Innovative Medicines South Africa

National Health Insurance
Policy Brief Series

Glossary of Healthcare Financing Terms

The purpose of this series of policy briefs on National Health Insurance (NHI) and the related IMSA web-site is to put in the public domain material and evidence that will progress the technical work of developing a National Health Insurance system in South Africa. This includes tools for costing NHI and evidence on where savings could be achieved in moving to a future mandatory system with universal coverage.

As with all technical areas there is a language used by people in that field which can be difficult for others to understand. In healthcare financing the terms come from a combination of health economics, health policy, social security and actuarial science. This is a growing document and it will be expanded during the course of the policy brief series as needed. The IMSA NHI glossary is organised into subject areas and related concepts are defined together.

1. Health System Goals and Objectives

- Accessibility
  - A measure of the proportion of a population that reaches appropriate health services.[1]
  - Access includes the ability of a sick person to gain entree to the system in order to establish a diagnosis and plan therapy. It then also includes the ability to move between differing levels of the system i.e. from primary care to specialist or even highly specialised care. Access is a function of many combined factors including funding policy, service capacity and structure, and management. It is the ability of the system to provide sufficient supply of services to meet the demand (suggested definition)
- Financial Accessibility
  - Financial accessibility measures the extent to which people are able to pay for care, usually measured through a community-based willingness and ability to pay survey.[1]
- Geographical Accessibility
  - Geographical accessibility measures the extent to which services are available and accessible to the population. It is, of course, linked to the distribution of infrastructure in a given region but also to the actual offering of these services at these facilities. Geographical accessibility will vary according to local means of transportation, as well as the local topography.[1]
- Cultural Accessibility
  - Cultural accessibility considers whether access to health services is impeded by cultural taboos. Three examples are provided: (i) can women use reproductive health services if all the physicians in the facility are male? (ii) will persons who belong to an

ethnic minority use services that are staffed by the majority population? (iii) will persons use health services for processes that are considered natural, that is without the need for health intervention such as pregnancy?.[1]

- Universal access to Healthcare
  - Universal access to healthcare refers to all people having an equal opportunity to gain entry to a quality accredited health facility for diagnosis and therapy, regardless of their socio-economic class and ability to pay, ethnicity or physical disability. Accessibility includes not being obstructed by issues of transportation and affordability (suggested definition).
- Universal coverage
  - Universal coverage with the health care insurance function may be defined as physical and financial access to necessary health care of good quality for all persons in a society.[2]
  - Universal coverage includes access to an appropriate health care facility of good quality for all at an affordable cost regardless of socio- economic class, ethnicity or physical disability (alternative definition).
- Coverage
  - Coverage encompasses the extent to which a basket of defined services is available to people through cost sharing and cross-subsidisation. [3]
- Efficiency in healthcare
  - Efficiency in health can be defined as "the extent to which objectives are achieved by minimising the use of resources. [1]
  - There are many specific uses of the word "efficiency" in health economics, including:
    - Technical efficiency - producing the maximum possible sustained output from a given set of inputs
    - Productive efficiency - health outcomes (outputs) cannot be produced at a lower cost without compromising on quality gains
    - Social efficiency - no person can be made better off without making someone else worse off
    - Macro-economic efficiency - containment of rising cost of care (includes financial sustainability).
    - Micro-economic efficiency - efficiency in the production of care.
- Equity in healthcare
  - Equity in healthcare is about fairness and justice in the distribution of costs, benefits and opportunities in the health sector. Equity is therefore an ethical and subjective concept. Consequently, there are varied views on what equity in the health sector means. Nevertheless, the dominant perspective on equity is that "everyone should have equal opportunities to maximise their health status (irrespective of socio-economic, demographic and geographic characteristics of different individuals/groups within the population). Accordingly, the incidence of health care financing should be distributed according to ability to pay, and

benefits should be distributed according to need. This view (referred to as the egalitarian perspective) has been the guiding principles for many health systems in recent years and is the basis for the definitions below.

