

Why the Economic Aspects of Healthcare are not Unique

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ABSTRACT: Frequent claims suggest that healthcare and its production are not only different from other goods, but that they differ to such an extent that healthcare should be viewed as unique. Various features of healthcare, such as the lack of a perfect market and the existence of information asymmetry, are cited as evidence of this claim. However, such a view results from unduly emphasising the characteristics of healthcare as being atypical. This article redresses this imbalance by taking an alternative approach and examines the ways in which the economic aspects of healthcare are similar to those of other goods. It was found that the differential aspects are less distinctive than claimed and the economic aspects of healthcare are not unique.

Keywords: Healthcare Sector; Medical Economics; Economic Competition; Competitive Behavior; State Medicine; Insurance Selection Bias; Patient Participation; Health Services Research.

المخلص: تشير الادعاءات المتكررة إلى أن الرعاية الصحية وإنتاجها لا يختلفان فقط عن السلع الأخرى، ولكنهما يختلفان إلى حد أنه يجب النظر إلى الرعاية الصحية على أنها سلعة فريدة. يتم الاستشهاد بالعديد من ملامح الرعاية الصحية، مثل عدم وجود سوق مثالي وعدم تطابق المعلومات، كدليل على هذا الادعاء. غير أن مثل هذا الرأي ينتج من التأكيد المفرط على خصائص الرعاية الصحية باعتبارها غير نمطية. يعالج هذا المقال هذا الخلل عن طريق اتخاذ نهج بديل ويدرس أوجه تشابه الجوانب الاقتصادية للرعاية الصحية مع تلك الموجودة في السلع الأخرى. وقد وُجد أن الجوانب التفاضلية أقل تميزاً من تلك المزعومة وأن الجوانب الاقتصادية للرعاية الصحية ليست فريدة.

الكلمات المفتاحية: قطاع الرعاية الصحية؛ الاقتصاد الطبي؛ المنافسة الاقتصادية؛ السلوك التنافسي؛ طب الدولة؛ التحيز في اختيار التأمين؛ مشاركة المريض؛ بحوث الخدمات الصحية.

FREQUENT CLAIMS HAVE BEEN MADE THAT healthcare and its production are not only different from other goods, but that they differ to such an extent as to make healthcare unique. Some of the characteristics ascribed to healthcare in support of this view are uncertainty, complexity, information asymmetry, outcomes of mistakes being significant and the objectives of healthcare transactions being vague and possibly conflicting.^{1,2} Yet while healthcare has some unique features, as all goods do, it is not as different as some proponents assert. A central point to consider is that the principles of economics do not fail to operate just because they are applied to healthcare. Weisbrod described all things as different and yet the same, thereby highlighting that healthcare is not a unique commodity because it does not differ from every other commodity in all its features.³ Additionally, economic analyses of healthcare can be conducted with the same tools and principles that apply to other goods and industries.⁴ Although many wish to point to the uniqueness of healthcare, an equally justifiable

approach is to consider the alternative view that the differences are much less dramatic. In doing so, it is appropriate to take the perspective of Ibadi Muslim scholars who “educate their students on not blindly imitating other scholars. Instead they teach them to follow the lead of the evidence.”⁵ In a similar light, Oman’s poet and scholar Al-Rawahi wrote “knowledge emerges from proof.”⁶ Therefore, an exploration of the ways in which healthcare is similar to other goods may promote a greater understanding of healthcare’s true economic nature when compared to other goods.

This article will present the following 12 aspects of healthcare with related claims to uniqueness as well as counterclaims: (1) an (im)perfectly competitive market; (2) a hybrid market; (3) government intervention; (4) moral hazard; (5) adverse selection; (6) information asymmetry; (7) the effects of information and communication technology (ICT); (8) agency; (9) price discrimination; (10) the life or death nature of healthcare; (11) the impact of risk and uncertainty on the healthcare market; and (12) a market analysis.

An (Im)Perfectly Competitive Market

An initial argument to counter is the notion that healthcare is different because it violates the assumptions that underlie a perfect market.^{2,7} Olsen discussed many ways in which the real world market for healthcare is said to violate the key assumptions behind the perfect market model.⁷ Olsen's list provides a good summary of the common arguments of this viewpoint including assumptions about the availability of full information, the presence of impersonal transactions, the existence of private goods, selfish motivations that support interactions, the presence of many buyers and sellers, the potential for free entry and exit and the availability of homogenous products.⁷ Olsen's contention in relation to these assumptions is that healthcare exhibits characteristics that are counter to this model and are uniquely demonstrated.⁷ However, an examination of these claims leads to a different conclusion.

