A New Institutional Economics Perspective on the Relationship Among Societal Values, Governance Structure and Access to Rural Health Care Services

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Abstract: According to New Institutional Economics, transactional activities, governance structures, institutions and beliefs and values are related hierarchally. Williamson (2000) formalizes this framework to show that each governing level must be aligned with the adjacent level for transaction costs to be minimized. This framework is applied to the question of balancing costs and access in health care. Transaction costs in providing health care services can be minimized if all hierarchal functions are aligned. Examining the highest level associated with beliefs and values reveals that the beliefs of people might not be fully consistent with the institutions and governance structures expected or advocated in the area of health care, particularly in the context of rural health care services.

Key words: rural health care, cost, access, efficiency, new institutional economics, rights,

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Introduction

If the problem of providing adequate health care is paramount to society, then the case of health care services in rural society is of particular concern. Rural environments differ from urban areas because they are more isolated than urban ones and there is more variation in the health status of rural populations related to poverty, race, and ethnicity (Ricketts, 1999). There are two primary and interrelated concerns – cost and access. In this context, access refers to more than just distance to nearest physician or hospital facility. It reflects the availability of a variety of sources of care (preventive, emergency, etc), the quality of existing care, the ability to pay for health services and the option to use specialists rather than primary care physicians, among other measures (Strickland and Strickland, 1996; Schur and Franco, 1999). Greater access in low population rural areas is more costly than in urban areas, other things being equal, in part because of the high costs of many new medical technologies, which necessitates that they be concentrated in urban areas in order to spread fixed costs among a wider pool of patients (Ricketts, 1999).

There is an endogeneity issue that exacerbates the problem of rising cost of health care provision in rural society. Rural Americans tend to be poorer than urban Americans (see Ricketts, Johnson-Webb and Randolph, 1999). For example, in 2000 the percent of people living below the poverty level was 13.4 percent for rural Americans but 10.8 percent for urban dwellers. Furthermore, compared with urban counties, rural counties account for 481 of the 500 lowest per capita income counties, but only 150 of the 500 highest per capita income counties in

the United States, suggesting that poverty is disproportionately a rural problem (Miller and Rowley, 2002). People with low incomes tend to have poorer health relative to wealthier people, and poor health keeps people in poverty. Therefore, providing and maintaining quality health care services in rural areas with a population on average having poorer health increases the financial strain on the health care system.

Increased access can be achieved by increasing expenditures for health care in rural areas. For this reason, issues involving financing become a key concern, as evidenced by the fact that many federal efforts at restructuring rural health care services have focused on improving the financial stability rural health care centers and providers. For example, the Critical Access Hospital program, authorized as part of the Balanced Budget Act of 1997, was designed to reduce hospital closures in rural areas. The program allows rural hospitals to terminate their hospital status and become Critical Access Hospitals (CAHs). As a CAH, rural health centers and the physicians servicing them have the option of being compensated at more than 100 percent of allowable and reasonable costs (CMS, 2006).[1]

Because issues involving financing are important, the identification of cost-savings system-wide could provide resources needed to increase and improve access in rural areas. Traditionally, efforts to identify sources of cost savings have focused on moral hazard due to health insurance, fee-for-service reimbursement practices and defensive medicine (Cutler, 1994). An alternative is to emphasize comparative organizational structure – namely, transaction cost economics (Barnes and Fannin, forthcoming; Preker, Harding and Travis, 2000). The basic idea is that changing the institutional and governance structures defining how health care services are

[1] According to the Center for Medicare and Medicaid Services, payments to physicians providing outpatient services in CAHs "will be 115 percent multiplies by the amount under the Medicare Physician Fee Schedule multiplied by 110 percent" (CMS, 2006, p. 3). Additionally, "Medicare pays CAHs for most inpatient and outpatient services to Medicare beneficiaries on the basis of 101 percent of their allowable and reasonable costs" (CMS, 2006, p. 1).

organized could provide cost savings which would then make possible higher quality or more extensive access to health care services in rural areas. Transaction cost theory states that different modes of organizing, such as market exchange, long-term contracting or vertical integration, have different costs of governance depending on the attributes of those things that are being governed. For example, the problem of producing and distributing pharmaceuticals has fundamentally different characteristics than the problem of administering routine physical exams or providing emergency ambulatory care. Because these activities reflect different fundamental characteristics, how they are governed ought to be different as well. Simply, it is inappropriate to argue for or against a single form of governance structure across all cases and circumstance (e.g., by arguing that "markets are the solution to our health care woes" or "health maintenance organizations are always bad"). If a governance structure adopted or designed for a particular activity does not align well with the characteristics of that activity, then the costs of governance will be higher than they otherwise would have to be. According to Williamson, "simple governance structures should be used in conjunction with simple contractual relations and complex governance structures reserved for complex relations … Use of a complex structure to govern a simple relation is apt to incur unneeded costs, and use of a simple structure for a complex transaction invites strain" (1979, p. 239). In the case of rural health care, the existence of unneeded costs or strains means that access would be lower than it otherwise could be. Consequently, identifying the correct governance structures for different types of activities and transactions could result in lower overall healthcare costs, thus providing the resources needed to increase access to health care services in rural areas.

