FAMILY PLANNING AND HEALTH INSURANCE IN DEVELOPING COUNTRIES

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August 1997

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USAID Contract No. DPE-3056-C-00-1040-00
The PROFIT (Promoting Financial Investments and Transfers) Project seeks to mobilize the resources of the commercial sector to expand and improve the delivery of family planning services in selected developing countries. The PROFIT Project is a consortium of five firms, led by the international management consulting firm of Deloitte Touche Tohmatsu and including the Boston University Center for International Health, Multinational Strategies, Inc., Development Associates, Inc., and Family Health International.

This report is part of a series of PROFIT Publications, which address various topics related to PROFIT’s work in three strategic areas: innovative investments, private health care providers, and employer-provided services.

This research is supported by the Office of Population in the Center for Population, Health and Nutrition (G/PHN/POP) of the U.S. Agency for International Development (USAID), cooperative agreement number DPE-3056-C-00-1040-00.
ABSTRACT

Expanding the availability of insurance benefits for family planning services was one strategy investigated by the PROFIT Project as part of its effort to encourage private financing of such services. Most insurance providers are reluctant to add benefits that are not accident- or illness-related to their indemnity plans — the most common plans in developing countries. Adding family planning benefits does not produce significant cost savings for most providers because they rarely provide maternity benefits. Furthermore, the beneficiaries of such policies are in the highest income and educational groups and are most likely to already use family planning and to buy their services from the private sector. Therefore, efforts to expand the private provision of family planning through insurance initiatives should be focused on integrating family planning benefits into managed care plans. These plans already cover a range of preventive services, and they have more control over the extent to which the insured utilize covered benefits. Efforts to include family planning in managed care programs are particularly appropriate in areas where contraceptive prevalence is reasonably high but where family planning users depend largely on public sector providers, such as in Asia.
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## ACRONYMS

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<tr>
<td>AID</td>
<td>U.S. Agency for International Development</td>
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<td>AAR</td>
<td>Africa Air Rescue (Kenyan health care company)</td>
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<td>CIMAS</td>
<td>Commercial and Industrial Medical Aid Society</td>
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<td>HMO</td>
<td>Health Maintenance Organization</td>
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<td>IUD</td>
<td>Intrauterine device</td>
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<td>MAS</td>
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<td>MCH</td>
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<td>TIPPS</td>
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<td>UNIMED</td>
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EXECUTIVE SUMMARY

Private health insurance is available in most every country in the world, commonly in the form of indemnity insurance. Under an indemnity plan, the provider agrees to reimburse the insured for medical expenses incurred in the event of an accident or illness. Some indemnity insurers offer health plans only as a vehicle for expanding sales of their primary products, such as life and disability insurance.

The insurance companies that provide indemnity plans are in the business of insuring against risks that are statistically predictable among large groups of people, or “risk pools.” These providers are reluctant to add benefits that would make the people covered by their plans more likely to receive benefits. This is called “moral hazard”: when the existence of an insurance benefit causes the insured to take actions or risks that s/he would not otherwise take, increasing the total cost of the benefits paid. Moral hazard makes indemnity insurers reluctant to include family planning as a benefit. In addition, adding family planning benefits does not produce any costs savings for insurers that do not provide maternity benefits. Nonprofit insurers are an exception. They are less concerned with moral hazard and are more willing to include benefits they consider social goods.

Unlike indemnity health insurers, which cover only expenses incurred as the result of accident or illness, managed care organizations assume responsibility for the covered individuals’ total health care. This makes managed care organizations more willing to include a range of preventive services, because the organizations themselves stand to gain from providing services that can avert other medical costs down the road.

Managed care organizations also have some control over the extent to which beneficiaries utilize covered services, which can allow them to successfully promote use of the family planning benefit. For example, unlike traditional indemnity insurers, managed care organizations may control which health care practitioners patients see and which services those practitioners provide. In many cases, managed care organizations directly employ the health practitioners.

In some countries, the very success of the government in providing family planning services may discourage health insurers or managed care organizations from providing family planning benefits. Specifically, having such benefits does not necessarily lead people to switch their sources for family planning, and many continue to use their existing government clinics for services and supplies.

