Postgraduate Certificate in Health Financing and Budgeting

Financial Management In Healthcare

Accountability in healthcare refers to the responsibility of healthcare providers to deliver high-quality services and to be answerable for their actions, decisions, and outcomes. This concept is closely related to transparency, governance, and quality of care. In the context of financial management in healthcare, accountability involves ensuring that healthcare providers are responsible for the effective and efficient use of resources.

Activity-Based Costing (ABC) is a method of costing that assigns costs to activities, such as patient care, research, and education, rather than to departments or functions. This approach helps healthcare organizations to identify areas where costs can be reduced or optimized. Related terms include cost allocation, cost center, and activity analysis.

Budgeting in healthcare involves the process of planning, allocating, and managing financial resources to achieve organizational goals and objectives. A budget is a detailed financial plan that outlines projected income and expenditures over a specific period. Related terms include financial planning, resource allocation, and cost control.

Capitation is a payment method in which a healthcare provider is paid a fixed amount per patient for a specified period, regardless of the number or type of services provided. This approach is often used in managed care organizations and is intended to incentivize providers to deliver high-quality, cost-effective care.

Case Mix is a measure of the severity and complexity of patients treated by a healthcare provider. It is often used to adjust payments to providers to reflect the relative cost of treating different types of patients. Related terms include diagnosis-related groups (DRGs) and resource intensity.

Clinical Governance is a framework for ensuring that healthcare organizations provide high-quality, safe, and effective care. It involves monitoring and improving clinical practices, managing risks, and enhancing patient experience. Related terms include quality improvement, patient safety, and clinical effectiveness.

Cost-Benefit Analysis (CBA) is a method of evaluating the costs and benefits of a healthcare program or intervention. It involves comparing the expected costs of a program with its expected benefits, expressed in monetary terms. Related terms include cost-effectiveness analysis and cost-utility analysis.

Cost-Effectiveness Analysis (CEA) is a method of evaluating the costs and outcomes of a healthcare program or intervention. It involves comparing the expected costs of a program with its expected health outcomes, such as quality-adjusted life years (QALYs). Related terms include cost-benefit analysis and cost-utility analysis.

Cost-Sharing is a payment arrangement in which patients pay a portion of the costs of healthcare services, such as copayments, coinsurance, or deductibles. This approach is intended to incentivize patients to use

healthcare services wisely and to reduce unnecessary utilization.

Diagnosis-Related Groups (DRGs) are a system of classifying patients into groups based on their diagnosis, procedure, and severity of illness. DRGs are often used to adjust payments to providers to reflect the relative cost of treating different types of patients.

Disinvestment is the process of withdrawing or reducing investment in a healthcare program or service that is no longer effective or cost-effective. This approach is intended to free up resources for more effective or higher-priority programs.

Efficiency in healthcare refers to the ability of healthcare providers to deliver high-quality services at lower cost. This concept is closely related to productivity, quality, and value for money. In the context of financial management in healthcare, efficiency involves optimizing resource use, reducing waste, and improving processes.

Evidence-Based Medicine (EBM) is an approach to healthcare that involves using best available evidence to inform clinical decisions. EBM is intended to improve the quality and safety of care, reduce unnecessary variation, and enhance patient outcomes.

Financial Management in healthcare involves the process of planning, allocating, and managing financial resources to achieve organizational goals and objectives. This includes budgeting, forecasting, financial reporting, and financial analysis.

Financial Planning in healthcare involves the process of developing a detailed financial plan that outlines projected income and expenditures over a specific period. This includes budgeting, forecasting, and financial modeling.

Funding Models in healthcare refer to the different ways in which healthcare services are financed, such as fee-for-service, capitation, or salary-based payment. Each funding model has its own strengths and weaknesses, and the choice of funding model can influence the behavior of healthcare providers.

Global Budget is a payment arrangement in which a healthcare provider is paid a fixed amount for all services provided to a patient over a specific period. This approach is intended to incentivize providers to deliver high-quality, cost-effective care.

Healthcare Financing refers to the ways in which healthcare services are paid for, such as through insurance, out-of-pocket payments, or government funding. Healthcare financing is a critical component of health systems, as it can influence access to care, quality of care, and health outcomes.

Health Economics is the study of the economic aspects of healthcare, including the production, distribution, and consumption of healthcare services. Health economics involves the application of economic theories and methods to analyze healthcare issues and evaluate healthcare programs.

Health Technology Assessment (HTA) is a systematic evaluation of the clinical, economic, and social implications of a healthcare technology, such as a new drug or medical device. HTA is intended to inform decision-making about the adoption and use of healthcare technologies.

Incremental Budgeting is a method of budgeting that involves making small, incremental changes to the previous year's budget, rather than starting from scratch. This approach is often used in healthcare organizations, as it can simplify the budgeting process and reduce the risk of error.