This paper provides some insight into the relationship among governance structure, cost and access to health care in rural society. The premise is that the identification of appropriate

governance structures cannot be made in a vacuum, independent of the broader institutional environment. Of course, this idea is well known among scholars associated with New Institutional Economics. Institutions matter, as North (1990) persuasively claims. Governance structures must reflect the characteristics of transactions they govern, but such structures must also align with the institutional environment within which they are embedded. Alignment is important not only because it provides a means of promoting cost-savings and hence access, but also because it helps to reconcile two critical observations. First, while new forms of organization, such as health maintenance organizations (HMOs) and provider networks, "have dominated the urban health care environment, [they] have been slower to develop in rural areas" (Ricketts, 1999, p. 1). Second, there is a growing acceptance of the idea that health care is a right and that health care policy "should be concerned with the design of 'just' mechanisms for allocating scarce health care resource" (Aday and Andersen, 1981, p. 4). The basic argument of this paper is that efforts to respond to the first observation – e.g., by promoting HMOs, vertical integration, flexible contracting arrangements, and other alternative health care governance structures in rural areas – might conflict with the second observation, resulting in a misalignment between the institutional environment and the evolving governance structures within the health care system. The contribution of this paper is in providing a framework for thinking about the provision of health care in rural areas rather than in providing specific solutions to specific problems.

Williamson's Four Levels of Social Analysis as a Coordinating Framework

Williamson (2000) provides an effective framework for examining the relationship among beliefs and values, institutional environment, governance structures and transactional

characteristics and activities. According to Williamson, these four concepts are related hierarchally, as depicted in Figure 1.[2] At the bottom is the level at which transactions and related activities, products and services exist. In this context, a transaction is a decision regarding how an economic asset is utilized by and transferred among economic agents. With respect to health care, this is the level at which decisions regarding what physician and hospital services to provide (e.g., acute care center or full-service hospital), and at which cost.

Figure 1 about here

Moving up to level 2 is the governance structure, which consists of the specific methods and rules by which transactional decisions are made (Williamson, 1979). For example, decisions regarding the use and transfer of economic assets could be made bilaterally as mutual agreements among agents reacting to price signals generated by markets, or they could be made unilaterally by agents designated as possessing authority to direct such activities within firms (Coase, 1937). More generally, scholars distinguish among market exchanges, long-term contracting, and vertical integration. Each mode has a different set of processes, rules and coordinating mechanisms controlling how transactional decisions are made and enforced (Williamson, 1991). At this level, the cost of transacting is fundamental in explaining how economic activity is organized. Organizational structures that arise are expected to be those that minimize the costs of governing transactions – where costs of governing include search and information costs, bargaining costs, and cost of enforcing transactional agreements – given the idiosyncratic

[2] I reverse the numerical designation that Williamson uses for the levels. For instance, what he designates as Level 1 I designate as Level 4. I do this to maintain consistency during the discussion. Speaking of a "higher level" refers to both a higher number (e.g., 3 relative to 2) as well as a higher level in the depicted hierarchy (e.g., institutional environment relative to governance structures).

characteristics of the transaction they govern, such as asset specificity, uncertainty and frequency, and the persons involved in the transactions, such as being boundedly rational and potentially opportunistic (Williamson, 1979). In the context of health care, this level reflects such questions as whether physicians are linked to hospitals by contract or employment, whether hospitals are vertically integrated into ancillary medical services (ambulatory services, lab testing, etc), or whether an area's hospitals are controlled by a single organization or operate independently.

Level 3 consists of institutions. North (1990, p.3) defines institutions as the "rules of the game in society or … the humanly devised constraints that shape human interaction." Hodgson (2006, p. 2) defines institutions as "systems of established and prevalent social rules that structure social interactions." Just as governance structures "govern" how transactional activities occur, institutions "govern" the operation of governance structures. An important institution is a system of property rights defining who is entitled to own and operate economic assets and under what circumstances economic assets may be transferred among agents. Examples include capitalism and socialism; in capitalistic systems individuals are entitled to own and control economically-meaningful property, whereas in socialistic systems these entitlements are generally controlled by the state. Within in the context of health care, the question of whether health services are provided by government or through markets is determined at the institutional level. This is also the level at which overarching governmental rules regarding the provision of health care exist. For instance, rules prohibiting physicians of Medicare and Medicaid patients from making referrals for services in which the physician has a financial stake, informally known as "Stark II" laws (see Kolber, 2006) exist at the institutional level. Level 4 is an extension of the institutional environment and reflects the norms, customs, beliefs, habits and values of members

of society (North, 2005; Hodgson, 2006). With respect to health care, whether people believe health care is a privilege or a right is embodied at this level. More will be said about this later.

The hierarchal ordering reflects the idea that a higher level acts as a limiting constraint to a lower level, represented by the solid lines in Figure 1. Thus, the primary direction of causality is from level 4 down through the hierarchy. However, lower levels can influence higher levels by means of feedback effects, represented as dashed vertical arrows. In this sense the relationship is symbiotic (North, 1990). Whereas the higher level defines what is feasible at lower levels, it can also adjust to characteristics of lower levels, albeit more slowly than lower levels change. Because higher levels change more slowly than lower levels, path dependency plays an important role in defining how well lower levels function. For example, changes in governance structures (level 2) might be needed to reflect changing characteristics of transactional activities at level 1. But if level 4 beliefs and level 3 institutions do not adjust to reflect needed changes at the governance level, current structures may not be fully effective in governing the transactions, thus resulting in increased transaction costs. Governance structures can adjust only to the extent that the institutional environment allows, which in turn must reflect the norms, belief systems and habits of members of the society. The central insight here is that each level of Williamson's hierarchal system must align with the adjacent level. Governance structures must align with the characteristics of transactional activities (Williamson, 1979), institutions must align with given governance structures (North, 1990), and social norms and beliefs must conform to existing institutions (North, 2005). Misalignment will cause tensions and unnecessary costs within the system, which ultimately cause negative impacts on transactional activities.

Consider the case of market exchanges. A market exchange is a bilateral agreement between two more or individuals, each seeking their own interest, but cooperating because each

perceives that the benefits from doing so exceed the costs. In order for this transactional activity to function at level 1, the level 2 market structures must support bilateral agreements by, for instance, providing a low-cost means for agents to find each other, agree on transactional terms, and enforce agreements. In order for market structures to perform these functions, Level 3 institutions must support market structures by, for instance, defining and protecting property rights over economic assets and by not interfering with the voluntary agreements of individuals. Level 3 institutions in turn function best when Level 4 norms, values, and beliefs reflect the ideas that liberty and the pursuit of one's interests are appropriate social constructs and, importantly, one's access to goods and services is a privilege not a right in the sense that access is granted only after a voluntary payment is received by goods holders.