Working with managed care organizations offers a better opportunity to shift clients away from government family planning programs than working with indemnity providers. This is because managed care providers are more likely to offer integrated services, including preventive care, and because managed care organizations have more control over their provider networks and...
therefore can more easily encourage their providers to promote the use of the family planning benefit.

In sum, efforts to expand the private provision of family planning through insurance are most likely to have a favorable impact when they are:

- not directed toward providers of traditional indemnity plans unless they are nonprofit
- focused on integrating family planning services into managed care plans
- targeted to countries where contraceptive prevalence is relatively high but where family planning services are provided primarily by the government, such as in Asia.
1. METHODOLOGY

Can family planning benefits be integrated into private health insurance programs in
developing countries? Under what conditions will health insurance policies or managed care plans
include family planning benefits? Answers to these questions are crucial to the design of any
strategy which looks to health insurance (or managed care plans) as a means to finance private
sector provision of family planning services. Expanding the availability of insurance benefits for
family planning services was one of the strategies investigated by the PROFIT Project, as part of
its effort to encourage private financing of family planning services.

This paper presents the opportunities and obstacles that exist for the inclusion of family
planning benefits under various types of private health insurance plans, ranging from indemnity
to managed care. Where appropriate, cases are presented to provide illustrations of the discussion.

This paper is based upon:

- A review of published literature, as well as written information from previous USAID efforts
  in this area (for a bibliography, see p. 15).

A review of the literature pertaining to private health insurance and health maintenance
organization benefits and services in developing countries does not reveal widespread explicit
inclusion of family planning benefits. Among the 13 cases identified, only six clearly include
family planning among their proposed or covered benefits. These six cases—including three
plans in Brazil, one in the Philippines, one in Kenya and the Medical Aid Societies of Zim-
babwe—are highlighted in this paper.

- Selective inquiries into the health insurance industry in countries where PROFIT has a
  stationed country representative (Brazil, India, Philippines, Indonesia and Zimbabwe).

- The original research plan for this paper also envisioned working through an NGO (Marie
  Stopes International), to determine the conditions under which Marie Stopes clinics were able
to obtain insurance reimbursement for family planning. The authors hypothesized that some
of the fees charged by these clinics might be reimbursed, explicitly or implicitly, by health
insurance programs. Local clinic managers, subject to the strong pressure for self-sufficiency,
would have an incentive to "push the envelope" in testing the availability of insurance reim-
bursement.

Marie Stopes International cooperated with PROFIT by distributing the survey to clinic
managers. Unfortunately, only one response was received (from a clinic in Central America).
We cannot conclude from this lack of response that clinics like Marie Stopes are unable to
collect from local health insurers. Harried clinic managers probably did not have the time to fill out the survey. However, our other research suggests that explicit family planning benefits are rare in developing country health insurance programs, and even the business-oriented managers at Marie Stopes probably receive few reimbursements from health insurance programs.
2. STUDY FINDINGS

2.1 INDEMNITY INSURANCE

Most of the health insurance sold in the developing world, outside of Latin America, is indemnity insurance. In an indemnity insurance plan the company agrees to reimburse the insured for medical expenses incurred in the event of an accident or illness. Some indemnity health insurers offer health insurance only as a vehicle to expand their more basic products, such as life and disability insurance.

The insurance companies are in the business of insuring against risks which are statistically predictable in large “risk pools.” The companies are afraid of any benefit that would encourage an insured to take actions which might increase the probability of receiving a benefit. Called “moral hazard” in the insurance business, this is the situation where the existence of an insurance benefit causes the insured to take actions or accept risks which he would not otherwise take, increasing the total cost of the benefit that is paid out. The insurers may exclude coverage of maternity benefits for this reason and, in fact, many indemnity insurance plans in developing countries do not include maternity care. In addition, if the policy does not cover deliveries, it is hard to make the argument that family planning will save money for the insurer.

If a health insurance policy does not cover maternity care, it is difficult to persuade the insurer to offer family planning benefits. Moreover, family planning is another benefit initiated by the insured, not an externally occurring risk of disease or accident. Therefore, it is likely to be a cost that the traditional insurer will avoid.

