Health Economics Information Resources: A Self-Study Course

This class was created from modules originally presented at the Medical Library Association as a **Continuing Education workshop** on May 18, 2002 in Dallas, Texas, by **Moira Napper**, University of Aberdeen, Health Economics Research Unit (HERU), and **Jean Newland**, Lippincott Library @ Wharton, Wharton School, University of Pennsylvania.

The online interactive format for this course and the review, quizzes, and related content have been developed by Laura Larsson, MLS, and Charles Hendricksen, PhD, Cedar Collaboration.

Want more information?

To find out more about this online learning opportunity, including its introduction and aims, as well as find out how to test yourself to advance your learning, take a quiz, get a Certificate of Success, and help us out with an evaluation, go to the Introduction and Purpose page.

Want to begin learning?

To begin learning about health economics, go to Module 1, Part 1: Scope of Health Economics and start reading.

Health Economics Information Resources: A Self-Study Course

Introduction and Purpose

This online course:

- Describes the scope of health economics and its key information resources
- Highlights the sources and characteristics of health care financing information in the U.S.
- Outlines issues relating to the quality of health economic evaluation studies
- Guides users in the identification, retrieval, and assessment of high quality health economic evaluation studies and related publications

The purpose of this course is to provide an overview and discussion of important sources of health economics information so that course participants can:

- Develop more systematic and effective approaches to its identification and retrieval
- Gain greater understanding about its quality and role in health policy formulation and decision-making

Course Structure

The course is presented in four modules, listed below. Learners should begin with Module 1 and progress linearly through the modules in order to maximize the

Related Content:

- Glossary of Terms
- Key General Economics Concepts
- Bibliography
- Web Sites
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learning of this concept.

Module 1 - The Scope of Health Economics and Key Information Sources

Module 1 is divided into **two** parts:

- Part 1 - Outlines the **scope of health economics** and and includes the **Williams' model of the Structure of Health Economics**
- Part 2 - Outlines and highlights the **type of information** which may be required for health economics and where to find it

Module 2 - Sources and Characteristics of Information Relating to Health Care Financing in the US

Material for this module was prepared by Jean Newland, Librarian, Wharton School, University of Pennsylvania. It contains information on sources of information relating to **health care financing** in the United States.

Module 3 - Identification and Retrieval of Health Economic Evaluations

Module 3 presents an effective approach to systematic searching of published health economic evaluation studies by:

- Explaining the definition and purpose of economic evaluation studies
- Highlighting the characteristics of the health economic evaluation literature
- Examining how economic evaluation studies are indexed in the two major bibliographic databases, MEDLINE and EMBASE

Module 4 - Principles of Critical Appraisal of Health Economic Evaluations

Module 4 provides an introductory guide to quality appraisal of published health economic evaluation studies by:

- Explaining why appraisal is required
- Explaining each of the key areas to consider in the critical appraisal of health economic evaluation studies
- Providing an appraisal of a selected paper
  - **Appraised Paper**
  - **Case Study** - An economic evaluation of thrombolysis in the community

Additional Content

A **glossary** of health economics and related terms is provided for your use and links have been made to appropriate terms. A list of **Web sites** and a **Bibliography** for improving access to health economics information is also linked for viewing.

A Glossary - A valuable glossary of terms is included with hypertext links from the text to the terms.

List of Web sites - Useful Web sites that you can go to for additional information.

Bibliography - Citations used in the compilation of this learning.

Key General Economics Concepts - A few **key economics concepts** not covered in these modules but relevant to an understanding of health economics are included in a separate, optional section. No concepts from the Key Health Economics Concepts will be used in the quizzes.

Additional Information

Using the Learning

This online course has been designed to work with Microsoft Internet Explorer® version 4+ and Netscape™ version 4+.

The course includes two different types of links that may be used to view glossary terms, or visit another Web page.

Words and phrases that appear in bold blue are glossary items. Put your mouse over the term to view a definition. You can also click the link to visit the definition in the full glossary. You may view the entire Glossary by selecting the Glossary link in the course sidebar.

Words and phrases that appear in blue and are underlined, are links to web sites such as other pages of the course or to other sites. Visited links are red.

To return to the beginning of this course, click on the Home Page link that appears in the Menu bar.

Learning as You Go: Testing Yourself

Many pages have a link at the bottom of the page called: **Test Yourself**. A question based on the content that appeared on that

page will appear. After answering the question. click the **Return to Lesson** link and **Next** at the bottom of the screen to continue on in the module.

Quizzes, Evaluations and the Certificate of Success

At the end of each module you may elect to try the quiz associated with that module's content. You must take the quiz and get 7 correct out of 10 questions correct in order to get the **Certificate of Success** for that module. (You may retake each of the quizzes as many times as you like).

The Certificate is intended to be printed on a color printer, but you may also use a black and white printer as easily.

When you have completed each module we invite you to give us **feedback** via the online evaluation form. We will use this information to improve this and other learning opportunities.

Health Economics Information Resources: A Self-Study Course

Glossary of Frequently Encountered Terms in Health Economics

Note: Additional key general economics concepts can be found elsewhere in this learning opportunity.

Access to Health Care

1) The degree to which individuals are inhibited or facilitated in their ability to gain entry to and to receive care and services from the health care system. Factors influencing this ability include geographic, architectural, transportational, and financial considerations, among others. (MeSH uses the term 'Health Services Accessibility'.

2) Entry [to the health care system] is dependent on the wants, resources, and needs that individuals bring to the care-seeking process. Ability to obtain wanted or needed services may be influenced by many factors, including travel distance, waiting time, available financial resources, and availability of a regular source of care. (Turnock, 2001)

Allocative Efficiency

Assesses competing programs and judges the extent to which they meet objectives. An allocation of resources such that no change in spending priorities could improve the welfare of one person without reducing the welfare of

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another.

Attitude to Health

Public attitudes toward health, disease, and the medical care system. (MeSH)

Average Cost - see Cost

Benefit

The sum (usually expressed in money terms to make it commensurate with cost) of the effects on well-being (positive or negative) which a particular program bestows upon society. NB. as with costs, **all** benefits, and disbenefits, which result from a particular program are considered relevant, regardless of who gains them. Some of these benefits, such as relief of pain or suffering, are referred to as 'intangible'. These are difficult to quantify but attempts have been made to value them using for example, **QALYs** or the **willingness-to-pay** approach.

Benefits

The dollar amount available for the cost of covered medical services.

Beneficiary

Any person, either a subscriber or a dependent, eligible for service under a health plan.

Blue Cross/Blue Shield

A combined medical plan offered through a worker's place of employment that combines both hospital and physician coverage.

Capitation

A fixed amount of payment per patient, per year, regardless of the volume or cost of services each patient requires.

Clinical Effectiveness

...The application of interventions which have been shown to be efficacious to appropriate patients in a timely fashion

to improve patients' outcomes and value for the use of resources (Batstone, 1996).

Controlled Vocabulary (Librarianship)

Specific words and phrases (descriptors) used when creating subject headings for a book, article, etc. for a specific index or catalog. (Riverside)

Co-payments (Co-pay, user charge)

A fixed dollar payment that is made by the patient to the provider at the time of service. (Glossary)

Consumer Behavior

The observable behavior that a health care consumer does when deciding to acquire health care.

Consumer Expenditure Survey

Collects current consumer expenditure data, which provide a continuous flow of data on the buying habits of the American consumers.

Consumer Price Index (CPI)

Prepared by the U.S. Bureau of Labor Statistics, it is a monthly measure of the average change in the prices paid by urban consumers for a fixed market basket of goods and services. The medical care component of CPI shows trends in medical care prices based on specific indicators of hospital, medical, dental, and drug prices.

Controlled Vocabulary (Librarianship)

A means of searching a resource using words or terms selected by the creator of a resource or by an organization or individual other than the user of the resource. In contrast to a keyword, which can be any word or term selected by the user of the resource. Searching a resource using controlled vocabulary is usually more precise and focused than searching by keyword. (University of Wisconsin)

Cost

The economic definition of cost (also known as opportunity cost) is the value of opportunity forgone, strictly the best

opportunity forgone, as a result of engaging resources in an activity. Note that there can be a cost without the exchange of money. Also the economists' notion of cost extends beyond the cost falling on the health service alone, e.g., includes costs falling on other services and on patients themselves.

