HNP – Health Systems Reform Flagship Course Glossary

TERM	*DEFINITION*
ACCESS	In the Flagship Framework, access is an intermediate performance goal that refers to how health services are made available to, and are reached by, the people who need them. Access combines the concepts of "effective availability", "physical availability" (see separate entries) and utilization of services.
ACCREDITATION OF HEALTH PROVIDERS	"An evaluative process in which a health care organization undergoes an examination of its operating procedures to determine whether the procedures meet designated criteria as defined by the accrediting body, and to ensure that the organization meets a specified level of quality."
ANALYSIS, ETHICAL	A process for assessing and selecting health policy according to a philosophical and values-driven point of view.
ANALYSIS, POLITICAL	A process for assessing the political factors that affect the feasibility of adopting or implementing a selected health reform.
ANALYSIS, TECHNICAL	A process of determining what resources and capacities are required to address a health problem in society, and how they should be applied, to adopt and implement health reform. A technical analysis may include epidemiological, economic, demographic, and implementation analyses.
AVAILABILITY, EFFECTIVE (OR REALIZED)	The degree to which it is possible for members of the population to find and receive appropriate health care for health needs, despite barriers such as high prices, limited hours of operation, or cultural appropriateness.
AVAILABILITY, PHYSICAL	The degree to which health goods and services (including providers, beds, and commodities) are present and usable when and where the population needs access to them.
BEHAVIORAL ECONOMICS	A branch of economics that studies the effects of psychological, intellectual, and emotional factors on individuals' economic decision-making, particularly when those decisions would not be indicated by classical economic theory.
BEHAVIOR CHANGE	Efforts put in place to change people's personal habits and attitudes. In public health, the goal is usually to prevent disease.
BENCHMARKING	The process of using the example (and measure) of one health system's performance (or some other external standard) to assess the performance of another one. Benchmarking is often used as the starting point for a discussion of performance problems.
BENEFIT PACKAGES	A set of services that can be feasibly financed and provided under actual circumstances in which a given country finds itself
BETTER HEALTH OUTCOMES	Positive changes in health that result from measures or specific health care investments or interventions
BUDGET, GLOBAL	A payment method that sets an all-inclusive operating budget and output targets in advance. A global budget is a means of bundling health services and it creates incentives to control expenses while meeting targets.
BUDGET, LINE-ITEM	A payment method that sets a budget for each particular expense category (or "line") based on past and projected costs. Line-item

	budgeting creates incentives to over-estimate budgetary requirements and to spend the full budget, rather than incentivizing cost control and efficiency.
CAPITATION (PAYMENT)	A payment method that establishes a budget per person. Capitation is commonly a fixed rate paid to a practitioner per patient per month, regardless of which services are (or are not) used. Capitation incentivizes providers to use resources efficiently, but also to avoid caring for patients whose conditions risk costing more than the set payment to treat.
CATASTROPHIC EXPENDITURES	Health expenditures that force households to "sacrifice other basic needs such as food and education with serious consequences for the household or individuals within it." Catastrophic expenditures are estimated by "calculating a household's spending on health care as a percentage of that household's income or total expenditure (which are indicators of a household's ability to pay for health care costs) and comparing this to a specific threshold."
CAUSAL CHAIN	The series of successive explanations of the sources of a performance problem; a series of explanations within a causal tree created when causal analysis is conducted.
CHANGE TEAM	A group of people who collaborate to shepherd a health reform through policy design and adoption. Change team members are often people with policy expertise and the political capacity to mobilize others in support of the reform. The composition, positioning and power of a change team has a significant impact on the likely success of the reform efforts.
CITIZEN ENGAGEMENT	This is a two-way interaction between citizens and governments or the private sector with an aim of giving citizens a stake in decision making in order to improve intermediate and final outcomes
COLLECTIVE ACTION DILEMMA	A collective action dilemma was defined by Mancur Olson (1965) as a situation in which costs fall on concentrated and well-organized groups, while benefits accrue to dispersed and non-organized groups. Health sector reforms frequently pose collective action dilemmas, and policy makers face significant challenges in seeking to overcome the difficult politics when powerful opposition from organized groups (such as a medical association) confronts weak mobilization among likely beneficiaries who are not well organized (such as low-income or rural citizens).
COMMUNITARIANISM	The ethical perspective of communitarianism posits that the values of a community depend on the characters of those who are part of it, and that public policy should ensure that individuals can develop “virtue” (as defined by the community) in order to produce a good society. A “universal communitarian” believes that there is a single and universal model for a “good” individual and society, while a “relativist communitarian” believes that the definition of “good” is inherently contextual and varies across different societies.

