THE SOCIOECONOMIC DIMENSION OF HEALTH IN ROMANIA

Selina Toplicianu
Valahia University of Târgoviște, România
selina_ionete@yahoo.com

Mihai Mieilă
Valahia University of Târgoviște, România
m_mieila@yahoo.com

Valerică Toplicianu
Valahia University of Târgoviște, România
vtoplicianu@yahoo.com

Abstract

The purpose of this paper is to analyze the interaction between human health and the socio-economic conditions in which it occurs.

Form the individual health point of view, the health is an element component of the individual needs system. But, from the national perspective, the health is a broader concept that implies economic, social, and psychological influences.

The study will employ the method of statistical data analysis. The source of these data will consist from the official national and international reports issued by the institutions involved in these tasks.

Having as start point the reality of the increasing needs and limited resources for the health care aims, results the necessity of diminishing the impact of risk factors, besides the well-balanced resources management.

The social dimension of health analysis has to take into account that health care market does not operate by the rules of a free market; it is a typical case of "market failure". The analysis of risk factors with social implications (alcohol, tobacco, drugs, poverty) is about to be done in conjunction with health services market, with income and, not least with government health policy.

In Romania, the financing gap in health care, lead to an increased incidence of certain diseases. These diseases determine direct implications in the economy (labor productivity, the use of working time, etc.), and also in the level of welfare.

The process of searching of the most appropriate way in organizing the Romanian health care system consisted of privatization of primary health sector (family doctors, pharmaceuticals), and in decentralization and aggregation in the secondary health care (hospitals). This reform did not resolve the inconsistency between funding opportunities and health needs.

Based on these developments, we consider that state policies should be adapted to the realities, based on a coherent system of indicators to highlight the relationship between the health status of population and economic growth.

Keywords: health, health determinants, financing of health, welfare, social development, medical ressources.

1. INTRODUCTION – THE SOCIAL PERSPECTIVE OF HEALTH

Health is a broad concept, with implications both at individual (via the individual's biologic heritage) and social levels. It represents an essential component of the concepts of “quality of life” and “human development”. Health is not only a basic human right but also a perquisite of economic development.

Health, as economic concept, and its (downstream and upstream) influences have issued multiple debates. On the agenda of governments and international institutions, the health represents an important issue. In this respect, one of the World Health Organization and UNICEF developed the action plan “We Can End Poverty 2015” in the framework of the joint-program “Millennium Development Goals”. The Center for Global Health and Economic Development (CGHED) plays a major role in mobilizing and developing global health programs, aiming to increase quality of care, especially for disadvantaged population categories, the sustainable economic development, and monitoring of Millennium Development Goals.

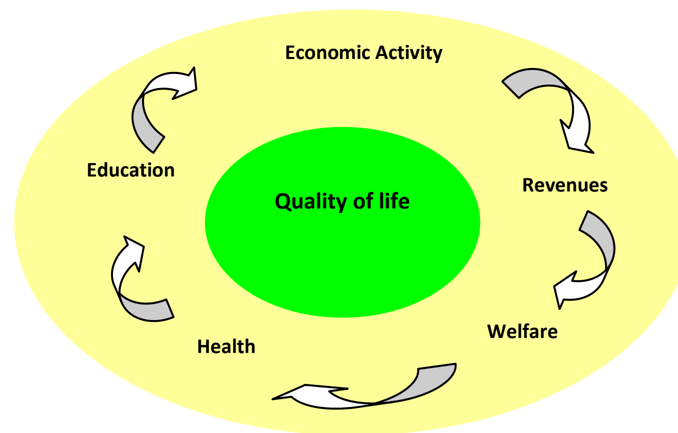

Figure 1. The relationship activity – health – quality of life

Source: Processing authors

The importance of health requires a three-dimensional analysis, based on changes involved: political-demographic, economic and social. There may not be operated a clear distinction between the three aspects of health; they interact and exert joint influence on each other, which causes changes in society as a whole. Therefore, in the following presentation, besides the economic perspective of health, there has to be encompassed the social development points, as effects of disease or of its' absence.