In considering the production process, costs may be differentiated as follows:

- **Average costs** - equivalent to the average cost per unit; i.e., the total costs divided by the total number of units of production.
- **Fixed costs** - those costs which, within a short time span, do not vary with the quantity of production; e.g., heating and lighting.
- **Incremental cost** - the extra costs associated with an expansion in activity of a given service.
- **Marginal cost** - the cost of producing one extra unit of a service.
- **Total costs** - all costs incurred in the production of a set quantity of service.
- **Variable costs** - those costs which vary with the level of production and are proportional to quantities produced.

In considering health problems, costs may be differentiated as follows:

- **Avoided costs** - costs caused by a health problem or illness which are avoided by a health care intervention.
- **Direct costs** - those costs borne by the healthcare system, community and patients' families in addressing the illness.
- **Indirect costs** - mainly productivity losses to society caused by the health problem or disease.

Cost Allocation

The assignment, to each of several particular cost-centers, of an equitable proportion of the costs of activities that serve all of them. Cost-center usually refers to institutional departments or services. (MeSH)

Cost Analysis

Analysis of the comparative costs of alternative interventions or programs. Does not include consequences. (Drummond)

Cost-benefit Analysis (CBA)

An economic evaluation in which all costs and

consequences of a program are expressed in the same units, usually money. CBA is used to determine allocative efficiency; i.e., comparison of costs and benefits across programs serving different patient groups. NB. Even if some items of resource or benefit cannot be measured in the common unit of account; i.e., money, they should not be excluded from the analysis.

Cost Comparison

Cost comparison compares only the costs of two or more interventions or programs. (Zarnke)

Cost Control

The containment, regulation, or restraint of costs. Costs are said to be contained when the value of resources committed to an activity is not considered excessive. This determination is frequently subjective and dependent upon the specific geographic area of the activity being measured. (Dictionary)

Cost Description

Examines the costs of a single intervention or program. Does not include the consequences of the intervention and no comparison is made with an alternative intervention. (Zarnke)

Cost-effectiveness

The point at which the minimum amount of input (and therefore cost) is used to achieve a given output.

Cost-effectiveness Analysis (CEA)

An economic evaluation in which the costs and consequences of alternative interventions are expressed cost per unit of health outcome. CEA is used to determine technical efficiency; i.e., comparison of costs and consequences of competing interventions for a given patient group within a given budget. See also **Technical Efficiency**

Cost-minimization Analysis (CMA)

An economic evaluation in which consequences of competing interventions are the same and in

which only inputs, that is, costs are taken into consideration. The aim is to decide the least costly way of achieving the same outcome.

Cost of Illness

The personal cost of acute or chronic disease. The cost to the patient may be an economic, social, or psychological cost or personal loss to self, family, or immediate community. The cost of illness may be reflected in absenteeism, productivity, response to treatment, peace of mind, QUALITY OF LIFE, etc. It differs from HEALTH CARE COSTS, meaning the societal cost of providing services related to the delivery of health care, rather than personal impact on individuals. (MeSH)

Cost of Illness Study

Aims to identify and measure the total costs attributable to a particular disease. These are not a type of economic evaluation as they are not used to assess the costs and benefits of alternative interventions or programs. They may provide useful information which can be used in the context of an economic evaluation of interventions related to the disease category, although care must be taken as not all costs included in a cost of illness study represent resource costs (Donaldson). Cost of illness studies may also be utilized in the estimation of the economic burden of disease.

Cost Outcome Description

Describes the costs and consequences of a single intervention or program. No comparison is made with an alternative intervention. (Zarnke)

Cost Sharing

Provisions of an insurance policy that require the insured to pay some portion of covered expenses. Several forms of sharing are in use, e.g., deductibles, coinsurance, and copayments. Cost sharing does not refer to or include amounts paid in premiums for the coverage. (Dictionary)

Cost-utility Analysis (CUA)

A form of economic study design in which interventions which produce different consequences, in terms of both quantity and quality of life, are expressed as 'utilities'. These are measures which comprise both length of life and

subjective levels of well being. The best known utility measure is the 'quality adjusted life year' or QALY. In this case, competing interventions are compared in terms of cost per utility (cost per QALY). See also **Quality-Adjusted-Life-Year**.

Costs and Cost Analysis

Absolute, comparative, or differential costs pertaining to services, institutions, resources, etc., or the analysis and study of these costs. (MeSH)

Decision-Making

The process of making a selective intellectual judgment when presented with several complex alternatives consisting of several variables, and usually defining a course of action or an idea. (MeSH)

Deductible (excess)

A fixed dollar amount that the patient must pay before reimbursement begins; in most indemnity plans there is no separate deductible for drugs. (Glossary)

Direct Service Costs

Costs which are directly identifiable with a particular service. (MeSH)

Discounting

A technique which allows the calculation of present values of inputs and benefits which accrue in the future. Discounting is based on a time preference which assumes that individuals prefer to forego a part of the benefits if they accrue it now, rather than fully in the uncertain future. By the same reasoning, individuals prefer to delay costs rather than incur them in the present. The strength of this preference is expressed by the discount rate which is inserted in economic evaluations.

Drug Approval

Used for investigational new drug application. (Emtree)

Drug Costs

The amount that a health care institution or organization

pays for its drugs. It is one component of the final price that is charged to the consumer (FEES, PHARMACEUTICAL or PRESCRIPTION FEES). (MeSH)

Note: EMBASE uses Drug Cost (singular)

Drug Formulary

A list of drugs, usually by their generic names, and indications for their use. A formulary is intended to include a sufficient range of medicines to enable physicians, dentists, and, as appropriate, other practitioners to prescribe all medically appropriate treatment for all reasonably common illnesses. (AcademyHealth)

Drug Utilization

Drug prescription and use patterns.

Economic Appraisal - see **Economic evaluation**

Economic Burden of Disease, see **Cost of Illness**

Economic Competition

The effort of two or more parties to secure the business of a third party by offering, usually under fair or equitable rules of business practice, the most favorable terms.

Economic Evaluation

The systematic appraisal of costs and benefits of projects, normally undertaken to determine the relative economic efficiency of programs. See **Cost-benefit analysis**, **Cost-effectiveness analysis**, **Cost-minimization analysis**, **Cost-utility analysis**.

Economic Value of Life - see **Value of Life**

Economic Value Theory

The intrinsic worth of a commodity. If defined in terms of money, value determines price. It is traditional to separate the concepts of use value and value in exchange. Value in use is not an intrinsic quality of a commodity, but its capacity to satisfy human wants. Value in exchange is the worth of commodity in terms of its capacity to be exchanged for another commodity. In classical economics the existence of use value was a prerequisite for

commodities to have value in exchange. A commodity must possess UTILITY or usefulness in order for it to be produced or exchanged. (adapted from the Macmillan Dictionary of Modern Economics. 4th edition. Basingstoke. Macmillan. 1992)

Economics

(1) The science of utilization, distribution, and consumption of services and materials. (MeSH)

(2) The study of how individuals and societies choose to allocate scarce productive resources among competing alternative uses and to distribute the products from these uses among members of the society. (World Bank, 2001)

Effectiveness

The contribution which a program makes to individuals' utility or welfare, normally through better health, but not necessarily solely through better health.

Efficiency

Making the best use of available resources; i.e. getting good value for resources. See also **Allocative efficiency** and **Technical efficiency**.

Employer Health Costs

That portion of total HEALTH CARE COSTS borne by an individual's or group's employing organization. (MeSH)

Epidemiology

The study of the distribution of determinants and antecedents of health and disease in human populations; the ultimate goal is to identify the underlying causes of a disease, then apply findings to disease prevention and health promotion. (Turnock, 2001)

Equity

The degree to which some distribution or other is judged to be 'fair'. 'Fairness' involves a value judgment so; e.g., 'greater equality' need not imply 'greater equity'.