CONDITIONAL CASH TRANSFERS FOR HEALTH	Conditional cash transfers "aim to reduce poverty by making welfare programs conditional upon the receivers' actions. The government (or a charity) only transfers the money to persons who meet certain criteria. These criteria may include enrolling children into public schools, getting regular check-ups at the doctor's office, receiving vaccinations, or the like. CCTs are unique in seeking to help the current generation in poverty, as well as breaking the cycle of poverty for the next through the development of human capital."
CONTRACTING FOR HEALTH	"Contracting is when a financing agency (government, insurance entity, or development partner), also known as a "purchaser," provides resources to a nonstate provider (NSP, such as a nongovernmental organization [NGO] or private sector firm), also known as a "contractor," to provide a specified set of services, in a specified location, with specified objectives and a set of measurable indicators of success, over a defined period."
COST-BENEFIT ANALYSIS	A process of systematically assessing the relationship between the outcomes of an approach and the required inputs, in which both are expressed in monetary terms.
COST-EFFECTIVENESS ANALYSIS	A process of systematically assessing the relationship between inputs and outcomes of various courses of action in which outcomes are measured in terms of the impact, for example, on health status.
COVID - 19	An illness caused by a novel coronavirus called severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2; formerly called 2019-nCoV), which was first identified amid an outbreak of respiratory illness cases in Wuhan City, Hubei Province, China
COVID – 19 RESPONSE	This is an attempt at containing the spread of COVID-19 pandemic to decrease morbidity, mortality, deterioration of human assets and rights, social cohesion, and livelihoods.
COVID – 19 VACCINATION PLANS	This is an operational plan to implement and monitor COVID-19 vaccination roll out in a country
CUSTOMER (OR CONSUMER OR CITIZEN) SATISFACTION	A measure of how customers (or consumers or citizens) evaluate the health care they receive.
DECISION SPACE	The degree of authority and range of choices that a decision maker can wield over any given function in a health system. Decision makers may have little authority, and therefore limited latitude, to make changes in some arenas but more authority and fewer constraints in others. These dimensions define a decision space, and vary at different levels of government.
DEEP DIVE COURSE	These are part of the Health Systems Flagship Ecosystem – normally they are offered after the delivery of the Flagship course. They are recommended, but not required, offered to participants who have completed the Flagship Course who want to go deeper into solving a particular challenge/problem using a Health Systems Approach.

DELIVEROLOGY	A systematic approach to driving progress and creating results in the implementation of public policy; the term was popularized by Sir Michael Barber.
DIAGNOSIS RELATED GROUPS	Diagnosis-Related Group (DRG) is "a statistical system of classifying any inpatient stay into groups for the purposes of payment. The DRG classification system divides possible diagnoses into more than 20 major body systems and subdivides them into almost 500 groups for the purpose of Medicare reimbursement. Factors used to determine the DRG payment amount include the diagnosis involved as well as the hospital resources necessary to treat the condition."
DIAGNOSTIC TREE	An analytical tool for determining and representing the series of causes of a problem. In a diagnostic tree of a health system performance problem, branching points represent possible causes for a situation, and multiple causes for a problem can co-exist.
EARMARKING	Earmarking can involve dedicating an entire tax to fund a particular program (e.g., a dedicated payroll tax earmarked for social health insurance) or setting aside a fixed portion of a particular tax to fund a program (e.g., a fixed proption addition, there are numerous examples of situations where earmarked funds have been diverted to other activities, especially in poor governance settings of general tax revenues allocated to the health budget). If health spending is low or unstable, an earmarked tax may be seen as a way to insulate health spending from other competing publicly funded activities.
EFFECTIVE COVERAGE	The degree to which adequate and appropriate health insurance coverage is actually provided to its intended target audiences.
EFFICIENCY	A measure of how much can be accomplished towards set goals with a finite set of resources. A health system can be considered "efficient" when the right services are produced, and are produced in the right way, to achieve the desired goals. (See separate entries on technical efficiency and allocative efficiency.)
EFFICIENCY, ALLOCATIVE	The degree to which a system, such as a health system, produces the most gains possible in a performance outcome (such as health status) through appropriate distribution of resources across different activities. Allocative efficiency affects what is produced, and seeks to produce the optimal set of outputs to achieve the given goal. It is typically determined by planners and budget allocators, more than by managers or providers.
EFFICIENCY AND HEALTH	"Efficiency measures whether healthcare resources are being used to get the best value for money...Efficiency is concerned with the relation between resource inputs (costs, in the form of labor, capital, or equipment) and either intermediate outputs (numbers treated, waiting time, etc) or final health outcomes (lives saved, life years gained, quality adjusted life years (QALYs))."
EFFICIENCY, TECHNICAL	The degree to which an output (such as a health service or commodity) is provided or produced at the minimum possible cost per unit. Technical efficiency depends on how inputs are used to create outputs

