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# Healthcare System Restructuring and the Effects of Globalization on Post-Soviet Transitional Economies

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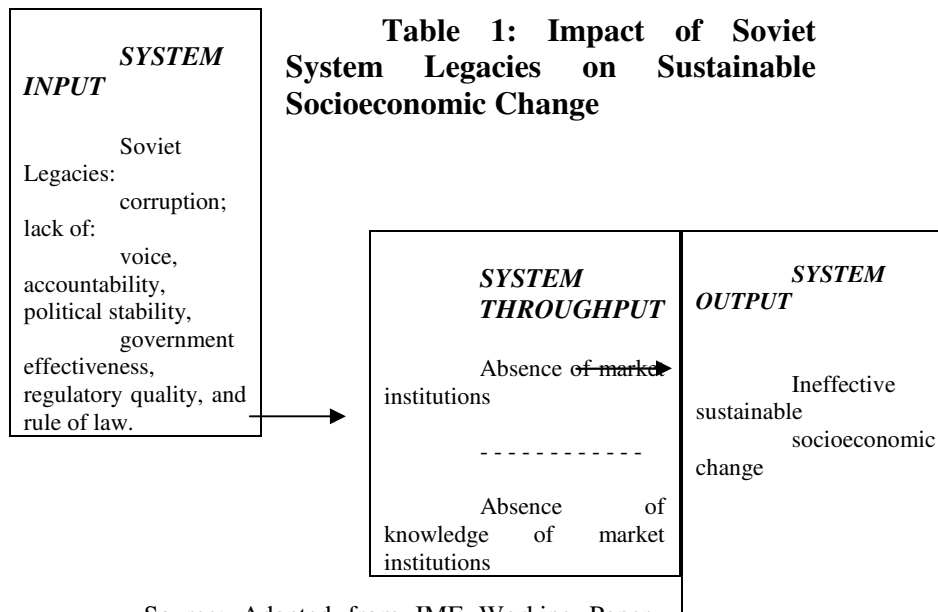
## ***Abstract***

*Initial strategic priorities identified by the global community for the post-Soviet nations upon acquiring independence were for macroeconomic reengineering. While it was generally acknowledged that the functioning of the social welfare system of the Soviet Union was inefficient and ineffective, emphasis on the improvement of healthcare quality and safety, cost reduction, and revenue enhancement for fiscal viability remained unaddressed during post-Soviet economic restructuring. Microeconomic institutional management focused on organizational processes and human capital development, especially for the healthcare sector, was largely ignored. In addition, the need for gauging patient satisfaction, providing a more supportive clinical environment for practitioners, and strengthening the teaching and research environment was becoming more evident. Mechanisms to track program results and fiscal responsibility remained absent from any reengineering plan. This situation remains the same today even as many of these nations are participating in international organizations such as the European Union (EU), the North Atlantic Treaty Organization (NATO), and the United Nations (UN) in their efforts to globalize their health systems. This paper will examine some of the many challenges facing these health systems as they rapidly transition from communism to more globally focused democratic governments all within a period of just over a decade.*

## **Introduction**

With the fall of the Soviet Union in 1991 and the resulting independence of its once centrally controlled regions, Western countries were challenged to provide effective mechanisms to restructure these command economies into more democratic, market-focused organizations. Various Western management models based on a team management approach, using participative decision-making, human capital development, and fiscal responsibility, were proposed as a prerequisite for joining the international community within a globalization framework. However, even when financing was provided by the international community, monitoring mechanisms were never stressed, and managers were not required to adhere to fiscal responsibility criteria during this reengineering period – at least, in this context – by the healthcare sector. In the reshaping of the governance of social and public institutions, emphasis was given to fostering the development of “reflexive” social stakeholders to act as change agents. It was anticipated that these leaders would be better prepared to deal with risk and uncertainty and encourage changes in the behavior of individuals and institutions. They, and those they fostered, would be more adaptive to democratic changes and be self-monitoring. This behavior change process was seen as essential in moving these countries toward greater democratic participation and for defining sustainable solutions designed to strengthen new organizational structures. But how could system changes occur when the change agents were steeped in communist ideology and bureaucratic behavior that relied on being directed by a central authority? The Soviet legacy of widespread societal corruption is cited by the World Bank as being a major factor for delaying these sustainable development efforts. According to Aidis and Mickiewicz (2005) corruption

continues to negatively affect entrepreneurs' motivation to grow and compromises the credibility of the investment environment (see Table 1).



