

BRINGING INSTITUTIONS INTO HEALTH ECONOMICS

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Resumen

Se formula una nueva propuesta sobre la economía de la salud que involucre a las instituciones. Las decisiones relacionadas con la salud se toman bajo algún tipo de incertidumbre, en especial en lo que tiene que ver con las instituciones que se ocupan o se desenvuelven en esta área. El abordar estas instituciones de una manera seria permite que pasemos de la economía de la atención médica (lugar en dónde se concentran la mayor parte de las investigaciones) a una economía real de la salud. Este paso también permite que expliquemos el aumento del gasto en salud como un resultado de la interacción entre las instituciones sociales. En este enfoque, la unidad del análisis se ha desplazado más hacia la norma que hacia algún agente individual; en resumidas cuentas, el agente del estudio es la institución

Palabras claves: instituciones, comportamiento, salud, normas, hábitos. **JEL:** B520, B410, I10, I19.

Abstract

A reformulation of health economics is proposed that explicitly involves institutions. Decisions regarding health are taken under uncertainty, in the face of which institutions work and allow dealing with it. Taking institutions seriously allows moving forward from the economics of medical care (on which the mainstream has focused) to a real economics of health; it also allows explaining the growth of health expenditure as the result of the interaction of social institutions. In this approach, the unit of analysis is changed to the rule, rather than the individual agent. The subject of study is the institution.

Key words: Institutions, Behaviour, Health, Rules, Habits. **JEL:** B520, B410, I100, I190.

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**Documentos FCE
Escuela de Administración y
Contaduría Pública
ISSN 2011-6314**

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Periodicidad: Trimestral

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In his article taking stock of health economics, Mark Blaug (1998:S65) showed his surprise regarding the fact that this area of study was not more frequented by heterodox economists. *“Health economics would seem to be a perfect topic for heterodox dissent and yet, surprisingly enough, radical economists and Marxists have not on the whole been attracted to health economics. Still, and this is my main point, health economics is a field which must make the average neoclassical economist squirm because it challenges his or her standard assumptions at every turn. Perhaps that is precisely what makes it so interesting to study.”*

Health economics has become a rapidly developing branch of economics since its emergence in the 1970s. However, it has had to face important limitations since then. Firstly, as Arrow (1963) mentioned in his pioneering article on the topic, the system’s main characteristic lies in the ubiquity of radical uncertainty. When there is uncertainty, there is neither sense in characterizing individuals’ behaviour as the maximizing of an objective function, nor in drawing conclusions about policy from static models. Hence, when health economics is limited to imitating the standard text of microeconomics, changing the name of the agents or products, it is simply evading the problem.

A second difficulty is of a more semantic nature. Arrow made it clear that health economics does not deal with health but rather the health service industry; those who came to work in the field after him concentrated exclusively on the health service industry, but calling such a disciplinary field “health economics.” The suggestion that conclusions derived from studying the health service industry are applicable lay hidden behind the erroneous use of the terms (i.e. health policy, this being a much wider field).

This article is aimed at proposing a reformulation of health economics thereby making it worthy of using this name and taking uncertainty seriously. Such reformulation is based on the notion of institution, which becomes a key subject, and introducing the rule as the unit of analysis in place of the maximizing individual.¹

¹ Although habits are extremely important in a theory of institutions (as they allow to explain how individuals interact with institutions), habits are not that important when we

The term institution is used here to refer to a “durable system of established, embedded and potentially codifiable social rules and conventions that structure social interactions” (Hodgson, 2004: 297). Individuals’ and firms’ actions are moulded by institutions and can be described as propensity-driven repetitive behaviour, such as habits and routines (Hodgson, 1997)ⁱ. Not only maximizing an objective function can be seen as one among several possible rules, but maximization itself becomes impossible in many cases due to the conditions imposed by bounded rationality (Simon, 1976). Individuals use rules in such situations letting them act where the mere use of reason hampers action (Keynes, 1936). There are also social mechanisms reinforcing the adoption of a system of rules.