	and is often determined by managers and workers. (This concept is also known as “productive efficiency.”)
ELASTICITY OF DEMAND	The percentage change in demand for a good or a service in response to a percentage change in its price. Demand for health services is generally seen as inelastic but may in fact be affected by changes in prices.
EPIDEMIOLOGICAL TRANSITION	The changing profile of health and disease that typically occurs as a society becomes wealthier. Most commonly, an epidemiological transition involves a reduction in morbidity and mortality from infectious diseases and an increasing prevalence of non-communicable diseases related to lifestyle and longer life expectancies.
EQUITY IN HEALTH FINANCING	The absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically.
EQUITY, HORIZONTAL	The degree to which a public policy has a similar impact on all people within a single income group.
EQUITY, VERTICAL	The degree to which a public policy has a similar impact on all income groups in a population.
ETHICS, POLITICS AND TECHNICAL PERSPECTIVES	This is a lens to which an individual uses to view a problem; it could be through a practice of government approach or through a knowledge and skill approach
FINANCIAL RISK PROTECTION	An ultimate goal of health reform in which individuals and households are able to avoid unexpected expenses or extreme impoverishment due to poor health and the costs of paying for health services.
FINANCIAL SUSTAINABILITY AND HEALTH FINANCING	The ability of a government to maintain public finances at a credible and serviceable position over the long term (OECD, 2013). Fiscal sustainability implies governments are able to maintain policies and expenditure into the future, without major adjustments and excessive debt burdens for future generations. For the health sector ... how governments achieve fiscal sustainability matters, rather than it becoming a simple cost-cutting exercise... the fiscal sustainability of health also becomes a question of political economy.
FINANCING, COMMUNITY	A method of raising money (or other resources such as construction materials or labor) from the community to cover the costs of health services. With community financing, communities operate and control the coverage and/or provision of their primary and secondary health care services through locally based pre-payment schemes or social insurance. Community financing is believed to improve primary care at the local level, promote transparency and accountability, and increase the acceptability of health services provided.
FINANCING INCIDENCE	Also called progressivity of financing, financing incidence pertains to the ways in which the burden of health financing is distributed.
FISCAL SPACE FOR HEALTH	Fiscal space can be defined as the availability of budgetary room that allows a government to provide resources for a desired purpose without any prejudice to the sustainability of a government’s financial position. Fiscal space for health refers to the ability of governments to increase spending for the sector without jeopardizing the government’s long-term solvency or crowding out expenditure in other sectors needed to

	achieve other development objectives. Fiscal space analysis is one tool to assess, monitor, or predict the sources and level of public resources available for the health sector.
FOUR P'S OF MARKETING	The four components of social marketing that can be adapted to make a product (or intervention) more attractive are: Product, Price, Placement, and Promotion.
FRAGMENTATION IN POOLING	"Fragmentation refers to the existence of a large number of separate funding mechanisms (e.g. many small insurance schemes) and a wide range of health-care providers paid from different funding pools. Different socioeconomic groups are often covered by different funding pools and served by different providers. Fragmentation reduces the possibilities for income and risk cross-subsidies in the overall health system."
GENERAL REVENUE	General revenue is one of the mechanisms for collecting revenues and involves direct taxes (such as personal income tax), indirect taxes (such as VAT), revenues from government owned enterprise or assets (such as natural resources).
GOVERNANCE	A complex set of political processes undertaken by a government or other authority related to defining priorities and decision-making about policies and implementation. In addition, governance involves establishing regulations, assuring transparency, and enforcing accountability.
HEALTH BENEFITS PACKAGE	An explicit list of health services and products that are provided for individuals covered by a health insurance scheme.
HEALTH FINANCING FORUM	Annual Health Financing Conference hosted by the World Bank Group in 2020 it was held virtually in 2 parts in July and November.
HEALTH INSURANCE, COMMUNITY-BASED	Community-based health insurance (CBHI) refers to "any not-for-profit insurance scheme that is aimed primarily at the informal sector and formed on the basis of an ethic of mutual aid and the collective pooling of health risks, and in which the members participate in its management."
HEALTH INSURANCE, PRIVATE	A non-governmental (either for-profit or not-for-profit) system in which insured parties voluntarily pay a premium in return for guarantees of specific compensation or benefits if certain unpredictable events (such as ill health) occur in the future.
HEALTH INSURANCE, SOCIAL	A system in which all eligible individuals must enroll and pay premiums in return for guarantees of specific compensation or benefits if certain unpredictable events (such as ill health) occur in the future. Many social insurance systems levy premiums as a percentage tax on an individual's wages. Social health insurance systems may have a wider pool of risk, as well as of revenue sources, than private health insurance systems.
HEALTH INSURANCE, SUBSIDIZED	Subsidized health insurance refers to "coverage that's obtained through financial assistance from programs to help people with low and middle incomes."
HEALTH INSURANCE REGULATION	Health insurance regulation pertains to "financial solvency of insurance companies, promoting risk spreading, protecting consumers against