Externalities

These are negative or positive utilities accruing to an individual from another person's consumption. For example, if the majority of a community is vaccinated against an infectious disease, the resulting herd immunity benefits those who have not been vaccinated.

Fees and Charges

Fee: A charge for a service rendered. (World Bank 2001)

Charge: The amount asked for a service by a health care provider. Its contracted with the cost, which is amount the provider incurs in furnishing the service. It is difficult to determined precise costs for many services, and in such cases charges are substituted for costs in many reimbursement or payment formulas (often with the stipulation that the hospital's bookkeeping follow certain rules). (World Bank 2001)

Finance

1) As a broad managerial field, finance is the art or science of obtaining and managing funds.

2) The manipulation of money and credit; the fields of banking, taxes, and insurance, and the money, foreign exchange, and investment markets. Finance directly involves other fields such as accounting, marketing, and production. It is an integral part of management in all three sectors of the economy (i.e., the private, non-profit, and public sectors). (Rhea)

Financial Management

The obtaining and management of funds for institutional needs and responsibility for fiscal affairs.

Financing

In health care finance, these are the methods of gaining, and the sources of, revenue in health services. Modes of financing include third-party payers, public grants, contracts with managed care, government contracts, direct public/government payment for service, philanthropic grants and payments for service, loans, bonds and self-pay.

Financing, Organized

All organized methods of funding. (MeSH)

Full Economic Evaluation

Full economic evaluations are studies in which a comparison of two or more treatments or care alternatives is undertaken and in which both the costs and outcomes of the alternatives are examined. See also, **Cost-benefit analysis** (CBA), **Cost-effectiveness analysis** (CEA), and**Cost-utility analysis** (CUA).

GREAT

Grampian Region Early Anistreplase Trial (GREAT). This is a single study randomized controlled trial. The study was multi-centered covering 29 rural general practices and one hospital. The follow-up period was four years. No loss to follow-up was reported.

Gross Domestic Product (GDP)

GDP is the market value of the goods and services produced by labor and property located in the United States. A barometer of the U.S. economy, it illustrates the pace at which the economy is growing or shrinking.

Gross National Product (GNP)

The market value of all final goods and services produced in a given time period (usually one year) by the nationals of a country residing either in the country or abroad. (Glossary)

Health Care Costs

The actual costs of providing services related to the delivery of health care, including the costs of procedures, therapies, and medications. It is differentiated from HEALTH EXPENDITURES, which refers to the amount of money paid for the services, and from fees, which refers to the amount charged, regardless of cost. (MeSH)

Note: Embase uses Health Care Cost (singular)

Health Care Financing - see **Financing**

Health Care Markets - See **Health Care Sector**

Health (Care) Policy

Decisions, usually developed by government policymakers, for determining present and future objectives pertaining to the health care system. (MeSH)

Health Care Reform

Innovation and improvement of the health care system by reappraisal, amendment of services, and removal of faults and abuses in providing and distributing health services to patients. It includes a re-alignment of health services and health insurance to maximum demographic elements (the unemployed, indigent, uninsured, elderly, inner cities, rural areas) with reference to coverage, hospitalization, pricing and cost containment, insurers' and employers' costs, pre-existing medical conditions, prescribed drugs, equipment, and services. (MeSH)

Health Care Sector

Economic sector concerned with the provision, distribution, and consumption of health care services and related products. (MeSH)

Health Care Rationing

Planning for the equitable allocation, apportionment, or distribution of available health resources.

Health Care Utilization - see **Utilization**

Health Economics

The study of how scarce resources are allocated among alternative uses for the care of sickness and the promotion, maintenance and improvement of health, including the study of how healthcare and health-related services, their costs and benefits, and health itself are distributed among individuals and groups in society. (World Bank 2001)

Health Expenditures

The amounts spent by individuals, groups, nations, or private or public organizations for total health care and/or its various components. These amounts may or may not be equivalent to the actual costs (HEALTH CARE COSTS) and may or may not be shared among the patient, insurers, and/or employers. (MeSH)

Health Inequalities

The gap in health status, and in access to health services, between different social classes and ethnic groups and between populations in different geographical areas (Source NHS Public Health Electronic Library)

Health Insurance

Given that illness is unpredictable and that everyone's future health status is uncertain, demand for health care is also uncertain. The institutional response to this uncertainty is the development of insurance mechanisms whereby covered individuals make regular payments to some risk-pooling agency in return for guarantees of some form of reimbursement in the event of illness. This agency might be a public body or a private firm, the payments might be premiums or taxes, and the benefits might be indemnities (fixed cash payments) varying across illness events, reimbursement of all or part of actual health care expenditure, or direct provision (public or private) of services as needed." (Evans)

Health Maintenance Organization (HMO)

An HMO is a prepaid health plan delivering comprehensive care to members through designated providers, having a fixed monthly payment for health care services, and requiring members to be in a plan for a specified period of time.

(Health) Outcome

In health economics, the term ‘outcome’ is used to describe the result of a health care intervention weighted by a value assigned to that result. (adapted from: Purchasing and providing cost-effective health care. Drummond MF & Maynard A (eds). Edinburgh. Churchill Livingstone. 1993. and Kielhorn A. and Graf von der Schulenburg J.M. The health economics handbook. 2nd ed. Chester. Adis International. 2000)

Health Planning

Planning for needed health and/or welfare services and facilities. (MeSH)

Health Service Planning - see **Health Planning**

Health Services Research

The integration of epidemiologic, sociological, economic, and other analytic sciences in the study of health services. Health services research is usually concerned with relationships between need, demand, supply, use, and outcome of health services. The aim of the research is evaluation, particularly in terms of structure, process, output, and outcome. (From Last, Dictionary of Epidemiology, 2d ed) (MeSH)

Health Status

1. The degree to which a person is able to function physically, emotionally and socially, with or without help from the health care system. (Source: NHS Public Health Electronic Library)

2. The level of health of the individual, group, or population as subjectively assessed by the individual or by more objective measures. (MeSH)

Health Technology Assessment

Evaluation of biomedical technology in relation to cost, efficacy, utilization, etc., and its future impact on social, ethical, and legal systems. (MeSH, use: Technology Assessment, Biomedical when searching)

Hospital Costs

The expenses incurred by a hospital in providing care. The hospital costs attributed to a particular patient care episode include the direct costs plus an appropriate proportion of the overhead for administration, personnel, building maintenance, equipment, etc. Hospital costs are one of the factors which determine HOSPITAL CHARGES (the price the hospital sets for its services). (MeSH)

Note: Embase uses Hospital Cost

HYE (Healthy Years Equivalents)

These have been suggested as an alternative to QALYs. The advantage of HYEs is that they fully represent individual preferences without imposing restrictive assumptions associated with QALYs. HYEs are measured using a two-stage gamble technique where the health state is described to the respondent, along with the duration of the state, and the respondent is asked how many years of life in full health would be equivalent to this

scenario. (HERU Glossary)

Indemnity

Monies paid by an insurer to a provider, in a predetermined amount in the event of a covered loss by a beneficiary; differs from reimbursement, which provides coverage based on actual expenses incurred. There are fewer restrictions on what a doctor may charge and what an insurer may pay for a treatment under indemnity payment, and generally there are also fewer restrictions on a patient's ability to use specialty services.

Industrial Organization

Industrial organization is concerned with the working of the market economy and generally organizes its approach in terms of market structure, conduct and performance of firms as well as the role of public policy with respect to market structure. (Macmillan)

Insurance

A method of providing for money to pay for specific types of losses, which may occur. Insurance is a contract (the insurance policy) between one party (the insured) and another (the insurer). The policy states what types of losses (see risk) are covered, what amounts will be paid for each loss and for all losses, and under what conditions. Two types of insurance commonly spoken of in health care are: (1) insurance covering the patient for health services (health insurance, also called a "third party payer"); and (2) insurance covering the health care provider for risk associated with the delivery of health care (liability to a patient for malpractice, for example) (World Bank, 2001) See also **Health Insurance**

Insurance Premiums

The payment individuals make to obtain health insurance.