This article presents the field of health economics and its development during the last few decades. It then shows how there is a problem regarding the coherence of the unit of analysis for traditional health economics; it therefore proposes using the rule as the unit of analysis. In this approach, institutions emerge and work grounded on social mechanisms in situations of extreme ignorance regarding the future, hence the types of ignorance existing in the health sector are identified, uncertainty is emphasized and the relevant institutions are examined. The implications for the sector arising from the existence of such institutions are shown. Lastly, attention is drawn to the advantages for health economics resulting from adopting the proposed approach.

Health economics

Kenneth Arrow’s 1963 article entitled, “Uncertainty and the Welfare Economics of Medical Care,” marked the discipline’s commencement. Arrow differentiated between health and health services, making it clear that they only deal with providing health services, this being just one of the many factors determining health. He also pointed to uncertainty as being these services’ fundamental characteristic and the source of economic problems arising in this market. Uncertainty regarding the incidence of disease and the effectiveness of treating it has brought about the absence of markets for actions leading to health which could be identifiable or even technologically possible.

focus on health, in particular on the evolution of health expenditure. For in this field it is the effects of the system of rules that matter, not so much the causal mechanisms explaining why the individual acquires habits and follows rules.

Once analysis became focused on the health services industry and this good's special characteristics had been identified, later studies were centered on determining whether standard economic analysis could be applied to analyzing the health services industry. The applicability of conventional economic analysis was mainly defended by North American economists such as Paul Feldestain, Martin Feldestain, Josep Newhouse and Charles Phelps, for whom the market was the only entity capable of adapting itself to consumers' different desires. Other forms of health assignation would be inefficient as they would produce an excess or deficit in the production of those services which individuals wished to consume, coming with different quality and prices to that which they were willing to pay. It is considered that the consumption of services depends on an individual's income level from this viewpoint and it is accepted that consumers reign supreme and take decisions seeking to maximize their benefits. It can thus be deduced that the demand for health services is initiated by the patients.

Whilst consumers are considered to be sovereign and maximizers, the same does not happen with doctors to whom maximizing conduct is not attributed; rather, emphasis is placed on changing their ethical behaviour. The topic of induced demand is thus evaded; this being understood as doctor-initiated demand where patients would not have accepted if the same information had been made available to them as to the doctor. This is a recognized and important phenomenon due to its implications in public policy (Rodriguez, 1988). Many studies which have followed this approach have sought to estimate health service demand elasticity, price and income.

Michael Grossman (1972) formulated his model of health service demand in the 1970s as deriving from the demand for health. Health results from many things in this model, health services simply being one more consumer item. Even though this argument seems obvious, it had not been tackled in the bibliography before 1972. Grossman considered health capital to be another form of human capital and (like all forms of human capital) it is individuals who combine different consumables for their production process, in the sense that when individuals have greater education they have greater ability for combining consumables and improving their health production. Health thus becomes a consumer good and investment good here (Grossman, 2000). Even though this model was innovative, it continued to be based on consumer sovereignty.

These studies generally evade the topic of uncertainty and suppose that an individual is able to identify the characteristics of the services in demand and

evaluate the quantities and prices offered by the market. Blaug (1998) pointed out that the large amount of studies in this line dealt with the USA's existing health system which is not just private but also privately financed via medical insurance, meaning that the concepts of standard economics can be applied to market prices and maximizing utility. On the contrary, a public health system's dependence on public provision does not provide ideal terrain for economic analysis. British health economics has thus not been eclipsed by the US model but can be considered to be an everyday alternative to it.

The British approach recognizes that health services obey need rather than desire and that this is randomly produced; the market is thus rejected as the mechanism for assigning, distributing and evaluating the efficient use of health services. The assignation and rationing mechanism thus depends on the notion of need where individuals receive care whilst the experts independently determine a patient's disposition and ability to pay. As the objective is to provide equality of treatment independently of the ability to pay, studies respecting equity have received a lot of attention. Le Grand (2000) and Culyer and Wagstaff's (1993) work is representative of this line of thought.