	fraud, and ensuring that consumers are paid the benefits that they are promised."
HEALTH REFORM CYCLE	A model describing how policies for the health sector are designed, implemented and evaluated. In the Flagship Framework, the health policy cycle is an iterative process that involves: problem definition, causal diagnosis, policy development, political decision, implementation and finally, evaluation. Evaluation leads to identification of new problems and the cycle begins again.
HEALTH SECTOR REFORM	The complex process of designing and implementing policies that purposefully seek to influence the societal and institutional policies and organizations that create, protect and promote the health of the population.
HEALTH STATUS	A measure of how healthy a population is, often assessed using an index that combines various measures such as life expectancy, mortality and morbidity rates, or prevalence of priority health problems.
HEALTH SYSTEM	A complex arrangement of treatment providers, prevention services providers, financiers and intermediaries, input producers, planners, administrators and regulators whose collective efforts result in the provision of health care services. The Flagship Framework views the health system as the means to achieve three ultimate goals: health status, customer satisfaction, and protection from financial risks related to health care expenses.
HEALTH SYSTEMS CONSTRAINTS	These are challenges affecting the delivery of high-quality care; they may include a shortage of health workers, ineffective supply chains, or inadequate information systems, or organizational constraints such as weak incentives and poor service integration.
HEALTH SYSTEM STRENGTHENING	A complex process and set of actions intended to improve structures and processes in the health system in order to improve the system's performance in achieving its ultimate aims, namely: improved health status of the population, consumer satisfaction with health services, and financial risk protection from the costs of health care.
HEALTH TECHNOLOGY ASSESSMENT	Health technology assessment (HTA) "is a multidisciplinary activity that systematically examines the safety, clinical efficacy and effectiveness, cost, cost-effectiveness, organizational implications, social consequences, legal and ethical considerations of the application of a health technology – usually a drug, medical device or clinical/surgical procedure." HTA "seeks to provide health policy-makers with accessible, useable and evidence-based information to guide their decisions about the appropriate use of technology and the efficient allocation of resources."
HNP	Health, Nutrition and Population
HUMAN CAPITAL	Consists of the knowledge, skills and health that people invest in and accumulate throughout their lives, enabling them to realize their potential as productive members of society
IMPLEMENTATION	The process through which a public policy is carried out in practice to produce social impacts.

IMPOVERISHING EXPENDITURES	Health expenditures that are so large relative to a household's income that they push the household into poverty.
INCENTIVE STRATEGIES	Approaches to changing behavior by changing the benefits that accrue to individuals or groups if they adopt the desired new behaviors.
INNOVATIVE FINANCING	Innovative financing entails "non-traditional applications of ODA, joint public-private mechanisms, and flows that either support fundraising by tapping new resources or deliver financial solutions to development problems on the ground."
INSTITUTIONAL SUSTAINABILITY OF HEALTH FINANCING	The ability of the country to maintain key programs, deliver capacity and health benefits for an extended period of time after a major reduction in domestic financing, or in the financial, managerial or technical assistance provided by an external donor.
INTEGRATION OF EXTERNALLY FINANCED PROGRAMS	Reducing fragmentation, complexity, monitoring and tracking of external health financing. Ensuring coordination and adequate financial and programmatic accountability to the public of government donors, international NGOs, UN agencies and philanthropic foundations.
INTEREST GROUP	A social group that has a set of common interests and seeks to influence the government (or other institution) to move in a particular direction to protect those interests. Examples of interest groups in the health sector include consumer groups, medical associations, and pharmaceutical industry associations.
INTERSECTORAL ACTION	An intervention or action that involves multiple government sectors (such as health, education, and agriculture) working together, often in a coordinated and integrated way, to improve health status in society.
ISSUE-ATTENTION CYCLE	How particular problems (or "issues") can attract high levels of public importance and action ("attention") at one point in time and then fall to a much lower level.
LEVELS OF CARE	This is the organization of health care into levels of increasing complexity with a goal of maintaining continuous access to care for the purpose of promoting, maintain, monitoring and restoring health.
LIBERALISM	action." See also the entries for positive rights (the foundation of "liberal egalitarian" perspectives) and negative rights (which underlie "libertarian" perspectives).
MONITORING AND EVALUATION (M&E)	Monitoring and evaluation are two, often complementary, approaches to assessing how a program or intervention is working. Monitoring focuses on tracking and analyzing the extent of progress toward the goals and objectives of an intervention, while evaluation is an assessment of the significance and impact of an intervention on final outcomes.
MORAL HAZARD	A concept from economics in which providing protection against risk (including cost) increases the likelihood of an individual taking the risk (or using a service) because the costs will be paid by others. Moral hazard is a major concern for health insurance providers, which fear that people with coverage may overuse services or medications which they do not pay for out-of-pocket.