If Olsen's model of healthcare is applied to legal services, the limited differences between healthcare and other goods becomes apparent. Indeed, Arrow noted that the demand for medical services might be compared to that for legal services related to criminal defense or civil lawsuits.¹ In the case of legal services, there will be uncertainty in regard to whether the consumer will need legal services in the future and asymmetric information as to the quality of services to be provided. Interactions between a lawyer and their client are based on trust. Some legal services involve externalities, in that defending an innocent person helps them and their family, as well as benefiting society by allowing the accused to remain a productive member of society. Alternatively, convicting a guilty person brings justice to their victims and protects society at large. Legal practitioners are restricted by professional codes of ethics. Depending on the population and location, few legal practices or accredited specialists may be available. Legal services have restrictions on who can practice. They are differentiated by branding and advertising. Higher quality legal services can be signalled via premises with more amenities. A healthcare transaction can be considered similar to that of any good that is subject to the information asymmetries of a principal-patient or patient-practitioner relationship. Furthermore, private-sector goods and services are more heterogeneous than goods that are available in the healthcare sector.

Perfectly competitive markets exist in theory only; in practice, all markets are imperfect. That being the case, one may wonder why a perfectly competitive market structure is employed in economic thought. The reason for utilising such a concept is that it

provides a baseline comparison tool by which to judge the operation of markets in practice and evaluate how far they deviate from the ideal. The perfectly competitive market structure can be described as a gold standard that is used as a benchmark to assess the explanatory power of alternative market models to evaluate changes in price and outputs.⁸ It can be used to analyse a market structure and the efficient allocation of resources. Additionally, it is useful as a means of predicting the effects of changes, such as increased demand, on the market. For example, a socialist economic model will fail to allocate resources efficiently because, rather than relying on market price signals that indicate consumer demand and a willingness to pay, it attempts to calculate a price in the absence of necessary information.

The error in using the notion of the perfectly competitive market to judge the ways in which healthcare is different is that it establishes an unrealistic standard by which to judge. This phenomenon was well-noted by Demsetz, who described it as a Nirvana approach.⁹ Using this fallacy, proponents present a straw man argument by limiting the choice to a perfect ideal and what is cast as an imperfect present condition. Demsetz describes those who espouse a Nirvana fallacy as seeking "to discover discrepancies between the ideal and the real and if discrepancies are found, they deduce that the real is inefficient".⁹ The reasonable alternative is to accept the truth of markets and information availability as they are and take a comparative institutional approach to finding which of the existing real alternatives can provide a solution to the problem under consideration. After all, perfect competition means no competition at all because the things that actually occur in markets, such as some participants being price makers, do not happen.⁹

Hybrid Market

Hybrid market approaches, such as the quasi-market of the UK National Health Service (NHS), do not advance the case of healthcare being unique. The definition of a quasi-market is not fixed but usually implies attempts to move a state-controlled monopoly towards a competitive market. In the NHS, the notion of the quasi-market was defined by Le Grand as "markets where the provision of a service is undertaken by competitive providers as in pure markets, but where the purchasers of the service are financed from resources provided by the state instead of from their own private resources".¹⁰ This notion has never been fully realised in the UK because there never has been adequate competition to bring about the desired efficiency but nor can there be while the state intervenes

in the market to act as a brake on competition. In the early 1990s, an internal or quasi-market was created in the UK NHS with a purchaser–provider split designed to provide competition amongst providers who would be rewarded for improving efficiency and quality. However, competition remained internal, heavily regulated and, as a result, failed to bring about any significant change. Realising the failure to achieve the efficiencies desired, the NHS moved further towards marketisation.