- Equity in health financing
  - Also termed “fair financing”. This is the case where wealthier groups contribute a greater proportion of their income to the overall financing of the healthcare than poorer groups. Equity in health care financing also advocates for the protection for the poor from catastrophic health care expenditure.
- Equity in resource allocation
  - Resources for healthcare (clinics, human resources, hospitals, budgets) should be distributed in such a way that gives greater preference to those that have a greater need for healthcare (most vulnerable - poorer, those with greater disease burden etc.).
- Horizontal equity
  - “Equal treatment for equal needs”. This implies that the health care system should deal with two individuals with the same health needs in the same way.
- Vertical equity
  - The “unequal but equitable treatment of unequals”. This implies that those with different needs for health care should be treated differently, according to the extent of need.
- Quality in healthcare
  - The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.[1] Quality is a perceptual, conditional and subjective attribute relating to a product or service. Quality in healthcare includes the delivery of safe care that is consistent with current medical knowledge and customer-specific values and expectations.
- Responsiveness in healthcare
  - The WHO has defined several dimensions of responsiveness. These are: autonomy; information; confidentiality; dignity; prompt attention; quality of basic care; access to social support network; and choice of providers. Responsiveness reflects the individual’s actual experience with a health system. The fundamental goals of a health care system therefore can be expected to improve health outcomes and respond to the legitimate expectations of a population.
  - There are certain prerequisites which are required for a system to achieve its goals. These include:
    - Ensuring that there are adequate financial resources; trained staff; appropriate facilities, equipment; and pharmaceuticals.
    - The appropriate allocation and utilisation of resources
    - Regulatory framework ensuring stakeholder participation, and relationship management

- Infrastructure for continuous monitoring and evaluation and clinical governance.

• Sustainability	• Sustainability of the health sector refers to the ability of the health system (based on its organization, financing mechanism, structure, etc) to adequately generate resources for the provision of good quality health care today and in the future. Implicit in this is the ability of the health system to change with the changing needs of the population that is served. • Sustainable development is defined as development which bequeaths to future generations an opportunity set for human welfare equal to or greater than that enjoyed by the current generation. [4]

2. Social Security Systems

• Tiers or pillars in a social security system	• Social security systems have components that are commonly grouped into three tiers, defined by the way individuals contribute to each tier and draw benefits from that tier. [5] This terminology usually applies to defining pension systems but can also be broadly applied to health systems.
• First tier of a social security system	• This refers to elements of social security where the individual makes no explicit contribution (i.e. is non-contributory) to earn entitlement to benefit, but the tier is funded out of general taxation, and is publicly managed. An example would be the State Old Age Grant or the public health system in South Africa.
• Second tier of a social security system	• Part of the social security system where mandatory contributions made by a certain group of individuals determines access to the benefits they can receive. It is referred to as contributory and compulsory and could be publicly or privately managed. An example would be a social health insurance system in which all employed workers contributed and from which they would be able to draw benefits.
• Third tier of a social security system	• Part of the social security system where contributions made voluntarily by individuals determines the benefits they receive. It is contributory but voluntary and could be publicly or privately managed. An example is the medical scheme environment in South Africa, where membership may be a condition of employment but is otherwise not legally required.