The one exception to this rule is the nonprofit indemnity health plan. Experience has shown that nonprofit insurers are less concerned with moral hazard and are more open to including certain benefits, such as family planning because they view it as a social good. This was the case with CIMAS in Zimbabwe.

Regardless of whether the plan is for-profit or nonprofit, the indemnity insurers have little control over the medical decision making of the individual provider which can make the promotion of family planning difficult. In comparison, managed care organizations often have direct control over the provider (through employment) or indirectly through utilization and quality review mechanisms. If the managed care organization wants all providers to discuss the possibility of family planning during prenatal counseling, it can establish the necessary protocols. The indemnity insurer cannot.

We conclude, in general, that traditional indemnity health insurance plans in developing countries are reluctant to provide family planning benefits. This occurs because most of these plans are run as a sideline to life and disability insurance. These companies see themselves as “pooling risk” for accidents—including ill health—and not covering the comprehensive health care needs of enrollees. Strategies based on trying to include family planning benefits into traditional indemnity insurance programs are therefore likely to have little impact.
CASE ONE
THE MEDICAL AID SOCIETIES—ZIMBABWE

Zimbabwe has one of the highest contraceptive prevalence rates in Sub-Saharan Africa, but provision of services is dominated by the public sector. The government would like to shift those who can afford to pay, or who have other alternatives for financing their family planning needs, such as medical insurance, away from the public sector. The USAID-funded TIPPS project worked in Zimbabwe with the nonprofit Zimbabwean insurance industry from 1986–1989 to add family planning benefits.\(^1\)

Consistent with its approach of targeting industry leaders, TIPPS began working with CIMAS (Commercial and Industrial Medical Aid Society), the largest of 28 Medical Aid Societies (MAS) operating in Zimbabwe. In Zimbabwe, all health insurers, called locally Medical Aid Societies, are private, nonprofit health plans; at the time, none included family planning services in their benefit package. TIPPS conducted a cost-benefit analysis of family planning, maternity and pediatric costs to demonstrate the benefit of including family planning. However, the real deciding factor was CIMAS management, who felt it would be the correct course to take to include family planning benefits given the government’s efforts to stem population growth.

In late 1995, PROFIT conducted an assessment of private provision of family planning in Zimbabwe.\(^2\) The study found that virtually all 24 existing MAS, covering 731,350 beneficiaries, offered family planning benefits. They reimburse for a broad range of services including oral contraceptives, Norplant®, IUDs, tubal ligations, diaphragms and spermicidal jellies. However, few members were taking advantage of the benefits. This might be because they are unaware that family planning is covered or that they prefer to use their traditional provider, the public sector.

Clearly, TIPPS’ success in convincing CIMAS to introduce family planning benefits has had a domino effect on the other Zimbabwean insurers. PROFIT’s efforts have focused on improving utilization of those benefits by more aggressively marketing them to plan members and by providing family planning training to private practitioners including doctors and pharmacists.

\(^{2}\)Adamechak, Susan E. Assessment of the “Private Medical Sector in Zimbabwe.” Conducted for the PROFIT Project and USAID/ Zimbabwe, February 1996.

2.2 MANAGED CARE

In the managed care organization, motivations and control come together to create an environment more favorable to including family planning in the benefit package. The managed care organization assumes the responsibility for the patient’s health care, not just to indemnify him/her against certain medical contingencies. It is more conducive to include a range of preventative services. Where there is an economic benefit in averting other medical costs, the managed care organization will collect the savings.
2. METHODOLOGY

For example, PROFIT initiated a project with Africa Air Rescue (AAR), a local Kenyan health insurer, that hires doctors for its own clinics. AAR was interested in introducing managed care concepts to its plans and responded promptly and positively to PROFIT’s requirement that family planning be part of the benefit package. In addition, a number of Brazilian HMOs have responded similarly to various initiatives from USAID projects. There is also investor interest in expanding U.S. models of managed care to South America and the more prosperous developing countries in Asia. Such initiatives may represent the best opportunity to use “health insurance” as a lever to increase private provision of family planning services.

