:

1. Develop written strategy for quality assurance, including objectives sought, provider settings or types targeted for change, and standards for evaluating improvements. Quality assurance efforts should include at least two main types of activity:

(a) workshops to introduce quality issues to major actors in the private sector and to consumers, and (b) institutionalization of quality assurance systems among major provider groups. This latter aspect is particularly important given the probable growth of different forms of organized health care as an indigenous private sector response.

2. Plan initial series of quality assurance workshops. This includes a series a quality assurance modules and plans for where and when to carry out workshops. For example, workshops may be designed to include four or five one-day modules, to be carried out once per month; this cycle could be repeated in cities around the country such that the four modules are carried out ten times each for providers in different areas. Different modules should be developed for all target groups identified in the written strategy, including solo providers, group providers, clinics, and insurance companies/group purchasers.
3. Pretest QA workshops.
4. Implement workshops in target areas; include quality issues in consumer education activity (Activity 1.E).
5. Develop plan for institutionalization of quality assurance systems in private sector providers and group purchasers.
6. Dissemination of quality assurance issues and approaches.
7. Establish quality assurance fellowships for supporting training and research in quality assurance (through university, medical organization or insurance companies).
8. Organize quality assurance study tour for key policy makers and key private sector decision leaders
9. Introduce quality assurance institutionalization into targeted delivery systems. This involves supporting the establishment of formal quality and monitoring review procedures in some combination of provider systems and insurance/group purchasers.

Relationship to screening criteria:

Alleviating government burden

To the extent that improved quality leads to stronger preference for private sector services, public burden is decreased. Also potential contribution in that referral to tertiary government services arising from cases of poor quality medical services can be eliminated.

Macrolevel cost containment	Quality improvement does not come free of cost, but to the extent that improved quality leads to reductions in unnecessary utilization (either by eliminating unnecessary interventions or by preventing complications from misdiagnosis or poor treatment), the macrolevel cost of quality improvements can be offset by other savings.
Linkages	Most important link is to Activity 1.E., Consumer Education.
Feasibility	No technical or managerial reasons to limit implementation. Activity helped by the many models and standards in health and family planning services devised over the past several years.
Profitability	To the extent that demand responds to increased quality of care, quality improvements can be seen by providers as translating into profit.
Stimulating/ generating more resources for health	Evidence from some studies in other countries shows that people are more willing to pay for services when higher quality is perceived.
Leveraging resources with USAID investment	Demand for higher quality services causes providers to use their own resources for quality improvements over time.

Pros/strengths: Builds upon the tendency of physicians, as shown in the interviews, to attend substantive issue workshops as a major source of information on medical practice; to the extent that demand responds to quality, this activity incorporates a demand based approach to quality enhancement, and providers have demonstrated responsiveness to demand changes.

Cons/weaknesses: Quality assurance systems require certain important elements, such as audit and review procedures, peer review, and establishment of standards of quality. A well-established quality assurance system, implemented by large insurance carriers or other group purchasers, can dedicate a fixed proportion of resources to quality assurance (e.g., 1% of health expenditures). This activity is but a first step in that direction.

Potential USAID constraints: None envisioned.

Milestones: Completion of written quality assurance strategy; completion of quality assurance workshops; completion of institutionalization strategy.

Benchmark indicators: Number of participants in quality assurance workshops.

Red flags: Unwillingness of insurance or other group purchasers to participate; poor response to offering of quality assurance workshops.

Expected overall impact: Increased consumer demand (individual and group) for quality improvements; increasing importance of non-capital quality in privately provided health services; institutionalization of quality assurance in the private health delivery system; establishment of technical capability in quality assurance in a stable Moroccan institute

Estimated activity cost: Costs for this activity are based on the following technical inputs:

1. **Technical Resource Requirements:**

Step	Duration (Months)	Person Months	Special Skill Areas
1	1	1	Quality assurance
2	1	2	Quality assurance
3	1	1	Quality assurance, training
4	12	5	Quality assurance, training
5	1	4	Quality assurance, MIS
6	-	-	(implemented by clearinghouse)
7	6	3	Quality assurance, training
8	2	2	Quality assurance, training
9	12	12	Quality assurance, management, MIS
		30	

2. **Additional resource requirements:** \$ 25,000 to endow quality assurance fellowship; \$20,000 for quality assurance study tour.

3. **Total estimated activity cost:**

TOTAL PERSON MONTHS	TECH. PERS.	TRAVEL+ PER DIEM	OTHER DIR. & INDIRECT	PASS- THROUGH	TOTAL ACTIVITY COST
30	100	15	175	45	335

ACTIVITY 1.E: Implement a consumer education campaign.

Discussion: Many providers mentioned a standard package of services they offer, and generalists normally included education, family planning and well child care high on their lists. Those who did not refer to standard packages in their interviews most often made some reference to their service mix being driven by consumer demand.

This situation creates an opportunity to encourage the use of appropriate services which can improve the public health. Increases in the volume of preventive services delivered by the private sector will come from three sources: (1) drawing patients away from the public sector, (2) drawing patients away from the informal sector (e.g. self-help through pharmacies) or (3) newly created demand. Any of these three conditions represent desirable changes in service production and consumption.

This activity will introduce a number of stimulants to encourage the shift in consumer demand toward privately produced preventive services, such as prenatal care, oral rehydration therapy, family planning and immunizations.

Problem areas/constraints addressed by activity: Weak consumer knowledge on health services and quality of care; lack of market for preventive services and lower-cost providers (e.g., paramedical).

Implementation steps:

1. Select a committee of leading technical public health representatives including government, universities and provider associations. Convene a committee meeting to identify priority preventive services which can be provided by the private sector. Some priority health interventions may be specific to different regions of the country.
2. Involve private sector providers at large through a targeted campaign aimed specifically at this group — mailings, workshops, information dissemination, etc. Involve private sector providers in planning and execution, emphasizing combined benefits of public good and higher earnings for the providers.
3. Select a local media/marketing group to collaborate in development of messages and materials and a public education strategy.
4. Review existing public health education messages appropriate for use in new consumer education strategy, including a review of materials produced in other countries, such as the successful USAID-funded private physician ORT consumer education campaign in Egypt. (This review will probably involve travel of two individuals to two or three countries, perhaps including the U.S.).
5. Prepare full strategy, messages and materials.
6. Pretest and revise messages and materials.
7. Launch consumer education activities.
8. Monitor, evaluate, and modify.

Relationship to screening criteria

Alleviating government burden	Contributes both by encouraging appropriate utilization of private services and encouraging lower unnecessary use of public services.
Macrolevel cost containment	Can potentially have major impact by reducing inappropriate or inefficient self-treatment and strengthening the demand for appropriate preventive services. Increases in costs due to higher use of preventive services, such as prenatal care will be more than offset by savings in curative services.
Individual service/product cost containment	Appropriate prescriptions and diagnoses and prevention should lower the cost of illness episode and eliminate some curative costs.
Linkages	Shifts in consumer behavior (choice of provider, timing of access to provider, specific service requests, etc.) are an integral part of the overall strategy of encouraging different supply responses. Greater demand for preventive services may lead to greater use of public facilities as well.
Feasibility	Consumer health education techniques are well developed and tested; can easily build upon consumer education in Morocco and other countries.
Stimulating/ generating more resources for health	Most significantly, changes in consumer behavior can lead to more resources being made available for precisely those services (i.e., preventive services) which are encouraged. Based upon the impact on reducing inappropriate use (e.g. self-prescription), can reduce waste from the consumer side, making more resources available without greater expenditures.
Leveraging resources with USAID investment	Small USAID investment expected to lead to large privately-financed demand.
Enhancing equity and access for target groups	Leads private sector to provide more appropriate services by strengthening demand for them.
Enhancing quality	Quality considerations can be included in specific messages; overall improvements in consumer knowledge contributes to overall strategy of improving the appropriate use of services and products, leading to better quality of care.
Promotion of efficient models of resource use	Strongly promotes preventive services and other cost-effective health services.