3. The Healthcare Financing Function

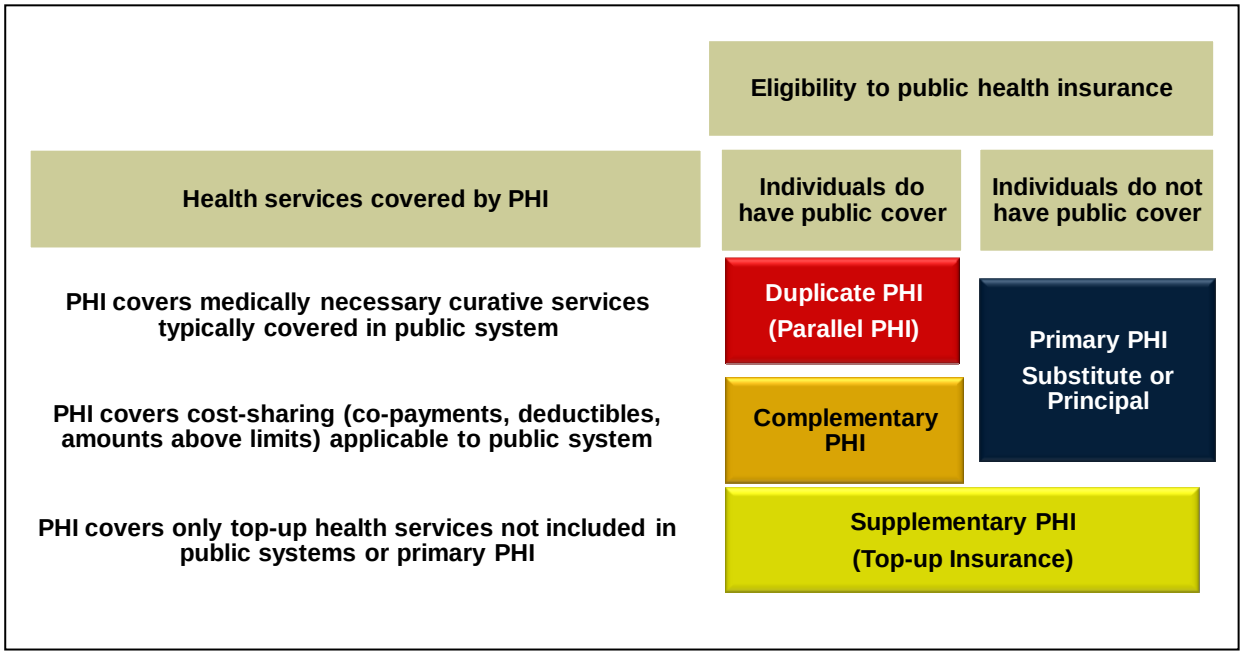
- **Healthcare financing function**
  - To make funding available, as well as to set the right financial incentives for providers, to ensure that all individuals have access to effective healthcare. The purpose is to reduce or eliminate the possibility that an individual will be unable to pay for such care, or will be impoverished as a result of trying to do so.
  - To ensure access, three interrelated functions of health system financing are crucial: revenue collection; pooling of resources and purchasing of interventions from healthcare providers. [6]
- **Revenue collection**
  - The process by which the health system receives money from households and organizations or companies, as well as from donors.
  - Ways of collecting revenue: general taxation; mandated social health insurance contributions (usually salary-related and almost never risk-related); voluntary private health insurance contributions (usually risk-related); out-of-pocket payments and donations. [6]
- **Pooling**
  - The accumulation and management of revenues in such a way as to ensure that the risk of having to pay for health care is borne by all the members of the pool and not by each contributor individually.
  - The "insurance function" within the health system, whether explicit (people knowingly subscribe to a scheme) or implicit (tax revenues).
  - The main purpose is to share the financial risk associated with health interventions for which the need is uncertain. Pooling reduces uncertainty for both citizens and providers. [6]
- **Health insurance**
  - "A mechanism by which money is raised to pay for health services by financial contributions to a fund; the fund then purchases health services from providers for the benefit of those for whom contributions are made or who are otherwise covered by the scheme" [7].
  - Health insurance is defined as healthcare that is financed through the distribution of financial risk associated with the variation of health care expenditure by pooling cost over time (pre-payment) for different individuals (pooling).
- **Purchasing**
  - The process by which pooled funds are paid to providers in order to deliver a specified or unspecified set of health interventions on behalf of a particular population for which the funds have been pooled [8].
  - Purchasing uses different instruments for paying providers, including budgeting. [7]
- **Passive purchasing**
  - Implies following a predetermined budget or simply paying bills when presented, often on a fee-for-service basis. [6]

• Strategic purchasing	• Involves a continuous search for the best ways to maximize health system performance by deciding which interventions should be purchased, how, and from whom. It involves the use of selective contracting and incentive schemes. [6]
• Single purchaser (Single Payer)	• According to Kutzin[2] "the organisation of purchasers in any health system can be categorised according to the number of these organisations and the extent to which they compete with each other. Some health systems are described as "single payer". Canada is frequently cited as an example of a single payer system, even though it has a different purchaser in each of its provinces. This suggests that a definition of single payer is needed for clarification. It is useful to think of this as a single purchaser for the main service package on behalf of the entire population living in a defined geographic area"
• Multiple purchaser	• "Many countries have more than one significant purchaser of services covering different groups of people in the same geographic areas" (Kutzin[9]). Often these are public and private systems that can in turn relate to each other in various ways.
• Provision or delivery	• The sum total of healthcare provided by healthcare practitioners and other healthcare providers. May be a mix of public, private and NGO delivery.
• Out-of-pocket (OOP) payments	• Include any direct payments made by patients to health care providers at the point of use. • Are amounts which a family is required to pay for healthcare that are separate from any contributions to voluntary or mandatory insurance or through general taxation. These could arise because the family has no health insurance cover or from having to pay user fees in public facilities. Even if the family has health insurance, could arise as a result of co-payments, deductibles, benefit limits or exclusions. It also applies to the use of medical savings accounts which individualise family health expenditure.
• Stewardship	• The ultimate responsibility for the overall performance of a country's health system lies with government, which in turn should involve all sectors of society. • It encompasses the tasks of defining the vision and direction of health policy, exerting influence through regulation and advocacy, and collecting and using information.

