Advanced Professional Diploma in Healthcare Economics

Healthcare Markets and Competition

Healthcare Markets and Competition Glossary

A

Accountable Care Organization (ACO)
An ACO is a group of healthcare providers that work together to coordinate care for a specific population of patients. ACOs are responsible for the quality and cost of care provided to their patients, with the goal of improving outcomes and reducing costs.

B

Block Grant
A block grant is a fixed amount of funding provided by the government to states for specific programs, such as Medicaid. Block grants give states more flexibility in how they use the funds but may result in reduced federal oversight and accountability.

C

Competition
Competition in healthcare refers to the rivalry between healthcare providers, insurers, and other entities to attract patients and customers. Competition can lead to lower prices, better quality of care, and increased innovation.

Consumer-Directed Health Plans
Consumer-directed health plans are health insurance plans that give individuals more control over their healthcare spending. These plans typically have high deductibles and encourage individuals to make informed decisions about their healthcare.

D

Drug Formulary
A drug formulary is a list of prescription drugs that are covered by a health insurance plan. Formularies often categorize drugs into tiers based on cost and may require prior authorization for certain medications.

E

Electronic Health Record (EHR)

An electronic health record is a digital version of a patient's medical history that is maintained by healthcare providers. EHRs allow for the sharing of patient information across different healthcare settings and can improve coordination of care.

F

Fee-for-Service
Fee-for-service is a payment model in healthcare where providers are reimbursed for each service or procedure they perform. This payment model has been criticized for incentivizing unnecessary care and driving up costs.

G

Generic Drug
A generic drug is a medication that is chemically equivalent to a brand-name drug but is sold under its chemical name. Generic drugs are typically less expensive than brand-name drugs and can help reduce healthcare costs.

H

Health Maintenance Organization (HMO)
An HMO is a type of health insurance plan that requires patients to see healthcare providers within a designated network. HMOs typically require patients to choose a primary care physician and obtain referrals for specialist care.

I

Integrated Delivery System
An integrated delivery system is a network of healthcare providers and facilities that work together to deliver coordinated care to patients. Integrated delivery systems aim to improve quality of care and reduce costs through better coordination and communication.

J

Joint Commission
The Joint Commission is an independent nonprofit organization that accredits and certifies healthcare organizations in the United States. Accreditation by the Joint Commission indicates that a healthcare organization meets certain quality and safety standards.

K

Key Performance Indicators (KPIs)

Key performance indicators are metrics used to evaluate the performance of healthcare organizations. KPIs can include measures of financial performance, patient satisfaction, quality of care, and other important indicators.

L

Long-Term Care
Long-term care refers to a range of services and supports for individuals who have chronic health conditions or disabilities. Long-term care can be provided in a variety of settings, including nursing homes, assisted living facilities, and home care.

M

Medicaid
Medicaid is a joint federal and state program that provides health insurance to low-income individuals and families. Medicaid covers a wide range of healthcare services and is an important source of coverage for vulnerable populations.

N

Network Adequacy
Network adequacy refers to the sufficiency of a health insurance plan's provider network to meet the needs of its enrollees. Regulators may set standards for network adequacy to ensure that patients have access to timely and appropriate care.

O

Out-of-Pocket Costs
Out-of-pocket costs are expenses that patients must pay for healthcare services that are not covered by insurance. Out-of-pocket costs can include deductibles, copayments, and coinsurance, and can vary depending on the type of insurance plan.

P

Preferred Provider Organization (PPO)
A PPO is a type of health insurance plan that allows patients to see any healthcare provider, but offers lower out-of-pocket costs for services received from providers within the plan's network. PPOs do not require referrals for specialist care.

Q

Quality Improvement

Quality improvement in healthcare refers to efforts to improve the delivery of care and outcomes for patients. Quality improvement initiatives may focus on reducing medical errors, improving patient satisfaction, and implementing best practices.

R

Risk Adjustment
Risk adjustment is a method used to account for differences in health status among patients when comparing the performance of healthcare providers. Risk adjustment helps ensure that providers are not unfairly penalized for treating sicker patients.

S

Single-Payer System
A single-payer system is a healthcare financing system in which a single entity, typically the government, pays for healthcare services for all residents. Single-payer systems aim to simplify administration and reduce costs by eliminating private insurance.

T

Telemedicine
Telemedicine is the use of technology to provide healthcare services remotely, such as through video consultations or remote monitoring. Telemedicine can improve access to care, particularly in rural or underserved areas.

U

Utilization Management
Utilization management is the process of reviewing and approving healthcare services to ensure that they are medically necessary and cost-effective. Utilization management programs may require prior authorization for certain services.

V

Value-Based Payment
Value-based payment is a reimbursement model that ties payments to the quality and outcomes of care provided, rather than the volume of services. Value-based payment programs aim to incentivize high-quality, cost-effective care.

W

Wellness Program

A wellness program is a set of activities and initiatives designed to promote healthy behaviors and prevent illness among employees or members of a health plan. Wellness programs may include incentives for participation, such as discounts on insurance premiums.

X

Expenditure
Expenditure refers to the amount of money spent on healthcare services or programs. Healthcare expenditures can include costs for hospital care, physician services, prescription drugs, and other healthcare-related expenses.

Y

Yield Management
Yield management is a pricing strategy used in healthcare to maximize revenue by adjusting prices based on demand. Yield management can help healthcare providers optimize capacity utilization and improve financial performance.

Z

Zero-Based Budgeting
Zero-based budgeting is a budgeting technique that requires organizations to justify all expenses from scratch each budget cycle, rather than using the previous year's budget as a baseline. Zero-based budgeting can help healthcare organizations identify cost-saving opportunities and prioritize spending based on strategic goals.