The problem that Le Grand identified with the NHS reforms was the government holding onto central control and not promoting adequate reward for quality competition.¹¹ The existence of a quasi-market means that the market is partly similar to a competitive market and suggests that healthcare in a quasi-market is less unique as it has features which are similar to those of a competitive market. In short, the closer it becomes to a real market, the less unique it is. The theoretical preconditions of the quasi-market are the same as for any market. When quasi-markets fail, they fail doubly because they face the failure caused by government in addition to ordinary market failures. It is not the nature of healthcare that is different as a service, but rather it is the constraints placed upon it by government that affect its operation. Regulation can produce unnecessary restrictions on entry to industries. Again, this characteristic is no different to other industries, such as banking and finance, which also must operate within the constraints of governmental regulation.

Government Intervention

Many authors who want to claim the healthcare market is different from markets for other goods are also those who advocate governmental intervention in the market.¹ It is no coincidence that they strongly wish to point out healthcare's differences because they believe it provides them with some basis for advocating for government's involvement. As DiLorenzo explains, "having 'proven' that markets 'fail,' the analyst then proposes government intervention under the *assumption* that no such failures will infect government."¹² This point betrays their economic ideology, if not their political one, because if they were free market advocates, they would not be calling for government intervention in the first place and secondly, they would be proposing ways that the free market could prevent and correct market failure. Instead, they point to the supposed failings of the market to deliver efficiency, using these as a pretence for government intervention while completely ignoring government's failings. This line of thinking is deceitful,

or at the very least demonstrative of an unsophisticated understanding of market operations. It is a further illustration of the fallacy of the Nirvana perspective that Demsetz referred to.⁹ This is not just a Western capitalist viewpoint. The principles of Islamic economics, based on the teachings of the *Qur'ān* and the Sunnah literature recording the traditional social and legal customs and practices of the Islamic community, promote a free market without regard to the type of good or service being offered. This practice assumes that such items are allowed (*halāl*) for a Muslim to consume. The *Qur'ān* contains verses which specifically allow and encourage trade and uphold the right to private property. Islam approves of using the market mechanism rather than government intervention to set prices and handle the distribution of goods. This approval is demonstrated by the example of the Prophet Muhammad who refused to fix the price of goods when people asked him to do so.¹³ Nevertheless, this article is not about whether a free market or government intervention approach is desirable but rather about the validity of the arguments of those who claim the healthcare market is essentially different from other markets.

Moral Hazard

Markets react to failures by creating solutions to disparities, with insurance being a classic example of a way to manage risk. Of course, solutions may not be perfect. For instance, moral hazard occurs in the context of health insurance, when the policy holder withholds or misinforms the insurer about their risk and changes their health behaviour after being covered by insurance.¹ Moral hazard describes the tendency for people who are insured to use more healthcare resources when shielded from the actual direct cost by a total or partial subsidy, which insurance provides. Additionally, people tend to take less care of their health knowing they are protected by insurance should an insured event occur. This problem leads to less efficient insurance, especially for those with a low-risk profile. However, moral hazard is common to all types of insurance by the very nature of insurance, rather than the market it occurs in. Although moral hazard may indeed result in the lack of a complete market for private insurance, the same problem would eventuate if the government provided the insurance. Whatever failures are present in the market, it does not necessarily follow that a public sector solution will correct them.² There is no evidence to prove that state monopoly providers are more altruistic, ethically superior or provide better quality service than competitive providers.¹⁰ Even the characteristic of public goods,

which is invoked to grant healthcare uniqueness, is not sufficient justification for government involvement. Goodman and Porter developed a model which finds that government production will never be optimal and will respond to changing market conditions in non-optimal ways.¹⁴

Adverse Selection

Adverse selection has been identified as a market problem for health insurance.¹ Adverse selection occurs when the pool of insured participants becomes weighted towards high risk individuals due to information asymmetry between the insured and the insurer. People who are in good health have less incentive to purchase health insurance than those who experience poor health. Yet those with poor health will have greater incentive for utilisation of the healthcare resources paid for by insurance and take out more comprehensive coverage.¹⁵ When the insurance company, whether public or private, cannot determine the risk of the insured party due to asymmetric information, premiums rise to accommodate the risk from all insured. If the insurance company could know who the low-risk clients were, they could offer them lower premiums. It has been observed that adverse selection can arise in the market if the government intervenes with regulations that prohibit insurers from placing conditions in a contract to account for known risk factors.¹⁵ If premiums continue to rise, it provides a disincentive for healthy people to pay for something for which they do not have a pressing need. As a result, the insurance market becomes overweighted with more ill clients and the volume of claims can lead to market failure.¹⁶ However, pooling risk and reduced incentive also occurs with compulsory third party insurance for motorists. Akerlof's description of the failure of health insurance due to the diminishing quality of participants can also be found in the market for used automobiles.¹⁶ It has to be understood that while the title of his paper alluded to poor-quality used automobiles, colloquially referred to as "lemons" in North America, the principles he described are valid for both markets.¹⁶ This similarity demonstrates that the phenomena described are not unique to the healthcare market.

