

# Economics of Health Care Practice Test (Sample)

## Study Guide



**Everything you need from our exam experts!**

**This is a sample study guide. To access the full version with hundreds of questions,**

**Copyright © 2026 by Examzify - A Kaluba Technologies Inc. product.**

**ALL RIGHTS RESERVED.**

**No part of this book may be reproduced or transferred in any form or by any means, graphic, electronic, or mechanical, including photocopying, recording, web distribution, taping, or by any information storage retrieval system, without the written permission of the author.**

**Notice: Examzify makes every reasonable effort to obtain from reliable sources accurate, complete, and timely information about this product.**

**SAMPLE**

# Table of Contents

<b>Copyright</b> .....	<b>1</b>
<b>Table of Contents</b> .....	<b>2</b>
<b>Introduction</b> .....	<b>3</b>
<b>How to Use This Guide</b> .....	<b>4</b>
<b>Questions</b> .....	<b>6</b>
<b>Answers</b> .....	<b>9</b>
<b>Explanations</b> .....	<b>11</b>
<b>Next Steps</b> .....	<b>17</b>

# Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

# How to Use This Guide

**This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:**

## **1. Start with a Diagnostic Review**

**Skim through the questions to get a sense of what you know and what you need to focus on. Don't worry about getting everything right, your goal is to identify knowledge gaps early.**

## **2. Study in Short, Focused Sessions**

**Break your study time into manageable blocks (e.g. 30 - 45 minutes). Review a handful of questions, reflect on the explanations, and take breaks to retain information better.**

## **3. Learn from the Explanations**

**After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.**

## **4. Track Your Progress**

**Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.**

## **5. Simulate the Real Exam**

**Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.**

## **6. Repeat and Review**

**Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning.**

## **7. Use Other Tools**

**Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.**

**There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly — adapt the tips above to fit your pace and learning style. You've got this!**

SAMPLE

## **Questions**

- 1. What does "vertical integration" refer to in health care systems?**
  - A. The combination of similar health services across different organizations**
  - B. The merger of healthcare services and providers within the same organization**
  - C. The collaboration between hospitals and insurance companies**
  - D. The outsourcing of specific health services to external providers**
- 2. Which element is crucial for influencing the utilization of health care services?**
  - A. Consumer's knowledge of medical procedures**
  - B. Availability of transportation to health facilities**
  - C. Out-of-pocket costs**
  - D. Popularity of health trends**
- 3. What are health care externalities?**
  - A. Costs or benefits affecting parties involved directly in care**
  - B. Costs or benefits of health care that affect third parties**
  - C. Direct payments made by individuals for health services**
  - D. Fixed charges imposed by health insurance companies**
- 4. What is the implication of price discrimination in healthcare?**
  - A. It ensures everyone pays the same price**
  - B. It may increase overall costs for some patients**
  - C. It leads to equal access to services**
  - D. It promotes fair competition among providers**
- 5. What are "value-based payment models"?**
  - A. Payment based on the volume of services delivered**
  - B. Reimbursement tied to quality and efficiency of care**
  - C. Payment models without any regard for outcomes**
  - D. Reimbursement based on the cost of services**

- 6. What are externalities in health care economics?**
- A. Costs or benefits impacting third parties not involved**
  - B. Internal costs borne by hospitals for treatment procedures**
  - C. Strict regulations on health care pricing**
  - D. Potential risks associated with new medical technologies**
- 7. What is a consequence of competitive market theory in health care?**
- A. Increased collaboration among providers**
  - B. Higher prices due to reduced competition**
  - C. Improved quality due to provider competition**
  - D. Decreased access to health services**
- 8. In government-provided health insurance, what can moral hazard lead to?**
- A. Lower spending on health services**
  - B. Increased cautiousness among insured individuals**
  - C. More frequent utilization of health services**
  - D. Decreased demand for health services**
- 9. What does the concept of "managed care" primarily focus on?**
- A. Increasing provider salaries**
  - B. Controlling costs while maintaining quality**
  - C. Dismissing low-cost services**
  - D. Eliminating competition among providers**
- 10. What term is commonly used to refer to individuals who share the same parents?**
- A. Cousins**
  - B. Siblings**
  - C. Aunts and Uncles**
  - D. Friends**

## **Answers**

SAMPLE

1. B
2. C
3. B
4. B
5. B
6. A
7. C
8. C
9. B
10. B

SAMPLE

## **Explanations**

1. What does "vertical integration" refer to in health care systems?
- A. The combination of similar health services across different organizations
  - B. The merger of healthcare services and providers within the same organization**
  - C. The collaboration between hospitals and insurance companies
  - D. The outsourcing of specific health services to external providers

Vertical integration in health care systems refers to the merger or consolidation of healthcare services and providers that operate at different levels of care within the same organization. This concept involves integrating various entities along the continuum of care, such as hospitals, outpatient facilities, and rehabilitation services, enabling a seamless delivery of care from one provider. This can enhance efficiency, improve patient outcomes, and offer a more coordinated approach to treatment, as patients can receive all necessary services under one organizational umbrella. In a vertically integrated system, the organization has control over multiple stages of health care delivery, which can lead to better management of healthcare costs, streamlined services, and improved patient experiences, as the flow of information and care transitions are potentially smoother. The other options represent different approaches to health care organization but do not specifically capture the essence of vertical integration, which focuses on the internal consolidation of services at various stages of care within a single organization.