MULTI-CRITERIA DECISION ANALYSIS (MCDA)	A method of assessing the possible impacts of alternative multiple interventions by reviewing the possible outcomes in various dimensions of performance. MCDA is an alternative to cost-effectiveness analysis (see separate entry).
NATIONAL HEALTH ACCOUNTS	A framework and tools for measuring and tracking data on a nation's health expenditures.
ORGANIZATIONAL CAPACITY FOR HEALTH FINANCING	Organizational capacity refers to the resources, knowledge, and processes employed by the organization. For example: staffing; infrastructure, technology, and financial resources; strategic leadership; program and process management; networks and linkages with other organizations and groups. Organizational capacity is conceptualized as a predictor of process and performance and resultant health outcomes. For example, advanced organizational capacity in the form of electronic surveillance systems will impact awareness of an outbreak and timing of response (process/performance) that may prevent additional morbidity and mortality (outcomes).
OUT-OF-POCKET PAYMENTS	Out of pocket payments refers to "any direct outlay by households, including gratuities and in-kind payments, to health practitioners and suppliers of pharmaceuticals, therapeutic appliances, and other goods and services whose primary intent is to contribute to the restoration or enhancement of the health status of individuals or population groups. It is a part of private health expenditure."
PANDEMIC RESPONSE	This is an attempt at containing the spread of a pandemic to decrease morbidity, mortality, deterioration of human assets and rights, social cohesion, and livelihoods.
PARETO-OPTIMAL MARKETS	A market situation in which the only way to increase one consumer's utility is to decrease some other consumer's utility. This condition was first described by the economist/engineer Vilfredo Pareto. For a Pareto-optimal market to exist, consumers must have complete knowledge and the market must be completely competitive. Most health care markets are not Pareto optimal, because consumers lack specialized knowledge while participating; therefore, the markets are regulated to protect the consumers.
PARTICIPATORY BUDGETING	This is a democratic process in which community members decide how to spend or allocate part of a public budget. It allows citizens to identify, discuss, and prioritize public spending projects, and gives them the power to make real decisions about how public money is spent.
PAYER	The entity (such as a government or an insurance plan) that decides on what health services to pay for and which manages the methods used to pay for them.
PAY-FOR-PERFORMANCE	Pay-for-performance is an "umbrella term for initiatives aimed at improving the quality, efficiency, and overall value of health care. These arrangements provide financial incentives to hospitals, physicians, and other health care providers to carry out such improvements and achieve optimal outcomes for patients."