4. The Role of Private Health Insurance

• Public Health Insurance	• Includes healthcare coverage that is financed through taxation or an income related payroll tax including social security contributions.
• Private Health Insurance (usually abbreviated as PHI)	• Private health insurance is primarily distinguished from public coverage programmes by its funding through non-income related premiums, paid usually on a contract between a private party and an insurance entity, as opposed to taxes or social security payroll contributions.[10]
• Voluntary Health Insurance (VHI)	• Health insurance which is taken up and paid for at the discretion of individuals (whether directly or via their employers.[1]
• Mandatory Health Insurance = compulsory or, statutory health insurance or coverage	• Health insurance under an obligatory scheme by law, usually with contributions that are income-related.[1] • A distinction should be drawn on the nature of the mandate: for example there is a difference between mandatory contribution and mandatory coverage. The effect of mandatory contribution will be to lead to but no coerce mandatory coverage.

The terminology for the different roles that can be played by private health insurance can be complex and it may be easier to understand from a diagram, as shown below[10].



• Principle Private Health Insurance	• "Private insurance for health costs, which for the insured individual represents the only available access to cover where a social security scheme does not apply. This includes employers compulsory schemes if cover is privately insured or self-insured" [10]

• Substitutive Private Health Insurance	• "Private insurance for health costs, which substitutes for cover which would otherwise be available from a social insurance or publicly financed insurance or employer's scheme". [10]
• Duplicate Private Health insurance = Parallel health insurance	• "A private insurance that offers cover for health services already included under public health insurance. … It does not exempt individuals from contributing to public health insurance".[10]
• Complementary Health Insurance	• "A private health insurance that complements coverage of publicly insured services or services within principal/substitute health insurance, which is intended to pay only a proportion of qualifying care costs, by covering all or part of the residual costs not otherwise reimbursed e.g., co-payments" [10] (Qualifying care refers to services covered by the public system.)
• Supplementary Health Insurance= Top-up Insurance	• "A private health insurance that provides coverage for additional health services that are not covered within the public scheme. Depending on the country, it may include services that are uncovered by the public system such as luxury care, elective care, long-term care, dental care, pharmaceuticals, rehabilitation, alternative or complementary medicine, etc., or superior hotel and amenity hospital services (even when other portions of the service (i.e. medical component) are covered by the public system)". [10]
• "Carrier" role for medical schemes	• A role in which medical schemes coordinate administration of set package of benefits; receive contributions collected through the revenue system. (Suggested definition)

5. Providers and Stakeholders in South Africa

• Department of Health	• Responsible for stewardship of the entire national health system in South Africa which includes the public sector, private providers and NGOs. • Responsibility for licensing of healthcare practitioners devolved to various statutory bodies. • At provincial level is a funder and provider of healthcare for the public health system.
• Healthcare practitioners	• Doctors, dentists, nurses, pharmacists and allied health professionals (such as radiotherapy technicians, dieticians and physiotherapists). Should also include registered complementary medicine practitioners and African traditional health practitioners but common usage often implies excluding these groups.
• Healthcare providers	• General term which includes all healthcare practitioners together with facilities for delivering healthcare such as hospitals, clinics and pharmacies.
• NGO	• Non-governmental organisation. Healthcare may be

	delivered by NGOs in a particular interest area, for example HIV/AIDS. The service is often donor-funded.
• Healthcare funders	• The bodies performing the healthcare financing function: could be medical schemes, insurance companies, Bargaining Council schemes, employers or Government.
• Medical schemes	• The vehicles for private health insurance in South Africa. They reimburse their members for actual expenditure on health and are governed under the Medical Schemes Act of 1998. [11] Medical schemes are run on a not-for-profit basis and are essentially mutual societies, owned by their members. They are governed by boards of trustees of which 50% must be elected from the members.
• The Council for Medical Schemes	• The regulator of medical schemes. A statutory body with the Registrar and board appointed by the Minister of Health. An annual industry levy provides operating funds. Also has responsibility for accrediting third-party administrators, managed care organisations and healthcare brokers.
• Third party administrator (TPA)	• Is an administrator providing claims processing and revenue collection services to medical schemes. Typically for-profit and sometimes listed companies.
• Self-administered	• Where the administration function is provided by the medical scheme or insurer internally.
• Long-term insurance	• Insurance provided by companies licensed by the Financial Services Board. The contract is for a lifetime or a long period, provided premiums are paid. Provides cover for life events like death, disability or retirement and often has a substantial investment component.
• Short-term insurance	• Insurance provided by companies licensed by the Financial Services Board. The contract covers one year at a time. For example, provides cover for the loss by fire or theft of household goods and vehicles or for the subsidence, flooding or other damage to a house. Cover also provided to businesses, governments and other entities. Wide range of items covered from satellite insurance to a singer insuring her voice.
• The Financial Services Board	• The regulator of long-term and short-term insurers, retirement funds, brokers, asset managers and other financial intermediaries. A statutory body with funding provided by industry levies.
• Demarcation	• Used in South Africa to denote the conflict surrounding the extent to which long-term and short-term insurers can engage in health insurance without doing the business of a medical scheme which is restricted to accredited medical schemes.

