

Appendix B

Glossary of Acronyms and Terms

Acronyms

AFDC —Aid to Families with Dependent Children
AHCPR —Agency for Health Care Policy and Research (PHS)
BLS —Bureau of Labor Statistics (USDOL)
CABG -coronary artery bypass graft
CBO -Congressional Budget Office (U.S. Congress)
CDC -Centers for Disease Control (PHS)
CHAMPUS -Civilian Health and Medical program of the Uniformed Services (Department of Defense)
CPS -Current Population Survey (U.S. Bureau of the Census)
CRS -Congressional Research Service (U.S. Congress)
EBRI —Employee Benefits Research Institute
ECA —Epidemiologic Catchment Area program (National Institute of Mental Health)
EPSDT —Early and Periodic Screening, Diagnosis, and Treatment program (Medicaid)
GAO General Accounting Office (U.S. Congress)
HCFA —Health Care Financing Administration (USDHHS)
HIE —Health Insurance Experiment (RAND Corporation)
HMO -health maintenance organization
IOM —Institute of Medicine (National Academy of Sciences)
MEDTEP —Medical Treatment Effectiveness program (AHCPR)
NAMCS —National Ambulatory Medical Care Survey
NCHS —National Center for Health Statistics (CDC)
NHIS —National Health Interview Survey (NCHS)
NMCES —National Medical Care Expenditure Survey (USDHHS)
NMCUES —National Medical Care Utilization and Expenditure Survey (USDHHS)
NMES —National Medical Expenditure Survey (USDHHS)
MSA —metropolitan statistical area
OBRA-89 -omnibus Budget Reconciliation Act of 1989 (Public Law 101-239)
OBRA-90 -Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)
OHTA -Office of Health Technology Assessment (AHCPR)
OTA -Office of Technology Assessment (U.S. Congress)

PHS —U.S. Public Health Service (USDHHS)
PORT —Patient Outcomes Research Teams (AHCPR)
PPO —preferred provider organization
PTCA —percutaneous transluminal coronary angioplasty
RWJF —Robert Wood Johnson Foundation
SSI -Supplementary Security Income
USDHHS —U.S. Department of Health and Human Services
USDOL —U.S. Department of Labor

Terms

Access to health care: Potential and actual entry of a population into the health care delivery system. Elements of access include availability, affordability, and approachability.

Acute condition: Generally an injury, an *illness*, or an *impairment* of limited duration. For purposes of the *National Health Interview Survey* conducted by the U.S. Department of Health and Human Services, an acute condition is a physical or mental condition that has lasted less than 3 months; is not a condition that normally lasts more than 3 months (e.g., *diabetes*, *arthritis*); and is of sufficient consequence to have involved either at least one doctor visitor at least 1 day of restricted activity. Compare *chronic condition*.

Adverse events: Untoward events involving patients. Adverse events are typically unanticipated poor patient outcomes, such as death or readmission to the hospital. Other incidents such as improper administration of medications or patient falls are also considered adverse events, even if there is no effect on the patient.

Agency for Health Care Policy and Research (AHCPR): A Federal agency created in 1989 by an act of Congress to serve as the Federal Government's focal point for medical effectiveness and health services research. The purpose of AHCPR is to enhance the quality, appropriateness, and effectiveness of health care services and to improve access to that care. Programs within AHCPR include the Medical Treatment Effectiveness program (MEDTEP), which seeks to understand the effects of variations in health care practices on patient outcomes and develops and disseminates scientific information in an attempt to improve patient care; the Office of the Forum for Quality and Effectiveness in Health Care, which facilitates development of *clinical practice guidelines* for specific conditions and treatment services; the Office of Science and Data Development, which develops data-