This is the reason why health should not be regarded in its' simple sense, that is, the "absence of disease", but in a broader context, taking into account its triple size, as effect, on the one hand, of the determinants complex that condition it (age, sex, living conditions, environment, working conditions, environmental conditions, accessibility and quality of health services etc.) and, on the other hand, the risk factors as result of each individual life style (food, alcohol, tobacco etc.) .

The social factors have influence not only on population state of health but also on the future efforts of society in assuring an equitable and proper level of health.

This paper work is part of a larger step with the purpose of identifying the ways to decrease the health expenses (risk factor reduction, preventive medicine, expensive reduction in all hospital units by applying management accounting, a good elaboration and administration of budgets for each medical unit etc).

In performing this study we have utilize the statistic analyze of data using as sources of information the official reports of national and international institution with function in this area.

The risk factors analyze with social implication (alcohol, tobacco, drugs, pauperization) must be accomplish in correlation with the health services market, with incomes level and, last, but not the least, with government policy in health area.

The connection between different range of indicators (earnings – life expectancy at birth, health amounts – life expectancy or infant mortality, welfare – risk factors), even if has a medium intensity, can represent the base of a better management of the health resources.

Within this study we have analyzed the situation of 27 countries, members of EU, and we will try to place Romania comparative with the other states members.

2. LITERATURE REVIEW

Given the influences to and from health, J. de Kervasdoué dismantles the belief that medicine and health are synonymous and, that is, more medicine doctors would lead to improvement in population health status. It reminds that the researches conducted by Thomas McKeown proved the improved life expectancy in Europe of the 1950s was a result not of increase in the number of physicians, but of transformation in life conditions. Nutrition and hygiene have improved, mainly due to growth due to industrial revolution. (2009:14)

The health systems development in the years 1950-1970, was a process that deployed in parallel with economic growth and leaded to social development in European countries. (B Palier, 2004:24).

The contemporary literature emphasizes the link between health state of population and the economic situation. Thus, in the book "Health and economic growth – Findings and Policy Implications", G.L.

Casasnovas, B. Rivera and L. Currais, states that "Investing in the health sector will create important benefits in economic policy and social development". (2005:50).

In the 2004 Report of the Mexican Commission on Macroeconomics and Health, the health is considered as an asset with dual role: to create incentives, but also to minimize the balance damages due to adverse conditions (related to individuals or natural disasters). Thus, results the emphasis on improving public health role in protection against adverse situations (sickness, death, unemployment, disease, economic crises, natural disasters). (2004:38).

M. J. Husain (Keele University) argues that, if there is a positive between productivity and income, and, if the health results in income increase, that implies the state of health should lead to increase in income and, therefore, to well-being.

The role of investment in healthcare, in order to ensure a healthy population as a decisive factor of production is also stated by T. Schultz. (1981).

In the work "European Union Health Policy" C. Busoi and C. Vladescu, develop aspects of the influence of lifestyle upon health status. (2011:207).

There is an inter-connection between the quality of life, the health determinants and the economic development, and there are an important number of studies and models developed in this regard, such as: M. Lalonde (1976), Dahlgren and Whitehead (1992), R.M. Anderson (1995), Hamilton and Bhatia's cube model (1996), Lisa Berkman (2000), or Etches pyramid model (2006).

Ariel Beresniak and Gérard Duru emphasize that health studies without addressing economic and health determinants would not allow an objective analysis and present many possible methods and tools used in medical-economic evaluation. (2005:106)

A functional society depends on the health status of its members, but also the degree of disease control. In sociological studies, there is increasingly used the term of "the role of sick person", taking into account both people with diagnosed disease, but also the hypochondriac. For this reason, the Preventive Medicine, as new addressed branch of medicine, is acquiring new dimensions. This underlines the need for "healthy habits", referring to food, exercise and environmental conditions own life.