Investments

The investing of funds for income or profit. (MeSH)

Labor Economics

The aspects of economics concerned with the supply and demand for labor. This includes factors affecting the participation rate, wage bargaining and organized labor,

training, hours and conditions of work, practices concerning hiring, redundancy, labor turnover, migration and the age of retirement. (Black)

Managed Care

Managed care is a health care plan that integrates the financing and delivery of health care services by using arrangements with selected health care providers to provide services for covered individuals. Plans are generally financed using capitation fees. There are significant financial incentives for members of the plan to use the health care providers associated with the plan. The plan includes formal programs for quality assurance and utilization review. HMO's, PPO's and POS plans are examples of managed care.

Marginal Analysis (MA)

The evaluation of the change in costs and benefits produced by a change in production or consumption of one unit; i.e., examines the effect of small changes in the existing pattern of health care expenditure in a given setting.

Marginal Benefit

The value of benefit derived when output is increased by one unit.

Marginal Cost - see **Cost**

Medicaid

A joint federal/state program providing some payments for some health services for some individuals whose income and resources are insufficient to pay for their own care.

Medical Ethics (MeSH uses Ethics, Medical)

The principles of proper professional conduct concerning the rights and duties of the physician, relations with patients and fellow practitioners, as well as actions of the physician in patient care and interpersonal relations with patient families. (From Stedman, 25th ed) (MeSH)

Medical Practice Variations - see **Physician's Practice Patterns**

Medicare

A federal entitlement program of medical and health care coverage for the elderly and disabled and persons with end-stage renal disease.

Medicine

The art and science of preventing, diagnosing, and treating disease, as well as the maintenance of health. (MeSH)

MeSH Tree (Librarianship)

The National Library of Medicine's (NLM's) controlled vocabulary thesaurus. MeSH is the acronym for **Me**dical **S**ubject **H**eadings. (NLM)

Methods of Benefit Assessment

Methods used by insurance companies to assess the health benefits individuals receive based on the insurance they purchased.

National Health Expenditures

This measure estimates the amount spent for all health services and supplies and health-related research and construction activities consumed in the United States during the calendar year. Detailed estimates are available by source of expenditures (for example, our-of-pocket payments, private health insurance, and government programs), and by type of expenditures (for example, hospital care, physician services, and drugs), and are in current dollars for the year of report. Data are compiled from a variety of sources.

Opportunity Cost

The notion of cost used in economics. See also, Cost

Option Appraisal (OA)

The systematic examination of the relative advantages and disadvantages of alternative options in meeting specific health objectives before resources are committed to one or more programs. The foundations of option appraisal are in cost-benefit analysis and it usually used in appraisal of capital developments in the NHS.

Organization of Economic Cooperation and Development (OECD)

An international organization of developed countries, which produces international statistics on healthcare systems in member countries and provides a forum for research and discussion about economic issues. (Glossary)

Out-of-pocket Expenditures

The portion of medical expenses a patient is responsible for paying. (Nevadans)

Outcome Description

Examines only the consequences of a single intervention or program. (Drummond)

Partial Evaluation

Partial evaluations constitute a number of economic study types which consider costs and/or consequences, but which either do not involve a comparison between alternative interventions or do not relate costs to benefits. (see module 3)

Pharmacoeconomics

Economic aspects of the fields of pharmacy and pharmacology as they apply to the development and study of medical economics in rational drug therapy and the impact of pharmaceuticals on the cost of medical care. Pharmaceutical economics also includes the economic considerations of the pharmaceutical care delivery system and in drug prescribing, particularly of cost-benefit values. (From *J Res Pharm Econ* 1989;1(1); *PharmacoEcon* 1992;1 (1) (MeSH)

Physician's Practice Patterns

Patterns of practice related to diagnosis and treatment as especially influenced by cost of the service requested and provided. (MeSH)

Point of Service Plan (POS)

A plan that contains elements of both HMO's and PPO's. They resemble HMOs for in-network services in that they both require co-payments and a primary care physician. Services received outside of the network are usually reimbursed on a fee-for-service basis.

Preferred Provider Organization (PPO)

This is a health plan generally consisting of hospital and physician providers. The PPO provides health care services to plan members usually at discounted rates in return for expedited claims payment. Plan members can use PPO or non-PPO health care providers; however, financial incentives are built into the benefit structure to encourage utilization of PPO providers.

Priority Setting and Rationing (MeSH term is Health Care Rationing)

Planning for the equitable allocation, apportionment, or distribution of available health resources. (MeSH)

Psychology

The science dealing with the study of mental processes and behavior in man and animals. (MeSH)

Public Health

Activities that society undertakes to assure the conditions in which people can be healthy. These include organized community efforts to prevent, identify and counter threats to the health of the public. (Turnock, 2001)

Public Policy (and Finance)

A course or method of action selected, usually by a government, from among alternatives to guide and determine present and future decisions. (MeSH)

Purchasing Power Parities (PPPs)

PPPs are the rates of currency conversion that eliminate the differences in price levels between countries. The PPP rate is formed by pricing the same, fixed basket of goods and services across different countries in the national currency of each country. For example, if an identical basket of goods and services cost 500 French Francs (FF) in France and US$100 in the US, then the PPP conversion rate would be calculated at five FF to one US$.

Quality-Adjusted-Life-Year (QALY)

(1) Units of measure of utility which combine life years gained as a result of health interventions/health care programs with a judgment about the quality of these life

years.

(2) A common measure of health improvement used in cost-utility analysis, it measures life expectancy adjusted for quality of life. (World Bank, 2001)

Quality of Life

A generic concept reflecting concern with the modification and enhancement of life attributes, e.g., physical, political, moral and social environment; the overall condition of a human life. (MeSH)

Reimbursement

Payment for services. Payment of providers by a third-party insurer or government health program for health care services. Reimbursement can be either PROSPECTIVE REIMBURSEMENT or RETROSPECTIVE REIMBURSEMENT. MEDICARE has evolved a complex reimbursement system based of DRGs. Reimbursement is a major influence on the structure of the American health care system. Changes in the reimbursement mechanisms impact the cost and delivery of service, as well as trends in medical education and specialization.

Remuneration Methods & Incentives

Remuneration methods are payment/reimbursement methods which may include DRGs, and other payment methods. See **Reimbursement. Incentives** are "implicit or explicit inducements that influence behavior. In the workplace, refers to financial or psychological rewards designed to motivate employees to perform above an established standard. Incentive wages are one way in which PROSPECTIVE payment systems encourage health care providers to use fewer procedures and make fewer office appointments. In contrast, the fee-for-service reimbursement system rewards providers for increasing UTILIZATION of health care services.

Resource Allocation

Societal or individual decisions about the equitable distribution of available resources. (MeSH)

Resources

The basic inputs to production - the time and abilities of individuals, natural resources such as land and capital

(facilities, equipment, etc.). (World Bank, 2001)

Risk (actuarial)

An actuary's statement of the risk presented by a group of individuals, which is being considered for enrollment in health care insurance. This risk statement is the basis for rating the group, i.e., determining the insurance premium to be charged. For community rating, the risk statement is for entire community; for experience rating, the statement is for a smaller group, such as the employees of a given corporation.

Scarcity

A situation in which the needs and wants of an individual or group of individuals exceed the resources available to satisfy them.

Sensitivity Analysis

A technique which repeats the comparison between inputs and consequences, varying the assumptions underlying the estimates. In so doing, sensitivity analysis tests the robustness of the conclusions by varying the items around which there is uncertainty.

Socioeconomic Determinants of Health

The entire range of individual and collective factors-and their interactions-that affect the health of the people of Canada. These factors may include income and social status; social support networks; education; employment and working conditions; social environments; physical environment; personal health practices and coping skills; healthy child development; culture; health services; gender; biology and genetic endowment. (Health Canada)

Socioeconomic Factors

Social and economic factors that characterize the individual or group within the social structure.

Sociology

A social science dealing with group relationships, patterns of collective behavior, and social organization. (MeSH)

State Children's' Health Insurance Program (SCHIP)

A largely federally funded Medicaid program designed to help states expand health insurance to children whose families earn too much for traditional Medicaid but not enough to afford private health insurance.