Pros/strengths: Potential large-scale impact; ability to modify content from centralized location after reviewing information yielded by monitoring system; campaigns are specially tailored to achieve desired changes in consumer behavior.

Cons/weaknesses: Controls on outcome are only indirect; after consumer education, requires supply side changes and other structural changes to have desired impact.

Potential USAID constraints: As with cons/weaknesses, the success of consumer education depends on the consumer response.

Milestones: Physician associations involved; messages developed and pre-tested; campaign initiated.

Benchmark indicators: Increase in physicians reporting key services being highly utilized; satisfactory recognition and recall surveys.

Red flags: Lack of interest by private sector providers; lack of response from providers; lack of positive recall by consumers; inordinate increases in some services included in consumer education messages.

Expected overall impact: Increase in demand for key preventive services; increase in private sector role in providing target services.

Estimated activity cost: Costs for this activity are based on the following technical inputs:

1. Technical Resource Requirements:

Step	Duration (Months)	Person Months	Special Skill Areas
1	1	1	Public health, communications
2	1	1	Communications
3	1	2	Communications
4	2	3	Communications
5	1	2	Communications
6	-	-	
7	18	13	Communications

21

2. Additional Resource requirements: Travel during special research (\$20,000); communications/broadcasting/distribution costs (\$275,000).

3. Total estimated activity cost: (costs in US\$ * 1,000)

TOTAL PERSON MONTHS	TECH. PERS.	TRAVEL+ PER DIEM	OTHER DIR. & INDIRECT	PASS- THROUGH	TOTAL ACTIVITY COST
21	70	11	122	275	478

GROUP 2: ACTIVITIES TO HELP THE PRIVATE SECTOR RESPOND TO MARKET SIGNALS

OVERALL OBJECTIVE OF GROUP 2 ACTIVITIES: To make available to providers and investors the technical and financial resources to meet the needs of business expansion. Interviews have shown that the private sector generally does not carry out market analysis, business projections, cost and pricing analysis, marketing development, or other technical development activities which could be used presently or after changes in market conditions. These Group 2 activities will provide resources to support the anticipated results of Group 1 activities.

ACTIVITY 2.A.: Implement a loan guarantee and technical assistance program to support improved lending practices.

Discussion: Interviews indicate that lending practices have resulted in producing medical services that disproportionately emphasize small-scale capital equipment and physical infrastructure. The intention of this program is to modify lending conditions to make more financial resources available for alternative delivery modes.

Problem areas/constraints addressed by activity: The absence of capital for delivery modes other than small-scale, capital equipment intensive practices; absence of capital for development of health services in markets other than unsaturated urban areas; lack of access to capital for human resources, non-capital intensive business development, and marketing.

Implementation steps:

1. Identify legal or tax waivers which are needed and conduct a review of existing loan and loan guarantee programs in Morocco, with their financial profile, problems, procedures, etc.
2. Select a steering committee including senior representatives from the financial and medical communities and the government.
3. Identify or establish an implementing bank/agency.
4. Establish budget envelope and projections of capital regeneration, based on calculations of operating expenses, principle defaults, and earned interest.
5. Specify priorities to be encouraged through loans. These may include: geographical setting, population coverage, total growth potential, or potential contribution to the desired outcome of reducing public resource burden, as well as soundness of business plan and profitability.
6. Establish loan application evaluation procedures.

7. Solicit applications (through commercial channels or through clearinghouse, in repeated cycles or on an ongoing basis); track applications (this may or may not require additional setup of tracking systems, depending on implementing institution).
8. Select recipients, funding, and support through technical assistance for business development (ongoing).
9. Carry out portfolio management/recapitalization (ongoing).

Specific assessment in relation to selection criteria:

Individual service/product costs containment	Successful loan use will require competitive costs structures.
Feasibility	Clearly feasible; USAID experience with loan guarantees for the small manufacturing and export sector provides a good model.
Profitability	For the borrowers, profitability must be included as part of the business plan and application process. For the lenders, guaranteed loans are by nature more profitable than riskier loans.
Linkages	Sends signal to private sector investors/providers in support of Group 1 activities.
Leveraging resources with USAID investment	As the loan guarantee program is ongoing, the amount of resources directly leveraged continue to increase throughout the life of the program.
Enhancing equity and access for target groups	Needs to be assessed for each proposal. Can be built into program priorities.
Enhancing quality	Needs to be assessed for each proposal. Can be built into program priorities as specific requirements as part of the loan process, and through technical input at the application and review stage.

Benchmark indicators: number of loans granted; total value of loan portfolio; volume of services provided; increases in services in target areas; financial performance based on projections made during implementation steps.

Milestones: Preparation of loan application package; initiation of lending; first complete cycle of loans (repayment completed).

Red flags: Absence of adequate proposals from the field; failure to obtain necessary waiver authority; failures exceeding initial projections (in number of volume).

Expected Overall Impact: creation of a market for non-capital intensive loans.

Expected activity cost: Costs for this activity are based on the following technical inputs:

1. **Technical Resource Requirements:**

Step	Duration (Months)	Person Months	Special Skill Areas
1	2	3	Financial/legal experts
2	1	1	Finance or management
3	2	2	Finance
4	1	2	Finance and banking
5	2	3	Public health and management / health management
6	1	2	Finance or management
7	ongoing	6	Finance, management, MIS
8	ongoing	33	Health finance, management, MIS
9	ongoing	6	Finance and banking, MIS
		58	

2. **Additional resource requirements:** Loan guarantee fund; a figure of \$1,000,000 is used for planning purposes. More detailed estimates need to be prepared. It is difficult to predict performance of the fund; total amount of credit leveraged will depend on default rate and growth. Ongoing fund can be used for continued expansion of credit or reprogrammed to other activities or technical assistance in fifth or sixth year of project, if objectives have been met and nonguaranteed loans become more available.

3. **Total estimated activity cost: (costs in US\$ * 1,000)**

TOTAL PERSON MONTHS	TECH. PERS.	TRAVEL+ PER DIEM	OTHER DIR. & INDIRECT	PASS- THROUGH	TOTAL ACTIVITY COST
58	202	44	354	1,000	1,601

ACTIVITY 2.B: Support the development of an in-country capacity and market for management consulting activities in the health sector.

Discussion: Private providers, group associations, and clinics all demonstrate serious managerial weaknesses which limit their ability to expand into new markets or to develop cost savings and efficiencies in their operations. This observation is made by the providers themselves, and is also evident by the near total absence of technical management applied to health activities (market studies, efficiency studies, pricing/bundling/packaging/marketing, etc.). Management consulting capability exists in Morocco, but to date the demand from the health sector for these services has been minimal. This activity will prompt the development of a private sector capability to carry out management studies, building on existing capability. The underlying strategy anticipates the growth of the health side of the management consulting industry in Morocco in response to needs in the private health sector, while generating more interest in and use of management techniques. This activity is closely tied to the training of health managers (through Activity 2.C. and Activity 2.D), the small grants for case studies (Activity 2.E), and the loan guarantee program (Activity 2.A).