A central insight offered by a new institutional economics perspective in health care is that rising costs need not be fully attributed to neoclassical considerations of demand outstripping supply, resource scarcity or production constraints. Rather, rising costs might also be attributed to transaction costs resulting from misaligned governance structures that are not adapting to changes in the transactional characteristics of health care activities. Correcting the misalignment will result in cost savings that could be used to increase or improve access or services to rural communities.[3] This is consistent with a small but growing literature attempting to show how organizational and governance structures are adapting to more closely align with transactional characteristics in health care (see, for instance, Robinson and Casalino, 1996; Coles and Hesterly, 1998; Greenberg and Goldberg, 2002; Barnes and Fannin, forthcoming).

Beliefs and Values Regarding the Provision of Health Care in Society

[3] See Yvrande-Billon and Saussier (2005) for a discussion of research in which scholars identify the degree to which misalignment of governance structures affects organizational performance.

According to New Institutional Economics, each governing level illustrated in Williamson's coordinating framework (Figure 1) must be aligned in order for transaction costs to be minimized. The governance structure chosen must align with the characteristics of the transactional activities and the institutional environment must align with the governance structures. The importance of appropriate linkages at the transaction, governance and, to some extent, institutional, levels within the context of health care is recognized in the literature (e.g., Preker, Harding and Travis, 2000). However, there is relatively little scholarship examining the importance of level 4 beliefs, norms, values and customs, particularly with respect to the problem of providing adequate health care to society. Part of the reason is that norms, culture and related concepts are believed to be too broad and vague to allow systematic economic analysis (Guiso, Sapienza, and Zingales, 2006). Nevertheless, an understanding of rural health care cost and access issues cannot be complete without a recognition of the ideas, beliefs and values existing at level 4 and how they affects the functionality of levels 1, 2 and 3.

Not only do institutions matter, but "ideas matter" as well (Denzau and North, 1994, p. 3). The ideas important here are those that embody beliefs and values as they relate to economic activity. These ideas have been recognized in the context of ideology (Denzau and North, 1994; North, 2005) and culture (Guiso, Sapienza, and Zingales, 2006). According to North (2005, p. 140), institutional change is constrained by the belief structures that exist in society. For example, he states that "modern" beliefs or "sentiments of democracy and egalitarianism" were not part of the social and institutional landscape of continental municipalities during the Middle Ages, thus limiting the development of institutions needed to foster economic growth and development. Beliefs are important because they form the basis for how people perceive and filter information that comes from their environment and experiences. When the mental models

that people construct to structure this information are "shared" or similar across groups of people, they become ideologies. Denzau and North (1994, p. 4) define ideologies as "the shared framework of mental models that groups of individuals possess that provide both an interpretation of the environment and a prescription as to how that environment should be structured." It is this "sharedness" of mental models that makes possible the development and evolution of institutions needed to affect economic performance and change. Beliefs that are common tend to enhance institutional effectiveness, while those that are not tend to weaken institutions. Thus, two individuals, facing identical institutional constraints and incentives, but having different ideologies will respond differently to their environments. The reason is that individuals with different ideologies will interpret the same information and incentives differently and will consequently make different choices within that environment. Guiso, Sapienza, and Zingales (2006) also highlight the importance of beliefs in their discussion of culture. In their view culture consists of "those customary beliefs and values that ethnic, religious, and social groups transmit fairly unchanged from generation to generation" (p. 2). They show that culture can directly affect the expectations and preferences of people and, as a result, impact economic outcomes.[4]

If the beliefs and values of people affect the institutional environment, and if the institutional environment in turn affects the governance structure and indirectly the nature and efficiency of transactions occurring, then the beliefs and values of people regarding health care within society ought to have an impact on issues relating to health care cost and access. This is a straightforward application of Williamson's coordinating framework illustrated in Figure 1. Consequently, efforts to alter the governing structures of health care, by, for instance, adopting

[4] In their analysis, this effect can be recognized as causal because they focus only on those beliefs and values transmitted from parent to child, such defined by religiosity and ethnicity.

market-based contracting programs or vertically-integrated hierarchal structures will succeed to the extent that the characteristics of the transactional activities (at level 1) are appropriate for the governance structures chosen *and* if the beliefs and values of people (at level 4) are consistent with the institutional environment needed to effectively and at low cost govern the governance structures. Stated differently, alignment efforts proceeding from the "bottom-up" in Williamson's coordinating framework must also correlate with alignment proceeding from the "top-down." The implication for health care access is that identifying misalignment and correcting it will lower transaction costs in the provision of rural health care services and hence free resources that could be used to increase access in rural settings.

Beliefs supporting flexibility in choice of governance structure

What beliefs and values are important in the evolution, adoption and diffusion of transaction-cost reducing governance structures? If existing governance structures are not aligned with the characteristics of the transactional activities and hence are required to change so as to lower transaction or governance costs, then organizational systems that are flexible are more likely to adopt the preferential systems than organizations that are relatively rigid. Private organizations operating in a market environment are more likely to have an incentive to lower costs (in order to increase profits) and hence to have this requisite flexibility than public or governmental organizations.[5] According to Preker, Harding and Travis (2000, p. 781),

> Unlike public organizations, private firms have the flexibility, indeed the requirement, to adjust their governance structure to changes in the market environment. This makes them fruitful sources of better practices for governance arrangements. Public agencies that

[5] Although not a study of changing organizational form per se, Chakravarty, Gaynor, Klepper and Vogt (2005) find that compared to not-for-profit hospitals, for-profit hospitals have higher rates of entry and exit in response to changing market conditions, thus supporting the idea that private organizations seeking profits might be more flexible that organizations in which the profit motive does not exist.