Important developments have also happened in Great Britain regarding how results in health are evaluated. The literature on evaluating treatment for managing disease was centred on analysing cost-benefit and cost-effectiveness up to 1980. The former presents problems due to the difficulty of evaluating benefits in monetary terms. This type of analysis has been excluded in the UK due to the technical impossibility of measuring costs. Cost-effectiveness analysis is also limited because there is no strong evidence about the effectiveness of treatment; however, the British have defined a quality-adjusted-life-years (QALY) indicator for cost-utility analysis. QALY criteria deliberately reject Pareto's criterion regarding ability to pay for treatment and accept comparing effects according to how a patient perceives them (Blaug, 1998).

The two currents of the discipline's development are subject to the differences inherent in the health systems predominating in both countries; the US system is orientated more towards efficiency rather than equity whilst the UK has concentrated more on equity than efficiency. US analysis has concentrated on the market and that in the UK on non-mercantile assignation. Event though being important when developing policy, the UK school's theoretical position surely has weaknesses, as not explaining how

the market works leads to supposing that this has been well-described from the other viewpoint.

Both currents have tried to provide a solution to an empirical problem: the evolution of expenditure. Increased costs are significant in both systems though the problem is greater in the US, in spite of private participation being much greater in this country and a competitive market being expected to promote efficiency (Porter and Olmstead, 2004).

Increased spending has been attributed to different causes; demographic transition is one of these, increasing chronic and degenerative disease and thereby producing prolonged demand for sophisticated and costly treatment having poor curative capacity. Another argument put forward refers to problems regarding work productivity, making “Baumol’s cost disease” applicable to the sector as, according to Baumol, the relative costs of a sector like this become increased, since wages are proportionally increased in all sectors (Baumol and Bowen, 1966). Other reasons have been identified such as the interests of the pharmaceutical industry determining guidelines for consuming services, changes in social costumes (Ortún, 1992) and the absence of price mechanisms (the last being questionable, given that private health systems have not been shown to be a suitable alternative for containing costs).

Studies by Newhouse (1977), Parkin, McGuire and Yule (1987) and Guertham and Jönsson (2000), comparing different countries’ health expenditure, reveal that income is the factor explaining variation in spending and that elasticity even becomes greater than the unit, medical care thereby being considered to be a luxury good. Guertham and Jönsson have also found that using primary attention lowers health expenditure and that the mechanism for remunerating doctors influences costs. Per capita payment tends to lower expenditure more than payment for services, bringing one once again to the topic of inducing demand (Guertham and Jönsson, 2000).

The second problem to be resolved consists of explaining health economics, not just health service economics, as health (and thus an individual’s wellbeing) depends more on a different behaviour rather than on treatment assigned when a person becomes ill. Consequently, concentrating on supply and demand is, in the best of cases, a narrow approach.

In what follows, it is supposed that theoretically satisfactory health economics must provide a reply to these two questions within a coherent theoretical framework. The following section shows that defining a suitable

unit of analysis presents an important theoretical difficulty from both health economics' viewpoints.

The unit of analysis

Health economics uses conventional microeconomics for posing problems, taking individual agents as the unit of analysis (i.e. hospitals, doctors and patients). Preferences, initial provision and technology are taken as given; interaction in the market leads to optimum assignment of resources in perfect competition. When imperfection occurs, the result becomes altered within this reference framework. This is the case with the US viewpoint emphasizing the market; however, it also occurs in the British one which seeks equity with assignment provided by a state entity but the unit of analysis continues being the patient, doctor or hospital.

This broad shared framework has led to wide discussion which, however, does not alter it. The US view may be criticized for assuming that doctors are guided by ethics and do not take economic considerations into account, but theoretically it is not a problem as altruistic preferences may be assumed in the neoclassical scheme. The difficulty in explaining the growth of expenditure is of much greater interest here.