Problem areas/constraints addressed by activity: Lack of access to and use of management techniques for planning, operations, and finance; lack of technical ability to identify new markets and to monitor and respond to changing demand; lack of technical ability to apply innovative or competitive approaches to producing and delivering health services.

Implementation steps:

1. Identify existing technical resources in country, including local management consulting firms, international management and accounting firms, universities, and other training institutions. Identify each organization's level of experience in the health sector.
2. Establish a set of requirements for management studies and analyses to be incorporated into the loan solicitation process.
3. Directly commission special studies (through Activity 2.E).
4. Sponsor "professionalization" of health management by organizing issues workshop or conference on management issues.
5. Institute technical resource referral services (by providing startup money through Activity 1.C).

Specific assessment in relation to selection criteria:

Alleviating government burden

Provides increased technical capacity to the private sector to develop new models of service production and to reach new markets previously untapped by the private sector.

Individual service/ product cost contnmt.	Through increased ability to produce services competitively, may lead to lowering costs of individual services or products.
Linkages	Supports the ability of the private sector to respond to changing market signals (Group 1 Activities); supports the development of technical resources for applicants to the proposed Loan Guarantee Program (Activity 2.A);
Feasibility	Strong feasibility due to high level of in-country management consulting resources. Demand from the health sector remains unclear.
Profitability	By encouraging the link between the health sector and technical resources, opportunities for profit exist on both sides. Buyers of technical resources are in essence buying techniques for increasing profit. For consultants, this activity is intended to contribute to the creation of an internal market for consulting services.
Leveraging resources with USAID invest- ment	Once a domestic market is established, ongoing growth would use private resources exclusively; all private sector resources thus applied to this industry would result from USAID seed money.
Enhancing equity and access for target groups	Use of market studies and other management techniques would enable private practitioners to assess the risk involved in attempting to reach new markets (including target groups), thus identifying target groups that can be served via the private sector.
Enhancing quality	Quality improvement can be instituted as an issue through workshops, conferences, and clearinghouse information sources; quality assurance consulting can be specifically encouraged through grants through either Activity 1.A or 2.A.
Promotion of efficient models of resource use	Better information normally results in more efficient choices.

Pros/strengths: Small consulting market already established; stimulates internal, indigenous supply and demand for services; uses market forces to apply technical resources to private sector needs.

Cons/weaknesses: Difficult to control quality of consulting services; unless incentives for technical quality are designed into the structure of the technical assistance, then TA might be provided on an inadequate or pro forma basis; over-reliance on consultant advice may inhibit development of in-house capabilities.

Potential USAID constraints: Willingness of private providers to use technical resource services unless required by, and paid, as part of loan or grant process.

Milestones: Health management conference; others not tracked by Activity would include number of contracts made between consultant services and investors/providers.

Red flags: Failures of new initiatives despite use of management technical assistance in development phase.

Expected overall impact: Will strengthen the ability of private sector providers to expand into new and efficient organizational models providing services to segments of the market not currently covered by private sector services.

Expected activity cost: Costs for this activity are based on the following technical inputs:

1. Technical Resource Requirements:

Step	Duration (Months)	Person Months	Special Skill Areas
1	1	1	Health management
2	1	1	Health management
3	-	-	Through Activity 2.E
4	3	3	Health management
5	2	2	Health management

7

2. Additional resource requirements: One-time conference cost of \$50,000 (excluding participation fees); startup money for referral service of \$20,000; seed money for special studies (through Activity 1.C) of \$100,000.

3. Total estimated activity cost: (costs in US\$ * 1,000)

TOTAL PERSON MONTHS	TECH. PERS.	TRAVEL+ PER DIEM	OTHER DIR. & INDIRECT	PASS- THROUGH	TOTAL ACTIVITY COST
7	21	0	37	170	228

ACTIVITY 2.C: Development of a set of training manuals and/or workshops for practitioners on marketing services to new groups, investment choices, and management.

Discussion: Training manuals and workshops can be effective tools for disseminating information and encouraging practitioners to try out new ideas. One key stumbling block for practitioners thinking of expanding into new markets (including rural areas, underserved populations, and new services) is the lack of information on how to reach new markets, choose appropriate investments, and manage a practice. These same problems adversely affect practitioners who are already established, thus perhaps decreasing the efficiency of their operations. While straightforward publicizing of medical services is illegal in Morocco, careful study of potential new markets and adaptation of medical practices to meet the needs of these markets can encourage the expansion of the private sector without infringing on medical ethics. Training manuals and workshops can teach practitioners new techniques, how to apply them to their needs, and where to seek outside assistance where more thorough study is required.

Problem areas/constraints addressed by activity: Failure of private sector to make use of management techniques to choose locations, target groups, types of practices, and investments. Underdevelopment of financial and medical record management within individual practices.

Implementation steps:

1. With key organizational actors (e.g. MSP) and a focus group of private practitioners, develop a recommended set of topics for training manuals and workshops. Identify possible locations.
2. Identify resources required to develop manuals and conduct workshops (Moroccan experts, external technical assistance if necessary, etc.).
3. Develop and pre-test training manuals. Develop core curriculum for workshops, perhaps centered around training manuals.
4. Schedule and conduct initial workshops. Assess outcomes to identify changes necessary for future workshops.
5. Evaluate outcome to determine if manuals and workshops are encouraging the types of private sector behavior desired.
6. Modify workshops.
7. Dissemination.

Specific assessment in relation to selection criteria:

Alleviating government burden	Directly stimulates the private sector and provides technical resources for the private sector to be able to expand into new service areas, new geographic areas, and new populations, and in so doing directly relieves the government burden for that coverage.
Individual service/product cost containment	Gives providers information to improve their own production efficiency; enables entry into markets for new services and new clients.
Linkages	Concentrating on areas including record keeping and billing can assist with implementation of other initiatives, such as insurance expansion.
Feasibility	Straightforward technical requirements of training.
Leveraging resources with USAID investment	Increased capabilities of private sector providers resulting from training can lead to long term effects in expanding service base and improving efficiencies of operations.
Enhancing equity and access for target groups	Supports the ability of the private sector to move into underserved areas, where a lack of technical resources (or the confidence from knowing that technical resources are available) may inhibit the propensity to explore new alternatives.
Enhancing quality	Quality issues should be specifically included among the set of training topics.
Profitability	Participation by private providers will be based on their expectation of expanding their services (and revenues) or reducing inefficiencies, leading to increased profits.

Pros and cons/strengths and weaknesses: Manuals and workshops often generate considerable initial interest which then quickly wanes without adequate follow-up. Aggressive evaluation and follow-up is necessary to ensure desired outcome.

Potential USAID constraints: Interest level of participants.

Milestones: Training manuals developed and pre-tested; key organizations contacted and their support obtained; workshop schedule developed and widely disseminated; first workshops conducted and evaluated.

Benchmark indicators: Number of manuals disseminated; number of private practitioners attending workshops; number of follow-up requests for information or assistance from practitioners.