Self Insured Plan

Plan offered by employers and other groups who directly assume the major cost of health insurance for their employees or members. Firms that self-insure generally obtain state tax benefits and freedom from mandated benefits.

Statistical Methods

The arithmetical tests that statisticians and health economists use to derive meaning from data.

Technical Efficiency

Assesses whether a given output can be achieved by using less of one input while holding all other inputs constant. This concept is related to cost-effectiveness. See also Cost-effectiveness and Cost-effectiveness analysis.

Third party payer

In health care finance, this is an insurance carrier, Medicare, and Medicaid or their government-contracted intermediary, managed-care organization, or health plan that pays for hospital or medical bills instead of the patient. Also know as “third party carrier”.

Underinsured

Refers to people who have some type of health insurance, such as catastrophic care, but not enough insurance to cover all their health care costs. (Nevadans)

Uninsured (MeSH uses the term Medically Uninsured)

Individuals or groups with no or inadequate health insurance coverage. Those falling into this category usually comprise three primary groups: the medically indigent (MEDICAL INDIGENCY); those whose clinical condition makes them medically uninsurable; and the working uninsured.

Utility

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World Bank. Health Systems Development. Health Economics. 2001. [online] Site URL.

Zarnke KB, Levine MAH, O'Brien BJ. Cost-benefit analyses in the health-care literature: don't judge a study by its label. *J Clin Epidemiol* 1997;50:813-822.

A term used by economists to signify the satisfaction accruing to a person from the consumption of a good or service. This concept is applied in health care to mean the individual's valuation of their state of well-being deriving from the use of health care interventions. In brief, utility is a measure of the preference for, or desirability of, a specific level of health status or specific health outcome. (Source Kielhorn A. and Graf von der Schulenburg J.M. The health economics handbook. 2nd ed. Chester. Adis International. 2000)

Utilization

The level of use of a particular service over time. (Managed)

Utilization Review

Evaluation of the necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities. In a hospital, this includes review of the appropriateness of admissions, services ordered and provided, length of a stay, and discharge practices, both on a concurrent and retrospective basis. Utilization review can be done by a peer review group, or a public agency. (AcademyHealth)

Value of Life

The intrinsic moral worth ascribed to a living being. (MeSH)

Voluntary Care

Care, usually by a family member. The market price is zero but there is an opportunity cost in terms of the alternative ways in which the carer could have utilized the time. A value would have to be imputed, perhaps based on the salary of a paid caregiver.

Willingness-to-pay (WTP)

A technique which aims to assign a value to health benefits by directly eliciting individual preferences in the views of samples of the general public who are asked how much they would be prepared to pay to accrue a benefit or to avoid certain events.

Definitions are compiled from the following sources:

Health Economics Information Resources: A Self-Study Course

Key General Economics Concepts

This section is intended to present the names and descriptions of concepts that were not covered in the four health economics modules available for study. Two academics with many years experience between them teaching health economics courses suggested that you might wish to explore these concepts on your own by reading some of the available health economics textbooks and articles listed in the bibliography.

Additional general and health economics concepts include:

Competitive equilibrium model

A model that assumes utility maximization on the part of consumers and profit maximization on the part of firms, along with competitive markets and freely determined prices.

Cost concepts

Differences in cost concepts such as direct and indirect (or overhead) costs (accountants' language) and fixed and variable costs (economists' language)

Demand curve

A graph of demand showing the downward-sloping relationship between price and quantity demanded. (Taylor)

Diminishing marginal utility of income

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Makes insurance worthwhile to risk averse individuals

Externalities

An externality is the situation in which the costs of producing or the benefits of consuming a good spill over onto those who are not producing or consuming the good. (Taylor)

Health production function

A production function is a relationship that shows the quantity of output for any given amount of input.

Health utility

Utility is a numerical indicator of a person's preferences in which higher levels of utility indicate a greater preference. (Taylor)

Macroeconomics

The branch of economics that examines the workings and problems of the economy as a whole—GDP growth and unemployment.

Microeconomics

The branch of economics that examines individual decision-making at firms and households and the way they interact in specific industries and markets.

The margin (marginal cost)

Marginal cost is the change in total costs due to a one-unit change in quantity produced. (Taylor)

Marginalism

The incremental determination of how much of some service or product to produce.

Price and income elasticities

Market sensitivities to changes in prices and incomes. **Price elasticity of demand** is the percentage change in the quantity demanded of a good divided by the percentage change in the price of that good. **Price elasticity of supply** is the percentage change in quantity

supplied divided by the percentage change in price. (Taylor)

Pricing in competitive and monopoly markets

Price refers to a particular good and is defined as the amount of money or other goods that one must pay to obtain the good. **Income elasticity of demand** the percentage change in quantity demanded of one good divided by the percentage change in income. (Taylor)

Supply and demand

Supply - a relationship between price and quantity supplied. **Demand** - a relation- ship between price and quantity demanded. (Taylor)

Supply curve

A graph of supply showing the upward-sloping relationship between price and quantity supplied. (Taylor)

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About these Modules

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- Introduction and Purpose
- Index

The Modules

Modules Available for Study:

- Module 1, Part 1: Scope of Health Economics Module 1, Part 2: Key Information Sources
- Module 2: Sources and Characteristics of Information
- Module 3: Identification and Retrieval of Published Health Economic Evaluations
- Module 4 : Principles of Critical Appraisal of Health Economic Evaluations

Related Content:

Health Economics Information Resources: A Self-Study Course

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Health Economics Information Resources: A Self-Study Course

Selected Web sites – Health Care Economics Research

This section links you to useful health economics resources on the Web.

Bureau of Labor Statistics. U. S. Department of Labor. Data Home

Price and expenditure data. Retrieve statistics, create tables.

Bureau of Labor Statistics Programs and Surveys Home

Program and survey documentation, detailed statistics, FAQS, contact information.

Bureau of Primary Health Care – Health Resources and Services Administration. U. S. Department of Health and Human Services

Includes databases on medically underserved, health professional shortages, others.

Community Health Status Indicators Project Health Resources Services Administration, U. S. Department of Health and Human Services

3,082 reports of health status indicators, one for each county in the nation. (Note: Data retired as of October 11, 2002)

Community Tracking Study - Center for Studying Health System

Related Content:

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Change

Community Reports provide information and insights about developments in the 12 communities that HSC is studying intensively over time to better understand the changing health system and variations across markets.

The Center for Studying Health System Change is a nonpartisan research organization and "seeks to provide objective, incisive analyses that lead to sound policy and management decisions, with the ultimate goal of improving the health of the American public.

Consumer Expenditure Survey - Bureau of Labor Statistics

Details of consumer health care expenditures

Consumer Price Indexes - Bureau of Labor Statistics

The Consumer Price Indexes (CPI) program produces monthly data on changes in the prices paid by urban consumers for a representative basket of goods and services.

Current Population Survey – U.S. Census Bureau

Annual Demographic Survey (March CPS Supplement) includes health insurance coverage.

Dartmouth Atlas of Health Care

"The Atlas project brings together researchers in diverse disciplines - including epidemiology, economics, and statistics - and focuses on the accurate description of how medical resources are distributed and used in the United States.

Data User's Reference Guide* - Centers for Medicare & Medicaid Services (CMS)

"The purpose of the Data Users Reference Guide is to introduce health care data users to the Medicare and Medicaid program data maintained by CMS." Details of raw data files, intended for use by researchers and analysts.

Directory of Data Resources* - Department of Health and Human Services

"a compilation of information about virtually all major data collection systems sponsored by the U.S. Department of Health and Human Services …"

Finding and Using Health Statistics: A Self Study Course - National Information Center on Health Services Research & Health Care Technology (NICHSR)**

A very useful interactive tutorial.

HCUPnet– Healthcare Cost and Utilization Project - Agency for Healthcare Research and Quality (AHRQ)

"…national statistics and trends and selected State statistics about hospital stays."

Health Economic Resources on the Internet – University of York

Some full text journals, annotated list of links

Health Economics and Decision Science - University of Sheffield

A research and education center for health care resource allocation decision-making working with both international and UK-based public and private agencies.