Source: Adapted from IMF Working Paper, Who Is Still Haunted by the Specter of Communism? Explaining Relative Output Contractions Under Transition (Berengaut, J. & Elborgh-Whoytek, K. (2005, p. 8).

### **Relationship of Public Policies to Social and Health Capital Development**

The National Institutes of Health (NIH) define social capital as the network of societal institutions and relationships (social environment) that together have a positive influence on the function of communities and individuals (<http://www.grants.nih.gov/grants>). This social environment, or social network, includes individual, institutional, and community-level characteristics, e.g., socioeconomic status (SES), education, coping resources and support systems, residential factors, and cultural

factors. Social determinants of health refer to factors in this social, cultural, and physical environment that interact to influence population health (<http://www.grants.nih.gov/grants>). Therefore it can be said that both public and private policies can set economic conditions that influence the nature and quality of daily environments and can cause pervasive affects on health status (Zollner, Stoddart & Smith, 2003). According to Zollner, Stoddart & Smith (2003), health capital is determined by an interaction of the following factors: genetic, life risks, environment, individual behavior, social group, and affiliated healthcare system. They believe that there is an interrelationship of health and health care – and that health care and the economy are not independent. “Health care is one of a broad array of determinants of health, and healthier populations tend to be more productive populations . . .” (Zollner, Stoddart & Smith, 2003, p. 1).

According to the World Bank,

The relationship between social capital and health has been documented since 1901 by Emile Durkheim. Since then research has continued to demonstrate that higher social capital and social cohesion leads to improvements in health conditions. Recent research shows that the lower the trust among citizens, the higher the average mortality rate (<http://www1.worldbank.org/prem/poverty/scapital/topic/health1.htm>).

But in the case of the Soviet Union, the social capital and social cohesion imposed by the Soviet political and economic system was never overwhelmingly adopted and incorporated into these nations. Upon independence

and the development of a more open political environment, once suspect health-related statistics that reflected a robust health capital for these nations started to be investigated and trended by global organizations, such as the World Health Organization (WHO) and in the case of the United States, the United States Agency for International Development (USAID) and the NIH. It was found that population mortality and morbidity rates, when available, exceeded those for most western societies and still do (<http://www.who.int/en> and <http://www3.who.int/whosis/mort/table.1>). Why was this situation occurring? Western analysts had insisted the Soviet social welfare system was one of the best in the world since it touted universal access to healthcare. Their education system and scientific establishment was also considered renowned.

The high mortality and morbidity rates can be partially explained by examining the underlying political ideology and enforced policies that emphasized the good of the “state” over the needs of the people. In their recent study of issues affecting socioeconomic transition of post-Soviet societies, Berengaut and Elborgh-Woytek (2005) show that “the Soviet system has, due to its relatively long duration, eradicated specific human capital comprising the memory of functioning markets, resulting in the absence of knowledge of market institutions due to a “generational” effect” (p. 8). During transition, while some of these countries were better able to fully recover economically from pre-independence socioeconomic conditions, “the specter of communism is still haunting these economies [because of] the peculiar combination of totalitarian politics, which hindered the development of a civil society, and administrative management of the economy, which resulted in pervasive economic distortions and lack of market institutions” (Berengaut & Elborgh-Woytek, 2005,

p. 4). Berengaut and Elborgh-Woytek (2005) conclude that the Soviet legacies had the greatest influence on the performance of former socialist economies during the transition process in institutional development and the development of human capital to function within these new institutions. In general, the Soviet legacies had an adverse effect on economic growth and this effect on economic growth depended on how deeply entrenched the legacies were at the onset of transition. In other words, public policy measures can improve public health through changes in the regulation and incentive structures that influence individual health behavior. Some of the countries experienced the effects of the Soviet legacy to a lesser degree than others because of a shorter period and intensity of communist rule (Cholewka, 1999); the existence of more independent organizations (e.g., the Catholic Church and independent labor union, Solidarity, in Poland); and a higher degree of integration with other European countries (e.g., the Baltic States with both the Scandinavian countries and their corresponding ethnic communities within the United States) (Berengaut & Elborgh-Woytek, 2005, p.10).