Red flags: Lack of interest in manuals/workshops; lack of follow-through by participants.

Expected overall impact: Encouragement of private sector expansion to serve USAID and GOM target groups; development of appropriate types of practices and investments to serve needs of these groups; improved management at individual practices.

Expected activity cost: Costs for this activity are based on the following technical inputs:

1. Technical Resource Requirements:

Step	Duration (Months)	Person Months	Special Skill Areas
1	2	1	Communications/training (especially focus groups); health management
2	1	1	Training
3	6	12	Training; health management
4	ongoing	26	Training; health management
5	1	2	Training
6	1	1	Training
7	ongoing	2	Training

45

2. Additional resource requirements: workshop costs or training manual costs of \$75,000.

3. Total estimated activity cost: (costs in US\$ * 1,000)

TOTAL PERSON MONTHS	TECH. PERS.	TRAVEL+ PER DIEM	OTHER DIR. & INDIRECT	PASS- THROUGH	TOTAL ACTIVITY COST
45	135	0	236	75	446

ACTIVITY 2.D: Provide formal training in health management for Moroccans planning on working in the private medical sector.

Discussion: A key element in developing the private medical sector will be the development of significant in-country capacity to administer and manage health facilities (e.g., clinics) in an effective and efficient manner. Currently, few individuals in Morocco have been formally trained in health management. According to individuals interviewed during the study, no formal degree course in health management exists within the country which would cater to the private sector.

While general management training (e.g., business school) can be helpful, it does not directly address problems specific to the health sector. Moreover, individuals with this training may be drawn to work in other sectors where more lucrative positions are available. This activity would fund graduate (two year master's level) training in health or hospital management at U.S. universities for 10 Moroccans (2 per year for five years, such that the last Moroccan would leave graduate school in year 7 of the project). These individuals would then move into management/administrative positions at private sector health institutions in Morocco. The universities should be chosen for the quality of the graduate programs and their ability to focus on health management issues relevant to the private sector in a developing country.

Because graduate courses normally take two years, some time will elapse before the first trainees complete this program. Therefore, an additional 6 to 12 Moroccans will be chosen during the first 1 to 2 years of the project to attend three-month training programs in health management in the U.S. The candidates would preferably be individuals in mid-career, with considerable experience in the Moroccan private health sector but lacking formal management training. Since at least one university in the U.S. offers such a training program in French, English language ability would not be required for those receiving short-term training.

Upon returning to Morocco, some or all trainees could be required to spend three months completing a case study, such as those described in Activity 2.E below. This would add to the overall knowledge base of the trainees and help place them in contact with potential employers.

Problem areas/constraints addressed by activity: Lack of training in health management in the private sector; inefficient delivery of health services.

Implementation steps:

1. Contact universities with suitable programs to establish number of openings, entrance requirements, fees, etc.
2. Choose a selection committee and establish standards for selecting candidates (previous education/work experience required, English language ability).
3. Advertise program in newspapers, at universities, and through associations covering potential candidates.

4. Select initial candidates for two-year and three-month programs. Initial selection should be by local selection committee; however, all successful candidates will also need to be admitted by a cooperating university.
5. Send first groups of trainees to attend programs.
6. Remain in contact with short- and long-term trainees to monitor and evaluate the quality of training and applicability to Moroccan private health sector. Supervise completion of case studies.

Specific assessment in relation to selection criteria:

Alleviating government burden	Within overall framework of developing private sector capacity.
Macrolevel cost containment	Promotion of stronger management skills in the private health sector in Morocco will not necessarily lead to lower expenditures in this sector, and in fact may assist in a broad expansion of the sector. Must be coupled with other measures to avoid explosion of services beyond narrowly defined needs, as individual facilities seek profit by encouraging consumption.
Individual service/product cost containment	Addition of management skills at specific facilities should allow improved efficiency and thus cost containment for individual services/products.
Linkages	Links to Activity 2.E, mini-contracts.
Feasibility	Depends on level of demand for trained health managers in private sector. This demand should be assessed and stimulated.
Leveraging resources with USAID investment	Leads to (1) long-term impact on private health sector after training is completed and (2) demonstration effect by creating career paths for the area of health management.
Enhancing equity and access for target groups	Limited to enhancing the ability to manage private sector expansion into areas otherwise not considered profitable.
Enhancing quality	Techniques for assessing and managing quality of care are often included in health management programs; can specifically be required as part of fellowship.
Promotion of efficient models of resource use	Not necessarily related — trained health managers operating in the private sector will focus on services/products which are profitable for the individual institution rather than efficient for the society as a whole. Must be coupled with efforts to render "efficient" services (e.g., preventive care, family planning) profitable for the institutions.

Pros/strengths: Strong management skills are an essential element of any robust private sector. This activity would begin a process of building these skills. These skills will be crucial if, for example, insurance coverage is expanded and cost and quality control elements are built into insurance systems.

Cons/weaknesses: The existence of a large number of trained health managers in other systems (e.g., the U.S.) has not slowed the escalation of private sector health care costs.

Potential USAID constraints: Ability to gain admission to appropriate, low-cost programs in the U.S.; availability of appropriate candidates interested in the program; demand for trained health managers in the Moroccan private health sector.

Milestones: Universities identified and cooperation obtained; program advertised and applications received; first candidates selected; first short-term trainees complete program and evaluate usefulness of training (6 months after return to Morocco); first long-term trainees receive degrees; evaluation of usefulness of training/availability of positions (10-12 months after return to Morocco).

Benchmark indicators: Number/quality of applications received; percentage of successful candidates accepting training opportunity; percentage of trainees completing programs; percentage of trainees finding employment and using skills in private health sector in Morocco.

Red flags: Lack of qualified, interested candidates; difficulty finding appropriate employment for program graduates.

Expected overall impact: Increase in the efficient management of private sector health facilities; increased ability of private health sector to respond to market signals.

Expected activity cost: Costs for this activity are based on the following technical inputs:

1. Technical Resource Requirements:

Step	Duration (Months)	Person Months	Special Skill Areas
1	2	1	Health management
2	1	1	Health management
3	1	1	--
4	3	2	--
5	1	2	--
6	Ongoing	5	Health management

12

2. Additional resource requirements: \$55,000/trainee for two-year program; \$9,000/trainee for 3-month program (tuition, fees, living expenses, and transportation)

3. Total estimated activity cost: (costs in US\$ * 1,000)

(costs assume 12 Moroccans attend short-term training; total would fall to \$674,000 if only six are sent)

TOTAL PERSON MONTHS	TECH. PERS.	TRAVEL+ PER DIEM	OTHER DIR. & INDIRECT	PASS- THROUGH	TOTAL ACTIVITY COST
12	40	6	70	658	774

ACTIVITY 2.E: Award mini-contracts for development of case studies and manuals of successful organizational models in the private health sector

Discussion: Case studies of clinics, group practices, HMOs, and other organizations that have been successful in providing services at a profit can help others learn from such experiences. How-to manuals based on these case studies would assist others in emulating these successful models. Moreover, developing these case studies and manuals could be an excellent entry into the health management consulting market for organizations strengthened through Activity 2.B or individuals trained through Activity 2.D.

Problem areas/constraints addressed by activity: Limited alternative models of service delivery in the private health sector; lack of knowledge of what steps to take to move into a new market (provide a new service, move into rural/periurban area, adjust organizational structure of providers to meet needs of market).