- bases to support research on patient outcomes; the Center for Research Dissemination and Liaison, which is charged with disseminating information to encourage adoption of MEDTEP findings and clinical guidelines; the Office of Health Technology Assessment (OHTA), which evaluates medical technologies, procedures, and services for the Public Health Service (primarily at the request of USDHHS' *Health Care Financing Administration*) and recommends whether they should be covered; and other intramural and extramural research programs. AHCPR is located in the Public Health Service in the U.S. Department of Health and Human Services.
- Aid to Families With Dependent Children (AFDC):** A federally supported, State-administered program established by the Social Security Act of 1935 that provides financial support for children under the age of 18 who have been deprived of parental support or care because of the parent's death, continued absence from the home, unemployment, or physical or mental illness.
- Ambulatory care:** Health care services provided to patients who are not inpatients of hospitals or other residential facilities (e.g., residential treatment centers, nursing homes). May include care provided to hospital outpatients. See also *office visit and physician contact*.
- Angiography:** A test to detect heart muscle and valve abnormalities and atherosclerotic blockages of the coronary arteries, in which a catheter (tube) is used to squirt dye into the heart chambers and coronary arteries while x-ray pictures are taken. Also known as heart catheterization, coronary angiography, and coronary arteriography.
- Angioplasty:** See *percutaneous transluminal coronary angioplasty*.
- Balloon catheter angioplasty:** See *percutaneous transluminal coronary angioplasty*.
- Beneficiary:** A person who is eligible for or receiving benefits under an insurance policy or plan. The term is commonly applied to individuals receiving benefits under the *Medicaid* or Medicare programs or covered under a *private health insurance plan*.
- Benefit:** A sum of money provided in an insurance policy payable for certain types of loss, or for covered services, under the terms of the policy. The benefits may be paid to the insured or on the insured's behalf to others.
- Blue Cross plan:** A nonprofit, tax-exempt membership corporation which provides coverage for hospital care and related services in a limited geographical area. Individual Blue Cross plans should be distinguished from their national association, the Blue Cross Association. A Blue Cross plan must be an independent, nonprofit membership corporation with a governing body whose membership includes a majority of public representatives.
- Blue Shield plan:** A nonprofit, tax-exempt membership corporation which provides health insurance coverage for physicians' services in a limited geographical area. Blue Shield coverage is sometimes sold in conjunction with *Blue Cross* coverage, although this is not always the case.
- Cavitation payment:** A method of payment for health services in which an individual or institution provider is paid a fixed amount for each person served in a set period of time, usually a year, without regard to the actual number or nature of services provided to each person. This is the characteristic payment method in *health maintenance organizations (HMOs)*. Compare *fee-for-service*.
- Case finding:** The identification of instances of a particular disease or condition through screening of asymptomatic people or surveillance of defined populations.
- Case management:** A term used in this background paper to mean monitoring and coordination of treatment rendered to patients with specific diagnoses or requiring high-cost or extensive services.
- Case mix:** A measure of the mix of cases being treated by a particular health care provider that is intended to reflect the patients' different needs for resources. Case mix is generally established by estimating the relative frequency of various types of patients seen by the provider in question during a given time period and may be measured by factors such as diagnosis, *severity of illness, utilization* of services, and provider characteristics.
- Categorically needy:** Individuals who are eligible for *Medicaid* benefits because: 1) they are members of a category of eligible persons receiving cash assistance under the Aid to Families With Dependent Children (AFDC) or Supplementary Security Income (SSI) programs; and 2) their income falls below specified levels. Compare *medically needy*.
- Causality:** Relating causes to the effects they produce. Most of epidemiology concerns causality, and several types of causes can be distinguished. A cause is termed "necessary" when a particular *variable* must always precede an effect. This effect need not be the sole result of the one variable. A cause is termed "sufficient" when a particular variable inevitably initiates or produces an effect. Any given cause maybe necessary, sufficient, neither, or both.
- Cellulitis:** An acute, spreading inflammation of deep sub-skin tissues, sometimes muscle tissues, and other connective tissues. It is caused by various bacteria from a wound, burn, or other opening in the skin.
- Central cities:** Central cities are defined in two different ways by the Bureau of the Census within the U.S. Department of Commerce. The largest city in each *metropolitan statistical area (MSA)* (also called *metropolitan area*) is designated as a central city. There

may be additional central cities if specified requirements, designed to identify places of central character within the MSA, are met. The balance of the MSA outside the central city or cities often is regarded as equivalent to “suburbs.”

Cesarean section: A surgical operation through the walls of the abdomen and uterus for the purpose of giving birth.

Charge: The price of a service or amount billed to an individual and/or third party. Compare *cost*.

Chronic condition: A problem or disease that is lingering and lasting, as opposed to acute. For purposes of USDHHS’ *National Health Interview Survey*, a condition is considered “chronic” if: 1) the respondent indicates it was first noticed more than 3 months before the reference date of the interview and it exists at the time of the interview, or 2) it is the type of condition that ordinarily has a duration of more than 3 months. Examples of conditions that are considered chronic regardless of their time of onset are *diabetes*, heart conditions, emphysema, and arthritis.

Civilian Health and Medical Program of the Uniformed Services (CHAMPUS): A Department of Defense program supporting private sector health care for dependents of active and retired members of the uniformed services.

Clinical practice guidelines: Systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical conditions.

Coinsurance: Coinsurance is a health insurance policy provision that requires the insured party and the insurer to share the covered losses in a specified ratio after the *deductible* has been met and before the maximum liability has been reached (e.g., 20 percent by the insured party and 80 percent by the insurer). Coinsurance is a type of *cost sharing*.