One of the more important explanations for the growth of expenditure lies in inducing demand. It has been known for a long time that diagnosis and treatment crucially depend on the doctor (given that one hopes that a doctor knows more than a patient). However, diagnosis and treatment importantly determine the type and quantity of health service consumption. This makes the idea of consumer sovereignty lose its sense in this case and patients cannot now be a unit of analysis, given that their decisions are not autonomous and their "preferences" are not given but rather determined by the doctor. Close relationships between doctors and medical supply companies or a medical team mean that doctors' decisions do become influenced by the suppliers. The widely known fact that repetitive behaviour greatly affect health can be added to this, finding that the explanation for these phenomena come into conflict with the idea of agents as the unit of analysis.

An important reason for why it is doubtful whether an individual agent should be the suitable unit of analysis is that generalized uncertainty impedes an agent being able to take decisions. Agents cannot concentrate on optimizing their choices as assigned by neoclassical theory because they do

not have the ability to make the calculations or the necessary information to do so. An individual then follows rules take by society. If we define institution as a “durable system of established, embedded and potentially codifiable social rules and conventions that structure social interactions”, being a reinforced system of socially adopted rules, it can be said that institutions are a more appropriate object of study for explaining topics referring to health; rules would thus represent a more suitable unit of analysis.

If it is important to note the existence of generalized uncertainty, it should also be observed that this is part of a greater set of problems regarding information in the health area. Ignorance of future events is manifest in several ways, some being characterized as being probabilistic (risk), others not (uncertainty) (Knight, 1928 / Keynes, 1936).

Basic uncertainty in health has to do with the emergence of disease and effectiveness of treatment. The occurrence of the first is as unpredictable as that of the second. If disease emerges relatively randomly amongst individuals, its extent and regularity are highly unpredictable for each particular individual. Uncertainty is just an extreme case of ignorance appearing in health in different ways.

One type of ignorance in this system refers to that of individuals; they do not have sufficient knowledge of a particular disease or how to diagnose it and treat it, so they go to a doctor who will provide treatment. The complexity of medical knowledge supposes that a patient’s information regarding treatment and its effects is inferior to that of a doctor. Professional socialization of physicians, on the one hand, and the making of a particular image of the doctor in the society, on the other hand, establish social rules of delegation and trust that work through institutions. Thus, in mitigating an individual’s uncertainty regarding the quality of treatment, following the set of rules is reinforced and this set is extended to the whole of society.

The following type of ignorance appears when a doctor is confronted with some symptoms for treating a disease. Passing from symptoms to disease is not mechanical but rather a process of exegesis. Indeed, symptoms for the same disease can be different according to a particular patient, as a patient represents an organic whole more than the sum of different organs. The idea of what is meant by health or disease depends on each age and culture. As with the above point, it cannot be known with certainty how an individual will react to a particular treatment. Different doctors may arrive at a different diagnosis when faced with determined symptoms (Cullis and West,

1984). It is possible that different doctors may not come to consensus concerning treatment regarding the same diagnosis.

New elements of ignorance appear if other relationships are considered (apart from the doctor-patient relationship). If a health system similar to that of many western countries is considered, it can be found that individuals' needs are attended by doctors. Doctors in turn work in more complex organizations such as hospitals and clinics which in turn maintain contracts with insurance companies which may depend on the state. In this situation, the insuring entity ignores whether what is paid for attending its affiliates is suitable or whether payment considerably exceeds the cost. A hospital administrator ignores whether a doctor is providing sufficient treatment for a patient, if it exceeds the rule or is insufficient and whether what is received will be sufficient for satisfying the demand for attention. A government may also ask whether the resources dedicated to the sector are being suitably used.

Some of the problems regarding information refer to risk situations, others can be considered to be information asymmetry and others as problems of radical uncertainty. It can therefore be postulated that ignorance leads to collective behaviour following rules in a setting in which it is mainly presented as uncertainty. In cases where ignorance is probabilistic, the rules may refer to using concepts of risk and may even include maximization procedures. However, maximization is just one more rule here. (Hodgson, 1997)

An institutional approach in action

Concrete examples of rules and institutions can now be considered. Each element of ignorance mentioned in the above section can be found in practice in different forms. The probability of the appearance of a particular disease may be computed, even though it would be impossible to make a prediction with certainty for a particular individual. Predictions are thus made for a set of people, understanding that such prediction will be fulfilled for the majority. Grouping is therefore chosen as a mechanism for counteracting risk associated with the occurrence of disease.