Information Asymmetry

The information asymmetry between purchasers and healthcare insurance providers, which contributes to moral hazard and adverse selection, also exists between patients and healthcare practitioners. Arrow identified the latter instance of information asymmetry as one

of the key problems that differentiates the healthcare market from other markets.¹ This aspect is hardly unique to healthcare and happens with goods as diverse as legal advice to automotive repairs. In healthcare, information asymmetry is usually framed as a lack of information on the patient's behalf, which puts them in a disadvantaged position.^{1,17} However, information asymmetry is shared by both the patient and practitioner.² Furthermore, with the growth of health information available on the Internet, patients' increased health literacy and support groups for particular conditions, a patient may now be better informed about their condition than their doctor.¹⁷ As there is more information available now on treatment input and outcomes, due in large part to the breadth of content and global reach of the Internet, the consumer's position can be strengthened, providing a basis for better decision-making. For example, people with chronic conditions who constitute a population that consumes a large proportion of healthcare resources, have increasingly more information about their health issues rather than less.¹⁸ Even Arrow has had cause to reconsider his position, conceding that contemporary improvements in the availability of health information may have helped to mitigate the consumer's lack of information.¹⁹

Effect of Information and Communication Technology

Electronic-health (e-health) promises to improve efficiency by decreasing costs while enhancing healthcare quality and empowering consumers.²⁰ The use of Information and Communication Technology (ICT) to deliver healthcare services locally and at a distance is described by the term "e-health," which also includes telehealth and telemedicine. The provision of e-health, underpinned by ICT, can be seen as the delivery or augmentation of healthcare services and information brought about by the nexus of business, public health and medical informatics.²⁰ In general, the effect of ICT on operations is to improve customer service and provide better results for an organisation. In healthcare, both providers and policymakers recognise the value in improving access and are interested in lowering delivery costs and improving standards of care. Despite its characteristics, the outcomes expected of the business of healthcare in terms of effectiveness and efficiency are the same as demanded of every other industry.²¹ The World Health Organization recognises the need for efficiency of operation and in its definition of e-health describes it, in part, as the cost-effective use of ICT to support health and healthcare.²² Other industries, which are heavily reliant on information, have sought to develop and utilise best practices in

managing information. As Kloss noted, healthcare does not face unique challenges in this matter because industries as diverse as banking, government and life sciences have had to deal with the same strategic and operational demands.²³

The nature of e-health, which is inherently networked and virtual, means that geopolitical barriers can be overcome. Eysenbach described e-health as dedicated to “networked, global thinking, to improve health care locally, regionally, and worldwide” through the use of ICT.²⁰ Due to the global nature of e-health, healthcare can be widely distributed in a cost-effective manner. For example, e-health can improve the access of geographically isolated people, such as rural communities, to a variety of medical specialties. ICT can also facilitate innovations such as internet prescribing. Doing so may lead to a new class of pharmaceuticals, termed over-the-Internet drugs, which still require restriction but can be safely dispensed by a qualified healthcare professional with a prescription delivered via the Internet.²⁴ Thus, the use of e-health removes another distinction of healthcare—its production. According to Cimasi this is inherently local but ICT makes it less so.²⁵ The efficient means of production and distribution via ICT reduces barriers to entry in terms of cost of facilities, enabling hub and spoke organisation models. Additionally, ICT can successfully assist in reducing the information asymmetry and agency problems that healthcare consumers experience.