Community rating: A method of determining health plan premiums by basing the premiums on the average costs of health services for all subscribers within a specific geographic area. Under community rating, the premium does not vary for different groups or subgroups of subscribers who have different specific claims experience. Compare *experience rating*.

Comorbidities: Diseases or conditions present at the same time as the principal condition of the patient.

Comparison group: In research, a group that does not receive the “experimental” intervention or program, but receives no or a different intervention. See also *experimental design*.

Condition: As defined for purposes of the *National Health Interview Survey* conducted by USDHHS, a departure from a state of physical or mental well-being. A health condition maybe an injury, an *illness*, or an *impairment*. See also *acute condition*, *chronic condition*.

Congestive heart failure: A syndrome due to heart disease. It is characterized by breathlessness and swelling from the buildup of fluids because of abnormal sodium and water retention. Congestion may occur in the lungs and/or in the surrounding blood vessels.

Control group: In a randomized clinical trial or other *experimental* or *quasi-experimental design*, the group receiving no treatment or some treatment with which the group receiving experimental treatment is compared. The control treatment is generally a standard treatment, a placebo, or no treatment. Compare *experimental group*.

Copayment: A type of cost-sharing which is a fixed dollar amount that a health plan enrollee is required to pay for a covered service (e.g., \$3 per prescription drug) and is applied toward the cost of each service received. A copayment is unlike *coinsurance*, the copayment amount typically does not vary according to the total *cost* or *charge* of the service. For example, a prescription drug plan might require a payment of \$2, \$3 or more for each prescription, regardless of the actual cost of the medication.

Coronary artery bypass graft (CABG): A type of heart surgery in which a leg vein or mammary (chest) artery is taken and sewn to a section of coronary artery below the point of blockage in order to supply the heart with blood. Placement of the graft is preceded by putting the patient on a heartlung machine and stopping the heart using an icy, cold, potassium-containing solution.

Cost sharing: A health insurance policy provision that requires the insured party to pay a portion of the costs of covered services. *Deductible*, *coinsurance*, and *copayment* are types of cost sharing.

Cost: Expenses incurred in the provision of services or goods. Many different kinds of costs are defined and used (e.g., allowable, direct, indirect, and operating costs). *Charges may or may not be the same as, or based on, costs*. Providers may charge more for a given service than it actually costs in order to recoup losses from providing other services where costs exceed feasible charges, or to make a profit or maintain an operating margin.

Cross-sectional (research design): Designs involving samples drawn to be representative of the entire population of interest, studied at a particular point in time.

Current Population Survey (CPS): A household sample survey of the United States civilian noninstitutionalized population that provides estimates of employment, unemployment, and other characteristics of the general labor force, the population as a whole, and various other subgroups of the population. The survey is conducted by the Bureau of the Census within the U.S. Department of Commerce. Annual data on health insurance coverage are obtained in the March supple-

ment to the Current Population Survey, which surveys a sample of households from the most recent decennial census.

Deductible: Under a health insurance policy, a dollar amount incurred by an insured individual for covered services-either a specific amount of money (e.g., \$200) or the value of specified services (e.g., 2 days of hospital care or one physician visit)-that the insured individual must pay before an insurer will assume liability for all or part of the remaining covered services. Deductibles are usually tied to some reference period over which they must be incurred (e.g., \$200 per calendar year, benefit period, or spell of illness). A deductible is a type of *cost sharing*.

Demand: In health economics, the amount of a good or service consumers are willing and able to buy at varying prices, given constant income and other factors. Demand should be distinguished from *utilization*.

Diabetes Type I: Insulin-dependent diabetes mellitus. A chronic metabolic disorder characterized by an inappropriate elevation of blood glucose level and impaired fat and protein metabolism, for which a lack or insufficiency of insulin production by the pancreas is responsible. If untreated (i.e. if the diabetic does not receive insulin from an outside source), complications progress from nausea, to a stupor, to a coma, and then to death.

Diagnosis-related groups (DRGs): Groupings of diagnostic categories drawn from the International Classification of Diseases and modified by the presence of a surgical procedure, patient age, presence or absence of significant comorbidities or complications, and other relevant criteria. See also *case mix*.

Disability: Any limitation of physical, mental, or social activity of an individual as compared with other individuals of similar age, sex, and occupation. The term frequently refers to limitation of a person's usual or major activities, most commonly vocational. There are varying types (functional, vocational, learning), degrees (partial, total), and durations (temporary, permanent) of disability. Public programs (such as Social Security and Medicare) often provide benefits to persons afflicted with specific disabilities.