The Health Plan Employer Data and Information Set (HEDIS®) – National Committee for Quality Assurance

Performance measures for managed health care plans for purchasers and consumers.

Health Economics Research Unit – University of Aberdeen

Abstracts of research, links to sites and more

Health Policy Center – Urban Institute

"…primarily concerned with issues related to how the dynamics of the health care market affect health care financing, costs, and access."

Health Services and Sciences Research Resources* - National Information Center on Health Services Research & Health Care Technology (NICHSR)**

Searchable database of information about research datasets and instruments/indices.

Includes description of and links to resources. Very useful finding aid.

Health Services Research Internet Sites **National Information Center on Health Services Research & Health Care Technology (NICHSR)**

Selected HSR Web Sites - see especially Health Policy and Economics and also Data Sets and Data Sources

Health Services Research Resources – Leonard Davis Institute, University of PA

Links to associations and alliances, foundations and organizations, research and policy groups.

Health Statistics – University of Pittsburgh Health Sciences Library System

Useful annotated list.

Inter-University Consortium for Political and Social Research (ICPSR)

A membership-based organization with over 400 member colleges and Universities around the world. Maintains and provides access to a vast archive of social science data, including Health and Medical Care Archive. Some datasets are publicly available. The site includes access and contact information for members and non-members.

Kaiser Family Foundation State Health Facts Online

Up-to-date health data on all 50 states, including demographic data and the economy, health status, health care costs, budgets, financing, and health insurance

Knowledge @ Wharton (select Health Economics)

"…a bi-weekly online resource that offers the latest business insights, information and research from a variety of sources. Includes interviews with industry leaders and Wharton faculty, articles based on the most recent business research, book reviews, conference and seminar reports…" Full text of faculty working papers available. Free, but registration required. (Direct link)

Leonard David Institute of Health Economics – University of Pennsylvania

A cooperative venture among Penn's schools of Dentistry, Medicine, Nursing, and Wharton. Description of research programs, full text of LDI Issue Briefs.

Medical Expenditures Panel Survey - Agency for Healthcare Research & Quality

"…data on the specific health services that Americans use, how frequently they use them, the cost of these services, and how they are paid for, as well as data on the cost, scope, and breadth of private health insurance held by and available to the U.S. population."

Medicare.gov

"The Official U.S. Government Site for People with Medicare"

National Association of Health Data Organizations (NAHDO)

"NAHDO is a not-for-profit membership organization dedicated to strengthening the nation's health information system." The site contains full text of current articles, as well as association news and information.

National Center for Health Statistics

NCSH is the nation's primary agency for vital and health statistics. Includes data on health status, use of health care, lifestyle, as well as on illness and disability.

National Health Accounts (CMS) (Formerly - National Health Care Expenditures)

Comprehensive annual data on all national expenditures related to health care.

National Vital Statistics System – National Center for Health Statistics

Data on births, deaths, marriages, fetal deaths.

Pennsylvania Health Care Cost Containment Council

(note: many states have similar Web sites)
Financial and performance analysis of hospitals, reports on health plans, benefits and care issues, and more.

Researchers (Information For) - Centers for Medicare and Medicaid Services (CMS) U.S. Dept. of Health and Human Services, [formerly, Health Care Financing Administration – HCFA]

Downloadable Public Use Data Files on providers, costs, payments. Detailed statistics on Medicare, Medicaid, SCHIP. National Health Care Expenditures. And more…

Resource Center – American Hospital Association

Fast facts, statistics, studies, and links. Useful search feature.

State Database – Urban Institute – New Federalism

"This database includes information on the fifty states and the District of Columbia in areas including income security, health, child well-being, demographic, fiscal and political conditions, and social services."

Statistical Resources on the Web – Health

University of Michigan Documents Center

WHO Statistical Information System – World Health Organization

"Health and health-related statistical information from the WHO Global Programme on Evidence for Health Policy"

World Health Report 2002 – World Health Organization

Health Systems – Improving Performance
Full text in PDF format.

Bolded entries - mentioned in presentation
* - documentation/guide
** - recommended tutorial
*** - finding aid

Health Economics Information Resources: A Self-Study Course

The Scope of Health Economics

Module 1 Quiz: Answer Key

This page provides the correct responses to each of the questions from the quiz on the Scope of Health Economics. Each question is repeated, and includes the answer and an explanation.

Quiz 1 (Module 1)

1.
The benefits associate with the best alternative use of resource is called:

A. Health economics
B. Health resources
C. Opportunity cost
D. Alternative activities

Explanation

The aim of economics is to ensure that the chosen activities have benefits which outweigh their opportunity costs OR the most beneficial activities

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are chosen within the resources available.

2.
The following is a list of the type of statistical date most often required in health economics. Which letter listed below does not belong in the list?

A. financing health care
B. epidemiological
C. cost of care
D. demographic
E. nutrition data
F. socioeconomic
G. comparative

Explanation

Nutrition data, while important is generally not relevant to health economics as described in this module.

3.
Select the specialist health economics journal/s within the economics discipline

A. BMJ
B. Health Economics
C. B and D
D. Journal of Health Economics
E. A and B

Explanation

Health Economics and Journal of Health Economics investigate all aspects of health economics such as the theory and methods of economic analyses and theory and methods of health policy.

4.
The site with substantial content on cost-QALY ratios is called

A. The CEA Registry
B. The Health Economic Evaluations Database (HEED)
C. Evidence Based Health Care
D. The NHS Economic Evaluation Database (NHS EED)

Explanation

The CEA Registry (formerly known as the Harvard CUA Database) features a Reference list of studies that have used costs per QALY to measure health benefits 1976-1997. It contains a Comprehensive League table of Cost-QALY Ratios, a League table of cost-QALY ratios which adhere to the Washington Panel and a catalog of Preference Scores used for QALYs as well as a checklist used to appraise CUA studies.

5.
Value-added sources provide some additional information over and above bibliographic details.
True or False?

Explanation

Value-added sources provide some additional information over and above bibliographic details. The nature and form of this information varies. Examples include: Evidence Based Health Care and ACP Journal Club.

6.
The following is a list of disciplines, some of which relate to health economics. Which discipline does not belong in this list?

A. Health Education
B. Anthropology
C. Health Services Research
D. Statistical Methods
E. Public Health / Epidemiology
F. Psychology

Explanation

Health Economics incorporates the thinking of additional disciplines both within the health field and beyond. If we look beyond health, we must incorporate pure economics, finance and insurance, industrial organization, labor economics, public policy (and finance), sociology, and statistical methods into our thinking. Within the health arena, the disciplines of health services research, medicine,

medical ethics, psychology and public health / epidemiology must be considered when considering health economics.

7.
PsycINFO and PAIS International do not contain health economics citiations. True or **False**?

Explanation

PsycINFO covers psychology and related disciplines including medicine, psychiatry and nursing. Use these and other search terms to retrieve health economics citations from this database: Budgets, Cost Containment, Costs and Cost Analysis, Economy, Health Care Costs, Money, and Resource Allocation. PAIS International covers public, social policy and the social sciences in general US focus.

8.
Which of the following statements is untrue and does not belong in this list? Grey literature is characterized as material:

A. Not published through regular book-publishing channels
B. Not subject to formal bibliographic control
C. That can be difficult to identify and obtain
D. That is generally available only in print (not electronic format)
E. That can be country-specific

Explanation

Grey literature is characterised as material that is not published through regular book-publishing channels, is not subject to formal bibliographic control (indexing for large bibiographic databases such as Medline), and can be difficult to identify and obtain; and lastly, it is often country-specific. The grey literature is available in print and digital formats.

9.
The HMIC – Health Management Information Consortium (UK) Database is the combined catalogs of the UK Department of Health, the King's Fund and the Nuffield Institute for Health. **True** or False?

Explanation

The HMIC - Health Management Information Consortium (UK) Database is the combined catalogs of the UK Department of Health, the King's Fund and the Nuffield Institute for Health. It is intended to provide valuable information for health managers and administrators in the areas of health policy, health economics, social policy and care and public health and primary care. The database contains about 300,000 citations.