Agency

Agency problems are not unique to healthcare. The problem, as it occurs in healthcare, is when a patient's interests are compromised by the provider who is performing the role of agent in an imperfect manner to maximise personal profit. Gaynor observed that the type of agency problems that exist in healthcare also occur elsewhere.²⁶ He noted it to be an inherent characteristic in the provision of a professional service.²⁶ However, such problems occur in every organisation. Indeed, agency is a prevalent aspect of economic reality and occurs between doctors and patients just as it does between employees and managers. Subsequent to Arrow's 1963 paper, it was recognised that the ethics of healthcare practitioners can act to ameliorate the risk of patients being taken advantage of by providers due to consumer information asymmetry. This market failure is termed ‘supplier-induced demand’. Traditionally, this failure has meant relying on the professionalism of the practitioner to prevent over-servicing. Additionally, there is the notion of the practitioner as one who guards against moral hazard. This is aided by practitioner ethics

and concern for the best interests of the consumer, which are accepted as placing some limitations on practitioner over-servicing.²⁷ Evans suggested that the deliberate cultivation of physician professionalism is designed to prevent inappropriately taking advantage of opportunities for personal gain.²⁷ Ethics enforced by healthcare institutions also play a part.¹⁷

Price Discrimination

Price discrimination can occur in healthcare, where the prices consumers pay for identical services are contingent upon their ability to pay or the discretion of the healthcare practitioner. For example, Australian specialist physicians were found to charge their higher income clients more, and fee gaps vary widely between specialties.²⁸ Price discrimination in healthcare may be considered unfair, depending upon the context of its application, but this characteristic is hardly unique to it and can be found in many other industries. Price discrimination, as a matter of fact, is not always bad. On one hand, an example could be an airline selling the same class of seating at different prices depending upon how far in advance tickets are purchased. Charging different prices for the same product to enhance revenue is price maximising. This business practice is profitable and, although it may be considered unfair, it provides consumers with choice. In a healthcare setting, this practice could mean that one patient who is prepared to wait for treatment may use a free public hospital while another may prefer to pay to be treated sooner by a private clinic.

It is important to note that price discrimination does not necessarily result in another person paying more because someone else paid less. What may be considered fair price discrimination, for example, is if a student is granted a discount on the cost of tuition through merit-based scholarships. In a healthcare setting, price discrimination could mean that a patient receives free or discounted treatment as an act of charity by a private healthcare provider. In addition, every healthcare system which is not subjected to regulated prices experiences price discrimination as a completely normal occurrence.²⁹ Differences in price for products that seem alike are quite common, as for example when the active ingredient contained in a drug is sold as a generic versus branded product. Evidence exists for considerable variation in price even for standard consumer products where it would be easy for consumers to search and discover best offers. Sometimes price discrimination is simply a response, either public or private, to the externalities arising in a market.

Life or Death?

One of the characteristics of healthcare, which is said to make it unique rather than merely different, is that its provision is a matter of life or death. However, this concern is not unique to healthcare. In terms of the legal system, a lawyer may be protecting a client from life imprisonment or a death sentence. A skydiving instructor literally has the rookie jumper's life in their hands; they must instruct the trainee to deploy their parachute or deploy it for them, for failure is almost certain to result in fatal consequences. Commercial airline pilots are responsible for the safety of hundreds of passengers at any one time. Like healthcare, a team effort is involved, from the pilot to aircraft mechanics to air traffic controllers. Additionally, the need for medical care in this argument is often overstated. In regard to the need for medical care, a concept Fuchs found to be imprecise and of little analytical value, he observed that the need for medical care exists on a continuum at any particular time, varying from emergency and life-saving surgery to blackhead extraction.³⁰ Fuchs further stated that, of the billions spent on health, surely a large proportion did not entail matters of life or death.³⁰ Similarly, Weisbrod observed that "not all medical care is vital to life—indeed, most is not."³ Instead, advances in healthcare have allowed for a wider variety of conditions that cause pain and discomfort to be treated.

Risk and Uncertainty

Where there are differences between healthcare and other goods, such as risk and uncertainty, they tend to be differences of degree. Similar to Arrow, Morrisey contended that while many industries experience the effect of these factors, the combined effect of them is what seems to make health services distinctive.³¹ However, he qualifies this observation by noting it is a basic mistake to make extravagant claims of the healthcare industry's distinctiveness.³¹ Challenge, change and complexity are pervasive amongst most organisations, and healthcare is no exception. Responding to the claim that providing healthcare is unlike other industries due to its multidimensional, specialised nature and the lack of knowledge clients have to evaluate it, Porter and Teisberg agreed that these are characteristics of health services but are in essence no different to other industries.³² Many organisations must supply highly complex and technologically sophisticated equipment in telecommunications and computing, some of which play critical roles in saving lives, such as in air traffic control. Healthcare can learn from other industries about the way that they

have handled challenges and apply those lessons to decision-making. Healthcare is often characterised as risky, such as in the description of it being a matter of life or death. However, other high-risk industries such as aviation and petroleum production have information gathering procedures and systems in place to manage and improve safety. As such, it is not justified to claim knowledge gained from other industries cannot be applied to healthcare because of its supposed uniqueness.³³