However, even after nearly a decade and a half of independence, results of interventions by international organizations to restructure these healthcare systems have not been entirely successful. Individual health and wellness behavior was not emphasized during the Soviet era and health risk behaviors and uncontrolled communicable disease rates are still problematic. Western public health observers are still reporting increasing rates of otherwise preventable communicable diseases such as anthrax, gastrointestinal diseases, and tuberculosis; high risk behavioral conditions such as HIV/AIDS and other sexually transmitted diseases; health effects of uncontrolled environmental degradation and contamination; substance abuse; and chronic respiratory diseases associated with

tobacco abuse; and chronic diseases of their increasing populations of those age 60 years and above (WHO, 2000). Continued non-compliance to Western health system management models might indicate a disutility (lack of usefulness or value) and discontent (lack of satisfaction) with these programs. These results also indicate that there is an inability of the international community to define and face the real underlying and unresolved problems within these Soviet-influenced societies.

The majority of the populations of most of these Soviet republics did not consider the Soviet network of societal institutions and relationships (social environment) as having a positive or beneficial influence on the function of their communities. Since the Soviet system was forcibly imposed on them, there was an underlying mistrust by the citizenry of its institutions, policies, and practices. As a result, the population did not totally 'buy-in' to the imposed political culture, its value systems, and behavioral norms. They did not consider themselves as having any personal investment, concern, or interest, that is, to become 'stakeholders' within the Soviet system. Stakeholder can be defined as "one who has a share or an interest, as in an enterprise" - each having a unique interest and perspective of what constitutes benefit (<http://www.answers.com>). Various coping measures were used to survive within this totalitarian state, including certain risk behaviors such as substance abuse and attempts at suicide or personal injury to escape intolerant socioeconomic, political, and/or religious persecution. As a result, governmental mechanisms were imposed on the population to maintain control that included granting or declining socioeconomic privileges, such as housing, education, employment, healthcare, clothing and food allowances, and/or permission for internal or international travel. And yet, governmental subsidies were, and still are, maintained for

bread, tobacco, and alcohol. Until independence, these factors influenced population healthcare system access, health practices, and resulting high mortality and morbidity rates.

Independence from the Soviet Union was not complete, spontaneous, or accompanied by violence throughout the entire region due to entrenched communist philosophy and practices - hence the term, “Velvet Revolution,” coined for the six-week period between November 17 and December 29, 1989 that brought about the overthrow of the Czechoslovak communist regime (<http://archive.radio.cz/history>). Evidence that vestiges of the manner in which these socioeconomic and political systems were still administered, as well as attempts by the population to change them, was shown by Ukraine successfully demanding, and gaining, political change in Spring 2005 as a result of what was termed, the “Orange Revolution.” In addition, the Central Asian republics are currently undergoing their own intense struggles for sociopolitical change.

In general, there is need for more research into the influence of social capital and SES in the causation of health disparities and whether intervening upon social capital is feasible and has a potential for improving outcomes and reducing disparities. However, beyond the physical health needs of these populations, there is need for more research into the psychosocial factors that influence how people feel about themselves viewed within the context of their present circumstances and future prospects for SES improvement within their political environment. That is, improving and maintaining quality health status (health capital) can be viewed as a result of the interaction of social capital and public policy, that is, the building of trust among citizens in combination with formal and



informal social networks (NIH web site). Trust combined with formal and informal social networks help people to:

- Access health education and information,
- Design better health care delivery systems,
- Act collectively to build and improve infrastructure,
- Advance prevention efforts, and
- Address cultural norms that may be detrimental to health (<http://www1.worldbank.org/prem/poverty/scapital/topic/health1.htm>).