Disease: Any deviation from or interruption of the normal structure of function of any part, organ, or system (or combination thereof) of the body that is manifested by a characteristic set of symptoms and signs and whose etiology, pathology, and prognosis may be known or unknown. See *condition*.

Drug: Any chemical or biological substance that maybe applied to, ingested by, or injected into humans in order to prevent, treat, or diagnose disease or other medical conditions.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program: A State and federally

funded, State-administered program under Medicaid that is intended to provide preventive screening exams and followup services for illnesses, abnormalities, and treatable conditions to Medicaid-eligible children under age 21. The EPSDT benefit was enacted in 1967 and significantly expanded in 1989.

Effectiveness: Effectiveness is a particular application of *efficacy*, that is, it reflects the performance of an intervention under ordinary conditions by the average practitioner for the typical patient.

Efficacy: Efficacy has been defined by the Office of Technology Assessment as the probability of benefit to individuals in a defined population from a medical technology applied to a given medical problem under ideal conditions of use. Compare *effectiveness*.

Employment-based group health plans: A group health plan that is offered to employees by an employer.

Experience rating: A method of determining health plan premiums based on the historical utilization data and distinguishing characteristics of a specific subscriber group. Compare *community rating*.

Experimental design: Strictly speaking, a research design in which research participants are randomly assigned to one or more *experimental groups* or one or more *control or comparison groups*. Compare *quasi-experimental design*.

Experimental group: In a randomized clinical trial, other experiment, or evaluation research, the group receiving the treatment being evaluated for safety or efficacy. The experiment treatment may be a new technology, an existing technology applied to a new problem, or an accepted treatment about whose safety or efficacy there is doubt. Compare *control group*.

Federal poverty level: The official U.S. Government definition of poverty based on cash income levels for families of different sizes. Responsibility for changing poverty concepts and definitions rests with the Office of Management and Budget in the Executive Office of the President of the United States. The poverty thresholds for the continental United States in 1992 were \$8,810 for one person, \$9,190 for two persons, \$11,570 for three persons, and \$13,950 for four persons. Alaska and Hawaii have higher thresholds.

Federally qualified HMOs: A *health maintenance organization (HMO)* which has been determined by the Department of Health and Human Services (USDHHS) to meet the standards set forth in Title XIII of the Public Health Service Act, in such areas as financial and administrative stability, quality, scope of services covered, and rate-setting practices. An employer who provides *health insurance* coverage to employees may be required to offer a federally qualified HMO as an alternative to other health benefits plans offered.

Fee-for-service: A method of billing for health services under which a physician or other practitioner charges

separately for each patient encounter or service rendered. Under a fee-for-service payment system, expenditures increase if the fees themselves increase, if more units of services are provided or if more expensive services are substituted for less expensive ones. This system contrasts with salary, per capita or other prepayment systems, where the payment to the practitioner is not changed with the number of services actually used. Compare *cavitation payment*.

Health Care Financing Administration: An office in the U.S. Department of Health and Human Services that has primary responsibility at the Federal level for administering *Medicaid*.

Health care provider: Any person in one of the broad range of disciplines that specializes in providing *personal health services*. The term includes, but is not necessarily limited to, health educators, nurses, nurse-midwives, nurse-practitioners, psychiatric nurses, clinical psychologists, clinical social workers, and physicians.

Health insurance: In the traditional sense, health insurance is an arrangement for transferring and distributing risk associated with sickness or injury. It is an arrangement under which one party, an insurer, contracts to do something of value for another party, an insured or beneficiary, upon the occurrence of a specified harmful contingency (e.g., sickness or injury). Insurance allows the individual insured to pay a small, definite cost, a *premium*, for protection against paying for a large loss which might occur. In this background paper, the term health insurance is used broadly, to include both *private health insurance coverage* (e.g., employer-subsidized coverage at the workplace or self-purchased coverage for individuals) and *public coverage* (e.g., coverage provided by *Medicaid* and the *Civilian Health and Medical Program of the Uniformed Services [CHAMPUS]*). Private health insurance coverage is most likely to conform to traditional definitions of insurance, requiring individuals to pay premiums in exchange for being reimbursed for covered losses associated with sickness or injury. Private health insurance also includes so-called prepaid health plans (e.g., *health maintenance organizations*) that, while they require the payment of premiums, also are more likely to cover services not associated with sickness or injury (e.g., *preventive services*). Public coverage does not typically involve the payment of a premium, and public coverage plans differ in the extent to which they cover services not associated with sickness or injury. There is considerable debate about whether the purpose of health insurance should be to protect people from financial catastrophe or to assure them *access to a range* of health services. See also *third-party payment*.