In the literature (Dennis Raphael, 2004), factors with clear influences on health, called *health determinants* can be found under the following group (see figure 1.):

- Basic determinants are intrinsically related to the individual;
- Factors related to individual behavior (lifestyle);
- Socio-economic conditions;
- Social and community networks.

Most of determinants in population health status are linked by a bi-univocal relation with the country's economic degree and education level. Fogel (1994), Barro (1996) and Sala-i-Martin (2004) studied, on the one hand, the relationship between health and economic growth, and, on the other hand, the relationship between health and wealth. In this respect, they proved that the higher level of human capital health, the higher the positive effect on labor productivity and growth rate. A reduced rate of employees with health problems has as effect, both for organization and community, increased ability to improve the education and performance, a diminished number of days in a state of physical or mental work incapacity, absenteeism due to illness. A healthy worker is less prone to disease, is energetic, alert, productive, and better paid. Also, a non-sick worker has power, is vigorous, is resilient and, besides his/her skills, creativity and technological knowledge, is generator of positive returns.

Pan American Health Organization and Inter-American Development Bank conducted a research on impact of health on long-term growth, but also on household productivity. The study was deployed in less developed countries and issued the following conclusions: there is a relationship between poverty and inequality and human capital accumulation, as well as between variations in economic growth and social development. Although the increased life expectancy, the different degrees in health policies implementation, sometimes in different areas of the same country, leading to inequalities between rich and poor. (Lopez-Casasnovas Guillem, Berta Rivera, Luis Currais, 2005: 5)