In the face of the question of identifying disease by means of the exegesis of symptoms, a doctor is helped by standardized rules laid down in the profession's protocols which has originated semiotics. The same happens regarding treatment. The protocol defines which the disease's symptoms are

and which treatment should be followed according to the case. The institution of the protocols referring to attention allows action to be taken regarding the uncertainty of treatment. Treatment cannot be effective in some cases and may even become harmful, but opting for a particular institution limits the consequences which this may produce for the provider.

An individual's ignorance regarding the quality of treatment is counteracted by the license granted by an authority for guaranteeing minimum quality.

A social system of rules (i.e. an institution) is the response to uncertainty in all these cases, and not individual decisions. Institutions are those entities regulating the doctor-patient relationship and the way doctors are organized. The definition itself of what is considered disease results from a process of interpretation mediated by patients' systems of socially accepted beliefs and those of their families and by doctors' collectively accepted protocols. Institutions are thus the object of study and rules must constitute the unit of analysis given that an individual's disease, treatment and behaviour are mediated by such institutions. Health economics rethought in this way could easily deal with questions relating to both the market and those referring to non-mercantile situations.

An even more important benefit of the proposed approach is that it facilitates moving from health services economics to health economics and proposing more relevant policies.

Recommendations concerning how to improve health and how to reduce expenditure are currently concentrated on the individual even though it has been shown that this unit of analysis presents difficulties given that individuals do not act in isolation but within a context. It is clear that if one accepts that the definition of disease has a social nature, then acting on particular individuals does not guarantee change being achieved in any of them.

Institutions make the system reduce the possibilities of choice and maximization. The patient does not choose in the health system; it is the doctor who "chooses" and does so based on rules such as the protocols pre-established by the profession, in such a way that choice is delimited by them and what appears in the protocols is conditioned by the influence of innovations produced in the industry. There are thus few things to choose; the rules are simply followed in this case. The mechanism for reinforcing the system of rules is the pairing made up of fear of death and the hope of postponing it, where both are common cultural factors in this type of society.

When analysis focuses on the relationship between the health service industry and individuals, the problem lies in coming back to a system for improving the objective (i.e. health), forgetting that this is not just the industry. A start is thus made on considering that the work of prevention applied to patients provides a result and, of course, the service industry seeks to offer or broaden its portfolio of services without identifying and therefore involving the true causes.

The problem has to do with confusing health with health services. Health economics concentrating more on institutions could more easily deal with other factors affecting health. As Dever (1976) and McKewon (1979) have pointed out, the determinants of health mostly arise outside the setting for providing health services. Elements such as diet and sanitary conditions carry more weight in preventing and eliminating disease, whilst health services only appear later on, often as the result of others habits and behaviour. For instance, tuberculosis was eliminated as a result of changes in the population's diet and sanitary conditions long before medically effective therapy became available (Evans, 1996).

In the sense that social rules also explain a good part of habits and behaviour leading to or avoiding disease, institutional analysis will allow them to become involved in the field of health economics, forming a continuum which could closely cooperate with sociology and social psychology.

Conclusions

In a situation of ignorance regarding the future, most of which is not probabilistic (uncertainty), the suitable unit for analysis ceases to be the individual agent and becomes rather the rules, these in turn being organized into institutions or systems reinforced by socially accepted rules.

Concentrating on institutions leads to a clearer view of problems related to health, explains the growth of spending on health and allows going beyond health service economics to cover most of the determinants of health. An institutional approach therefore constitutes a theoretical improvement allowing to design more relevant health policies for the world which we live in.

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ⁱ Note that this is different from just repetitive, non-reflective behaviour, such as in Lindbladh and Lyttkens, 2002.