Health maintenance organization (HMO): An organization that, in return for prospective per capita

(*cavitation*) payments, acts as both insurer and provider of comprehensive but specified health care services to a voluntarily enrolled population. Prepaid group practices and individual practice associations are types of HMOs.

Health outcome: A measure of the effectiveness of preventive or treatment health services, typically in terms of patient *health status*. Attributing changes in outcomes to health services requires distinguishing the effects of the many other factors that influence patients' health.

Health status: The state of health of a specified individual, group, or population. Health status maybe measured by obtaining *people's subjective assessments of their health*; by one or more indicators of mortality and morbidity in the population, such as longevity or maternal and infant mortality; or by using the incidence or prevalence of major diseases. Most of these are, of course, measures of disease status, but they are used as proxies in the absence of measures of either objective or subjective health. Conceptually, health status is the proper outcome measure for the effectiveness of a specific population's medical care system, although attempts to relate effects of available medical care to variations in health status have proved difficult.

Household: As defined by the Bureau of the Census within the U.S. Department of Commerce, all the persons who occupy a housing unit (i.e., a house, an apartment or other group of rooms, or a single room occupied or intended for occupancy as separate living quarters).

Hypokalemia: An abnormally low potassium concentration in the blood. It may be manifested by renal disease, by gastrointestinal disorders, and by disorders of the nerves in muscles ranging from weakness to paralysis.

Illness: Generally, any departure from good health.

Impairment: A physiological, anatomical, mental loss, or "abnormality" caused by accident, disease, or congenital condition. An impairment may be the underlying cause of a *disability*. Compare *disability*.

Inpatient: A person who has been admitted at least overnight to a hospital or other health facility (which is therefore responsible for his or her room and board) for the purpose of receiving health services. **Inpatient care** means the care given to inpatients.

Length of stay: The number of days during which a patient remains in a hospital or other institution, from admission to discharge. Ordinarily the day of admission is counted, but the day of discharge is not. When admission and discharge take place on the same day, the length of stay is generally considered to be 1 day.

Malignant hypertension: Severely high blood pressure that is characterized by the thickening of small arteries and by hemorrhaging.

Managed care: A term applied to a myriad of payment and/or delivery arrangements that attempt to control or coordinate enrollees' use of health services in order to control health care expenditures, to improve the quality of health care, or both. These arrangements range from organized health care delivery systems (e.g., staff model *HMOs*) to specific features of health care plans (e.g., *preadmission certification programs, utilization review programs*, use of *clinical practice guidelines*).

Medicaid: A federally aided, State-operated and administered program that provides medical assistance for low-income people meeting specific income and family structure requirements. Those eligible to receive Medicaid coverage include individuals with low incomes who are elderly, blind, have disabilities, are members of families with dependent children, or certain pregnant women and young children. States establish eligibility requirements that are subject to Federal guidelines. There is substantial variation among States in terms of eligible populations, range of services offered, limitations imposed on services, and reimbursement policies.

Medically needy Medicaid recipients: People who receive Medicaid under State "medically needy" programs. States have the option to offer Medicaid to medically needy people who would be categorically eligible for Medicaid but whose income and resources lie above the standards for *Aid to Families with Dependent Children (AFDC)*. Each State sets its own medically needy resource and income standards up to 133.33 percent of State AFDC income standards.

Medium and large firms: As defined by the U.S. Department of Labor's Bureau of Labor Statistics' 1989 Survey of Employee Benefits, establishments with 100 workers or more in all private nonfarm industries.

Meta-analysis: The quantitative analysis of a large collection of results from individual studies for the purpose of integrating the findings.

Metropolitan area: A geographic area consisting of a large population nucleus, together with adjacent communities which have a high degree of economic and social integration with that nucleus. Metropolitan areas are also known as metropolitan statistical areas (MSA). An area qualifies for recognition as an MSA if: (1) it includes a city of at least 50,000 population, or (2) it includes a Census Bureau-defined urbanized area of at least 50,000 with a total metropolitan population of at least 100,000 (75,000 in New England). In addition to the county containing the main city or urbanized area, an MSA may include other counties having strong commuting ties to the central county. The territory outside metropolitan statistical areas is referred to as nonmetropolitan.

Metropolitan statistical area (MSA): See *metropolitan area*.

Mortality rate: The death rate, often made explicit for a particular factor (e.g., age, sex, or specific cause of death). A mortality rate contains three essential elements: 1) the number of people in a population group exposed to the risk of death; 2) a time factor; and 3) the number of deaths occurring in the exposed population during a certain time period (the numerator).