> have tried adjusting public organizations to changes in the market environment have often encountered problems with underlying incentive structures and their sustainability.

Beliefs and values that are supportive of organizational flexibility are therefore necessary. The beliefs and values, and the institutional environments aligned with them, expected to be *most* consistent with this requisite flexibility are those recognizing private property, the pursuit of profit, and the acceptability of excludability in product attributes so that access to products and services is considered a privilege. Simply, the evolution and diffusion of governance structures according to transaction cost theory principles operate best in an environment supportive of private enterprise rather than in the public sphere. This is not to say that transaction cost theory cannot be applied to public organizations or politics generally. On the contrary, new institutional economics can inform immensely on public bureaucracies and politics (Williamson, 1999; Dixit, 1996; Moe, 1984). However, it must be "modified in essential ways" (Moe, 1990, p. 119). From a comparative economics perspectives, beliefs supportive of market processes broadly construed are expected to be more conducive to the evolution, adoption and diffusion of organizational change within the health care system than beliefs and values supportive of public intervention and government provision of health care services.

Figure 2 about here

This idea is represented in the panel (a) of Figure 2. Consider the important belief that access to goods and services is a privilege. This belief is based on the idea that potential recipients of goods and services are not entitled to them if they are unwilling or unable to make payment. That is, sellers of goods and services have the right to exclude non-payers from access

(in the case of private as opposed to public goods, which technically are not excludable). This level 4 belief is requisite for the level 3 institutional environment in which laws exist supporting private enterprises and the protection of property. In this environment, organizational structures at level 2 would be most flexible to adjust to the particular transactional characteristics existing at level 1. Thus, if there are changes in the specific transactional characteristics at level 1, level 2 governance structures could adapt in this environment by, for instance, moving toward greater vertical integration or more extensive contracting as the case may be. The point here is if transaction cost principles suggest the need for the adoption of alternative governance structures given the characteristics of the transactional activities in question, then such change might be viable within an environment in which people believe, among other things, in the idea that access to goods and services is a privilege.

Beliefs regarding access to health care

What beliefs and values are important with respect to the provision of health care in society? Perhaps the most important beliefs and values are those that revolve around question of who is entitled to health care. Should people gain access to health care services on the basis of willingness and ability to pay, or some other principle? Are we prepared to deny access to care for people who are unable to pay for it? Is health care a right or a privilege?

A number of commentators have argued that the "solution" to the problem of rising costs and inadequate provision of and access to health care services must involve greater efforts to allow the profit motive and the invisible hand of the market to guide the activities of demanders (e.g., patients) and suppliers (e.g., physicians and hospitals). For example, Epstein (1997) argues that markets should allocate scarce health care resources unfettered by governmental or other

constraints. Herzlinger (2004, p. A12) states that "health care, like everything else in our economy, must follow market principles." An editorial in the Wall Street Journal uses LASIK (a form of laser surgery to correct myopia and related types of eye problems) to assert that market forces ought to be allowed to operate in the health care system. The editorial presents information showing the cost of LASIK declining, the point being that there is no cost crisis for this medical procedure. According to the editorial (Wall Street Journal, 2006, p. A18),

> Proponents of government-run health care keep insisting that medicine is different from everything else in the economy in being immune to market forces. But the LASIK example shows that where a market in health care is actually allowed to function, with transparent pricing and incentives to spend wisely, the market works very well. The goal of public policy should be to make sure there's such a market across the entire health-care industry.

Similarly, a former Chief Executive Officer of a health care insurance provider states that "it is ironic that a democratic country that prides itself on the benefits of its competitive markets, has not extended those same free-market principles to one of the largest sectors of its economy – namely, the health care industry" (quoted in Fettig, 1991).

Markets function best when buyers and suppliers are able to interact in such as way so as to allow them to collectively agree on an exchange price. The idea of an exchange price works well in many instances because people are comfortable with the excludability implications of such a process: Buyers who are willing and able to pay the price receive the goods or services, while those not able or willing to pay will not acquire them. Conversely, sellers who are willing and able to accept the going price will supply the goods or services, while those sellers not able or willing will not do so. These ideas are illustrated in Figure 3, which depicts a generic "market" for health care services. The upward-sloping line represents the marginal costs of providing health care, and the downward-sloping line represents marginal benefits to individuals receiving care. If the market clears, then under the typical "market" rule of access granted

according to willingness and ability to pay, in equilibrium there are buyers or patients who have access to medical services and there are potential patients who do not have access. If this is the case, then there are people who could benefit from medical services but who do not receive them. That is, to the right of the equilibrium there is an area in which marginal benefits are positive. Are we, as a society, willing to accept that fact that there are some people (maybe even a great many people), who would benefit from medical care but who are denied it because the cost of access for them is too high? This is more than an academic or philosophical question, as it lies at the root of what constitutes the basic beliefs and values of members of society regarding institutions governing the provision of health care.