CASE TWO
KENYA AAR

Africa Air Rescue (AAR) is a Kenyan health care company interested in lowering its costs, broadening access to health services among low-income workers and providing comprehensive health care including family planning. PROFIT made a loan to AAR to purchase a full service clinic facility and to open primary health care clinics in key residential areas. PROFIT also provided technical assistance in managed care, marketing and reproductive health.

AAR is an established insurer in Kenya that offers prepaid coverage for health services to employers and to individuals. It owns and operates its own outpatient facilities in Nairobi and Mombasa, and is the only health insurance company in Kenya to do so. The bulk of its members are company managers and wealthy individuals. However, AAR is interested in establishing a managed care business with the aim of lowering its costs and increasing the number of lower-income members.

AAR is currently establishing primary clinics in Nairobi’s residential areas to serve the 20,000 workers and their dependents working in the industrial area. The industrial area currently does not have family planning services available to employees and their dependents and AAR proposes to sell a pre-paid package of services including family planning to area companies.

By mainstreaming family planning into a fast-growing managed care organization that targets employers, PROFIT seeks to facilitate the broadening of family planning services through the commercial sector. Doing so requires the development of a more cost-effective means of delivering health services if a lower-income population is to be reached, and taking advantage of the economies of scale obtained by marketing these services to employers through AAR’s existing client base.
3. CHALLENGES AND ISSUES

3.1 COMPETITION FROM GOVERNMENT SERVICES

In some countries, the very success of the Government in offering family planning services may discourage health insurers or managed care organizations from providing family planning benefits. Even when family planning benefits are offered, where patterns of care are well established, the insured may continue to go to a government clinic for family planning while still using the other benefits available from private providers under an insurance or managed care plan. For example, family planning services were offered for free under the Healthsaver Plan initiated by PROFIT in the Philippines, but the services were not used by the Healthsaver enrollees. This may be a result of the fact that Healthsaver providers made no active effort to increase family planning utilization and the benefit was not promoted. Nonetheless, those who were using family planning, continued to use their existing sources of consultation and supply (usually government clinics).

In countries with successful government family planning programs (notably Asia), many middle-class users are obtaining family planning services from the government. As managed care develops a model for the provision of health services, these programs could offer family planning benefits to these groups. It should be possible to integrate these services into the benefit package, and the user might shift away from the government family planning program. However, as Healthsaver showed, this transfer will not occur just because the family planning service is a covered benefit.

A shift is more likely to occur if the family planning service is effectively integrated into other obstetric and gynecological services. For this reason, managed care offers better opportunity than indemnity insurance to shift clients away from government family planning programs. The managed care provider has every reason to encourage the integration of these services, and has more control over the way in which the services are provided.

3.2 ENROLLEE PROFILE AND FAMILY PLANNING IMPACT

Typically those with access to health insurance are the better educated workers in the formal economy, exactly those groups which are most likely to already have high contraceptive prevalence rates. Rural communities and the poor working outside the formal sector are the last to be reached by most insurance schemes, and this is where an increase in contraceptive prevalence is most needed.

Unfortunately, the groups covered by private or employer health insurance are exactly the groups that are likely to have the highest prevalence rates. PROFIT abandoned negotiations with a private health insurer in Jamaica when it became apparent that the insureds were generally higher-income workers with a high contraceptive prevalence. Subsequent research by the Boston University Center for International Health also showed that a majority of all outpatient care in Jamaica is purchased privately. Therefore, the individuals who would have been reached by a change in Jamaican health
insurance benefits were likely to be current contraceptive users obtaining their family planning in the private market.

In the Philippines, PROFIT launched a managed care plan called “Healthsaver” with a local insurance company, Philamcare. The plan was specifically targeted to the informal sector of the population, a group that had never been targeted, and included MCH and family planning benefits. The project showed that while this group was interested in private insurance products, marketing to them was expensive. In addition, dropout rates were high, presumably because income is low and insureds who do not like the service question the need to continue paying the premium. Can a system be developed for effectively and affordably marketing a private health insurance plan to the informal sector, currently not covered by health insurance? Certainly the opportunity exists, most importantly in Asia, where contraceptive prevalence is already high, but most users rely on government programs. Although the prevalence of private insurance (including managed care) plans is greatest in South America, these counties already have a relatively high contraceptive prevalence rate that is dominated by private provision and therefore a private sector family planning strategy based on insurance is unlikely to increase prevalence or reduce costs in the region.