• Business of a medical scheme	• Definition in the Medical Schemes Act, No. 131 of 1998. "The business of undertaking liability in return for a premium or contribution – (a) to make provision for the obtaining of any relevant health service; (b) to grant assistance in defraying expenditure incurred in connection with the rendering of any relevant health service; and (c) where applicable, to render a relevant health service, either by the medical scheme itself, or by any supplier or group of suppliers of a relevant health service or by any person, in association with or in terms of an agreement with a medical scheme." [11]
• Health insurance	• Used worldwide to denote any form of pre-payment for providing healthcare. • Also has a more limited sense in South Africa as insurance products sold by long-term and short-term insurers (as opposed to medical schemes).
• Broker	• An individual or company providing broker services. For medical schemes the definition includes the provision of service or advice in introducing or admitting members to a medical scheme; or the ongoing provision of service or advice in respect of access to, or benefits or services offered by the scheme. [11]

6. Health Insurance Terms

• Contribution or premium	• In life, short-term and health insurance (in the narrow sense), the amount paid to the insurer is called the premium. • In medical schemes the amount paid is called the contribution.
• Benefit	• Services covered under a health insurance contract or a medical scheme. [12]
• Eligible employees	• Are employees within the group who are eligible for health care coverage. This may be on a voluntary or compulsory basis. [12]
• Employee Contribution	• Is the amount the employee contributes towards the total contributions. [12]
• Employer subsidy	• An amount agreed as part of employment practice which may include negotiations with organized labour. May be expressed as a percentage of the contribution, a Rand amount or related to the cost of a certain medical scheme option. • Retired people used to continue to receive a subsidy from the last employer but this is no longer widespread and those currently working are unlikely to have a subsidy in retirement due to changes in employment practice.

• Tax subsidy or tax expenditure subsidy or tax relief	• An incentive offered by a government in the form of tax relief in order to encourage retirement provision or the take-up of insurance. • In South Africa there is tax relief for medical scheme contributions which is criticized at it applies only to those earning above the tax threshold.
• Tax threshold	• The income level at which an individual begins to pay income tax. Set annually in the Budget speech by the Minister of Finance and applies from 1 April of that year to 31 March of the following year. Set separately and typically higher for those over age 65.
• CPI	• Consumer Price Index. Index based on price of a basket of goods. CPIX removes the impact of mortgage rate changes [12] and was used as the core measure of inflation in South Africa but discontinued from 2009. Replaced with a revised definition using an updated basket of goods. Produced and published monthly by StatsSA.
• Wage inflation	• Index based on the increase in wages as published by StatsSA on regular basis.
• Medical inflation	• A frequently misused term. Technically it is the medical component of the CPI as produced by StatsSA. In general usage as a term covering the increase in healthcare costs due to price increases and changes in medical technology.
• Demographic characteristics	• Refers to the demographic mix, primarily on age and gender, of the members within a group. May include ethnicity or race but this is less common.
• Socio-economic characteristics	• Refers to factors like income, attained education, type of dwelling, urban-rural living or other characteristics which differentiate the population into risk groups with different needs.
• Risk	• The probability of an event occurring and the adverse financial consequences of that occurrence.
• Risk factors	• Demographic, socio-economic or health risk factors that can be used to predict the likelihood of needing healthcare. Applied typically to groups for insurance purposes but may also be applied to individuals if underwriting is permitted.
• Risk rating	• Charging a differential amount to each individual or group based on the perceived risk factors, as determined by the insurer.
• Community rating	• The process of developing and charging contribution rates based on the overall community (or option or scheme) claims experience rather than on group or individual specific claims data. There are many forms of community rating such as community rating by class that allow adjustments according to group