2. Which element is crucial for influencing the utilization of health care services?
- A. Consumer's knowledge of medical procedures
  - B. Availability of transportation to health facilities
  - C. Out-of-pocket costs**
  - D. Popularity of health trends

Out-of-pocket costs are a crucial element influencing the utilization of health care services because they directly affect a consumer's ability and willingness to access care. High out-of-pocket expenses, such as copayments, deductibles, and coinsurance, can deter individuals from seeking necessary medical attention, leading to unmet health needs and potential worsening of health conditions. When costs are high, individuals may delay or forgo care, even when they recognize a need, which can have serious long-term consequences for both individual and public health. Accessibility to health care is fundamentally shaped by economic factors, and the financial burden placed on consumers through these out-of-pocket costs significantly determines whether they will utilize available health services. Additionally, individuals with lower income or lacking insurance are particularly sensitive to these costs, further affecting their health outcomes and overall utilization of health services. In this context, understanding and addressing out-of-pocket costs is essential for policymakers and health care providers aiming to improve access to care and enhance population health. Other options, while potentially influential, do not have the same immediate and widespread economic impact on the decision to seek health care services as the financial barriers posed by out-of-pocket costs.

### 3. What are health care externalities?

- A. Costs or benefits affecting parties involved directly in care
- B. Costs or benefits of health care that affect third parties**
- C. Direct payments made by individuals for health services
- D. Fixed charges imposed by health insurance companies

Health care externalities refer to the costs or benefits that impact parties who are not directly involved in the health care transaction. These can include both positive and negative effects resulting from health care consumption and delivery that extend beyond the immediate participants in the process. For example, vaccination programs can lead to herd immunity, benefiting the overall community by reducing the spread of disease, even among those who are not vaccinated. Conversely, a negative externality might occur if a person with a contagious disease does not seek treatment, potentially spreading the illness to others. Understanding externalities in health care is crucial for policymakers who want to design interventions that address these broader impacts. In contrast, the other options focus on direct relationships or financial transactions concerning health care services, which do not capture the essence of externalities.

### 4. What is the implication of price discrimination in healthcare?

- A. It ensures everyone pays the same price
- B. It may increase overall costs for some patients**
- C. It leads to equal access to services
- D. It promotes fair competition among providers

Price discrimination in healthcare refers to the practice where providers charge different prices for the same service based on various factors, such as the patient's ability to pay, insurance coverage, or other considerations. The implication of this practice is that it may increase overall costs for some patients. When providers engage in price discrimination, some patients, especially those who are uninsured or underinsured, may end up paying higher prices than others who have better insurance coverage or are able to negotiate rates. This disparity can lead to increased financial burden for these patients, potentially limiting their access to necessary care or leading them to incur higher out-of-pocket expenses. Moreover, because healthcare costs are often passed on to patients, those paying higher prices can collectively contribute to rising healthcare expenditures, thus inflating overall healthcare costs within the system. In contrast, ensuring that everyone pays the same price would negate the concept of price discrimination, while equal access to services would hypothetically minimize disparities in healthcare accessibility, which can be contrary to the nature of price discrimination. Lastly, price discrimination does not inherently promote fair competition among providers, as it can create uneven playing fields based on pricing strategies that do not reflect a uniform cost structure.

## 5. What are "value-based payment models"?

- A. Payment based on the volume of services delivered
- B. Reimbursement tied to quality and efficiency of care**
- C. Payment models without any regard for outcomes
- D. Reimbursement based on the cost of services

Value-based payment models represent a significant shift in how healthcare services are reimbursed. These models specifically focus on linking reimbursement to the quality and efficiency of care provided rather than the sheer volume of services delivered. The objective is to encourage healthcare providers to deliver better patient outcomes while also managing costs effectively. In value-based models, factors such as patient satisfaction, health outcomes, and the effectiveness of care processes are taken into consideration. This approach incentivizes providers to focus on preventive care, chronic disease management, and overall health improvements rather than simply performing more procedures or services. As a result, it aligns the incentive structures in healthcare delivery with the goals of improving care quality and patient satisfaction while controlling costs, ultimately benefiting both providers and patients.