PAYMENT, CASE-BASED (DIAGNOSTIC RELATED GROUP, DRG)	A bundled method of paying for health care services in which a provider is paid a fixed amount per admission determined by the clinical characteristics of the patient.
PAYMENT, FEE-FOR-SERVICE	A method of paying health care providers in which the unit of payment is the specific service provided. FFS payment systems incentivize providers to perform more services and to seek out patients who are less healthy and more in need of services. FFS payment systems can result in over-use of services and higher costs if the reimbursement fee significantly exceeds the delivery cost to the provider.
PAYMENT, OUT-OF-POCKET	A payment method in which the patient pays for health services and medicines from the patient's own resources.
PAYMENT, PROVIDER	A general term that refers to the method used to pay physicians and other health services providers for services offered. Payment options include: fee-for-service, capitation, salary, or salary plus bonus. Each method creates different incentives related to technical efficiency and quality of health services.
PAYMENT, UNDER-THE-TABLE	Unofficial payments made to providers directly by patients from the patients' own resources, and above what the providers receive through the formal payment system. Also known as "informal payments" or "gratuities."
PERFORMANCE GOALS	The core aims of a health system. In the Flagship Framework, a health system's ultimate performance goals include: the health status of the population, citizen satisfaction with health services, and financial risk protection from health expenditures (see separate entries).
PERFORMANCE MEASURES, INTERMEDIATE	Health system characteristics that can be influenced by policy change and are a means to having an impact on ultimate performance goals. The Flagship Framework focuses on three intermediate performance measures: efficiency, access, and quality (see separate entries).
PERFORMANCE PROBLEM	An area of health system functioning that is targeted for priority attention and reform. The Flagship Framework focuses on selecting a performance problem of a specific ultimate health system goal as the starting point for conducting a diagnostic tree.
PHC AND PUBLIC HEALTH	Primary health care and public health have shared goals in addressing issues of disease prevention and health promotion in the community. Primary health care providers are principally focused on the health of individuals, while public health practitioners are increasingly oriented to responding to the collective health of the communities and populations.
POLICY CYCLE	The process by which policies are designed and utilized. (See separate entry: health reform cycle.) The Flagship Framework's cycle is: Problem definition → Diagnosis → Policy development → Political decision → Implementation → Evaluation; the Flagship Framework also emphasizes the role of ethics and politics throughout the policy cycle.
POLICY LEVER (OR POLICY INSTRUMENT)	An area of the health sector that can be changed by public policy, is typically under the control of policy makers, and which affects the performance of the health sector. The Flagship Framework proposes five

	POLICY LEVERs (or policy instruments): financing, payment, regulation, organization and behavior/persuasion (see separate entries).
POLICY LEVER, BEHAVIOR OR PERSUASION	The government's ability to influence how individuals act (in other words, to persuade them to change their behavior) on a population-wide basis to protect and promote health systems performance. Many persuasion POLICY LEVER activities aim to change behavior through information, education and social marketing, as well as other "nudge" activities; behavior POLICY LEVER activities can also be more coercive, such as indoctrination or prohibitions. This POLICY LEVER is typically directed at providers or patients.
POLICY LEVER, FINANCING	The government's ability to use different mechanisms to mobilize and allocate money to fund health sector activities. Financing (raising money) determines how much money is available, who bears the financial burdens, who controls the funds, how risks are pooled, and whether health care costs can be controlled.
POLICY LEVER, ORGANIZATION	The government's ability to shape how the health system is structured and how individual institutions function. Four primary characteristics of a health system included in "organization" are: the mix of institutions (public versus private) providing health care services; how activities are divided among these institutions; how these institutions interact with each other and with other political and economic systems in the society; and, the internal administrative structures and management of the institutions.
POLICY LEVER, PAYMENT	The structures and mechanisms by which health providers (physicians and facilities) are paid for delivering health services. Different payment methods create different kinds of incentives for the buyers and sellers of health services; these incentives influence their behaviors and can be adjusted to change health system performance.
POLICY LEVER, REGULATION	The government's ability to use coercive power to impose constraints on or change the behaviors of individuals and organizations in the health sector, both public and private. Regulatory actions can be used to organize and improve the functioning of markets, including protecting consumers against market failures. Regulation can include various forms of legal instruments to establish guidelines, set requirements and impose penalties for non-compliance.
POLITICAL ECONOMY OF HEALTH SYSTEMS	Health policy and systems research (HPSR) is an emerging field of study, with a recent emphasis on social science perspectives. These perspectives foreground the socio-political context of health systems, including how they are socially constructed by human agency and social structures (Sheikh et al. 2011, Gilson et al. 2011, 2012, Sheikh et al. 2014). This framing of HPSR implicitly draws from political economy analysis. 'Political economy' originally developed in the 18th century as a form of moral philosophy that examined the conditions that influenced the economic actions of states. It is today an interdisciplinary field with diverse academic influences, ranging from Marxist analysis, public choice theorists, and social scientists concerned with development.