	specific demographic data. [12]
	• Community rating in medical scheme legislation requires that every person on an option is charged the same community rate regardless of age, gender or other risk factors. Charging by income level is permitted and schemes may differentiate between adult and child rates.
• Underwriting	• A prospective risk assessment for the purposes of determining contribution level and/or benefit eligibility. [12] Occurs commonly in life insurance but is prohibited in medical schemes in order to prevent risk-rating.
• Open enrollment	• The status where no underwriting is applied to scheme applicants. [12] This is required in medical schemes.
• Credibility	• A term used to measure the reliability of claims data for a specific group for projecting future claims liabilities and, therefore, contribution requirements. If a group is described as having high Credibility, that means that the Claims data is judged to be very reliable for projecting the future liability. Generally, the larger the size of the group, the higher the credibility level. [12]
• Adverse Selection	• This occurs when a scheme enrols a poorer risk than the average risk of the group, usually as a result of the applicant having more knowledge of his health status. Adverse selection usually occurs when an insurer has better benefits and higher rates than competitors. Unhealthy members are attracted to the insurer for the higher benefits and, because of their health status, are more willing to pay the higher costs for that coverage. [12]
• Positive selection	• Is the reverse of adverse selection and occurs when a scheme enrols a better risk than the average risk of the current membership. This may be because the new members are healthier or younger on average. [12]
• Waiting period	• A time period which must elapse following a member's enrollment before which he or she is eligible to submit a claim. This may apply to non-emergency services only. A waiting period may also apply on a claim basis, for example, the number of hospital days which must elapse before a claim can be made. [12]

7. Medical Scheme Terms

- Member
  - Is the person responsible for paying contributions to the medical scheme. Also called Principal Member.
- Beneficiaries
  - All the individuals covered by a scheme including principal members and their dependants. (ASSA glossary [12]) Dependants are typically the spouse (including same-sex partners and sometimes multiple spouses) and children (including adopted children). Children are typically covered only until a certain age, as defined in the rules of the medical scheme, for example age 21 or age 24 if studying at a tertiary institution.
- Registered medical scheme
  - An open or restricted medical scheme registered in terms of the Medical Schemes Act [11].
- Restricted membership scheme
  - A medical scheme which restricts the eligibility for membership to an employer, union, profession, trade or industry, as defined in the Medical Schemes Act. [11]
- Open medical scheme
  - As opposed to a restricted medical scheme. Must accept any person who applies to be a member.
- Option
  - Package of benefits defined by the rules of a medical scheme. Must include Prescribed Minimum Benefits. A scheme may have one or multiple options and members can freely choose which option to join, usually on an annual basis.
- Prescribed Minimum Benefits (PMBs)
  - The Medical Schemes Act of 1998 re-introduced a minimum package of benefits to be provided by all schemes. The Prescribed Minimum Benefits (PMBs) consist of:
  - A list of some 270 diagnosis and treatment pairs (PMB-DTP). Introduced from 1 January 2000.
  - Emergency medical conditions (usually included in PMB-DTP). Clarified and in force from 1 January 2003.
  - Diagnosis, treatment and medication according to therapeutic algorithms for 25 defined chronic conditions (PMB-CDL). Introduced from 1 January 2004.
  - Details in Regulations to the Medical Schemes Act [11].
- DSP
  - Designated Service Provider. A health care provider or group of providers selected by a medical scheme as the preferred provider or providers to provide to its members diagnosis, treatment and care in respect of one or more prescribed minimum benefit conditions. [11]
- Personal medical savings account
  - A facility within an option to provide an internal savings account that can only be spent on healthcare. The benefits are limited to the balance in the savings account but the member makes the decision as to the mix of healthcare services to purchase.

• New generation plan (or option)	• A medical scheme benefit option that combines risk cover for hospital and chronic care with medical savings account cover for other (mainly out-of-hospital) events. [12]
• Co-payment	• The charge a Member is required to pay to the provider for certain health care services as required by the Member's Contract. Typical co-payments are fixed Rand amounts for doctor visits, prescriptions or hospital admissions. [12]
• Deductible	• The initial amount which must be paid by the member before a claim may be made under a contract. This may be on a per claim basis or for a specified period. [12]
• Commissions	• The portion of contributions paid to brokers or other external agents as compensation for services provided. Legislation now prohibits medical schemes paying anyone other than an accredited broker.
• Administration costs	• The costs incurred for administration services such as billing employers and members for contributions, processing claims and paying healthcare providers. Administration costs may be expressed as a Rand amount per member or as a percentage of premiums.
• EDI	• Electronic Data Interchange. A manner for claims submission where the required information is submitted electronically from the service provider to the medical scheme administrator. [12]