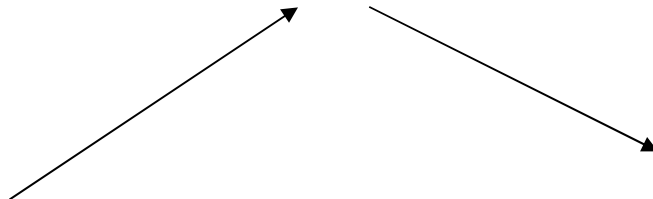
### **Relationship of National Economy, Healthcare Systems, and Sustainable Health Capital**

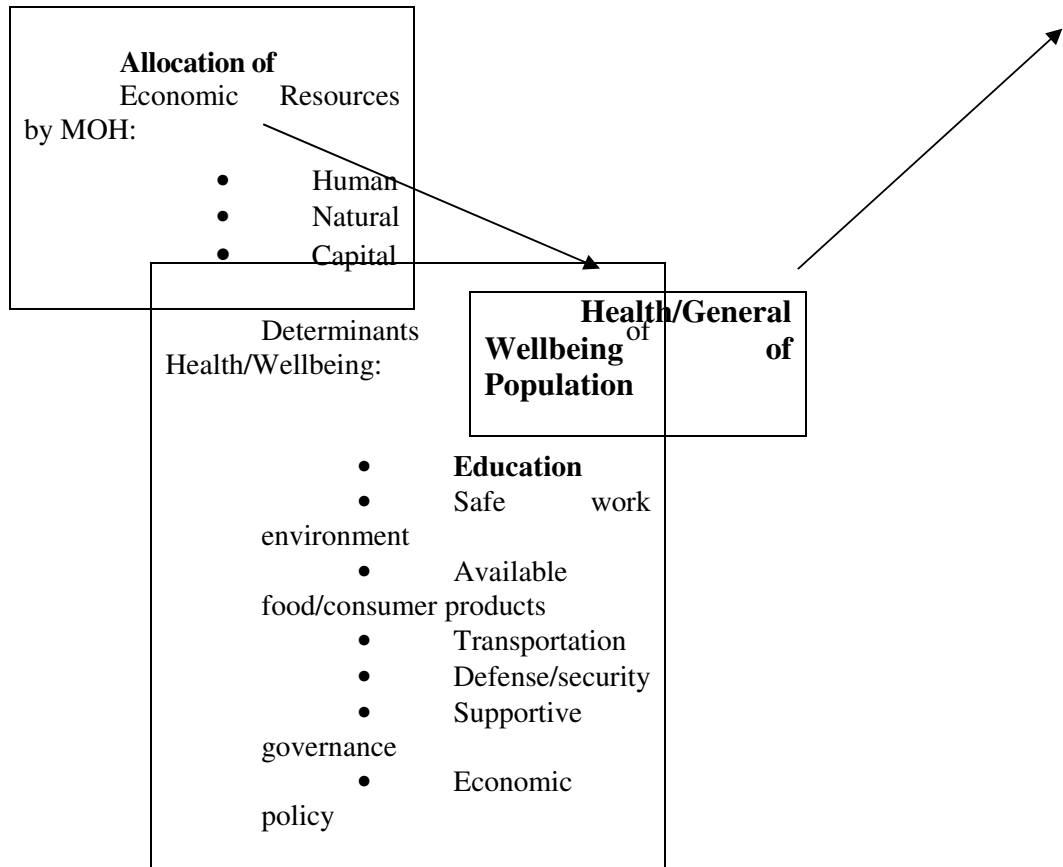
According to Zollner, Stoddart & Smith (2003), health systems and economic systems are perhaps the two most complex systems in all countries. They are often viewed as independent systems, but they are closely related either directly or indirectly. “The health status of a nation can be broadly defined as its physical, mental and social functioning and ability to cope with life’s daily challenges. It is used as an important determinant of national economic performance. Unhealthy societies do not prosper economically and often fail to achieve their economic potential, with adverse consequences for citizens . . .”(Zollner, Stoddart & Smith, 2003, p.7). Therefore, the acquisition and maintenance of optimal health status should be of prime importance to citizens and governments. Governments, that is, Ministries of Health (MOH, should invest in maintaining a level of healthcare expenditures commensurate with delivering comprehensive and high quality healthcare services to their populations and promoting healthier lifestyles for achieving longer life

expectancy, lower morbidity, and greater resiliency to cope with the daily stressors of life (see Table 2)