	Most recently, it is also being mainstreamed into development agencies, as demonstrated by the range of guidance documents produced on how to undertake applied political economy analysis for furthering organizational objectives (DFID, World Bank).
POLITICAL FEASIBILITY	The likelihood that a proposed health policy or reform can successfully be adopted and implemented within a particular society. Political feasibility depends on the relevant players, their levels of power, their positions on the proposed reform, and perceptions of its likely impact.
POLITICAL PROCESS	This is a process the formulation and administration of public policy usually by interaction between social groups and political institutions or between political leadership and public opinion.
POOLING AND HEALTH FINANCING	One of the three functions of a health financing system, pooling refers to the process of collecting revenues and transferring these revenues to purchasing organizations. It "ensures that the risk related to financing health interventions is borne by all the members of the pool, not by each contributor individually. Its main purpose is to share the financial risk associated with health interventions for which the need is uncertain."
PREVENTION, PRIMARY	Strategies that prevent diseases by addressing the root causes and risk factors (such as immunizations, promoting physical activity or preventing tobacco use).
PREVENTION, SECONDARY	Strategies that find and treat early symptoms of disease in order to prevent more complicated manifestations of a disease (such as screening for and treating hypertension to prevent heart attacks).
PREVENTION, TERTIARY	Strategies that reduce the progression, complications and consequences of an established disease.
PRIORITY-SETTING (PRIORITIES FOR REFORM)	A process of making decisions about which policies and reforms are most important or will be tackled first based on ethical, technical and political analyses.
PRIVATE PROVIDER	Individuals and institutions that deliver health care outside of the public sector.
PROVIDER CONTRACTING	This is the process of agreement between a health care providing organization and a health care provider in which the health care provider agrees to furnish specified services to enrollees of the health acre providing organization. The health providing organization retains the responsibility for the arrangement of the provision of those services.
PROVIDER COMPETITION	Provider competition can be defined as "rivalry among providers of health care, resulting in incentives for tailoring health care provision to the preferences of patients, with effects on prices, quality, service level, etc… Effective competition typically requires a number of preconditions to be met, including the existence of multiple providers, the easy entry and easy exit of providers and enough information on the prices and quality of providers."
PROVIDER PAYMENT MECHANISMS	Provider payment mechanism, also called provider payment method, is a "type of contract among two or more players—patients, providers, and payers—that creates specific incentives for the provision of health care and minimizes the risk of opportunistic behavior".

PUBLIC GOODS	A product that one individual can consume without reducing its availability to other people and from which no individuals can be excluded (in contrast to private goods). Examples include clean air, pollution control, or road construction.
PURCHASER-PROVIDER SPLIT	"Purchaser–provider split (PPS) is a service delivery model in which third-party payers are kept organizationally separate from service providers. The operations of the providers are managed by contracts. One of the main aims of PPS is to create competition between providers. Competition and other incentive structures built into the contractual relationship are believed to lead to improvements in service delivery, such as improved cost containment, greater efficiency, organizational flexibility, better quality and improved responsiveness of services to patient needs."
PURCHASING, STRATEGIC	Deliberate decisions about what to buy, from whom to buy, and how to buy health services and commodities to effectively strike a balance between gains in efficiency and improved quality and delivery of services.
QUALITY, SERVICE	An assessment of the convenience, hotel services, amenities, aesthetic features and degree of respect that patients encounter in health services.
QUALITY, TECHNICAL (OR CLINICAL QUALITY)	An assessment of how the skills of health care providers, inputs, and the system of health care delivery result in increased likelihood of the desired health outcome.
REGULATION	This is a rule made by a government or other authority to control conduct within their areas of responsibility
RESILIENT HEALTH SYSTEMS	Health system resilience can be defined as the capacity of health actors, institutions, and populations to prepare for and effectively respond to crises; maintain core functions when a crisis hits; and, informed by lessons learned during the crisis, reorganize if conditions require it.
RESOURCE ALLOCATION	Decision-making about how finite funds, supplies and human resources are distributed to address the needs of a particular population.
REVENUE MOBILIZATION FOR HEALTH	Revenue mobilization, one of the three functions of a health financing system, refers to the "way health systems raise money from households, businesses, and external sources." It deals with "sources of funds, structure of payments or contribution methods for health services and collection arrangements."
RIGHTS, NEGATIVE	Protections that guarantee individuals' freedom to choose what they want to do with their own lives and property, without intervention by the government. Negative rights are the basis for libertarian ethical perspectives that see the role of the government as taking minimal actions to protect individual property rights and personal liberty.
RIGHTS, POSITIVE	Protections that guarantee individuals a certain level of services and resources (such as a minimum level of income, shelter, education or health care) that makes other meaningful life choices possible and establishes equality of opportunity. Positive rights are typically associated with liberal egalitarian ethical perspectives that seek to