10.
International initiatives such as OECD and WHO are not large providers of health data. True or **False**?

Explanation

International initiatives such as OECD and WHO (listed below) are large providers of health data.

Did you score a 70% or above? If so, you've successfully completed the quiz on the Scope of Health Economics. You may now apply for a Certificate of Success. Continue on to the next module: Sources and Characteristics of Information.

Health Economics Information Resources: A Self-Study Course

Sources and Characteristics of Information

Module 2 Quiz: Answer Key

This page provides the correct responses to each of the questions from the quiz on the Sources and Characteristics of Information. Each question is repeated, and includes the answer and an explanation.

Quiz 2 (Module 2)

1.
The National Health Accounts are associate with which agency?

A. Agency for Health Care Policy and Research
B. Centers for Medicare and Medicaid Services (CMS)
C. NICHSR
D. Centers for Disease Control and Prevention
E. NIOSH

Explanation

- Glossary of Terms
- Key General Economics Concepts
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For the NHA, one needs just to consult the Centers for Medicare and Medicaid Services (CMS), formerly Health Care Financing Administration, homepage to find definitions of each category of medical service and source of funding, scope of the program, methodology of program, and source materials from which the NHA are developed.

2.
Children with no insurance receive health care through a program called what?

A. Medicare
B. Social Security
C. Maternal and Child Health Bureau
D. State Children's Health Insurance Program (SCHIP)

Explanation

Children who might not otherwise receive medical attention may do so through the State Children?s Health Insurance Program (SCHIP).

3.
When referring users to the NHA/NHE there are a number of limitations we should remember to tell them. Which item listed below is not a limitation?

A. limitations of the data
B. use of Website
C. data definitions
D. source materials
E. methodologies used

Explanation

As is the case whenever consulting statistical information, users need to be aware of the limitations of the data. It is critical that users familiarize themselves with the definitions, sources, and methodologies used in creating the NHA in order to grasp what is being measured and how that measurement is being accomplished.

4.
Medicare covers what percentage of which population?

A. 95%of the elderly
B. 20% of mothers and children
C. 87% of adolescents
D. 55% of the elderly
E. 49% of children

Explanation

We’re probably all most familiar with Medicare. This federal program provides a range of medical care benefits for persons aged 65 and over, disabled persons and their dependents and those suffering from chronic kidney disease. Medicare covers about 95% of our nation?s aged population, approximately 39 million in 2000.

5.
The National Health Accounts series has many important characteristics and aims to be comprehensive because it contains some/most/**all** of the main components of the health care system.

Explanation

The National Health Accounts series has many important characteristics and aims to be comprehensive because it contains all of the main components of the health care system.

6.
Federal expenditures have decreased/**increased** between 1960 and 2000?

Explanation

As you might imagine the trend here is the reverse of that for private funding. Public funding has generally increased over the long term from roughly 25% in 1960 to 45.2% in 2000. This increase, especially since 1965, is largely a result of greater federal expenditures and much significant rise in federal spending is accounted for by the Medicare and Medicaid Programs.

7.
In the year 2000, spending on health care services and products represented what percentage of the U. S. Gross Domestic Product?

A. 13.2 percent
B. 6.9 percent
C. 10.3 percent
D. 7.9 percent

Explanation

Spending on health care services and products reached $1.3 trillion in 2000, which was up 6.9 percent from the previous year. This $1.3 trillion figure represents 13.2 percent of the U.S. Gross Domestic Product (GDP), or the total value of goods and services produced that year in the U.S.

8.
People in OECD countries pay less for health per capita than people in the United State. **True** or False?

Explanation

The U.S. spends more on health care per capita but ranks very low with respect to overall health system performance.

9.
When we look at the various categories of expenditures (health care dollars) and the percentages of total dollars spend for each in the year 2000, program Administration and Net Cost consumes which percentage of the spending on health care?

A. 22%
B. 9%
C. 32%
D. 6%
E. 19%

Explanation

The pie chart that was used to characterize where the money went shows the various categories of expenditures and the percentages of total dollars spent for each. Hospital care accounted for 32% of the health care dollar. Physician and Clinical Services accounted for 22%. Other Spending - which includes dentist services, other professional services, home health, durable medical products, over-the-counter medicines and sundries, public health, research and construction - accounted for a hefty 24% with prescription drugs at 9%, nursing home care at 7%, and program administration at 6% of the total spending.

10.
The year with the most number of uninsured Americans (in millions) was:

A. 1995
B. 1996
C. 1997
D. 1998
E. 1999
F. 2000

Explanation

Those who had no health insurance in 1998 accounted for 44.3 million people total in the United States.

Did you score a 70% or above? If so, you've successfully completed the quiz on the Sources and Characteristics of Information. You may now apply for a Certificate of Success. Continue on to the next module: Identification and Retrieval of Published Health Economics Evaluations.

Health Economics Information Resources: A Self-Study Course

Identification and Retrieval of Published Health Economics Evaluations

Module 3 Quiz: Answer Key

This page provides the correct responses to each of the questions from the quiz on the Identification and Retrieval of Published Health Economics Evaluations. Each question is repeated, and includes the answer and an explanation.

Quiz 3 **(Module 3)**

1.
The variability in the quality of published health economic evaluation studies is not well documented. True or **False**

Explanation

The variability in the quality of published health economic evaluation studies is well documented in Jefferson, et al 2002a and Jefferson, et al 2002b.

- Glossary of Terms
- Key General Economics Concepts
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2.
The aim of economic evaluation is to ensure that the benefits from health care programs implemented are greater than the opportunity cost of such programs by addressing questions of _____ or _____. Select the correct answer from the list below.

A. Interpretive efficiency or Inclusive efficiency
B. Economic efficiency or Evaluative efficiency
C. Allocative efficiency of Technical efficiency
D. Informational efficiency or Requirements efficiency

Explanation

The aim of economic evaluation is to ensure that the benefits from health care programs implemented are greater than the opportunity cost of such programs by addressing questions of Allocative efficiency or Technical efficiency. Allocative efficiency assesses competing programs and judges the extent to which they meet objectives. Technical efficiency assesses the best way of achieving a given objective.

3.
The MeSH term "cost-benefit analysis" is used to index ALL types of economic evaluation studies, not just cost-benefit studies. **True** or False?

Explanation

This statement is true. The MeSH term ?cost-benefit

analysis? is used to index ALL types economic evaluation studies, not just cost-benefit studies.

4.
Partial evaluations do not provide information on efficiency. **True** or False?

Explanation

It is important to remember is that PARTIAL EVALUATIONS DO NOT PROVIDE INFORMATION ON EFFICIENCY.

5.
Important consequences may occur as a result of mislabeling. Mislabeling of partial evaluations as full economic evaluations can also result in the incorrect allocation of indexing terms at the point of inclusion into a bibliographic database and mislabeling will cause difficulties in identifying studies which are true economic evaluations. **True** or False?

Explanation

The answer is true as stated.

6.
Which of these statements about a FULL economic evaluation does not belong with the others?

A. FULL health economic evaluations are easily identified because they consider costs.
B. A FULL economic evaluation requires the identification, measurement, and valuation of BOTH costs and consequences.
C. A FULL economic evaluation requires the identification, measurement, and valuation of BOTH costs and consequences.
D. A FULL economic evaluation compares BOTH the costs and consequences (effectiveness; benefits) of TWO or more interventions

Explanation

A FULL economic evaluation compares BOTH the costs AND consequences (effectiveness; benefits) of TWO or more interventions. A FULL economic evaluation requires the identification, measurement and valuation of BOTH costs and consequences. A FULL economic evaluation is the ONLY type of economic analysis that provides valid information on efficiency. Some studies consider costs but do not involve comparisons between interventions or do not relate costs to benefits; these are considered partial evaluation studies.

7.
EMTREE does not provide an individual indexing term for each type of economic evaluation methodology. True or **False**?

Explanation

The answer to this question is false. There is a clear distinction within EMTREE between the different types of economic evaluation methodologies. EMTREE provides an individual indexing term for each type of economic evaluation methodology. In addition, EMTREE provides an additional indexing term - ?economic evaluation? (explodes). The terms ? cost control? and ?cost of illness? appear as narrower terms under ?economic evaluation?. This use of these two terms is not strictly correct as these are partial evaluation study types.