National Ambulatory Medical Care Survey (NAMCS): Funded and administered by the U.S. Department of Health and Human Services, Public Health Service, National Center for Health Statistics. NAMCS is a continuing national probability sample survey of ambulatory medical encounters. It collects data on physician-patient encounters in the offices of a sample of nonfederally employed physicians classified as "office-based, patient care physicians." Data are collected on patient characteristics and medical information, including expected source of payment.

National health expenditures: An estimate of national spending on health care made up of two broad categories: 1) health services and supplies, which, in turn, consist of *personal health care* expenditures (the direct provision of health care), program administration and the net cost of *private health insurance*, and government public health activities; and 2) research and construction of medical facilities.

National Health Interview Study (NHIS): Funded and administered by the U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control, National Center for Health Statistics. A continuing nationwide sample survey in which personal *household* interviews are used to obtain information on personal and demographic characteristics, *illnesses, injuries, impairments, chronic conditions, utilization* of health resources, *health insurance* coverage, and other health topics.

National Medical Care Expenditure Survey of 1977 (NMCES): Funded and administered by the U.S. Department of Health and Human Services, Public Health Service, National Center for Health Services Research, now known as the *Agency for Health Care Policy and Research [AHCPR]*, and National Center for Health Statistics. A nationwide sample survey which gathered information on the use of health services, health expenditures, and health insurance of the civilian noninstitutionalized population.

National Medical Care Utilization and Expenditure Survey of 1980 (NMCUES): Conducted by the U.S. Department of Health and Human Services, Public Health Service, National Center for Health Statistics. A series of several related surveys on health, access to and use of medical (and dental) services, associated *charges* and sources of payment, and *health insurance* coverage during 1980. The household portion of

NMCUES consisted of: 1) a national household survey of a sample of the civilian noninstitutionalized population, and 2) a household survey of the Medicaid-eligible populations of the States of New York, California, Texas, and Michigan. These two surveys each consisted of five interviews over a period of approximately 15 months to obtain information on *medical utilization*, expenditures, and other health-related information. A third survey, an administrative records survey, was designed to verify the eligibility status of the household survey respondents for the Medicare and *Medicaid* programs.

National Medical Expenditure Survey of 1987 (NMES):

Funded and administered by the U.S. Department of Health and Human Services, Public Health Service, Agency for Health Care Policy Research. A nationwide sample survey which collected data on health status, use of health services, health insurance coverage, health care expenditures and sources of payment for the civilian population of the United States during the period from January 1 to December 31, 1987.

Nursing home: Generally, a wide range of institutions which provide various levels of maintenance and personal or nursing care to people who are unable to care for themselves and who may have health problems which range from minimal to very serious. The term includes freestanding institutions, or identifiable components of other health facilities which provide nursing care and related services, personal care, and residential care.

Office visit: As defined by USDHHS' National Center for Health Statistics for the purpose of the National Ambulatory Medical Care Survey, any direct personal exchange between an ambulatory patient and a physician, or members of his or her staff, for the purposes of seeking care and rendering health services.

Orthoptics: The treatment of defective visual habits, defects of binocular vision, and muscle imbalance by re-education of visual habits, exercise, and visual training.

Out-of-pocket expense: Personal expenditures for the portion of health care services not covered by third-party payments.

Outcomes (of health care): Patients' health. In assessments of access and quality, outcomes acquire importance to the extent that they have resulted from prior medical interventions. But attributing changes in patients' health to medical care requires distinguishing the effects of care from the effects of the many other factors regarding patients and their environments that also influence health.

Patient satisfaction: Attitudinal measures of patients' personal evaluations of aspects of health care providers and services. Patient satisfaction measures are inherently subjective because they reflect personal experiences, expectations, and preferences, as well as the

standards patients apply when evaluating care. An example of a patient satisfaction measure would be to ask whether patients were satisfied overall or not completely satisfied with their most recent ambulatory visit.

Percutaneous transluminal coronary angioplasty (PTCA):

Minor heart surgery, in which a long wire catheter is inserted into the body near the groin and guided up through the patient's arteries to the arteries of the heart. A balloon at the end of the wire is inflated, squeezing any fat against the arterial wall, widening the passage, and thereby allowing more blood to flow to the heart. Also known as balloon catheter angioplasty.

Personal health services: Health services received by individuals: hospital care, physician services, dental services, other professional services, home health care, drugs and other medical nondurable, vision products, other medical durables, nursing home care, and other personal care.

Physician contact: As defined by the USDHHS' National Center for Health Statistics for the *National Health Interview Survey*, any contact with a physician directly or with a nurse or other person acting under the physician's supervision, whether in person or by telephone, for the purpose of examination, diagnosis, treatment, or advice, excluding physician contacts with hospital *inpatients* or for the purpose of mass screenings (e.g., in a trailer). Compare office *visit*.

