Postgraduate Certificate in Health Financing and Budgeting

Health Economics

Accelerated Economic Growth refers to a rapid increase in the production of goods and services in an economy, which can have both positive and negative impacts on a country's healthcare system. The term is often used in the context of low- and middle-income countries that are experiencing rapid economic growth. Related terms include economic development, poverty reduction, and health equity.

Access to Care is a term used to describe the ability of individuals to obtain health services when they need them. This concept is often used in the context of universal health coverage and is related to terms such as health insurance, health care utilization, and financial protection.

Accountability in health care refers to the process of holding individuals or organizations responsible for their actions and the outcomes of those actions. This concept is often used in the context of health system governance and is related to terms such as transparency, stewardship, and performance measurement.

Activity-Based Costing is a method of costing that involves assigning costs to specific activities or tasks within an organization. This approach is often used in the context of hospital finance and is related to terms such as cost accounting, budgeting, and financial management.

Adjusted Clinical Groups is a system used to classify patients into groups based on their health status and health care needs. This system is often used in the context of health insurance and is related to terms such as risk adjustment, health care utilization, and payment systems.

Adverse Selection refers to a situation in which individuals with higher health care needs are more likely to purchase health insurance than individuals with lower health care needs. This concept is often used in the context of health insurance markets and is related to terms such as risk pooling, premium setting, and regulation.

Alma-Ata Declaration is a statement of principles adopted by the World Health Organization in 1978, which emphasizes the importance of primary health care and health promotion. This declaration is often used in the context of global health policy and is related to terms such as health for all, primary health care, and community participation.

Annual Budget is a document that outlines the projected income and expenses of an organization over a one-year period. This concept is often used in the context of hospital finance and is related to terms such as financial planning, budgeting, and resource allocation.

Appropriation is the process of allocating funds to specific programs or activities within an organization. This concept is often used in the context of government finance and is related to terms such as budgeting, expenditure management, and fiscal policy.

Asset Management refers to the process of managing an organization's physical and financial assets in

order to maximize their value and minimize their costs. This concept is often used in the context of hospital finance and is related to terms such as capital budgeting, investment analysis, and facility management.

Average Length of Stay is a measure of the average number of days that patients stay in a hospital or other health care facility. This concept is often used in the context of hospital finance and is related to terms such as cost per case, payment systems, and resource utilization.

Average Revenue Per User is a measure of the average amount of revenue generated per user of a health care service. This concept is often used in the context of health insurance and is related to terms such as premium setting, reimbursement rates, and cost sharing.

Benchmarking is the process of comparing an organization's performance to that of other similar organizations. This concept is often used in the context of quality improvement and is related to terms such as best practices, performance measurement, and quality assurance.

Benefit Incidence Analysis is a method used to analyze the distribution of health benefits across different population groups. This approach is often used in the context of health equity and is related to terms such as benefit package design, targeting, and resource allocation.

Benefit Package refers to the range of health services and benefits that are covered by a health insurance plan. This concept is often used in the context of health insurance design and is related to terms such as coverage, access, and utilization.

Budget Allocation refers to the process of allocating funds to specific programs or activities within an organization. This concept is often used in the context of government finance and is related to terms such as appropriation, expenditure management, and fiscal policy.

Budget Cycle refers to the process of planning, implementing, and evaluating a budget over a specific period of time. This concept is often used in the context of hospital finance and is related to terms such as financial planning, budgeting, and resource allocation.

Capitation Payment is a method of paying health care providers a fixed amount per patient, regardless of the actual services provided. This approach is often used in the context of health insurance and is related to terms such as fee-for-service, payment systems, and cost containment.

Capital Budgeting refers to the process of planning and managing an organization's investments in physical and financial assets. This concept is often used in the context of hospital finance and is related to terms such as asset management, investment analysis, and facility management.

Case Mix refers to the mix of patients with different diagnoses and severity levels that are treated by a health care provider. This concept is often used in the context of hospital finance and is related to terms such as cost per case, payment systems, and resource utilization.

Catastrophic Health Expenditure refers to health care spending that exceeds a certain threshold, such as 10% of household income. This concept is often used in the context of health financing and is related to terms such as financial protection, universal health coverage, and poverty reduction.

Certificate of Need is a regulatory requirement that health care providers must meet before they can build or expand a facility or offer a new service. This concept is often used in the context of health care regulation and is related to terms such as licensure, accreditation, and quality assurance.