CASE THREE
PHILAMCARE

In 1994, the PROFIT Project joined with PhilamCare to implement a low cost health care plan entitled “HealthSaver.” PhilamCare is the leading HMO in the Philippines. As of 1992, PhilamCare had approximately 17 percent of the HMO market share in the Philippines, serving over 100,000 plan members. Prior to the proposed HealthSaver plan, PhilamCare members were mostly group enrollees in one of three plans which targeted employers (primarily managers) and wealthy individuals.

PhilamCare was interested in expanding its current target market to include the lower-income bracket which was estimated to be over 70 percent of the population. In doing so PhilamCare necessarily needed to include individuals working outside the formal economy. The HealthSaver Plan offered a relatively low cost private sector health care option to low-income Filipinos. Contributing to the Plan’s low cost is the fact that it is a low-option plan providing service at a single contracting hospital which is paid on a capitated basis. Although it excluded deliveries, the plan offered improved MCH services compared to the existing plans offered by PhilamCare, plus family planning benefits.

The outcome of the project has been mixed; financial sustainability of the HealthSaver plan has been positive. The numbers of hospitalizations and patient encounters were similar to the baseline, but the charges were much lower than in a fee-for-service environment. Utilization of family planning services remains extremely low. PROFIT and PhilamCare overestimated the participating hospital’s ability to manage a managed care plan and the first year disenrollment was high. Indeed, “copy cat” low-option/low-premium plans that target the same low-income market have emerged to compete with HealthSaver. While not yet confirmed, it is likely that their emergence will further the expansion of relatively low-cost private sector health care options. Encouraging those providers to include a family planning benefit and increasing utilization of that benefit by enrollees will be the challenge for the future.
3. CHALLENGES AND ISSUES

CASE FOUR
BRAZIL

Health Maintenance Organizations, by virtue of their ability to control affiliate providers, emphasis on preventative care and interest in managing costs, are more open to provision of family planning. In Brazil, three HMOs were identified which offer family planning services. These include: Promedica, Pro-Saude, and UNIMED.

Promedica is a for-profit HMO covering 98,424 members. Although individual plans are available, most clients are employees of business with contracts for coverage. The Promedica family planning benefit includes the full range of family planning services including: male and female sterilization, oral contraceptives, injectables, implants, IUDs, diaphragms, condoms and counseling.

Promedica has been providing family planning services in Brazil since 1982. The TIPPS project, which focused on increasing coverage of family planning by HMOs in Brazil, attracted the interest of Promedica in 1987 while presenting the results of a Brazilian cost-benefit analysis of adding family planning to health insurance coverage. Between 1988 and 1990, TIPPS and Promedica worked together to use the data gathered by Promedica on family planning utilization to analyze the cost benefit of provision of these services and to develop strategies to integrate family planning into their ongoing HMO services. The results of the data analysis did show declining birthrates, a positive outcome for Promedica which provides coverage for maternity care.

Pro-Saude, like Promedica, is a for-profit HMO providing direct payments to contracted physicians and clinics. They offer both individual and group plans mainly to employees of businesses. They offer a more limited array of family planning services including: counseling, oral contraceptives, IUDs, diaphragm fittings, condoms and spermicides.

The UNIMED cooperative of Brazilian physicians was founded in 1967. The cooperative is managed by physicians and provides medical services, diagnostic services and hospital care. UNIMED/Brazil is owned by 62,000 member physicians (1992) and services eight million clients, making it among the largest HMOs in the world. UNIMED/Brazil is comprised of 196 cooperatives; one such cooperative is UNIMED/Maceio, in the northeast of Brazil.

In 1993, the PROFIT project and UNIMED/Maceio negotiated to jointly purchase a medical facility. The purpose was to allow UNIMED to add a maternal child health/family planning clinic to their existing hospital. UNIMED hoped that the clinic would enable it to better control utilization costs and reduce payments to third-party providers. Savings realized were to be used to support MCH/FP activities.