## 6. What are externalities in health care economics?

- A. Costs or benefits impacting third parties not involved**
- B. Internal costs borne by hospitals for treatment procedures
- C. Strict regulations on health care pricing
- D. Potential risks associated with new medical technologies

Externalities in health care economics refer to costs or benefits that affect third parties who are not directly involved in a particular transaction or situation. For instance, if a person receives a vaccination, the immediate benefit is for that individual, but there is also a broader impact on public health; others are less likely to contract a disease due to increased immunity in the population. This is a positive externality, as the benefits extend beyond the individual. Similarly, negative externalities can occur when decisions made by individuals impact others negatively, such as when a person with a contagious disease does not seek treatment and spreads the illness to others. These externalities illustrate the interconnectedness of health outcomes and emphasize the importance of considering the wider societal implications of health care decisions, which can lead to market failures if not addressed appropriately. Other options focus on issues such as internal costs, regulations, or risks associated with technology, which do not capture the essence of externalities, as they pertain to direct financial or operational aspects within the health care system rather than the broader societal implications of individual actions.

**7. What is a consequence of competitive market theory in health care?**

- A. Increased collaboration among providers**
- B. Higher prices due to reduced competition**
- C. Improved quality due to provider competition**
- D. Decreased access to health services**

According to competitive market theory, one of the key consequences is improved quality due to provider competition. In a competitive market, various health care providers strive to attract patients by enhancing the quality of their services. This competition encourages providers to innovate, adopt best practices, and improve patient outcomes in order to differentiate themselves from their rivals. As a result, when providers are aware that patients have options, they are more likely to focus on delivering higher-quality care and better service, which ultimately benefits consumers. In contrast, the other options suggest scenarios that may not align with the principles of competitive market theory. For instance, increased collaboration among providers and decreased access to health services are typically associated with different market dynamics, such as monopolistic or oligopolistic environments. Higher prices due to reduced competition would also not reflect the intended outcomes of competitive markets where competition generally drives prices down, not up. Thus, improved quality stands out as a clear and positive consequence of competition in the health care market.

**8. In government-provided health insurance, what can moral hazard lead to?**

- A. Lower spending on health services**
- B. Increased cautiousness among insured individuals**
- C. More frequent utilization of health services**
- D. Decreased demand for health services**

Moral hazard refers to the phenomenon where individuals alter their behavior when they have insurance coverage because they do not bear the full cost of their actions. In the context of government-provided health insurance, this situation can lead to more frequent utilization of health services. When individuals know they are insured, they may be more likely to seek medical care, even for minor issues, since they do not personally incur the entire cost of that care. This can result in an increase in demand for healthcare services, as people feel less constrained by potential financial burdens. The dynamics of moral hazard emphasize that when patients are insulated from the costs associated with their medical care, they might overuse services, leading to higher overall healthcare expenditures. This trend is important for policymakers to consider, as it can impact the sustainability of public health insurance systems and overall healthcare costs.

**9. What does the concept of "managed care" primarily focus on?**

- A. Increasing provider salaries**
- B. Controlling costs while maintaining quality**
- C. Dismissing low-cost services**
- D. Eliminating competition among providers**

The concept of "managed care" primarily focuses on controlling costs while maintaining quality. Managed care is a system designed to streamline healthcare delivery by coordinating services, emphasizing preventive care, and implementing health management strategies that aim to reduce unnecessary expenditures. This approach involves a network of providers who deliver services under a set regulation that balances both cost efficiency and quality of care. By negotiating lower rates with providers and incentivizing certain health behaviors among patients—like preventive screenings or chronic condition management—managed care organizations strive to maintain overall healthcare quality while minimizing expenses. The premise is that proper management and coordination can lead to better health outcomes, ultimately benefiting both patients and payers. The focus on cost control is fundamental to managed care, making it an essential aspect of healthcare economics, influencing how services are accessed, delivered, and financed. It reflects the ongoing efforts in healthcare to find an equilibrium between providing high-quality services and keeping those services economically sustainable.

**10. What term is commonly used to refer to individuals who share the same parents?**

- A. Cousins**
- B. Siblings**
- C. Aunts and Uncles**
- D. Friends**

The term that is commonly used to refer to individuals who share the same parents is "siblings." Siblings are brothers and sisters who grow up in the same household and have a direct familial relationship through their parents. This term specifically denotes the connection between children who have the same mother and/or father, making it distinct from other familial or social relationships. Cousins refer to the children of one's aunts and uncles and do not share the same parents, while aunts and uncles are the siblings of one's parents, representing another generational relationship. Friends are individuals who may share social or personal connections but do not have a familial bond. Therefore, the term "siblings" accurately captures the essence of individuals who share parental lineage.

## Next Steps

**Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.**

**As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.**

**If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at [hello@examzify.com](mailto:hello@examzify.com).**

**Or visit your dedicated course page for more study tools and resources:**

**<https://healthcareecon.examzify.com>**

**We wish you the very best on your exam journey. You've got this!**