Chronic Disease Management refers to the process of managing chronic diseases, such as diabetes and heart disease, through a combination of preventive care, treatment, and support services. This concept is often used in the context of primary health care and is related to terms such as disease management, case management, and care coordination.

Claim is a request for payment or reimbursement submitted by a health care provider or patient to a health insurance plan. This concept is often used in the context of health insurance and is related to terms such as billing, reimbursement, and adjudication.

Clinical Governance refers to the process of ensuring that health care services are delivered in a safe and effective manner. This concept is often used in the context of quality improvement and is related to terms such as quality assurance, patient safety, and clinical effectiveness.

Community-Based Care refers to health care services that are delivered in community-based settings, such as homes, schools, and community centers. This concept is often used in the context of primary health care and is related to terms such as home-based care, community outreach, and social support.

Community Participation refers to the involvement of community members in the planning, implementation, and evaluation of health care services. This concept is often used in the context of primary health care and is related to terms such as community engagement, social mobilization, and empowerment.

Compliance refers to the process of adhering to laws, regulations, and standards that govern the delivery of health care services. This concept is often used in the context of health care regulation and is related to terms such as licensure, accreditation, and quality assurance.

Contribution is a payment made by an individual or organization to a health insurance plan or other health care financing mechanism. This concept is often used in the context of health financing and is related to terms such as premium, copayment, and coinsurance.

Contracting refers to the process of negotiating and agreeing on the terms and conditions of a contract between a health care provider and a health insurance plan or other payer. This concept is often used in the context of health insurance and is related to terms such as network development, reimbursement, and contract management.

Copayment is a payment made by a patient to a health care provider at the time of service. This concept is often used in the context of health insurance and is related to terms such as deductible, coinsurance, and out-of-pocket costs.

Cost Accounting refers to the process of assigning costs to specific products or services within an organization. This concept is often used in the context of hospital finance and is related to terms such as financial management, budgeting, and cost control.

Cost-Benefit Analysis is a method used to evaluate the costs and benefits of a particular program or intervention. This approach is often used in the context of health economics and is related to terms such as cost-effectiveness analysis, cost-utility analysis, and decision making.

Cost Containment refers to the process of reducing or controlling health care costs. This concept is often used in the context of health financing and is related to terms such as cost control, price regulation, and utilization management.

Cost Effectiveness refers to the ratio of the costs of a program or intervention to its benefits. This concept is often used in the context of health economics and is related to terms such as cost-benefit analysis, cost-utility analysis, and resource allocation.

Cost Minimization refers to the process of reducing the costs of a program or intervention while maintaining its effectiveness. This concept is often used in the context of health economics and is related to terms such as cost control, price regulation, and utilization management.

Cost Sharing refers to the process of dividing the costs of health care between patients, providers, and payers. This concept is often used in the context of health insurance and is related to terms such as copayment, coinsurance, and deductible.

Cost Utility refers to the ratio of the costs of a program or intervention to its benefits, measured in terms of quality-adjusted life years or other utility metrics. This concept is often used in the context of health economics and is related to terms such as cost-effectiveness analysis, cost-benefit analysis, and decision making.

Decentralization refers to the process of transferring authority and decision-making power from a central government to local governments or other organizations. This concept is often used in the context of health system governance and is related to terms such as devolution, deconcentration, and district health systems.

Deductible is a payment made by a patient to a health care provider before the patient's health insurance plan begins to pay. This concept is often used in the context of health insurance and is related to terms such as copayment, coinsurance, and out-of-pocket costs.

Demand Analysis refers to the process of analyzing the demand for health care services. This concept is often used in the context of health economics and is related to terms such as supply analysis, market research, and needs assessment.

Diagnosis-Related Group is a system used to classify patients into groups based on their diagnosis and treatment requirements. This concept is often used in the context of hospital finance and is related to terms such as case mix, payment systems, and resource utilization.

Disability-Adjusted Life Year is a metric used to measure the burden of disease, taking into account both the mortality and morbidity associated with a particular disease or condition. This concept is often used in the context of health economics and is related to terms such as quality-adjusted life year, cost-effectiveness analysis, and resource allocation.

Disease Management refers to the process of managing chronic diseases, such as diabetes and heart disease, through a combination of preventive care, treatment, and support services. This concept is often used in the context of primary health care and is related to terms such as case management, care coordination, and chronic disease management.