Figure 3 about here

In the case of computers, soccer tickets, tax preparation services and other consumer goods and services, most people are comfortable with the idea of excludability in that people who do not pay (because they are either unable or unwilling to do so) are not entitled to the goods and services, suggesting that for these goods access is a privilege rather than a right. Is this true in the case of health care generally? A number of scholars have argued that health care differs substantially from most other goods and services and that, as a result, the idea that access to health care should be a privilege based on ability and willingness to pay ought not to apply (Aday and Anderson, 1981).[6] For instance, Flood (2000, p. 28) asserts that health "has the characteristics of one of Rawls' 'primary goods' …, being something that a rational person would want irrespective of what else she would want, all other things being equal." This suggests

[6] Powers and Faden (2000) describe an evolution in the literature regarding the view that health care as a right. What began as a focus on a right to health care shifted to the question of what a minimum level of health care entails and why inequalities in access to health care exist and how they can be mitigated.

that access to health care ought to be guided by principles of justice rather than ability to pay. Daniels (1985) articulates a right to health care based on the principle of equality of opportunity. People have a right to access a minimum level of preventive and acute care, but that does not guarantee a right to a specific outcome, such as better health. Buchanan (1984) claims that there are good reasons to assert that people are entitled to a "decent minimum of health care." However, such as right does not necessarily mean that it would be a good thing if everyone in fact exercised that right or that society even has the capability of fulfilling it. Additionally, a right to health care is articulated in the United Nation's Universal Declaration of Human Rights (United Nations, 1948).[7]

There is a growing body of evidence suggesting that a growing majority of Americans are beginning to accept the notion that health care is a right and not a privilege. For example, the Center of Policy Attitudes (2000) summarizes an extensive evaluation of public and media polls on the subject of health care. They conclude that "in principle, most Americans seem to believe that health care is a right, like public education, that should be guaranteed by the government" (p. 1). In related research, Frohlich and Oppenheimer (1992) present experimental evidence showing strong support for the idea that a minimum guarantee or level of primary goods (e.g., food, water, housing, health care) should be given to all individuals, particularly those who are least well-off.[8]

If health care is a right, then the question arises as to what claim right-holders have with respect to that right. Claims may involve negative or positive duties. Negative duties imply a

[7] Article 25 of the Declaration states that "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including … medical care."

[8] The options presented to respondents were a floor constraint (maximize average subject to constraint that worse-off individuals receive a specified minimum), the difference principle (ensure that no incomes go up unless the incomes of worst-off persons increase), maximum income (maximize average income of all members of society) and range constraint (maximize income subject to constraint that difference between rich and poor not exceed some level).

claim by the right holder against non-interference from others. In some respects, the right to health care might imply a claim against others not to interfere with their ability to acquire it, but this is not likely what most people mean when they think or say "right to health care." Positive claims, on the other hand, are those that imply a duty to do something with respect to the right-holder. This means that if health care is a right involving a positive claim, then others – whoever they are needs to be determined – have a duty to provide that care. In other words, if health care is a right in the positive sense, then people who do not have access or who are either unwilling or unable to purchase health care services have a claim on others for health care. If so, then who should provide that care, and how? Answering these questions is beyond the scope of this paper. The point to be made here is only to make clear that *if* health care is believed to be a right, and *if* that right involves a positive claim on others, then it must be the case that some entity – e.g., government, employers, the wealthy – will have a duty to provide that care, regardless of expected costs and benefits to society, unless it can be successfully argued that certain types of medical procedures or services are not rights.[9]

That said, there is also evidence that people believe it is the government and the public sphere rather than private enterprise that ought to have a significant responsibility in ensuring all members of society have access to at least some minimum level of health care services. For example, the Center on Policy Attitudes (2000, p. 1) argues that "a strong majority believes the government should actively work to expand health insurance coverage to more Americans." Data from the General Social Survey corroborates this conclusion. Figure 4 shows that more than 80 percent of respondents believe the government definitely should or probably should have some

[9] For example, under the Clinton Administration universal health insurance proposal (Health Security Act of 1993), the following were recognized as exceptions: "custodial care (other than hospice), cosmetic surgery and procedures (with exceptions), hearing aids, eyeglasses and contact lenses for adults, in vitro fertilization, sex change surgery, private duty nursing, personal comfort items, and some dental procedures" (Diamond, 1994, note 3).

responsibility of providing health care for people who are sick. Figure 5 reveals the percent of respondents who strongly agree and agree that it is the responsibility of government to see "that people have help in paying for doctors and hospital bills" (as opposed to people taking "care of these things themselves"). For the 1983 to 2004 period, on average 28 percent of respondents believe strongly that the government should play a role, while 49 percent agree or strongly agree. Moreover, the graph reveals that there is a slight but positive increase in the trend. Over time, more people appear to believe or to accept the idea that the government has a duty to provide help with respect to medical care. People also increasingly believe that the government should be devoting more resources to health care issues. A poll sponsored by the National Science Foundation and conducted by the Roper Center revealed that 61 percent of respondents in 1981 believed that the government is spending too little on improving health care, while in 2001 the number expressing this view increased to 70 percent (NSF, 1981 and 2001).[10] The fact that people believe government should play a role or even a more active role in the health care system is consistent with the idea that people perceive health care, at least some degree to health care, to be a right.

Figures 4 and 5 about here

The implication of these views from a new institutional economics perspective is illustrated in panel (b) of Figure 2. An institutional environment in which people believe access to health care is a right and the government should be involved in providing that right may be quite different from an environment in which people believe access is a privilege. If the beliefs

[10] The surveys are telephone surveys of adults in the United States. The number of participants in the 1981 study was 3,193, while the number in the 2001 survey was 1,574.

and values of people (at level 4) are such that access to health care is considered a right, and if the government is seen as having an important (though not necessarily exclusive) role in the provision of that right (at level 3), then the level 2 governance structures that either emerge or are best appropriate for given characteristics of health care transactions at level 1 may also differ from what is expected in an environment in which access to health care is perceived to be a privilege. In other words, alignment of health care transactional activities with governance structures perceived to be appropriate in environments characterized by the belief that access to goods and services is a privilege may not occur, or may occur more slowly and at greater transaction costs, in an environment in which access to health care is considered a right. The reason is that in an environment in which access is considered a right or in which access is provided on the basis of some other value or principle other than ability and willingness to pay, alignment from the "top-down" (in Williamson's framework) may not correspond with alignment expected from the "bottom-up."