Implementation steps:

1. Develop format and goals for case studies and how-to manuals. (To whom are they targeted? What types of material should they cover?)
2. Advertise contracts among university groups, associations, returning trainees (c.f. Activity 2.D), management consulting organizations (c.f. Activity 2.B), and other possible groups.
3. Select 1-2 initial individuals/groups to develop first case studies/manuals.
4. Pre-test case studies/manuals with groups of private providers at workshops/seminars and at medical schools. Evaluate and modify format and content, incorporating results into procedures for selection of next case studies/manuals.
5. Select additional individuals/groups to develop 6-8 additional case studies/manuals.
6. Disseminate all case studies/manuals through associations, workshops, medical schools, etc.

Specific assessment in relation to selection criteria:

Alleviating government burden

By showing private providers how they can reach target groups while developing a successful practice, this activity will encourage more private practitioners to try to reach these groups.

Macrolevel cost containment

Case studies/manuals may be used to encourage lower-cost services rather than capital-intensive efforts, thus reducing macrolevel costs.

Individual service/product cost containment

Case studies/manuals can demonstrate ways for individual practitioners to control costs.

Linkages	Links to dissemination strategy in Activity 1.C. The development of case studies and manuals could be used to help organizations strengthened through Activity 2.B or individuals trained through Activity 2.D to gain experience.
Feasibility	Depends on interest in completing case studies/manuals (university researchers and consultants likely to be interested) and on openness of private practitioners to these products
Relationship to GOM/USAID strategic framework and goals	Supports dissemination of alternative private health practices.
Enhancing equity and access for target groups	May encourage more practitioners to direct services toward target groups.
Enhancing quality	Case studies/manuals may incorporate quality assessment and assurance in material.
Promotion of efficient models of resource use	This activity is aimed toward promoting models which are efficient and aimed toward target groups.

Pros/strengths: Relatively simple to complete; likely to be easy to find individuals/groups interested in developing case studies/manuals; not expensive; strong links with other activities.

Cons/weaknesses: Unclear whether case studies/manuals will be well-received by private practitioners or will actually encourage desired changes.

Milestones: Goals/format for case studies/manuals established; first case studies/manuals developed and pre-tested; all manuals completed and distributed.

Benchmark indicators: Number of manuals disseminated; external requests for manuals; anecdotal evidence of case studies/manuals being used and encouraging desired innovation.

Red flags: Lack of interest in case studies/manuals; difficulty finding individuals/groups to develop materials; failure of writers to match materials to the established format and goals.

Expected overall impact: Encouragement of (1) innovative approaches to organizing private health services, (2) adaptation of services to meet needs of target groups and include cost-effective interventions, (3) expansion of private sector into new geographical areas.

Expected activity cost: Costs for this activity are based on the following technical inputs:

1. **Technical Resource Requirements:**

Step	Duration (Months)	Person Months	Special Skill Areas
1	2	2	Health management/economics; training
2	3	1	Communications
3	2	1	—
4	4	3	Health management/economics; training
5	3	1	—
6	Ongoing	Ongoing	—
TOTAL		8	

2. **Additional resource requirements:** \$5,000-\$15,000 per case study or manual for mini-contracts

3. **Total estimated activity cost:** (costs in US\$ * 1,000)

TOTAL PERSON MONTHS	TECH. PERS.	TRAVEL+ PER DIEM	OTHER DIR. & INDIRECT	PASS- THROUGH	TOTAL ACTIVITY COST
8	28	6	49	100	183

GROUP 3: SPECIFIC PROGRAMS OR PROJECTS TO REDUCE HIDDEN PUBLIC EXPENDITURES ON PRIVATELY PROVIDED SERVICES

OVERALL OBJECTIVE OF GROUP 3 ACTIVITIES: To protect public resources from unnecessary subsidies and to expand opportunities for private providers to serve currently subsidized patients. This group of activities allows the public sector to cut back on services which could otherwise be produced by the private sector and to reduce subsidies for people otherwise able to pay for services. It also frees additional public resources for use on preventive services.

Under the current structure, limitations exist on the ability to redirect resources; sending appropriate market signals and enhancing the ability of the private sector to respond to those signals cannot be fully effective unless the result is a reduction of public expenditure on curative services. This problem manifests in two main ways. First is what private providers see as "unfair competition" from the public sector; this includes the artificially low prices charged for services which not only discourages the private sector from entering the market for those services but also diverts from the private sector patients who are eligible for public services and who would otherwise be able to pay for those same services through private providers. The second aspect is that the public sector provides hidden subsidization of curative care, leading to a distortion of prices and other market signals. As utilization of these services expands, the level of these hidden subsidies will also increase, leading to a long term, increasing drain on public resources.

ACTIVITY 3.A: Public sector cost-based pricing: update of prices charged for curative services provided by the public and the semi-private sector to private and/or insured patients; review and possible improvement of eligibility/waiver systems.

Discussion: One of the most common complaints by private providers in Morocco is the competition from the public sector, which provides services to segments of the market which could be covered by the private sector. This complaint is symptomatic of the broader problem of hidden subsidies which stifles the growth of private health services by allowing the use of publicly subsidized services by insured and private paying patients through CNSS. It also includes issues related to nonpaying patients in the public health system. Many of the patients using public services are indigent but, as reported by many in the private sector, a significant portion are not. At the same time, the pricing structure of CNSS encourages below-cost fees because of built-in subsidization and attracts use by insurers and other purchasers. These artificially low fees have two unintended effects: (1) They discourage other private providers from competing for provision of these services; and (2) to the extent that users of these services can actually pay for services (either individually or through third parties) such subsidies represent a diversion of public funds away from priority socio-economic or geographic groups and from priority public health services. Unless these circumstances are changed, increases in the private provision of services or increases in the demand for services through insurance will lead to an increased drain on public resources for these subsidized curative services. Furthermore, the private sector will be unable to enter the market for certain services unless those hidden subsidies which are not desirable are largely removed. Subsidies for preventive services, or other desirable subsidies, could be retained as necessary.

Problem areas/constraints addressed by activity: Unnecessary subsidies and competition from the public sector; inability of the private sector to compete with the public sector.

Implementation steps:

1. Determine the magnitude of public subsidies and the drain on public resources they represent (by determining what the real cost of curative services are). This will involve cost analyses for selected institutions to determine production costs (probably to include CNSS, two representative MSP hospitals, and two health centers) and extrapolations to the public health system.
2. Make available to decision makers results of estimates and analysis under Step 1 about the impact on the distribution of public resources and private sector development which results from subsidizing selective privately purchased services.
 - a. Workshop for policy decision makers
 - b. Ongoing policy discussions
3. Through policy dialogue and analysis, develop strategies for eliminating market distortions from inappropriate public subsidies. This includes defining the public and private roles and improving market segmentation so that competition between public and private providers for curative services is minimized.
4. Develop a prospective analysis and forecasting which explore potential savings from changes such as (1) contracting out public purchase of privately produced services and (2) marketing of publicly produced services to private purchasers (sales to private purchasers requires completion of cost-based pricing as described in the following activity).
5. Conduct a thorough review of existing waiver system and "cartes d'indigence", and develop a revised waiver system. Essential steps include:
 - review of users of public services, both economic and epidemiological aspects
 - establishment of new cutoff points
 - actuarial estimations based on new cutoff points
 - cost and revenue projections based on expected utilization
 - establishment of access monitoring board
6. Articulate new pricing policies.
7. Design strengthened waiver system.
8. Institute revised pricing system and strengthened waiver system.
9. Monitor use and revise pricing and waiver systems.