District Health System refers to a decentralized health system in which authority and decision-making power are transferred to the district level. This concept is often used in the context of health system governance and is related to terms such as decentralization, devolution, and local governance.

Donor Funding refers to funding provided by external donors, such as governments, foundations, and non-governmental organizations, to support health care services and health system development. This concept is often used in the context of health financing and is related to terms such as aid effectiveness, partnership development, and sustainability.

Drug Pricing refers to the process of setting the price of pharmaceuticals and other health care products. This concept is often used in the context of health financing and is related to terms such as cost control, price regulation, and access to medicines.

Earmarked Tax refers to a tax that is specifically designated for a particular purpose, such as funding health care services. This concept is often used in the context of health financing and is related to terms such as hypothecated tax, dedicated funding, and budget allocation.

Economic Evaluation refers to the process of analyzing the economic implications of a particular program or intervention. This concept is often used in the context of health economics and is related to terms such as cost-effectiveness analysis, cost-benefit analysis, and resource allocation.

Effectiveness refers to the degree to which a particular program or intervention achieves its intended goals and objectives. This concept is often used in the context of health care evaluation and is related to terms such as efficacy, quality, and outcomes.

Efficiency refers to the ratio of the outputs of a program or intervention to its inputs, such as costs or resources. This concept is often used in the context of health economics and is related to terms such as cost-effectiveness analysis, cost-benefit analysis, and resource allocation.

Empowerment refers to the process of enabling individuals or communities to take control of their own health and well-being. This concept is often used in the context of primary health care and is related to terms such as community participation, social mobilization, and health promotion.

Enrollment refers to the process of registering or enrolling individuals in a health insurance plan or other health care program. This concept is often used in the context of health insurance and is related to terms such as eligibility, coverage, and benefits.

Environmental Health refers to the branch of public health that focuses on the environmental factors that affect human health, such as air and water pollution and climate change. This concept is often used in the context of public health and is related to terms such as occupational health, infectious disease control, and

sustainable development.

Epidemiology is the study of the distribution and determinants of health-related events, diseases, or health-related characteristics among populations. This concept is often used in the context of public health and is related to terms such as infectious disease epidemiology, cancer epidemiology, and chronic disease epidemiology.

Equity refers to the principle of fairness and justice in the distribution of health care resources and services. This concept is often used in the context of health economics and is related to terms such as health equity, access, and utilization.

Essential Health Benefits refer to the minimum set of health benefits that must be covered by a health insurance plan. This concept is often used in the context of health insurance regulation and is related to terms such as benefit package design, coverage, and access.

Evidence-Based Medicine refers to the use of evidence from research and evaluation to inform clinical decision-making. This concept is often used in the context of quality improvement and is related to terms such as clinical effectiveness, guideline development, and quality assurance.

Expenditure Management refers to the process of planning, implementing, and monitoring expenditures in a health care organization or system. This concept is often used in the context of health financing and is related to terms such as budgeting, cost control, and financial management.

Externalities refer to the effects of a program or intervention that are not directly related to its primary goals or objectives. This concept is often used in the context of health economics and is related to terms such as spillover effects, social benefits, and cost-benefit analysis.

Fee-for-Service is a payment method in which health care providers are paid for each service they provide. This concept is often used in the context of health insurance and is related to terms such as capitation, payment systems, and cost containment.

Financial Management refers to the process of planning, implementing, and monitoring the financial activities of a health care organization or system. This concept is often used in the context of health financing and is related to terms such as budgeting, cost control, and expenditure management.

Financial Protection refers to the protection of individuals and households from financial hardship or poverty due to health care spending. This concept is often used in the context of health financing and is related to terms such as universal health coverage, social health insurance, and out-of-pocket payments.

Fiscal Policy refers to the use of government spending and taxation to influence the overall level of economic activity in a country. This concept is often used in the context of macro economics and is related to terms such as monetary policy, government revenue, and expenditure management.

Fixed Budget refers to a budget that is fixed or predetermined, and is not subject to change or revision. This concept is often used in the context of hospital finance and is related to terms such as variable budget, flexible budget, and cost control.

Formulary is a list of medicines and other health care products that are approved for use by a health insurance plan or other payer. This concept is often used in the context of health insurance and is related to terms such as pharmaceutical management, drug pricing, and access to medicines.

Functional Analysis refers to the process of analyzing the functions or activities of a health care organization or system. This concept is often used in the context of health economics and is related to terms such as activity-based costing, cost accounting, and financial management.