8. Reimbursement of Healthcare Providers

• Fee-for-service	• Is a form of payment to providers where the providers receive payment on a per service basis. This payment form is generally contrasted with Capitation which pays per person, not per service.
• Capitation	• This usually refers to a negotiated monthly payment per covered person paid to a medical care provider. In return for the capitation payment, the provider assumes responsibility for the provision of health services for that person for the agreed time period. [12]
• Per diem	• Reimbursement of an institution, usually a hospital, based on a set rate per day rather than on charges. May vary by service (e.g. obstetrics, medical, surgical, mental health, intensive care) or may be uniform regardless of the intensity of care. (Kongstvedt [13])
• Per case	• Reimbursement of an institution and healthcare providers based on a set rate per case, covering the total cost of the treatment, as in a fixed fee for a tonsillectomy or a hip replacement.

• Fee schedule	• A listing of codes for medical services with pre-set payment amounts. [12]
• NHRPL	• National Health Reference Price List published annually by the Department of Health. Used by private healthcare providers.
• UPFS	• Uniform Patient Fee Schedule published from time to time by the Department of Health. Used for public sector hospital events. Includes means test and differential payments according to means test.

9. Managed Care

• Managed Health Care	• Clinical and financial risk assessment and management of healthcare with a view to facilitating appropriateness and cost-effectiveness of relevant healthcare services within what is affordable. [12]
• Disease management	• Management of patients with chronic diseases. The management includes medical treatment and monitoring, medication, education and lifestyle management. [12]
• Drug Formulary	• A listing of prescribed medications. Under a closed formulary, benefits are only provided for medicines in the formulary. Under an open formulary benefits are available for other drugs based on the cost of the formulary drug. [12]
• Pre-authorisation	• A requirement in a policy contract that requires notification of the risk taker before accessing certain benefits. This usually applies to hospitalization under a medical scheme contract. [12]
• Protocol	• A set of guidelines in relation to the optimal sequencing of diagnostic testing and treatment for specific conditions. [12]
• Health Maintenance Organisation (HMO)	• Is a medical care organisation designed to deliver and finance health care services. An HMO provides comprehensive health care services to its Members for fixed, prepaid Premiums. HMO models differ according to the type of relationship they have with Providers and Members. [12] Some models are:
• Staff Model	• HMO's employ medical specialists to provide health care to their Members. All premiums and other revenues accrue to the HMO's which compensate the medical specialists by salary. [12]
• Group Model	• HMO's contract with medical specialists organised as a partnership or professional corporation. The HMO compensates the medical group at a negotiated per capita rate and the group is responsible for

compensating the medical specialists in the group. [12]

• Individual Practice Association	• HMOs contract with an IPA entity to provide health care services in return for a Capitation fee. The IPA in turn contracts with medical specialists who continue in their existing individual or group practices. [12]
• Preferred Provider Organisation (PPO)	• Is a program where contracts are established with providers of medical care in order to reduce the cost of medical care. Providers under such contracts are referred to as preferred providers. Usually better benefits are available for services received from preferred providers. Members may be allowed benefits for services from non-participating providers on an indemnity basis subject to limits or co-payments. The participating providers may be paid on a fee for service or capitation basis. [12]

10. Healthcare Terms

• Ambulatory care	• Health services that do not require hospitalisation. [12]
• Chronic conditions	• Medical conditions that tend to last indefinitely and tend to be degenerative in nature where treatment or medication aims to manage rather than to cure. [12]
• Morbidity	• The likelihood of medical care expenses occurring. This is usually measured according to age and sex. [12]
• Mortality	• The likelihood of death occurring. [12]
• Risk factors	• When used by doctors, factors that may predict the likelihood of an individual having a health event. As in the risk factors for diabetes include obesity. Frequently misunderstood when medical professionals talk to healthcare financing people. See risk and risk factors under health insurance terms below.
• Tuberculosis (TB)	WHO definition[1]: an infectious bacterial disease caused by Mycobacterium tuberculosis, which most commonly affects the lungs. It is transmitted via droplets from the throat and lungs of people with the active respiratory disease. In healthy people, the infection often causes no symptoms, since the person's immune system acts to "wall off" the bacteria. Tuberculosis is treatable with a six-month course of antibiotics. HIV[2] is the main reason for failure to meet TB control targets in high HIV settings. TB is a major cause of death among people living with HIV/AIDS.