Specific assessment in relation to selection criteria:

Alleviating government burden	Primary purpose of this activity.
Macrolevel cost containment	No overall increase in resource use (reduction in public expenditure offset by increases in private expenditure).
Individual service/product cost containment	Will raise the cost of individual services for unsubsidized services (assuming public health priorities continue to receive subsidization).
Linkages	Private providers will become more competitive with the subsidized (semi-public) providers, enabling them to compete for the organized purchasing market (i.e., insurance companies and large-scale employers).
Feasibility	Technically feasible; managerially feasible; political feasibility needs to be determined as part of the policy dialogue process. Political dynamics of support for current arrangements are likely to be complex. Any move to modify access to "free" public services is highly political and difficult. Needs careful development of consensus and implementation strategies.
Profitability	Creating opportunities for profit in services not currently profitable is central to this activity.
Stimulating/generating more resources for health	Not directly, though it will generate a larger number of private providers serving the insured population and current users of the public health system. It will also help redistribute resources for preventive/public health services and will increase non-public health revenues.
Leveraging resources with USAID investment	By supporting a redistribution of public resources, revenues etc. are indirectly made available for preventive/public health services.
Enhancing equity and access for target groups	Depends on effective waiver system and improved allocation of public expenditures.
Promotion of efficient models of resource use	By placing more curative services in the open market, the market should be able to respond to produce services at a lower unit cost and to discourage any tendency to overuse services based on an artificially low price, thus encouraging efficiency in both public and private sector markets.

Pros/strengths: Strengths lie mainly in the likelihood of this activity to promote potentially large-scale shifts in resources for curative services away from the public sector.

Cons/weaknesses: Major weakness is the inability to predict the results of policy dialogue or the willingness of the interested public and quasi-public parties to adopt changes; difficulties in the potential politicization of changes in access.

Potential USAID constraints: Mainly in limitations on the ability of the Mission to effect policy changes. Nonproject assistance can be useful to help encourage dialogue.

Milestones: Completion of analysis/cost study; workshop with policy makers; articulation of new pricing policy; articulation of new waiver policy; official announcement and distribution of new pricing and waiver policies; implementation of revised pricing structure and waiver system.

Benchmark indicators: Reduction in public hospital demand; increased levels of cost recovery in public hospitals and CNSS facilities; growth in private sector service provision to insured populations.

Red flags: Increase in the public share of the market for curative services. This would occur if the higher costs of unsubsidized services in the private sector were to drive consumers into the public sector. Effective competition would be expected to lead to a net decrease in use of public curative services over time, and eventually some public hospital closure. Any significant increase in use of public services in the two years following implementation of new pricing and access policies would therefore represent and signal problems either in public pricing and access policies or in private sector market response.

Expected Overall Impact: (1) Reduction of public expenditures for curatives services through (a) directly reducing access and use of these services in the public sector and (b) stimulating the development of alternative, private providers. Creates broader production base and enables a greater proportion of public resources to be dedicated to preventive services and services for target groups. (2) This leads to an increase in the proportion of public resources available for preventive care. (3) Private sector should develop its capacity to provide curative services. (4) Those services produced should yield greater efficiencies of production and more efficient patterns of use due to market forces on production and purchasing.

Expected activity cost: Costs for this activity are based on the following technical inputs:

1. **Technical Resource Requirements:**

Step	Duration (Months)	Person Months	Special Skill Areas
1	3	10	Health financing/economics
2	3-6	2	Health financing/economics, policy
3	12-24	7	Health financing/economics
4	2	4	Health financing/economics
5	4	5	Public health, health management
6	3	4	Public health, health finance
7	3	4	Public health, health management
8	1	1	Public health, health management
9	Ongoing	8	Public health, health management
TOTAL		45	

2. **Additional Resource requirements:** Nonproject assistance totalling \$400,000; workshop support in the amount of \$25,000.

3. **Total estimated activity cost:** (costs in US\$ * 1,000)

TOTAL PERSON MONTHS	TECH. PERS.	TRAVEL+ PER DIEM	OTHER DIR. & INDIRECT	PASS- THROUGH	TOTAL ACTIVITY COST
45	157	34	275	425	891

HOW TO USE ACTIVITIES TO THEIR FULLEST POTENTIAL

Many specific problems and problem areas were identified in Section V. One way to approach the resolution of these problems would be to develop an *ad hoc* response to each one. For example, Section V noted that the legal status of salaried medical practice in the private sector was unclear at best. This problem could be addressed on its own, through a specific change or clarification in the laws governing medical practice.

However, there certainly exist a host of problems that were not identified by this study, either because practitioners themselves have not yet identified them as constraints or because the interview format did not address all possible issues. Rather than taking an *ad hoc* approach, our strategy has been to design a structure within which a broad range of problems can be addressed — both those that were identified by this study and those still to be identified.

Taking our earlier example of salaried medical practice, it is expected that this issue will be dealt with using a number of the mechanisms set up through the implementation activities:

- a mini-contract (Activity 2.E) could be awarded to an individual to prepare a paper reviewing the legal status of salaried medical practice in the private sector.
- a temporary legal waiver (Activity 1.B) or permanent change could be adopted to allow salaried medical practice under certain conditions to ascertain whether this could enhance efficiency in the private health sector.
- information on the correct legal status of salaried medical practice could be disseminated through the clearinghouse (established by Activity 1.C).
- a workshop on the regulatory system (including the status of salaried practice, group practices, etc.) could be conducted (under Activity 2.C) to share this information with a wide group of practitioners.

As shown in this example, the structure set up through the proposed activities allows a broad range of constraints and problems to be addressed. The structure remains sufficiently flexible to allow the project to continue to identify new ways to stimulate the private health sector in Morocco to meet the growing and changing health needs of the population in the most efficient manner possible.

An example of an important service delivery area that should be integrated into project implementation is the expansion of private sector family planning/maternal and child health services. The importance of promoting the use of family planning and maternal child health services, as a priority set of activities, is well known and well developed within USAID and the GOM. No special activity has been developed for FP/MCH services; however, special consideration should be given to including these within the activities described above. Following are examples of ways in which FP/MCH services can be integrated into the activities mentioned above are listed below. (Costs are included in the cost estimates already performed under the specific activities.)

EXAMPLE OF INTEGRATING FP/MCH INTO ACTIVITIES

ACTIVITY INTO WHICH INTEGRATED	SPECIFIC FP/MCH FOCUS
1.C and 2.C	Informational brochures on "The Role of the General Practitioners in Women's Health and Family Planning".
1.A	Specific demonstration project to establish fee-for-service women's health clinics with physicians and nurse/midwives, which would include Norplant and perhaps minilap services.
1.A	Inclusion of IUD's and Norplant in social marketing programs for "qualified" MDs.
1.D	Focus on quality assurance in family planning services in overall set of quality assurance workshops.
1.C and 2.C	Targeted training manuals in managing FP/MCH services, including costs, obtaining information, sources of low cost contraceptives, etc.
1.C and 2.E	Case studies in successful private sector family planning services; case studies in the economics of providing family planning.
2.A	Incorporation of FP/MCH as preferential services for loans grants.
2.B	Tax holidays, waivers of lower rates for delivery of FP/MCH services.
1.C	Exposé on "business opportunities" for family planning services (e.g. for Norplant).