Gatekeeper refers to a health care provider who acts as a gatekeeper or referral agent, controlling access to specialist care or other health care services. This concept is often used in the context of primary health care and is related to terms such as primary care, referral systems, and continuity of care.

Generic Drug is a drug that is equivalent to a brand-name drug but is sold at a lower price. This concept is often used in the context of pharmaceutical management and is related to terms such as drug pricing, access to medicines, and cost containment.

Global Health refers to the health and well-being of populations around the world, and the global health issues and challenges that affect them. This concept is often used in the context of international health and is related to terms such as global health governance, international health cooperation, and health security.

Governance refers to the process of overseeing and managing a health care organization or system. This concept is often used in the context of health system governance and is related to terms such as leadership, management, and stewardship.

Gross Domestic Product is a measure of the total value of goods and services produced within a country's borders. This concept is often used in the context of macro economics and is related to terms such as national income, economic growth, and health expenditure.

Health Accounting refers to the process of accounting for health care expenditures and revenues within a health care organization or system. This concept is often used in the context of health financing and is related to terms such as financial management, cost accounting, and expenditure management.

Health Care Access refers to the ability of individuals to obtain health care services when they need them. This concept is often used in the context of health care evaluation and is related to terms such as availability, affordability, and acceptability.

Health Care Expenditure refers to the total amount of money spent on health care within a country or population. This concept is often used in the context of health financing and is related to terms such as health care spending, expenditure management, and cost control.

Health Care Financing refers to the process of raising and allocating funds to pay for health care services. This concept is often used in the context of health financing and is related to terms such as health insurance, out-of-pocket payments, and government funding.

Health Care Reform refers to the process of changing or improving the health care system, including its financing, delivery, and organization. This concept is often used in the context of health policy and is related

to terms such as health care restructuring, system reform, and policy development.

Health Care Utilization refers to the use of health care services by individuals or populations. This concept is often used in the context of health care evaluation and is related to terms such as access, availability, and quality of care.

Health Economics refers to the study of the economic aspects of health and health care, including the costs, benefits, and value of health care services. This concept is often used in the context of health economics and is related to terms such as cost-benefit analysis, cost-effectiveness analysis, and resource allocation.

Health Insurance refers to a type of insurance that provides financial protection against health care costs. This concept is often used in the context of health financing and is related to terms such as premium, copayment, and deductible.

Health Outcomes refer to the results or consequences of health care services, including improvements in health status, quality of life, and functional ability. This concept is often used in the context of health care evaluation and is related to terms such as effectiveness, efficacy, and patient satisfaction.

Health Promotion refers to the process of enabling individuals and communities to increase control over, and to improve, their health. This concept is often used in the context of public health and is related to terms such as health education, social marketing, and community development.

Health Sector refers to the part of the economy that is concerned with the provision of health care goods and services. This concept is often used in the context of health economics and is related to terms such as health care industry, health care market, and health care workforce.

Health System refers to the organization and delivery of health care services within a country or population. This concept is often used in the context of health system governance and is related to terms such as health care delivery, health care financing, and health care regulation.

Health Technology Assessment refers to the evaluation of the clinical, economic, and social impacts of a health technology, such as a drug, device, or procedure. This concept is often used in the context of health care evaluation and is related to terms such as cost-effectiveness analysis, cost-benefit analysis, and decision making.

Hospital Accreditation refers to the process of evaluating and recognizing hospitals that meet certain standards of quality and safety. This concept is often used in the context of quality improvement and is related to terms such as quality assurance, patient safety, and clinical effectiveness.

Human Resources for Health refers to the health workforce, including doctors, nurses, and other health care professionals. This concept is often used in the context of health system governance and is related to terms such as health workforce development, health workforce planning, and health workforce management.

Immunization refers to the process of protecting individuals and populations against infectious diseases through the use of vaccines. This concept is often used in the context of public health and is related to terms such as vaccine development, vaccination programs, and disease prevention.

Incentives refer to rewards or penalties that are used to motivate health care providers or patients to adopt certain behaviors or practices. This concept is often used in the context of health care evaluation and is related to terms such as pay-for-performance, quality improvement, and patient satisfaction.

Income Redistribution refers to the process of transferring income from one group to another, such as from the wealthy to the poor. This concept is often used in the context of health economics and is related to terms such as progressive taxation,