

## Health Systems Characteristics Survey 2016

### Glossary

**This glossary intends to assist national correspondents in the interpretation of certain key terms used in the 2016 Health System Characteristics survey. If there are key terms that are not covered in the glossary or you have questions regarding the application of key terms to specific situations and country context, please contact the Secretariat.**

**Accreditation of care facilities:** accreditation is a tool with which medical institutions, assisted by one or more external review bodies, assess the quality of services provided with regards to international standards. The results from the accreditation may be published or used as benchmarking. Accreditation is also used internally to implement quality standards in order to improve hospital management. In the case of primary care, the Joint Commission International accreditation standards are the most often in use worldwide.

**Acute-care beds (or curative care beds):** hospital beds that are available for curative care (HC.1 in the System of Health Accounts classification, excluding psychiatry). This includes beds accommodating patients where the principal clinical intent is to do one or more of the following: manage labour (obstetric), cure non-mental illness or provide definitive treatment of injury, perform surgery, relieve symptoms of non-mental illness or injury (excluding palliative care), reduce severity of non-mental illness or injury, protect against exacerbation and/or complication of non-mental illness and/or injury which could threaten life or normal functions, perform diagnostic or therapeutic procedures. This does not include beds allocated for other functions of care (such as psychiatric care, rehabilitation, long-term care and palliative care), beds in mental health and substance abuse hospitals (HP.1.2), beds for rehabilitation (HC.2) and beds for palliative care. The full SHA manual can be accessed through the OECD iLibrary.

**Basic benefit package:** refers to the range of goods and services covered by basic health care coverage (see below).

**Basic (primary) health care coverage:** refers to the first source of financial protection for health care users. There is no standard definition, and the range of the benefits covered by basic primary health care coverage varies across countries.

**Case management program:** these types of programs seek to monitor and coordinate treatments administered to patients with specific diagnoses, or who require high cost or extensive services. Case management programs entail the assessment of an individual's longer-term care needs and are followed by appropriate recommendations for care, monitoring and follow-up.

**Catastrophic out-of-pocket expenditures:** out-of-pocket payments greater than or equal to 40% of a household's non-subsistence income, i.e. income available after basic needs (other than health care) have been met.

**Co-insurance:** cost-sharing requirement whereby the insured person pays a share of the cost of the medical service (e.g. 10%).

**Continuous medical education (CME):** CME ensures that medical professionals maintain essential competencies and knowledge related to their field and are up to date on the new developments of their practice.

**Co-payment:** fixed sum (e.g. \$15) paid by an insured individual for the consumption of itemized health care services (e.g. per hospital day, per prescription item).

**Deductible:** lump sum that an insured person must pay out-of-pocket until insurance coverage kicks in. Deductibles can apply to a specific category of care (e.g. physicians' visits, pharmaceutical spending) or to all health expenditures (general deductible).

**Diagnosis Related Groups (DRGs):** refers to groups of hospital cases based on diagnoses, procedures performed and patient characteristics (age, gender and co-morbidities). "DRG" refers to the name of the first classification adopted in 1983 by Medicare in the United States but is often used as a generic term to refer to classifications of this type used in other countries, with other names.

**Health budget overrun:** When annual health expenditures exceed the initially budgeted health allocation, and thus require voting supplementary budgets.

**Implantable medical devices:** Medical implants are devices or tissues that are either temporarily or permanently placed inside or on the surface of the body, either used alone or in combination with other devices or technologies. Many implants are prosthetics, intended to replace missing body parts. Other implants deliver medication, monitor body functions, or provide support to organs and tissues.

**Purchaser of health care:** "Purchaser" refers to financing agents as defined in the System of Health Account, i.e. the "final payer". Depending on the country and type of service, purchasers either pay the provider directly or reimburse the patient after he/she receives care.

**Licensing of physicians:** in some countries, after completion of the medical curriculum, government agencies (or government approved medical association) grant licenses or certificates to physicians to allow practice. The licensing process usually involves extensive background checks on training and educational background, as well as, in some cases, additional professional examination. In addition, in some instances, licenses are only valid for a limited number of years; in order to practice, physicians might go through a **re-licensing** procedure (which might involve continuous medical education or involvement in peer-review processes).

**Line-item budget:** refers to payments in which the unit of payment is an expense category for an organization - for example, salary, supplies, transportation, drugs. Once the amount budgeted is

approved by the key purchaser, the provider has little discretion to switch funds across budget categories,

**Out of hours care:** refers to primary care services that are provided outside of normal week day and week-end working hours. These services may be provided via family physician consortia or through the operation of evening emergency clinics.

**Payment per case (DRG-like):** refers to a payment linked to the type and severity of hospital cases. Each patient is classified in a specific “diagnostic” group according to his/her principal diagnosis and a fixed reimbursement is given to the hospital for treating the patient.

**Prospective global budget:** the budget is defined annually and allocated to the hospital for the operating year.

**Primary care services:** include first contact services for diagnosis and treatment of acute and chronic illnesses, health promotion, disease prevention, health maintenance, counselling, and patient education, in a variety of health care settings. These services can be provided by primary care physicians and nurses or other types of clinical and non-clinical health professionals.

**Primary care physicians:** physicians who provide care to the patient at the point of first contact and take responsibility for the provision of continuing comprehensive care or for referral to another health professional. They do not limit their practice to certain disease categories. According to country-specific contexts, “primary care physicians” include general practitioners, family physicians, generalists, etc.

**Public health policy:** can be defined as “the organised response by society to protect and promote health, and to prevent illness, injury and disability.”

**Resource-based Relative Value Scale (RBRVS):** is a method used to determine the amount medical providers should be paid. It is widely used in United States to assign a relative value to procedures performed by physicians or other medical providers. This value is then adjusted by a conversion factor to determine the amount of payment.

**Reimbursement level:** refers to decisions pertaining to the level of coverage provided for a service/good by basic health care coverage. This level can be “fully reimbursed” or “reimbursed with cost-sharing requirements” for instance.

**Reimbursement price:** refers to the maximum reimbursement amount (e.g. reference price for drugs).

**Secondary health care of coverage:** refers to extra health care coverage that people can obtain in some countries, beyond basic (primary) health care coverage, e.g. private health insurance.

**Take-up (of a social benefit):** refers to a situation in which a person entitled to a social benefit (in cash or in kind) actually receives it.

**“Typical” employed adult:** the questionnaire refers to the *“typical” employed adult* as the most frequent and standard situation of insured (working age, does not qualify for exemptions/reductions of co-payments and doesn’t have any specific long-term condition).

**Third-party payer:** institution providing financing of basic primary coverage. Note that in the questionnaire, only the institution serving the largest share of the population should be considered.