[1] http://www.who.int/topics/tuberculosis/en/
[2] http://www.who.int/tb/challenges/hiv/en/index.html

• MDR-TB and XDR-TB	WHO definition[3]: one in three people in the world is infected with dormant TB bacteria. Only when the bacteria become active do people become ill with TB and it can usually be treated with a course of four standard, or first-line, anti-TB drugs. If these drugs are misused or mismanaged, multidrug-resistant TB (MDR-TB) can develop. MDR-TB takes longer to treat with second-line drugs, which are more expensive and have more side-effects. Extensively drug-resistant TB (XDR-TB) can develop when these second-line drugs are also misused or mismanaged and therefore also become ineffective. Because XDR-TB is resistant to first- and second-line drugs, treatment options are seriously limited.

Produced for IMSA by
Professor Heather McLeod
27 October 2009

Other Glossaries

World Health Organisation (WHO): Health Systems Performance Glossary[4]
http://www.who.int/health-systems-performance/docs/glossary.htm

European Observatory:
http://www.euro.who.int/observatory/Glossary/TopPage?term=1

Actuarial Society of South Africa (ASSA):

ASSA has a course in healthcare financing for actuarial students. The glossary developed for that course[12] initially by the University of the Witwatersrand and with input from other health actuaries, is the closest the funding industry in South Africa has to a glossary of terms. Substantial use has been made of that glossary here, updating it where needed. For a copy of the complete ASSA glossary contact the Executive Director, Wim Els: wim@assa.org.za

Acknowledgements

The initial work on a glossary of terms for health insurance in South Africa by Roseanne da Silva has been of immense value. ASSA have always made their glossary available when asked, in the interests of a common language amongst trustees, consultants and policy-makers.

The assistance of Dr Riyas Fadal and Simon Hendrie is gratefully acknowledged.

In the interests of a common language amongst all stakeholders, further contributions to this glossary are welcomed and encouraged. Disagreements are equally welcome as it is in the debate that new understandings are forged that benefit us all.

[3] http://www.who.int/tb/challenges/xdr/en/index.html
[4] Note that the WHO also has many other subject glossaries.

References

1. European Observatory. Glossary.
   URL: http://www.euro.who.int/observatory/Glossary/TopPage?phrase=A
2. Kutzin J. Towards Universal Health Care Coverage: A Goal-oriented Framework for Policy Analysis *Health, Nutrition and Population (HNP) Discussion Paper*. The World Bank; 2000.
   URL:
   http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/281627-1095698140167/Kutzin-TowardUniversal-whole.pdf
3. Colombo F, Tapay N, Panzera A, Oyomopito R. Private Health Insurance in OECD Countries. *The OECD Health Project.* 2001.
4. Anand S, Sen A. Human development and Economic Sustainability. *World Development.* 2000;28:2029-2049.
5. Coquereaumont MD, Ross-Larson B, eds. *Averting the Old Age Crisis- Policies to protect the old and Promote Growth*. Washington: Oxford University Press; 1994:402.
6. World Health Organization. The World Health Report 2000: Health Systems: improving performance. Geneva; 2000:206.
   URL: http://www.who.int/whr/en/index.html
7. World Health Organization. The World Health Report 2000: Health systems: Improving performance Geneva: World Health Organisation; 2000.
   URL: http://www.who.int/whr/2000/en/index.html
8. Kutzin J. A descriptive framework for country-level analysis of healthcare financing arrangements. *Health Policy.* 2000;56:171-204.
9. Kutzin J. A descriptive framework for country-level analysis of health care financing arrangements. *Health Policy.* 2001;56:171-204.
   URL:
   http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=11399345
10. Organization for Economic Co-operation and Development. *Private Health Insurance in OECD Countries*; 2004.
    URL:
    http://www.oecd.org/document/10/0,3343,en_2649_37407_33913226_1_1_1_1,00.html
11. South African Government. Medical Schemes Act, No. 131 of 1998, as amended; 1998.
    URL: http://www.medicalschemes.com/publications/publications.aspx?catid=9&selectId=31
12. Actuarial Society of South Africa. Subject SA1: Unit 1 - Principal Terms 2008.
13. Kongstvedt PR. *Managed Care: What It Is and How it Works*. Second ed. Maryland: Aspen Publishers; 2002:329.