Moreover, if health care services are provided on the basis of some criteria other than ability and willingness to pay, then efficiency may be sacrificed. There is a tradeoff between the efficiency of access granted according to ability and willingness to pay and the idea that access to health care is a right (Frohlich and Oppenheimer, 1997). If society wants to ensure that people who do not or cannot pay for health care services receive them, then it will be inevitable that health care expenditures will be higher than what is expected or desired under efficiency criteria. This is a fundamental implication of Figure 3. Providing health care services to the right of the intersection of marginal cost and marginal benefit will cause inefficiencies in the health care system characterized by marginal costs exceeding marginal benefits. Therefore, institutional alignment becomes even more crucial in order to minimize transaction costs; the costs of

providing health care can be controlled in part if specific health care functions are aligned with the governance structures as well as the institutional environment, including beliefs and values.

Beliefs and Values of Rural Versus Urban Areas

The analysis thus far suggests that a misalignment might be occurring within health care, in the sense that the beliefs and values of people existing at the institutional level may not fully support the requisite flexibility in the choice of governance structure that health care organizations and providers need to lower costs and improve access to health care services. The driver here is how people regard the question, "Is access to health care a right or a privilege?" However, in addition to the beliefs derived from and related to this question, there might also be important differences between rural and urban environments that exist at level 4 of Williamson's conceptual framework and that, consequently, affect the choice of governance structure. That is, if the beliefs, values and norms of rural residents are not the same as those of urban residents, then transaction cost-saving governance structures existing in urban settings will not automatically perform as expected in rural society.

There is some evidence suggesting that differences between rural and urban areas exist in the choice of governance structure within the health care system. Ricketts (1999) states that urban areas have been relatively more flexible in the adoption of alternative governance structures than rural areas. Libby (1997) finds significant differences in urban and rural areas in the prevalence of contracting for mental health services, which she subscribes to "economic and public organizational factors" (p. 323). There might be several reasons why differences exist between urban and rural environments. One reason is that there might be differences in the characteristics of the transactional activities that exist (e.g., at level 1), in terms of asset

specificity, likelihood of opportunistic behavior and frequency of transacting. If transactions have different characteristics depending on whether they occur in urban or rural settings, then the governance structures governing them will likely be different, too. Another, though not exclusive, reason is that the institutional environment of rural areas differs markedly from urban settings, either at the level of institutions or at the level of beliefs and values. Evidence exists suggesting that there are differences in the beliefs and values of urban and rural residents. If these beliefs are important enough, they may affect the entire institutional framework as suggested by Williamson's coordinating framework. For example, Strickland and Strickland (1996) study barriers to preventive health care services in a poor, rural community in the southern United States. Although they find that cost and even availability are cited as barriers, the most important barrier to access is the perception among rural residents that health care services are in fact needed. According to the researchers, "This belief was cited by more than half of the households in which dental, vision, prenatal, and children's general physical examinations had not been received" (p. 212). As an explanation, they suggest that "social values and norms associated with rural life may discourage the use of preventive services" (p. 208). The reason is that rural residents may "link the need for health care services with an inability to carry out normal role functions" (Slifkin, 2002). The idea is that, relative to urban residents, rural residents may be less likely to seek out medical care if they believe their ability to perform their roles is not significantly impaired, but they obtain medical care when problems are considered to be severe. These differences could impact the overall institutional environment and, as a result, affect the nature of health care governance structures that exist or that are diffusing within rural society. One implication of this is that research designed to assess differences in the choice of

governance structures comparing rural and urban areas might need to control for differences in the attitudes, values and beliefs of rural and urban residents.

Implications for Provision of Health Care in Rural Society

Because the problem of health care provision in rural society is complex, solutions to questions involving access and cost are also expected to be complex. The discussion presented here is designed to shed light on one aspect of this problem: how governance structures are related to the institutional environment and the characteristics of transactional activities reflecting the provision of health care. As suggested by a consideration of New Institutional Economics and the coordinating framework developed by Williamson (2000), cost savings can be achieved if the governance structures that oversee the functioning of health care are aligned with the characteristics of what is governed. Moreover, institutions must align with the governance structures and higher-level societal beliefs and values must also align with the institutions. Therefore, to the extent that societal values regarding access to health care differs from those regarding access to other kinds of goods and services, and to the extent that rural society differs from urban environments, then governance structures that are found to function well in market environments and in urban settings might not be fully effective in rural environments. In other words, it is not obvious or expected that contracting or vertical integration of hospital or physician services, for instance, which might function well in urban environments, will be effective in rural societies. There is a growing literature suggesting that alternative governance structures, particularly involving some degree, combination, or realignment of market-based transactions, contracting, and vertical integration might provide solutions to some cost and access issues in rural health care. These structures are all fundamentally market-

oriented, to the extent that they are based on the belief that scarce resources ought to be allocated on the basis of willingness and ability to pay. However, there is evidence that, at least in the context of health care, people are more apt to believe that health care is a right rather than a privilege. This suggests that even if changing governance structures result in costs savings, governance structures designed for or within market-based environments may not produce the desired results if they do not fully reflect the beliefs and values of citizens with respect to the question of health care access. For the problem of improving access to health care in rural society, identifying transaction cost lowering governance structures that appear to function well in urban setting may not perform as expected or desired in rural communities. Appropriate governance structures might need to be "modified in essential ways" (Moe, 1990, p. 119) according to the specific rural environments within which they are utilized, which would require a renewed and concerted effort at studying rural communities and the institutional environments existing therein rather than in merely transplanting governance structures from one setting to another.