Point-of-service plan: A health insurance benefits program in which subscribers can select between different delivery systems (i.e., *health maintenance organization*, *preferred provider organization*, and out-of-system *fee-for-service providers*) when in need of medical services, rather than making the selection between delivery systems at time of open enrollment. Typically, the *out-of-pocket* costs associated with receiving care from HMO providers are less than when care is rendered by PPO or noncontracting providers.

Practice guidelines: See *clinical practice guidelines*.

Preadmission certification: A process under which admission to a health institution is reviewed in advance to determine need and appropriateness and to authorize a *length of stay* consistent with norms for the evaluation.

Precertification: See *preadmission certification*.

Preexisting condition: As defined by insurers, a condition existing before an insurance policy goes into effect and commonly defined as one which would cause an ordinarily prudent person to seek diagnosis, care, or treatment.

Preferred provider organization (PPO): A type of group health plan which is a network of *health care providers* and facilities who agree to furnish certain services for declared fees lower than their usual prices. The covered member is then encouraged, but not required, to obtain health care services from a preferred

provider, with the incentives of lower deductibles or copayments.

Prehospitalization testing: Laboratory and other tests done prior to hospitalization on an outpatient or ambulatory basis, in order to reduce expenditures.

Premium: The price or amount which must be paid periodically (e.g., monthly) to purchase insurance coverage or to keep an insurance policy in force. Virtually all health insurance programs require the payment of a premium by the *beneficiary*, and/or by someone else (such as the employer) on the beneficiary's behalf. Premiums paid to *health maintenance organizations (HMOs)* or similar organizations are often called *cavitation* payments.

Preventive health services: Services intended to prevent the occurrence of a disease or its consequences. Preventive health care includes health care programs aimed at warding off *illnesses* (e.g., immunizations), early detection of disease (e.g., Pap smears), and inhibiting further deterioration of the body (e.g., exercise or prophylactic surgery). Preventive medicine is also concerned with general preventive measures aimed at improving the healthfulness of the environment and with the promotion of health through altering behavior, especially using health education. Preventive health services are sometimes categorized as primary, secondary, or tertiary. Primary prevention is aimed at reducing the incidence of a disease or health problem; **secondary prevention** is aimed at reducing the prevalence of a problem by shortening the duration among those who have the problem; and tertiary prevention is aimed at reducing complications. Compare *treatment services*.

Primary care: A familiar but elusive term that is variously considered to be: 1) first contact care; 2) an array of services that provides certain attributes including comprehensiveness, coordination, continuity and accessibility; 3) care provided by certain provider disciplines, including general or family practice, general internal medicine, and primary care nurse practitioners or physician's assistants; and 4) the de facto care that most people receive for most of the problems that bother them most of the time.

Private health insurance coverage: Insurance that is not *public coverage*. Includes direct and indirect group coverage (e.g., *employment-based group insurance plan*), as well as individual and family policies. See *health insurance*.

Prepaid health plans: See *health insurance*.

Procedure: A medical technology involving any combination of drugs, devices, and provider skills and abilities. Appendectomy (removal of an appendix), for example, may involve at least drugs (for anesthesia), monitoring devices, surgical devices, and physicians', nurses', and support staffs' skilled actions.

Process: The activities of health professionals in caring for patients. Process measures acquire validity as indicators of access and quality only to the extent that they have been found likely to improve or harm patient *outcomes*.

Prospective payment: Any method of paying hospitals or other health programs in which amounts or rates of payment are established in advance for a defined period (usually a year). Institutions are paid these amounts regardless of the costs they actually incur. These systems of payment are designed to introduce a degree of constraint on charge or costs increases by setting limits on amounts paid during a future period. In some cases, such systems provide incentives for improved efficiency by sharing savings with institutions that perform at lower than anticipated costs.

Provider: See *health care provider*.

Public coverage: *Third-party* coverage that is chiefly administered, operated, or financed by the Federal or State Governments. Examples are *Medicaid*, *Medicare*, and *CHAMPUS*. Compare *private health insurance coverage*. See *health insurance*.

Pyelonephritis: Inflammation of the kidney due to bacterial infection.

Quality assurance: Activities to safeguard or improve the *quality of medical care* by assessing quality and taking action to correct any problems found.

Quality of medical care: Evaluation of the performance of health care providers according to the degree to which the process of care increases the probability of outcomes desired by the patients and reduces the probability of undesired outcomes, given the state of medical knowledge. Which elements of patient outcomes predominate depends on the patient condition.