**Table 2: Economic Resource Expenditures by Ministries of Health (MOH) for Meeting Population Health/General Wellbeing Needs**

<p><b>Health Services:</b></p> <ul style="list-style-type: none"><li>• Primary Care</li><li>• Hospital/Community</li></ul> <p>Health Services</p> <ul style="list-style-type: none"><li>• Pharmaceuticals</li><li>• Social Services</li></ul>
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In tandem with this is the need to constantly monitor and evaluate the effectiveness of these health-related services in order to adjust for the dynamic aspects of shifting population needs and challenges to the structure and function of the healthcare system itself from political, social, and technical change. These challenges can take place in the national and international environments and range from decentralization to globalization and require the strategic planning and management of unforeseen events. This requires the involvement of key stakeholders,

anticipatory planning, building human capital, monitoring expenditures, and adjusting programs in response to changing demographics, epidemiologic trends, and socioeconomic conditions. However, “. . . due to relatively sustained government efforts and broad political consensus . . . only the Baltic states can convincingly demonstrate low rates of HIV infection due to improved statistical collection and monitoring programmes funded by the European Union” (<http://www.worldmarketsanalysis.com>).

For some states in the region, deep polarization of domestic political forces, widespread corruption, and civil war have prevented the implementation of sustained and comprehensive reform. This political reorganization and socioeconomic restructuring has allowed an upsurge in contagious diseases due to a breakdown in immunization coverage, a lack of preventive screening, and an absence of basic sanitary measures. The Director-General of WHO asserts that, “the levels of ill-health in countries pose a direct threat to their own national economic and political viability, and therefore to the global economic and political interests of . . . all countries. Therefore, investing in health is investing in national security” (<http://www.thepfizerjournal.com>).

According to WHO, as of 2003, levels of funding by governments throughout the post-Soviet region for their national health systems, measured in percent of gross domestic product (GDP), ranged from about 3.3 percent (Tajikistan) to about 5.8 percent (Belarus) SEE CHART . In general, the total population of these countries decreased while the population of individuals aged 60 years and over increased. Expenditures remained close to or only slightly increased from pre-independence levels. It is apparent that expenditures do not approach the healthcare needs of their populations for confronting the increasing mortality,

morbidity, and disability rates from human immunodeficiency virus (HIV), tuberculosis (TB), other communicable diseases and the other illnesses affecting the elderly populations (<http://www.who.int/en>).

For their research on the impact of institutional quality on the early transition phase of the post-Soviet nations, Berengaut and Elborgh-Woytek (2005) selected corruption as the primary indicator of Soviet system legacy “on the grounds that it is the one affecting the performance of economic agents most directly.” They found that other indicators closely related with the Soviet legacy of corruption include voice and accountability; political stability and absence of violence; government effectiveness; regulatory quality; and rule of law (Berengaut and Elborgh-Woytek, 2005).

Previous to the breakup of the Soviet Union, the healthcare system was rigidly ordered and controlled. And, as in the case of all highly centralized government systems, there was no accountability on the part of leadership to system users. There are estimates that no more than 10 percent of public expenditures for healthcare services may reach the target beneficiary, and that up to 90 percent may be swallowed up in the process of delivery with 70 to 75 percent of this amount being spent on salaries (<http://www.thepfizerjournal.com>). The healthcare system infrastructure kept advancing in decay from an inflexible, costly, and highly corrupt social welfare system that was impossible to maintain. “People in a centralized state tend to assume that delivery is the responsibility of the government and that financing and delivery go together” (<http://www.thepfizerjournal.com>). The mental and physical health needs of the population disappeared from the agenda of most of these governments as the Soviet economic system continued to collapse

(<http://www.worldmarketanalysis.com>). During the period of initial transition, these governments were unable or unwilling to envisage any alternative to the existing economic and social order and most actively resisted cooperating with change strategies.