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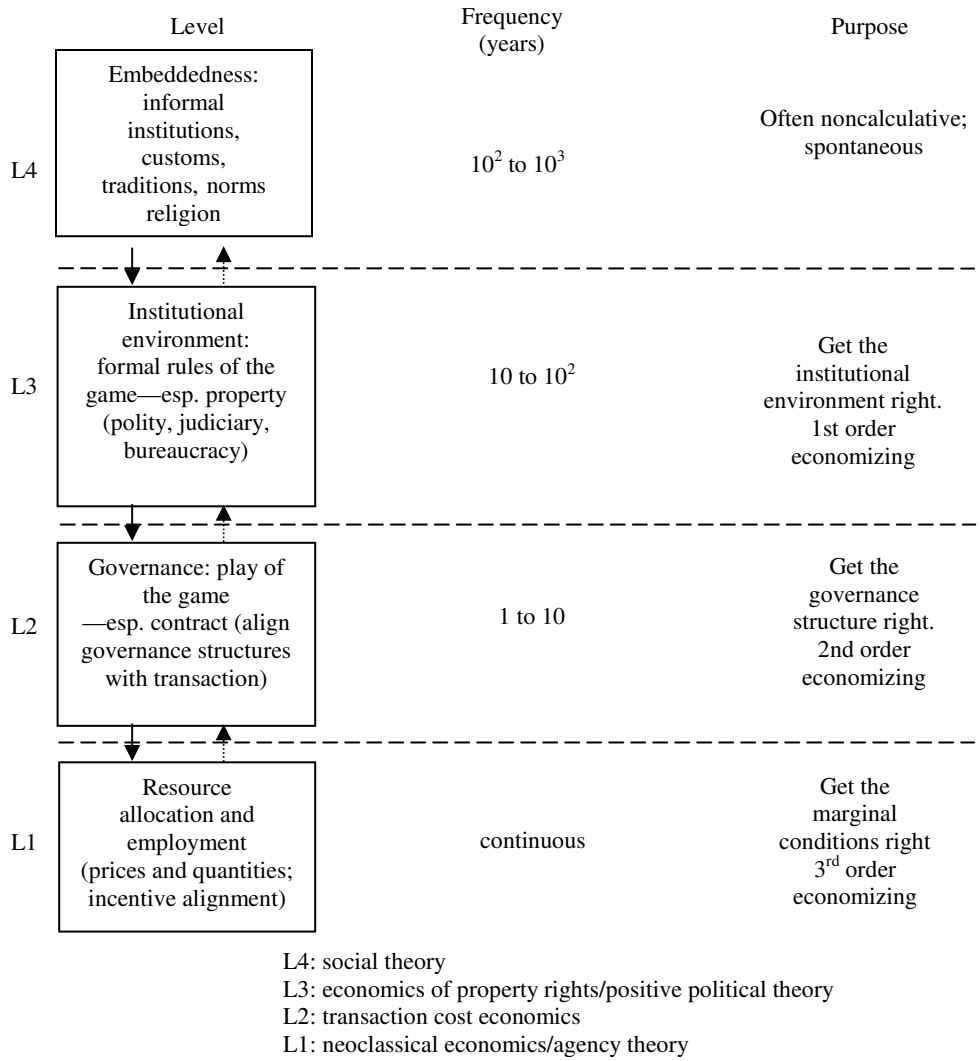
Figure 1. Williamson's coordinating framework



Source: Adapted from Williamson (2000).

Figure 2. Application of Williamson's coordinating framework when applied to question of whether access to goods and services is a privilege or a right.

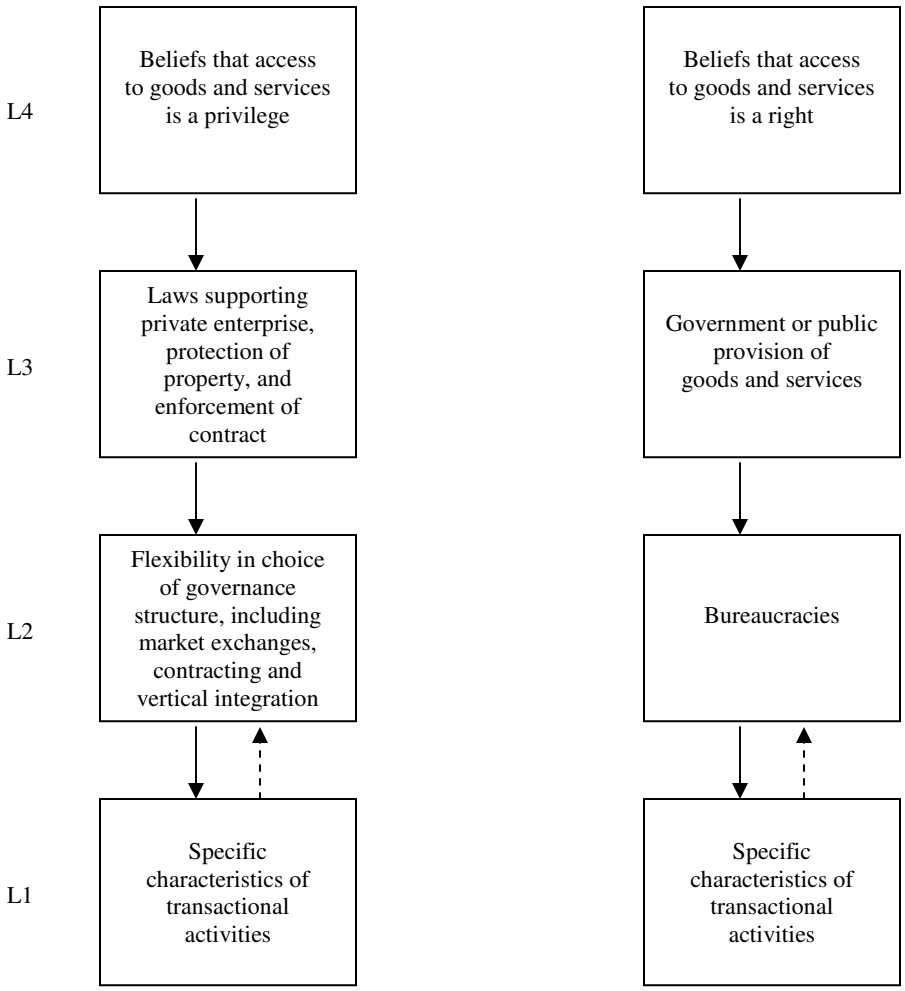


Figure 3. Implications of market-oriented demand and supply operations in a generic market for health care services.