This example also shows how any particular priority service can be included in the activities recommended above. Other initiatives, such as support of paramedical practice settings or support of appropriate technology medical equipment, can be encouraged through the same mechanisms of guaranteed loans, grants, and technical assistance.¹⁸

¹⁸ As mentioned in the early part of this document, we have intentionally stayed away from certain subjects which are being explored by other teams of specialists, including managed care, insurance, and pharmaceuticals. We have nevertheless raised some important considerations about the overall structure of the private sector. Furthermore, the demonstration project described under Activity 1.A above could include some components of these. A couple of additional highlights, guidelines, and caveats may be useful. In the area of managed care, the development of a demonstration HMO in Morocco risks becoming an end in itself. The development of managed care structures in Morocco must keep the overall "sectoral level" objectives uppermost (cost control, quality assurance, improved coverage for people otherwise lacking coverage, attracting patients away from public sector services, promotion of preventive health services, and sustainability), lest a managed care setting become the objective itself at the expense of broader changes which would improve the ability of the private sector to respond. Such a situation would not only represent a partially lost opportunity but could result in the imposition of an externally-imposed model which neither meets the needs of Morocco nor is compatible with Moroccan medical ethics. In the area of insurance, one key problem is that, as the market is currently structured, medical insurance is a deficit product or loss leader for insurers. Until medical insurance contracts can be

Implementation Mechanism

A large part of the technical work can be contracted out to local individuals, organizations, consulting groups, universities or associations. These activities will nevertheless require a great deal of administrative oversight and technical input to make them work as a set. There are at least three levels at which implementation needs to be considered.

- (1) **Preliminary activities:** some preliminary planning and analysis and some consensus building workshops should be carried out to prepare the ground for decision making and development. It is most useful to begin this work well in advance of a new bilateral project, through buy-in to a centrally funded A.I.D. project, Indefinite Quantity Contract, or similar mechanism.
- (2) **Nonproject Activities:** Some of the activities suggest nonproject assistance (or performance based programming) to support the overall process of modification. The decision of how to program nonproject assistance would of course be made during design of the project paper.
- (3) **Project implementation:** The substantial amount of administrative and technical oversight and technical assistance required could be managed by contracting with a number of local and international groups (selected based on technical capabilities and cost). Because of the number of subprojects needed to implement this diverse range of activities, the administrative burden and enhance technical coordination would be substantially reduced by having a single primary contracting entity which could in turn subcontract and administer significant portions of work through consulting groups, associations, media firms, universities and so forth. This oversight group would then be able to meet reporting requirements, monitor technical activities, and match technical needs with technical resources throughout the implementation period.

altered to make them more profitable, insurance companies will not be likely to place priority on expanding their coverage. Another important consideration is that expanded insurance coverage will increase the *demand* for services without addressing the problems of *supply*, e.g., spiraling costs, inefficiency, lack of cost control, inability to control quality of care, etc.

Technical Skills Required

The special skill areas required, in approximate level of effort in person months, are estimated below:

**TABLE 11
ILLUSTRATIVE COMPOSITION OF TECHNICAL SKILL AREAS**

	Pre.	1A	1B	1C	1D	1E	2A	2B	2C	2D	2E	3A	TOTAL
Finance/economist													
General health and policy	9	30	5				26				2	18	90
Pub. finance/tax			5										5
Banking							6						6
Health management	9	31	5	1	6		14	7	19	12	3	16	123
Quality assurance					12								12
MIS		9		3	4		12						28
Marketing and communications				20		20			1		1		42
Training					8				25		2		35
Public Health												11	12
TOTALS	18	70	15	24	30	21	58	7	45	12	8	45	353

Summary of Costs and Technical Requirements

The overall costs for the three activity groups and for preliminary activities totals US\$ 8,307,000, as shown below:

TABLE 12
COST ESTIMATES

(All Costs in U.S. Dollars '000)

ACTI- VITY	PERSON MONTHS	TECHNICAL PERSONNEL	TRAVEL & PER DIEM	OTHER DIR. & INDIR. COSTS	PASS- THROUGH	TOTAL COST
Prelim.	18.0	63	14	110	35	221
1.A	70.0	256	71	447	1,000	1,774
1.B	15.0	50	8	87	750	895
1.C	24.0	80	12	140	250	482
1.D	30.0	100	15	175	45	335
1.E	21.0	70	11	122	275	478
2.A	58.0	202	44	354	1,000	1,601
2.B	7.0	21	0	37	170	228
2.C	45.0	135	0	236	75	446
2.D	12.0	40	6	70	658	774
2.E	8.0	28	6	49	100	183
3.A	45.0	157	34	275	425	891
TOTAL	353.0	1,201	222	2,101	4,783	8,307
% DIST		14%	3%	25%	58%	100%

VIII. CONCLUSIONS: THE FUTURE OF THE PRIVATE HEALTH SECTOR IN MOROCCO

These activities have been designed to address the specific issues identified in the description and diagnosis sections, based on interviews and other available information. Specific problem areas/constraints addressed or covered by the individual activities are shown in Exhibit 3 on the following page.

Beyond directly addressing these problem areas, these activities, as a set, are expected to go as far as possible toward fulfilling the prescription set forth above. The private health market will have a more active exchange of market signals, and private providers will have more flexibility for organizing and delivering services in efficient ways; they will be better prepared with the technical and financial resources to be able to do so; and public sector resources will be better protected against the effects of growth and developments in the private sector which can have potentially serious consequences for the public health sector. The end result of these changes would be more resources available for health, increased production of health services, improved distribution and access to services, an improved skill base, more credit for health expansion, and a better understanding of selected issues and services on the part of both providers and consumers.

We have worked our way through an overview of private sector experience and identified significant factors which account for its particular market response or for the lack of a response. Based on this overview, we then mapped the underlying causes of these market characteristics and developed a strategic prescription for change. Our recommendations are firmly grounded in this approach of identifying problems, mapping the source of problems, prescribing a course for change and generating activities which respond to the problems identified.

In the absence of change, any increases in services in the private sector can be expected to concentrate on activities already receiving a disproportionately large share of Moroccan resources. We believe the recommendations presented here will lead to an improved market response, resulting not only in expansion but in increased efficiencies, improved distribution, and greater protection of public sector resources. The activities, as a set, meet the "dual litmus test" of profitability for the private sector and desirability from the perspective of the public good set forth in an earlier report.

These activities have been presented in modular form to make it easier for decision makers to make a selection which will actually be funded and implemented by USAID. After discussing the details of implementation, however, we need to step back and regain our perspective on the private sector. The purpose of all this work is to support the development of the private sector in such a way that the overall health of the Moroccan people can be better served by the combination of public and private resources. In short, we would like to help the private sector build upon its considerable infrastructure and talent pool, while benefitting from some of the mistakes made by the private sector in other countries. As a result of the implementation of these activities, we envision a private sector which is more competitive, more innovative, and more widely distributed, and providing more and better services to more people in an efficient way.