Not only did the legacy of communism affect the political and economic transition of these nations, but also “the United Nations system as a whole had been dislocated by the end of the cold war. The learning of new approaches in the new United Nations system was not without difficulty and false starts” (Zollner, Stoddart & Selbey, 2003, p.23). The world was not ready to assist with restructuring these fledgling post-Soviet economies. “But eventually a critical mass of concerned people was formed who were keenly aware that the world was off course politically, economically, and ecologically. Policy analysts, political advisers, and then politicians themselves came to see that there was a clear relationship between economic performance, income distribution and the health status of a nation” (Zollner, Stoddart & Selbey, 2003, p.24-25). This realization would involve a reshaping of governance into a process that included a political commitment to encouraging democratic participation in defining problems and priorities and in implementing solutions, developing and strengthening social and economic structures, and using various methods of communications technology to improve health for individuals (Zollner, Stoddart & Selbey, 2003).

According to Zollner, Stoddart and Selbey (2003), a continuing lack of confidence by the post-Soviet nations in the ability of their previous government and the international financial institutions to manage their economic development ensured that a process for globalization, privatization and deregulation continued.

With their experience with centralized control, these countries thought it better to globalize and go beyond their own borders to find solutions to the management needs of their national healthcare systems. However, in the process for rapid restructuring and globalization,

virtually all controls on health hazards . . . were relaxed under pressure to remove unnecessary production costs or restraint of trade. In health care the profit motive . . . was skewed in favour of innovations that offered the most promising returns on investment rather than improving the health of the population. In addition, the fleetingly fashionable concept of an enterprise having responsibility for, or accountability to, multiple stakeholders was rejected by governments, industrial pressure groups and think-tanks alike as self-defeating and unworkable. It was deemed to be against individual freedoms (Zollner, Stoddart & Smith, 2003, p. 21).

In the process of transition, these countries looked to join international organizations in the hope that they would quickly leave their economically ravaged countries behind and gain all the financial aid necessary to modernize and technically upgrade their economies. This was especially true for health systems. Practitioners were eager to join their Western counterparts in upgrading their skills and institutions with the latest in medical devices and computerized diagnostic techniques. However, the pace, range, and depth of integration with the international community was a bit overwhelming due to the fact that their education and management skills had fallen far behind Western methods. A “brain drain” situation was also occurring with the most skilled leaving for the EU and other Western countries for better economic opportunities. In addition to their economic restructuring, these countries had to deal with the international transfer of health risks due to their now open borders and increased use of telecommunication methods (<http://www.medscape.com>). It was apparent that they not only had to develop at a rapid pace politically and economically but globally as well. Transnational issues were now impacting upon national healthcare system functioning.

## Effects of Globalization on Post-Soviet Transitional Healthcare Systems

“Good health is not just the absence of disease, but the complete social and economic grounding. Links between health and economic development have been well documented”(<http://www.thepfizerjournal.com>). In 2001 the General Assembly of the United Nations devoted a session to a health topic, that is, the international effort to combat AIDS. This was the first time in UN history that the General Assembly did so. This underscored the growing link between health, economic development, and global security (<http://www.medscape.com>).

In very general terms, globalization can be defined as “the flow of information, goods, [technology], capital and people across political and economic boundaries” (Daulaire, N. (1999, p.22). This is not a new concept because people have always carried goods, products, information, and capital across borders. What is new is its scale and pace. “It was the result of the Cold War . . . that classical nation states began to be transformed into components of larger blocs of state power. The result was not the simply weakening of state power, but its transformation. These new forms of state are not merely agencies of response to globalization but . . . the creators of globalizing processes. Therefore, globalization is both conditional on political change and a condition for it” (<http://www.sussex.ac.uk>). Globalization can be seen as both an opportunity for international cooperation and a threat to national security. It can be characterized by five, often conflicting, themes:

- Economic transformation: financial volatility, marginalization, and labor insecurity,



- New trade regimes: winners and losers,
- A growing poverty gap: rising health inequalities,
- The electronic revolution: the knows and know nots, and
- New forms of governance: the proliferation of non-state actors.