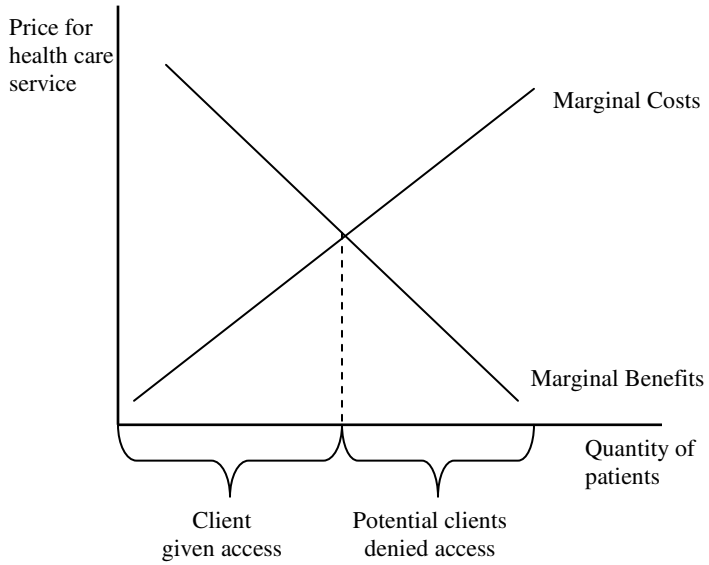
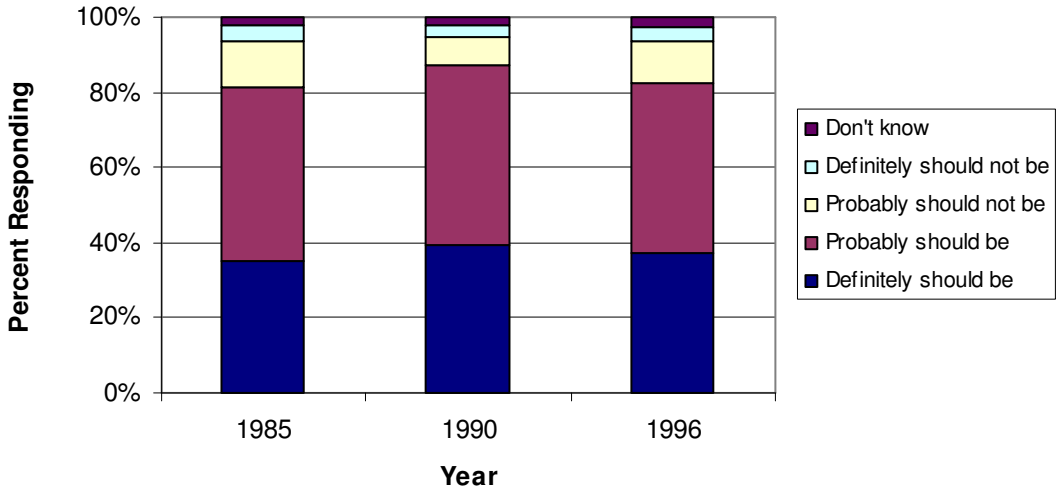
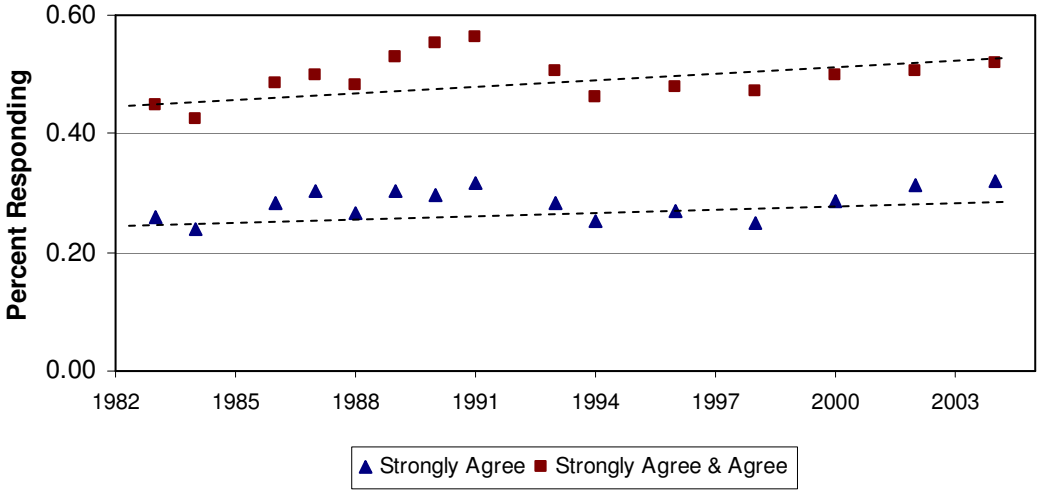


Figure 4. Percent of respondents who believe the government should have a responsibility to "provide health care for the sick."



Source: General Social Survey, variable name HLTHCARE, various years, with no answer and not applicable responses excluded from the calculation.

Figure 5. Percent of respondents who strongly agree and/or who agree that it is the responsibility of government to see "that people have help in paying for doctors and hospital bills" (as opposed to people taking "care of these things themselves"); with estimated trendline.



Source: General Social Survey, variable name HELPSICK, various years, with no answer and not applicable responses excluded from the calculation.