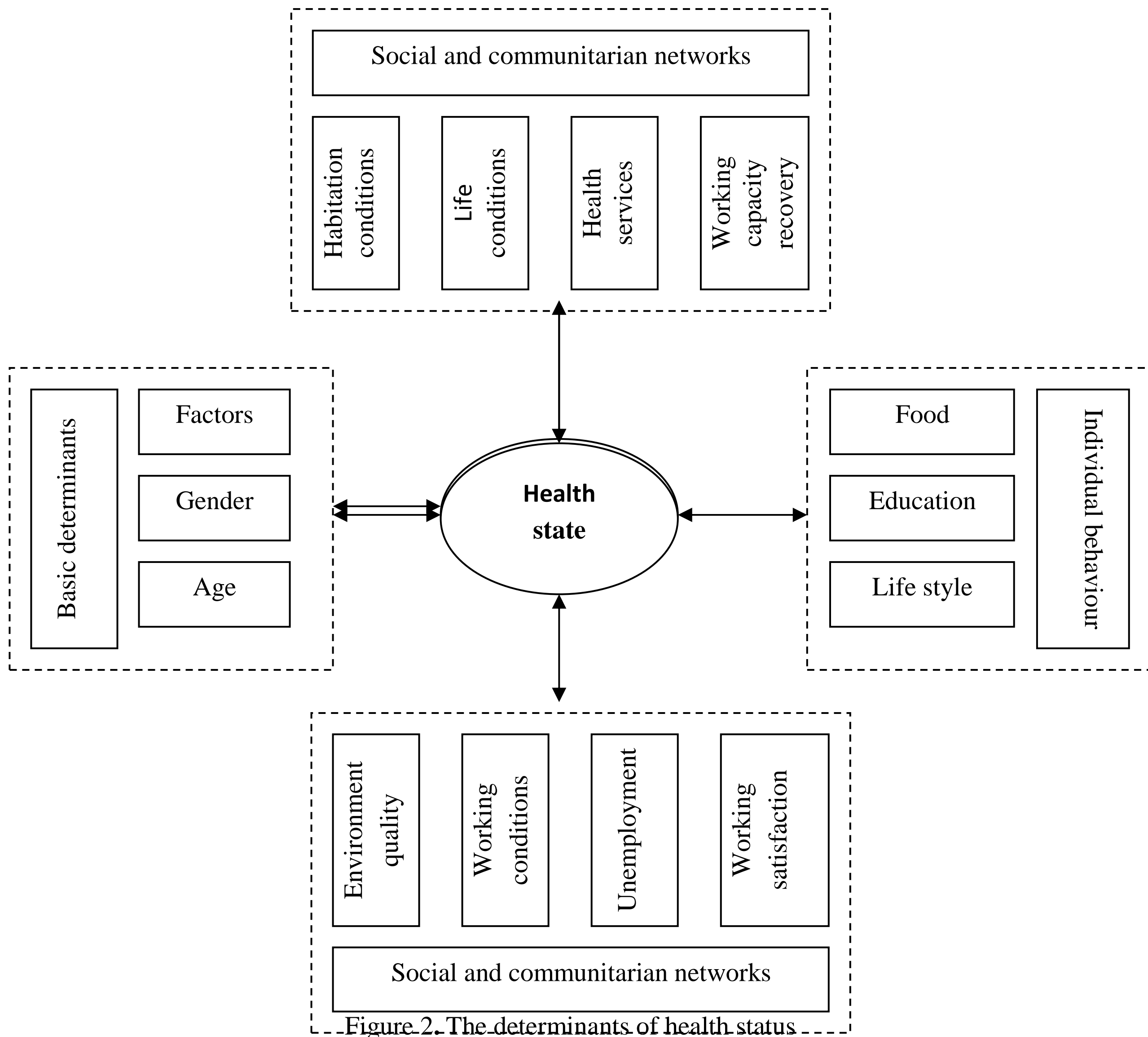

Figure 2. The determinants of health status
Source: devised by the author

3. THE SOCIAL DETERMINANTS OF HEALTH

There is a relationship between life expectancy at birth, infant mortality and morbidity rates and average incomes, as measured by GDP/capita, but this is subject to a public policies and resource allocation for health (health expenditure share in GDP , expenditure on health per capita, the significance of preventive medicine etc.).

As a general trend, from the data presented in Table 1 one may affirm that, within the European Union, in the countries with an increased GDP/capita (Sweden, Netherlands, Luxembourg) there is higher life expectancy and a low level of mortality in comparison with the countries with a reduced GDP/capita (Bulgaria, Romania). A closer analysis reveals a medium to low relationship between the GDP/capita and life expectancy at birth. That suggests the differences between countries in terms of healthy living are in a closer connection to society characteristics, not necessarily to the income: "Changing the social and cultural environment determines changes in the risk of disease" (Michael Marmot, Richard Wilkinson, 1999:87). This means that health is not a function of poverty, but a function of socio-economic and behavioral conditions.

Table 1

The impact of health financing on quality of life

Country	GDP/capita	Health expenditure (% in GDP)	Health expenditure (% in public budget)	Health expenditure /capita ($ PPP)	Life expectancy	Infant Mortality
Austria	36680	10.5	15.8	4150	80	4
Belgium	34760	11.1	14.8	4096	80	4
Bulgaria	11950	7.1	11.2	974	73	9
Czech Republic	22790	7.1	13.3	1830	77	3
Cyprus	18125*	6	5.8	1838	80	4
Denmark	37280	9.9	15.3	3814	79	4
Estonia	19280	6.1	11.9	1325	74	5
Finland	35660	8.8	12.6	3299	80	3
France	34400	11.2	16	3851	81	3
Germany	35900	10.5	18	3922	80	4
Greece	28470	10.1	13	3010	80	3
Ireland	37350	8.7	16	3796	80	4
Italy	30250	8.7	13.6	2836	82	3
Latvia	16740	6.6	10.2	1206	71	8
Lithuania	18210	6.6	12.8	1318	72	5
Luxembourg	64320	6.8	13.7	5996	80	2
Malta	17830*	7.3	12.3	4197	80	7
Netherlands	41670	9.9	16.2	4233	80	4
Poland	17310	7	10.9	1271	76	6
Portugal	22080	10.6	15.4	2578	79	3
United Kingdom	36130	8.7	15.1	3222	80	5
Romania	**13500**	**5.4**	**11.8**	**840**	**73**	**11**
Slovakia	21300	8	15.4	1849	75	6
Slovenia	26910	8.3	12.9	2420	79	2
Spain	31130	9	15.2	2941	81	4
Sweden	38180	9.4	13.8	3622	81	2
Hungary	17790	7.2	10.2	1506	74	6

*Source: World Health Statistics 2011, WHO 2011 * Year 2000*

However, given that for similar levels of income, sometimes there are significant differences in health status (Slovakia, Portugal), results that the income is not the most obvious indicator of hierarchy and it is necessary to add other impact indicators, in order to measure health risk factors (so-called “determinants of social health”).