	redistribute social resources to help the worst-off and provide all individuals in a population with equal opportunities.
RISK POOLING	Including people with widely varying levels of risk for disease in a health insurance program. Risk pooling recognizes that illnesses and the associated health care costs are distributed unevenly among the people in a population. By combining people with diverse levels of risk into a program, the contributions of those at low risk of needing health care subsidize the costs incurred by those who need health services.
RISK PROTECTION	An ultimate performance goal of a health system is to ensure that an individual does not become impoverished as a result of paying for health services. (See separate entry: financial risk protection.)
SECTOR (PUBLIC OR PRIVATE)	A sub-section of the economy, such as the health sector. The public sector refers to the set of organizations controlled by the government, while the private sector is comprised of organizations controlled by individuals, private corporations or non-governmental organizations.
SEPTEE CRITERIA	SEPTEE is an acronym coined by the Institute of Medicine to refer to the six aims of quality health care: Safe, Effective, Patient-Centered, Timely, Efficient, Equitable.
STAKEHOLDER ANALYSIS	The process of determining which individuals and groups have an interest in a particular policy, what their positions on the policy are, and the level of power that each has, in order to develop strategies that improve the political feasibility of adopting or implementing a public policy by strengthening supporters and weakening detractors.
SUPPLY CHAIN	The system of organizations, people, technologies, information, activities and processes which are used to make and deliver commodities (such as medicines or vaccines) from the point of production to the point of use by a patient.
SUSTAINABILITY AND HEALTH FINANCING	Sustainable health financing schemes ensure that populations have their needs met over the long term and that health systems remain functional.
TAXES, PROGRESSIVE	A tax rate that increases with income, such as one that takes a higher proportion of the income of people above a certain income-level.
TAXES, REGRESSIVE	A tax that takes a larger percentage from low-income people, such as a sales tax that takes the same amount from all purchasers regardless of how much of their income or assets the amount represents.
TRANSITIONS	
TOTAL HEALTH EXPENDITURE	A measure of spending on health that combines all public and private payments within a society, often presented per capita.
UNIVERSAL HEALTH COVERAGE (UHC)	A health system that ensures that everyone obtains the health services they need without financial hardships.
USER FEES	A sub-category of out-of-pocket payments in which the patient pays at the point of use for health services provided (in the public sector as well as the private sector).
UTILITARIANISM	A philosophical perspective that advocates assessing interventions by analyzing their consequences and selecting those that maximize the amount of well-being (or “utility”) that can be created for the

	population. (See also separate entries for objective and subjective utilitarianism.)
UTILITARIANISM, OBJECTIVE	A branch of utilitarianism that advocates the use of a common, measurable index of well-being to assess the value of various alternative interventions and seeks to maximize the amount of well-being (or "utility") that can be created with the available resources. An objective utilitarian typically selects policies with "the biggest bang for the buck," defining the "bang" as health gains as measured using the common index. This perspective provides the basis for measures such as quality-adjusted life years (QALYs) and disability-adjusted life years (DALYs), as well as for cost-effectiveness analysis.
UTILITARIANISM, SUBJECTIVE	A branch of utilitarianism that relies on the targeted beneficiaries of an intervention to provide their own assessments of the amount of well-being (or "utility") created for them and evaluates interventions based on the aggregate happiness created for the largest number of people possible. Utility is sometimes measured through willingness to pay (see separate entry). This approach is the basis for cost-benefit analysis (see separate entry) and can support using markets, which reflect individuals' preferences, to allocate health care.
UTILITY	A concept in classical economics articulated by Jeremy Bentham in 1789 that encompasses the feelings of happiness, satisfaction or well-being achieved when an individual's preferences are met.
UTILIZATION OF HEALTH SERVICES	The rate at which members of a population use health services, which can be measured in, for example, hospital admissions or outpatient visits per capita.
VOLUNTARY PREPAYMENT	Voluntary prepayment typically refers to "health insurance schemes that may be run by communities or for-profit or non-profit entities (and sometimes by governments)."
VOUCHERS FOR HEALTH	Vouchers are tokens that "can be used in exchange for a restricted range of goods or services" by tying "the receipt of cash to particular goods, provided by particular vendors, at particular times." "Health vouchers are seen as instruments that encourage the use of under-consumed services like family planning, treatment of infectious diseases, immunizations, mental health care, and maternal and child health services by subsidizing health-care costs."
WILLINGNESS TO PAY	A way to define the value of a service or commodity not by whether it is "needed" but by determining what people "want" based on how much money an individual (or institution) would spend to purchase it.

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