Quasi-experimental design: A research design involving an experiment that has a treatment, an outcome measure(s), and experimental units, but does not use random assignment to create the comparisons from which treatment-caused change is inferred. Instead, the comparisons depend on nonequivalent groups that differ from each other in many ways other than the presence of a treatment whose effects are being tested. The task confronting those who try to interpret the results from quasi-experiments is basically one of separating the effects of a treatment from those due to the initial noncomparability between the average units in each treatment group. Compare *experimental design*.

RAND Health Insurance Experiment (HIE): A large-scale controlled trial in health care financing with the objective of examining the effects of different organizational and financial arrangements for delivering health care services.

Robert Wood Johnson Foundation National Health Access Surveys: In 1978, 1982, and 1986 the Robert Wood Johnson Foundation sponsored national tele-

phone surveys. The 1982 survey consisted of telephone interviews of 3,000 families, intended to represent a cross-sectional sample of the U.S. population, and an oversampling of approximately 1,800 families with incomes below *the Federal poverty level*, **comprising a total of 6,610 individuals**. Information was **collected** on one **adult and one child (if present)** from each **household**. **The 1986 telephone survey sampled 10,130 individuals**. Persons with *chronic* or serious medical *illnesses* were oversampled to allow adequate evaluation of the *access* problems of those with illnesses, but the study group was weighted to represent the U.S. population as a whole. Because the primary focus of these surveys was on access, and not on differences by payment source, some of the reports compare the *uninsured* with the insured but do not differentiate between *Medicaid* and *privately insured* persons, nor do they always separate results for persons under and over age 65.

Severity of illness: The extent and intensity of a patient's *disease* or *condition*, indicated by the likelihood that the patient will suffer permanent *impairment, disability*, or death if no further treatment is provided. The likelihood of impairment, disability, or death depends on which diseases and conditions are present and the stage they have reached in the usual course of the disease or condition. Some attempts to measure severity of *illness* have **focused on the patient's principal disease or condition, the presence of coexisting disease**, and the stage of the disease. Other **attempts have emphasized the physiologic** status of the patient (e.g., measuring the extent of departure from "normal" values for a variety of physiologic functions such as the oxygen carrying capacity of the blood, body temperature, pulse rate, etc.). Presently, no single approach to severity of illness measurement has received widespread acceptance. Compare *case mix*.

Single-payer prospective payment program: See *prospective payment*.

Small establishments: As defined by the U.S. Department of Labor's Bureau of Labor Statistics' 1990 Employee Benefits Survey, private nonfarm firms with fewer than 100 workers.

Stapedectomy: The removal of the stapes (the innermost ossicle in the ear), and replaced with various prostheses and tissues. Often used to treat otosclerosis (the formation of spongy bone in the ear, resulting in progressively increasing deafness).

Statistical significance: A judgment, based on commonly agreed to statistical principles, that there is relatively little likelihood (typically from below 1 to below 5 percent) that an observed relationship between or among *variables* has occurred by chance.

Stop loss provision: The maximum insured individual's outlay or *out-of-pocket expense*, per a specified time period (e.g., a year), **usually excluding the plan deductible**.

Strabismus: A deviation of the eye that the patient cannot overcome without aid. The condition is due to a lack of parallelism of the visual axes of the eyes.

Third-party payment: Payment by a private insurer or government program to a health care provider for care given to a patient.

Treatment services: Services intended to cure or ameliorate the effects of a disease or other health problem once a problem has occurred. Compare *preventive services*.

Underinsured: People with *public* or *private insurance* policies that do not cover all necessary medical services, resulting in *out-of-pocket expenses* that exceed their ability to pay.

Uninsured: People who lack *private* or *public health insurance coverage*.

Utilization: Use; commonly examined in terms of patterns or rates of use of a single service or type of service, e.g., hospital care, physician visits, prescription drugs. Measurement of utilization of all medical services in any given period is sometimes done in terms of dollar expenditures. Use is also expressed in rates per unit of population at risk for a given period, e.g., number of admissions to a hospital per 1,000 persons over 65 per year or number of visits to a physician per person.

Utilization review: Evaluation of the necessity, appropriateness, and efficiency of the use of medical services based on some specified criteria. In a hospital, this includes review of the appropriateness of admissions, services ordered and provided, length of stay, and discharge practices, both on a concurrent and retrospective basis. Utilization review can be done by a peer review group, a public or private agency on its own behalf, or by a vendor.

Validity: A measure of the extent to which an observed situation reflects the true situation or an indicator measures what it purports to measure.

Variable: In research, a factor that is changeable and subject to variation. The independent variable establishes the value of the dependent variable(s) when a defined relationship exists between them.

Well-child care: *Preventive health care* for children, including immunizations, health education, parental guidance, physical examinations, and other tests that screen for illness or developmental problems.