Arrow admitted that "the risks are not by themselves unique; food is also a necessity, but avoidance of deprivation of food can be guaranteed with sufficient income, where the same cannot be said of avoidance of illness."¹ This argument for the difference inherent to healthcare is weak. First, it is admitted these risks are not unique. It is difficult to argue for the uniqueness of healthcare when water and food are necessary for survival, yet the government does not compel people to purchase water and food insurance lest they are unable to buy these items at a future date. Second, the acknowledgment of the existence of risk recognises that there is a possibility of adverse consequences occurring. Arrow's contention is that sufficient income guarantees the risk of being without food will not occur, which is not correct. If there is no food in the market, having the means to pay for it is of no use. Income does not guarantee the avoidance of risk but rather it allows one to meet the cost of dealing with it, assuming that income is sufficient and mitigating options exist. A salient example here is the purported origin of a Giffen good. This type of good was named after Sir Robert Giffen, supposedly after he observed an increased consumption of inferior quality potatoes as prices rose during a famine. However, this view can be easily debunked by considering that such a practice could not have been widespread as it is not possible to purchase more of a good when there are fewer such items available in the market.

Market Analysis

In considering the question of whether healthcare is a unique good with a market in need of a different means of understanding, a nuanced view is required because healthcare can be acknowledged as different in that it has its own important features and related challenges to solve. However, it is amenable to being analysed and managed with existing economic techniques and principles applied to other goods and industries. Pauly proposed that the question of difference can be considered in three parts.⁴ He stated that very few aspects of healthcare were not amenable to analysis with the usual tools, suggesting that the majority of

healthcare's characteristics can be treated the same or similar to other industries, and where those methods are not a perfect fit, they still work reasonably well. While the individual attributes of the healthcare market are not unique, Arrow said when "taken together, they establish a special place for healthcare in economic analysis".¹ However, Fuchs refuted this view, stating that "health care is, in many respects, similar to other goods and services. It is produced with resources that are scarce relative to human wants".³⁴ Healthcare exists as a market which can be divided into sectors or segments depending on the needs and preferences of consumers. This type of division is also found with other goods and shared characteristics between these markets are apparent. Thus, healthcare can be analysed using generic methods and tools that are applied across the entire market. Demarcating healthcare as unique inhibits the transfer of knowledge between healthcare and other sectors.¹⁸

Conclusion

Despite claims to the contrary, healthcare and its production is not unique among other industries. Healthcare does not exist in a perfect market as no goods truly do. While healthcare has features that are particular to it, this is no different to other goods. Notable characteristics of healthcare that have been proposed as evidence for its distinctiveness are in fact common to various industries. Major elements such as agency, barriers to entry, externalities, information asymmetry and uncertainty can all be found in, for example, legal services. The aspects of adverse selection and moral hazard are outcomes of insurance rather than healthcare. The emotive argument of healthcare being a matter of life or death is both overstated and not exclusive as the aviation industry provides a product that carries the same risk with each flight. Change and complexity are characteristics of the modern workplace and are prevalent in ICT. Therefore, an approach considering the similarities of healthcare with other goods prevents it from unnecessarily being viewed in isolation from broader economic thought. The practical and policy outcomes of this view for Oman, or any country concerned about the growing demand for healthcare and the concomitant expenditure required to fund it, is to treat healthcare the same as other goods. Such a step would prevent unnecessary government intervention in the market in the form of price controls that can lead to over- or under-consumption. Instead, it is possible to rely on market mechanisms to improve competition, increase efficiency, decrease costs and

offer consumer choice. Market mechanisms drive the production and distribution of other goods which are essential for life, such as food. Needy people can still be cared for because nothing about a market-based economy prohibits charity and philanthropy, and the combination of a market-based economy and charity is compatible with the views of Islamic society.

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