Insurance in healthcare refers to a system of financing in which individuals or groups pay premiums to a third-party payer, such as an insurance company, in exchange for coverage of healthcare costs. Insurance can protect individuals and families from financial risk and ensure access to necessary care.

Managed Care is a system of healthcare delivery that involves a combination of insurance and provider networks. Managed care organizations (MCOs) aim to control costs, improve quality, and enhance patient experience through care coordination, utilization review, and quality improvement initiatives.

Marginal Analysis is a method of evaluating the costs and benefits of a healthcare program or intervention at the margin, or the point at which the last unit of the program is provided. Marginal analysis is intended to inform decisions about the optimal level of resource allocation.

Need-Based Financing is a system of financing in which healthcare services are financed based on the needs of the population, rather than on the ability to pay. This approach is intended to ensure equitable access to necessary care, regardless of income or socioeconomic status.

Opportunity Cost is the value of the next best alternative that is foregone when a choice is made. In the context of financial management in healthcare, opportunity cost is an important consideration, as it can inform decisions about the allocation of resources.

Outcomes-Based Financing is a system of financing in which healthcare services are financed based on the outcomes achieved, rather than on the volume or intensity of services provided. This approach is intended to incentivize providers to deliver high-quality, effective care.

Pay-For-Performance (P4P) is a payment arrangement in which healthcare providers are paid based on their performance on specific quality metrics, such as patient satisfaction or clinical outcomes. P4P is intended to incentivize providers to deliver high-quality care and to improve patient outcomes.

Pharmaco-Economics is the study of the economic aspects of pharmaceuticals, including their cost, effectiveness, and value. Pharmaco-economics involves the application of economic theories and methods to analyze pharmaceutical issues and evaluate pharmaceutical programs.

Priority Setting in healthcare involves the process of allocating resources to different healthcare programs or services based on their relative priority. Priority setting is a critical component of health systems, as it can influence access to care, quality of care, and health outcomes.

Prospective Payment System (PPS) is a payment arrangement in which healthcare providers are paid a fixed amount for each patient based on a prospective payment schedule. PPS is intended to incentivize providers to deliver high-quality, cost-effective care.

Quality-Adjusted Life Year (QALY) is a measure of the value of a healthcare program or intervention, taking into account both the quantity and quality of life. QALYs are often used in cost-effectiveness analysis and

cost-utility analysis.

Resource Allocation in healthcare involves the process of allocating resources, such as staff, equipment, and facilities, to different healthcare programs or services. Resource allocation is a critical component of health systems, as it can influence access to care, quality of care, and health outcomes.

Retrospective Payment System is a payment arrangement in which healthcare providers are paid for services provided based on a retrospective review of claims. This approach is often used! In fee-for-service payment arrangements.

Return On Investment (ROI) is a measure of the return on investment of a healthcare program or intervention, expressed as a ratio of benefits to costs. ROI is often used to evaluate the financial performance of healthcare programs or services.

Risk Sharing in healthcare involves the process of sharing the financial risk of healthcare costs between different parties, such as insurers, providers, and patients. Risk sharing is intended to reduce the financial burden on individuals and families and to ensure access to necessary care.

Sensitivity Analysis is a method of analyzing the results of a model or simulation to determine how sensitive they are to changes in assumptions or parameters. Sensitivity analysis is often used in cost-effectiveness analysis and cost-utility analysis.

Stakeholder Analysis is a method of identifying and analyzing the interests and needs of different stakeholders, such as patients, providers, and payers. Stakeholder analysis is intended to inform decision-making about healthcare programs or services.

Supply-Side Financing is a system of financing in which healthcare services are financed based on the supply of services, rather than on the demand for services.

Sustainability in healthcare refers to the ability of healthcare systems to continue to provide high-quality services over time, without depleting resources or compromising the quality of care. Sustainability is a critical component of health systems, as it can influence access to care, quality of care, and health outcomes.

Time-Driven Activity-Based Costing (TDABC) is a method of costing that assigns costs to activities based on the time required to perform them. TDABC is intended to provide a more accurate and detailed understanding of the costs of healthcare services.

Value-Based Payment (VBP) is a payment arrangement in which healthcare providers are paid based on the value of care provided, rather than on the volume or intensity of services. VBP is intended to incentivize providers to deliver high-quality, cost-effective care.

Value For Money (VFM) in healthcare refers to the value of healthcare services provided, relative to their cost. VFM is a critical component of health systems, as it can influence access to care, quality of care, and health outcomes.

Zero-Based Budgeting is a method of budgeting that involves starting from a zero base and justifying every expenditure from scratch. This approach is intended to ensure that resources are allocated efficiently and effectively, and to reduce waste and inefficiency.