(<http://www.phmovement.org/pubs/issuepapers/walt.html>).

With globalization, and as borders open, there is a greater risk to health due to transmission of communicable diseases to humans and livestock. However, “global economic integration is a powerful force for increasing incomes and improving health. It is not an end in itself, but an economic tool that can be adapted to lead people away from the margins and into the mainstream of health” . . . . But, for a more satisfactory return on investment, further improvements in infrastructure should be made such as, changing the administrative structure to encourage privatization of social services; implementing programs based on a countries needs and cultural preferences (as long as these preferences do not cause a risk to the general public health); establishing programs in universal literacy; reallocating funding to subsidize health resources for the poorest consumers; and due to limited funds, focusing on preventive health measures instead of the more expensive traditional therapeutic/medical model that is physician controlled and highly technical. Resource allocation to healthcare systems is traditionally guided by physicians based in the hospital setting – a setting that consumes enormous amounts of these resources that could better be used for preventive measures. In addition to changing the financing and structure of health and social welfare programs, there needs to be changes to the education and

funding of indigenous researchers, establishing non-governmental organizations (NGOs) to administer health-related programs, and establish accountability standards for other government institutions to administer international aid wisely and within established criteria (<http://www.thepfizerjournal.com>).

The traditional view of global development was that if a person's income increased, he/she would be better able to pay for goods and services that made them healthy, that is, better food, a clean water supply, efficient sanitation systems, and medical care. A shift in economic thinking over the past few decades now puts health capital, that is, healthy workers, on a par with human capital that stresses educated workers, as key determining factors in income production. Investment in vaccines, drugs, and delivery systems increases the welfare of the poor much more rapidly and less expensively than any other form of investment. People who are healthy are physically and mentally fit to work and use their education to earn a living. Improvements in health strengthen a country's economy and lighten the overall burden of poverty. Outside investors are attracted to sites where healthy and educated workers are ready for jobs (<http://www.thepfizerjournal.com>).

Globalization of the treatment of disease should be easy, but in reality it is complicated by differences in social policy, political will, resource availability, government transparency, and social justice. "[This process] will take time, and healthcare reform is notoriously difficult to carry out when democratic institutions are weak or absent" (<http://www.worldmarketsanalysis.com>). In order to maximize the benefits of medical innovation through globalized treatment, at least two kinds of knowledge dissemination are required: high-level medical knowledge to practitioners and practical medical knowledge to the

patient within the entire society (<http://www.globalmedicalforum.org>). Technical advances in the use of information technology applied to healthcare will help to disseminate this knowledge within and beyond national borders. Both physicians and clients will be able to access healthcare information wherever they might be.

### **Conclusion**

Many economists believe that the market economy approach to sustainable economic development remains the relevant operative model when looking at the world in “holistic” terms (<http://www.thepfizerjournal.com>). But, this approach has not worked well in all developing countries, including the post-Soviet nations. More understanding is needed to determine why this is so. Not only is there a need to extend the notion of cultural sensitivity between nations but to one of cultural applicability within each country. There may be different goals for different cultures that may range from a more universal democratic political environment to individual empowerment within regional control and/or religious boundaries. Cultures have their own concepts of what constitutes health, quality of life, political control, and individual rights versus the good of the whole of society. It is important to target programs to the needs and available resources of the people to whom the programs are directed. The best use of information technology in healthcare will be the next globalization challenge, especially telemedicine. Telemedicine has the potential to improve access to healthcare systems by underserved populations and those excluded from healthcare by distance. “Insensitivity to local cultures has been described as, “one dark side of globalization” (<http://www.thepfizerjournal.com>). Healthcare management programs will fail if the same concepts are

implemented universally. And, if there are no human and financial resources to respond to the healthcare needs of the population, the same problems will arise (Cholewka, 1999, 2004).

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