EXHIBIT 3
ILLUSTRATIVE EXAMPLES OF PROBLEMS ADDRESSED BY ACTIVITIES

ACTIVITIES →	1.A	1.B	1.C	1.D	1.E	2.A	2.B	2.C	2.D	2.E	3.A
MARKET SIGNALS											
Limited alternative models	X	X	X			X		X	X	X	X
Confusion about rules/regulations	X		X					X	X	X	
Obsolete fee schedules		X							X		X
Burdensome setup requirements		X						X		X	
Inconsistent quality of care	X	X	X	X	X			X	X	X	
Quality of care = expensive equip.	X	X	X	X	X			X	X	X	
No market for indep. paramedics	X				X			X		X	
Recurrent tax on medical equip.		X									
TVA applied to all services		X									
Limited preventive reimbursement	X	X									
Lack of information about demand	X		X		X		X	X	X	X	
Absence of formal quality assurance	X			X			X	X	X	X	
Weak consumer knowledge			X		X						
MARKET RESPONSE											
Limited alternative models	X	X	X			X		X	X	X	X
Absence of market analysis		X	X			X	X	X	X	X	
Urban concentration of physicians	X	X			X	X		X		X	
Weak purchasing power	X									X	
Lack of rural support facilities	X	X				X				X	
Loans difficult to obtain for GPs						X		X		X	
Out of date fee schedules		X							X		X
Lack of training in health mgt.	X		X				X	X	X	X	
Poor continuing education			X	X				X		X	
PUBLIC SUBSIDIES											
Unnecessary public subsidies and competition									X		X

APPENDIX I. STUDY TOPICS IDENTIFIED IN THE ORIGINAL SCOPE OF WORK

1. **Financing problems and relationships between health sector professionals and banks and credit organizations.**
2. **Local constraints to the development of the medical sector (including the ban on group practice and payment of practitioners by salaries, forbidding outsiders to the medical profession from investing in the health sector).**
3. **Deficiencies in the rate making system for health care and services and reasons why the system is not implemented.**
4. **Preparation of a nomenclature of the services proposed in the private medical sector which would:**
 - a. **identify all medical acts performed in this sector,**
 - b. **define the conditions under which the fee-for-services and rates of reimbursement of such acts may be fixed and revised, and**
 - c. **index the conditions under which the practitioners may exceed the tariffs as per the nomenclature. This nomenclature could be prepared as a part of a negotiated covenant to be reached between:**
 - i. **the providers of health care,**
 - ii. **health insurance organizations,**
 - iii. **the Ministry of Public Health, and**
 - iv. **any party that may play some role at this level.**
5. **Pros and cons in the relationship between sector professionals and health insurance organizations.**
6. **Deficiencies in the administrative, financial and accounting management.**
7. **Standards of care and quality control utilized.**
8. **Process by which practitioners determine which sites they should select to set up their offices.**
9. **Reasons why doctors show so little interest in some areas and find some other appealing.**
10. **Process by which practitioners select or acquire medical equipment, including its costs and financing and level of use.**

11. As regards private clinics that invest heavily, it would be interesting to know whether these conduct prior analyses in order to:
 - a. identify the nature and extent of demand,
 - b. evaluate the costs of investing in buildings and medical equipment and the financing thereof,
 - c. assess the extend of current expenditure,
 - d. assess the foreseeable flows of activities (number of consultations, bed occupation rate), and calculate the expected returns over such investments.
12. Relationship between practitioners as part of sharing their experiences and directing patients to fellow-practitioners' offices.
13. Interest that group practice may offer (grouping of skills, development of reference systems, cost sharing, reinforcing the financial basis and guaranties offered in case of use of the bankin g/financing system, achieving economics of scale at health facilities level).
14. Concerning the practitioners having chosen group practice: have they found any snags at the legal/regulatory level? If the answer is yes, how did they manage to get around?
15. Interest taken by private practitioners in preventive medicine, and role they could play at such level.
16. Ways of keeping practitioners informed of the availability of the drugs they prescribe and the coming out of new pharmaceuticals.
17. Determine if the considerations used to prescribe drugs to patients consider extensively the cost of such drugs, or are the drugs mostly chosen according to their therapeutic value, irrespective of price considerations?
18. The question is whether the training the doctors follow in medical colleges prepares them to face the major problems they will have to cope with in daily routine practice.
19. Interest in practitioners' in-service training and the way such training should be run in their views.
20. Moroccan or foreign technical publications that are most regularly read and those which are subject to a subscription
21. The most consulted medical encyclopedias.
22. Deficiencies in the way medical dossiers are kept.

23. Proportion of graduated nursing staff employed, their quality and the appropriateness of their training vs. the demands of their activities as assistants of the medical professionals of the private sector.
24. Conditions of practice of independent nursing staff in the private sector (e.g., [male] nurses, midwives) and the nature of their duties.

APPENDIX II. METHOD USED FOR COST ESTIMATION

At this stage of project design it not possible to budget precisely. Unknown variables at this point include cost structures of local service delivery organizations, cost structure of local management consulting services, level of involvement (if any) of international consultants, and other direct cost needs (e.g., international travel).

Illustrative cost ranges are for initial planning purposes. These have been estimated by combining specific estimates of technical time needed with broad assumptions about other direct and indirect costs. Technical time is presented in person months. Within any given activity, no distinction is drawn between Moroccan person months and international consultants person months, even though the cost is different due to per diem, travel, and so forth. Whether or not international consultants are needed will of course depend on eventual technical specifications, interest by qualified Moroccan consultants, and a determination of value based on cost, experience and technical skill. USAID can apply a standard cost factor to technical person months based on its own best estimates. Technical person months are also estimated in terms of a blended rate, such that one person month of senior technical time may often be substituted by two person months of mid-level technical time. This disaggregated approach gives us an estimate of costs on a very gross order of magnitude which serves to give some sense of the relative costs of different activities.

A Lotus 1-2-3 spreadsheet is used to estimate activity cost. A copy of the template is provided along with this report, which USAID can use to modify cost estimates. Total cost is estimated based on the variables and assumptions shown in Exhibit III-A. The left column shows the variables used for cost estimation; the right column shows the assumptions upon which costs are derived. When using the Lotus 1-2-3 spreadsheet provided, interactive cost estimates can be made by changing the first two variables on the template provided; the component cost assumptions can be modified in the "key assumptions" section of the spreadsheet.

Not all costs are intended to be comprehensive. For example, the implementation of workshops (Activity 2.C) does not include any per diem, though some costs will be incurred by implementation or workshops around the country. These costs are generated by the cost estimation spreadsheet, and are integrated into non-personnel direct and indirect costs.

EXHIBIT II-A

COST ESTIMATION METHODOLOGY

VARIABLE	ASSUMPTIONS USED FOR COST ESTIMATES
Total person months for the activity	Estimated differently for each activity
Consultant blend	The proportion of technical time carried out by local versus international consultants; varies by activity, though for cost estimation purposes the average blend is 90% local consultants. Can be increased up or down using the interactive spreadsheet.
Cost per month of Moroccan time	Based on quotes obtained during the course of this study
Cost per month of international consultant	Assumed to be the current USAID maximum
Travel costs	Assumed to be one trip per month of international consultant
Per diem	Assumed to average \$80/day for international consultants
Other direct costs (offices, computers, support staff, local transportation, etc.) as a percent of technical personnel costs	Assumed to be 80% of the total cost of technical consultants
Indirect costs (overhead and fringe benefits) as a percent of technical personnel costs	Assumed to be 95% of the total cost of technical consultants

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