
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.

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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.