Although much delayed, UNIMED/Maceio did eventually open the FP/MCH clinic and is offering family planning services to its members. However the project ran into some difficulties. The population covered by UNIMED in the northeast is very different than the general population in Brazil. UNIMED members tended to have a higher contraceptive usage, more education, fewer children and a higher standard of living. To have a family planning impact the project would need to reach out to lower-income women. In the fall of 1993, the physician members of UNIMED/Maceio elected new management. The new management was far less committed to the MCH/FP component of the project than previous management and some UNIMED physicians were unwilling to decrease prices to attract lower income women. Moreover some physician members did not
support the MCH/FP clinic because they felt it competed directly with the services they provided in their private offices.

Unlike many HMOs, UNIMED is a cooperative, which has some characteristics that make it a more complex partner with which to work. These include:

- regular changes in leadership
- need for a majority vote for major decisions
- coop providers are not employees, but members, and have far more say in management decision making.

This makes the task of incorporating family planning benefits more complex. There is no single champion in management who can ensure that the project is implemented. The various voices of dissent have a greater say in this type of management structure.
4. CONCLUSIONS

Private health insurance, most commonly indemnity insurance, can be found in almost every country in the world. However, publicly available published literature on the industry in the developing world does not afford the opportunity to generally assess the family planning benefits available to beneficiaries. The available evidence suggests that most indemnity-type health insurance plans are reluctant to add benefits such as family planning which are not accident or illness related. Such plans rarely cover maternity, so they are less likely to benefit from the use of family planning. Furthermore, beneficiaries covered by such indemnity plans are in the highest income and educational groups. These are population segments where contraceptive use will be highest and women are already purchasing services from private providers.

Managed care approaches to private sector expansion of health services are among the solutions available to cash-strapped public health systems. Over the past 10 years, this solution has been recommended/or implemented in several developing countries, in particular in Latin America. The new openness to managed care principles provides a new opportunity for those interested in private sector family planning to work on linking family planning with health insurance alternatives.

In conclusion, we find that efforts to expand the private provision of family planning through insurance initiatives are most likely to have a favorable impact when they are:

- not based on traditional indemnity plans unless those plans are nonprofit
- part of a managed care plan
- introduced in a country where contraceptive prevalence is reasonably high but dependent on government programs for supply. Thus, Asia offers more favorable opportunities than Latin America to leverage a resource shift.
DEFINITION OF TERMS

**Capitation**: A system of paying for health care in which a provider of medical services receives a fixed amount for each enrolled patient. The amount does not change with the number of services received by the patient.

**Health Maintenance Organization**: An organization which assumes responsibility for all the health care needs of the insured patient for a set payment or capitation fee. Such an organization may be "closed panel," where most physicians are regular, staff employees. Kaiser Permanente is the oldest and most famous of such closed panel plans in the United States, and even controls its own hospitals. Other health maintenance organizations may use independent physicians of physician groups to provide care. This is usually referred to as an "open panel" plan, or an "independent practice association" (IPA). In the U.S., HMOs initially developed separate from, and in competition with, traditional indemnity health insurers. More recently, health insurers have moved to purchase or create their own HMOs.

**Fee-for-Service**: An arrangement in which the provider of medical services is paid for each service rendered. Payment can be made by the individual, or by an insurance company. A fee-for-service system provides strong incentives to increase the number of services provided, and favors specialist medical providers who perform procedures.

**Gatekeeper**: A primary care physician who controls the patient's access to medical specialists. This system is employed in the British National Health Service, where the general practitioner must refer the patient for specialist consultation. It also occurs in managed care plans, where the patient cannot obtain coverage for specialist care unless referred by the primary care gatekeeper.

**Indemnity Insurance**: A health insurance plan which reimburses patients for all, or a portion, of the bills they incur. Under such a system, patients may have to produce cash to pay providers at the time of service, and then receive reimbursement later from the insurance company. In such a system the insurer has no direct relationship with the provider.

**Managed Care**: In general, "managed health care" is a system in which a health care provider has explicit responsibility, and financial incentive, to determine the type and amount of care which a patient receives. Physicians are subject to additional "management forces" in their choice of treatment. A requirement that certain discretionary hospital admissions be approved in advance is a minimal form of managed care. Systems in which the provider receives a "capitation payment" or acts as a "gatekeeper" are more developed systems of managed care.
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