Certificate Programme in Healthcare Research Analysis

Health Economics and Financing

Health Economics and Financing Glossary

1. Access to Healthcare: The ability of individuals to obtain healthcare services when needed. It includes factors such as availability, affordability, and acceptability of services.

2. Acute Care: Short-term treatment for severe injuries or illnesses, typically provided in hospitals.

3. Capitation: A payment model in which healthcare providers receive a fixed amount per patient regardless of the services provided. It incentivizes providers to deliver cost-effective care.

4. Cost-Effectiveness Analysis (CEA): A method used to compare the costs of healthcare interventions with their outcomes to determine the most efficient use of resources.

5. Demand-Side Financing: Refers to mechanisms that provide financial support directly to individuals to increase their access to healthcare services, such as vouchers or cash transfers.

6. Fee-for-Service: A payment model in which healthcare providers are reimbursed based on the quantity of services they deliver. It can lead to overutilization of services.

7. Gross Domestic Product (GDP): The total value of all goods and services produced in a country within a specific time period. It is used to measure a country's economic performance.

8. Health Insurance: A financial mechanism that provides risk protection against healthcare expenses by pooling funds from individuals or organizations.

9. Health Technology Assessment (HTA): A systematic evaluation of the social, economic, and clinical impact of healthcare technologies to inform decision-making.

10. Indirect Costs: Costs associated with the consequences of illness or treatment, such as lost productivity or caregiver burden.

11. Medicaid: A government program in the United States that provides health insurance to low-income individuals and families.

12. Medicare: A government program in the United States that provides health insurance to individuals aged 65 and older, as well as some younger people with disabilities.

13. Out-of-Pocket Payments: Payments made directly by individuals for healthcare services not covered by insurance or other financing mechanisms.

14. Pay-for-Performance: A payment model that links financial incentives to the quality of care provided by healthcare providers.

15. Provider-Induced Demand: The phenomenon in which healthcare providers influence patients to demand unnecessary services to increase their revenue.

16. Quality-Adjusted Life Years (QALYs): A measure that combines the quantity and quality of life gained from a healthcare intervention. It is used in cost-effectiveness analyses.

17. Risk Pooling: The practice of spreading financial risk across a large group of individuals to reduce the impact of high healthcare costs on any one person.

18. Social Health Insurance: A financing mechanism in which healthcare costs are covered through contributions from individuals, employers, and the government.

19. Universal Health Coverage (UHC): Ensuring that all individuals have access to needed healthcare services without experiencing financial hardship.

20. Value-Based Healthcare: A delivery model that focuses on improving patient outcomes while reducing costs by aligning incentives with quality of care.

21. Vertical Integration: The consolidation of healthcare services under one organization to improve coordination and efficiency.

22. World Health Organization (WHO): A specialized agency of the United Nations that is responsible for international public health. It provides leadership on global health matters, sets norms and standards, and monitors health trends.