8.
Guidelines for conduct of an economic evaluation have been developed as a means of addressing the problem of quality variability in health economic evaluation studies. Guidelines may be categorized as those which address the conduct, reporting, or appraisal of economic evaluation studies. **True** or False?

Explanation

This statement is true; that is, guidelines have been developed as a means of addressing the problem of quality variability in health economic evaluation studies. Guidelines may be categorized as those which address the conduct, reporting, or appraisal of economic evaluation studies.

9.
This variability in the quality of published health economic evaluation studies has _____ implications for the identification and subsequent utilization of information on _____ in the health care decision-making process.

A. insignificant / economics
B. significant / systematic reviews
C. no significant / retrieval
D. significant / efficiency

Explanation

This variability has significant implications for the identification and subsequent utilization of information on efficiency in the health care decision-making process.

10.
The following are a list of keywords. Which terms are correct MeSH terms used in retrieving economic evaluation studies?

A. Cost-benefit analysis
B. A and C
C. Expansion costs
D. A and E
E. Costs and cost analysis

Explanation

A and E are correct. Cost-benefit analysis and Costs and cost analysis are both MeSH terms used in retrieving economic evaluation studies.

Did you score a 70% or above? If so, you've successfully completed the quiz on the Identification and Retrieval of Published Health Economics Evaluations. You may now apply for a Certificate of Success. Continue on to the next module: Principles and Critical Appraisal of Health Economic Evaluations.

Health Economics Information Resources: A Self-Study Course

Principles and Critical Appraisals for Health Economics Evaluations

Module 4 Quiz: Answer Key

This page provides the correct responses to each of the questions from the quiz on the Principles and Critical Appraisals for Health Economics Evaluations. Each question is repeated, and includes the answer and an explanation.

Quiz 4 (Module 4)

1.
Double-counting - counting the same cost twice - is a potential hazard in economic evaluation. **True** or False?

Explanation

Counting the same cost twice - double-counting - is a potential hazard in economic evaluation. An example of double-counting is counting the cost of a surgeon's time for an operation when that cost is already included in the fee.

- Glossary of Terms
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2.
There are three basic types of economic evaluation methodology: (1) cost-effectiveness analysis (CEA); (2) _____; and (3) cost-benefit analysis (CBA). What is the missing type? Select the correct answer from the list below.

A. insurance benefits analysis
B. technical efficiency analysis
C. clinical efficiency analysis
D. allocative efficiency analysis
E. cost-utility analysis (CUA)

Explanation

There are three basic types of economic evaluation methodology: (1) cost-effectiveness analysis (CEA); (2) cost-utility analysis (CUA); and (3) cost-benefit analysis (CBA)..

3.
Any economic evaluation where costs and benefits occur over a number of years should consider _____. (Fill in the blank with one of items from list below).

A. discounting
B. hypothesizing
C. alternative
D. surgery

Explanation

Individuals' or society's preferences for when to

incur costs and receive benefits is reflected in the discount rate. Any economic evaluation where costs and benefits occur over a number of years should consider discounting..

4.
Examples of health care resources include (but are not limited to) staffing, consumables such as supplies and equipment, overheads such as heating, lighting, cleaning, laundry services etc., and capital such as land, buildings and major items of equipment. **True** or False?

Explanation

This statement is true. Health care resources include staffing, consumables, overheads and capital..

5.
Cost benefit analysis (CBA) can be used to measure technical efficiency questions only. True or **False**?

Explanation

CBA can be used to measure both technical and allocative efficiency questions.

6.
Other related services costs relate to resources associated with community, ambulance, and voluntary services. As with health care resources they may be categorized as staffing, _____, overheads, and capital.

A. research
B. consumables
C. buildings
D. heating

Explanation

Other related services costs relate to resources associated with community, ambulance and voluntary services, As with health care resources they may be categorized as staffing, consumables, overheads, and capital..

7.
Are either or both of the following statements correct or incorrect? (Select the best answer). A. As a general rule cost effectiveness analysis and cost utility analysis require only health care costs to be collected. B. Cost benefit analysis requires all costs and benefits to be collected, no matter on whom they fall.

A. Statement A: yes (A is incorrect)
B. Statement A: no (A is correct)
C. Statement B: no (B is correct)
D. Statement B: yes (B is incorrect)
E. Both statement A and statement B are correct
F. Both statement A and statement B are

incorrect

Explanation

In fact, both statements are correct. As a general rule CEA and CUA require only health care costs to be collected. CBA requires all costs and benefits to be collected, no matter on whom they fall..

8.
The four main areas of resource use which may require specific identification and measurement of costs are: health care resources; other related services; clients and their families; and _____. (Fill in the missing area).

A. time lost from usual activity
B. randomized controlled trials
C. clinical trials
D. exercise

Explanation

Time lost from usual activity is the missing area. The four main areas of resource use which may require specific identification and measurement of costs are: health care resources; other related services; clients and their families; and time lost from usual activity..

9.
Cost-effectiveness analysis (CEA) can sometimes be used to provide limited information on _____ through a ratio of extra cost to extra benefit produced (incremental cost-efficiency analysis). (Select the correct phrase from the following list).

A. insurance benefits
B. technical analyses
C. technical efficiency
D. allocative efficiency
E. peer review

Explanation

CEA can sometimes be used to provide limited information on allocative efficiency through a ratio of extra cost to extra benefit produced (incremental cost-efficiency analysis)..

10.
Two patients have different treatments for the same condition. In Year 1 person A has surgery costing $3000. Patient B begins drug treatment with drugs costing $1000. Over three years, and despite an inflation rate of 5%, by adjusting costs for the rate of inflation the two treatments are shown to be _____ in terms of resources used.

A. much less efficient
B. not as efficient
C. more efficient
D. equally efficient
E. Much more efficient

Explanation

By adjusting costs for the rate of inflation the two treatments are shown to be equally efficient in terms of resources used. Each treatment has the same effect but different costs. With an inflation rate of 5% a cost of $1050 occurring in one year's time is equivalent to $1000 ($1050/1.05) now. With an inflation rate of 5% a cost of $1102.5 occurring in two year's time is equivalent to $1000 ($1102.5/1.0522) now. Use of unadjusted costs would lead to the conclusion that surgery is more efficient than drug therapy as it would appear less costly.

Did you score a 70% or above? If so, you've successfully completed the quiz on the Principles and Critical Appraisals for Health Economics Evaluations. You may now apply for a Certificate of Success.

Health Economics: Finding and Using Health Economics Resources

Evaluation

Please take a moment or two to answer these 10 questions. We will use the information collected to improve this and future online learning efforts.

1. These learning modules were easy to read and understand.

- ○ Strongly agree
- ○ Agree
- ○ Neutral
- ○ Disagree
- ○ Strongly Disagree

2. These learning modules provided me with new information.

- ○ Strongly agree
- ○ Agree
- ○ Neutral
- ○ Disagree
- ○ Strongly Disagree

3. These learning modules were fun

- Module 4 : Principles of Critical Appraisal of Health Economic Evaluations

Related Content:

- Glossary of Terms
- Key Health Economics Concepts
- Bibliography
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to do.

- ○ Strongly agree
- ○ Agree
- ○ Neutral
- ○ Disagree
- ○ Strongly Disagree

4. These learning modules will affect the way I think about health economics.

- ○ Strongly agree
- ○ Agree
- ○ Neutral
- ○ Disagree
- ○ Strongly Disagree

5. How long did it take you to complete these learning modules, including filling out this satisfaction survey?

- ○ Less than 1 hour
- ○ Less than 2 hours
- ○ more than 2 hours but less than 3 hours
- ○ more than 4 hours
- ○ I didn't keep track of the time

6. What did you like most about these learning modules?

7. What did you like least about these learning modules?

8. Where do you work?

Government Public Health - Federal

9. If you work in public health, what is your primary role within public health; e.g., health educator, researcher, educator, researcher, nurse, epidemiologist?

10. Other comments/suggestions?

Submit Your Evaluation

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