According to literature, the determinants of social health are: income and its distribution, education, unemployment and job security, working conditions, early development of child, nutrition, housing, social exclusion, social relations safety, health care, "genetic heritage", sex, race and the individual disability. The importance associated to these factors is greater than the importance assigned to biomedical indicators. The biomedical and behavioral risk factors are specified as follows: cholesterol, obesity, physical activity, diet, alcohol and tobacco. (Raphael, 2004: 2).

Health and growth are not mere determinants of human welfare. The interaction between them demonstrates that there is not possible to generate growth in the developing world without solving basic health problems. Also, the attainment, preservation and improvement of a certain level of population health are difficult to be conceived outside the process of generating economic growth.

From the point of view of health social determinants, we tried to analyze the situation in Romania in relation to other EU countries. The situation is presented in the table 2.

The maternal and child health during early life, prenatal care, births assisted under appropriate conditions, preventive and curative care have led to lower childhood mortality worldwide and the increased life expectancy. That determined social changes, in sense that parental decisions were channeled to the education of children. Increasing health and education level determine positive outputs in labor productivity and national income. Ensuring the vital needs and income growth represents the basics of consumption increase of common and luxury goods. Also, the consumer behavior appears makes possible the differentiation of goods, and the occurrence of consumption economy.

With a GDP/capita of $13,500 at purchasing power parity in 2008, Romania was, after Bulgaria, the second lowest performance in the EU. If this is added the fact that only 5.4% of GDP allocated to health expenditures, results that Romanian health expenditures represents the least amount per capita in the EU countries. The result is predictable: chronic underfunding of the Romanian health system. This situation is added to the fact that neither the other determinants of health does not place Romania in a better position, and the risk factors reach sometimes alarming values.

Housing is one of the key determinants of health. In terms of this factor, Romania is in a disadvantageous position compared to other European countries. Accounting for 54% of urban population, Romania is the last in the percentage of individuals using a reliable supply of drinking water and population using improved sanitation facilities.

If 99-100% of urban population consumes water from safe sources, for rural areas, the data are uncertain or insufficient. In the rural areas the water supply may be both from a reliable source (water network), as well as less proven sources (wells, natural springs, rivers, etc.). Romania occupies the last place in the EU in terms of sanitation facilities, with only 88% of urban and 54% of the rural population. For most EU countries, the percentage of available sanitation facilities is 100% with few exceptions (the Czech Republic with 99% in urban areas and 97% in Greece to 99% and 97%, Poland 96%, Estonia 96% and 94%, Lithuania 95%).

The third matter of habitat conditions is related to the type of fuel used for cooking and heating. It is considered that in developed countries (countries with gross national income per capita over $12,276), except Finland, the share of population using solid fuels is below 5%. For the rest, the weight range from 5% (Latvia) to 21% (case of Lithuania); in Romania, 17% is the share of population using solid fuels.

But revenues and habitat conditions are only prerequisites for ensuring proper health status. These indicators should be added to "biomedical and behavioral risk factors: cholesterol, obesity, physical activity, diet, alcohol and tobacco. (Raphael, 2004: 2).

The alcohol consumption represents a major risk factor in terms of health, due to the multiple influences. “In Europe, alcohol is the third risk factor for disease (of 26 risk factors), after tobacco and high blood pressure, before obesity” (Peter Anderson, Ben Baumberg, 2006: 17).

When referring to the effects of alcohol on health, there has to be considered not only the diseases caused directly (gastrointestinal disorders, cirrhosis, cardiovascular disease, cancer, immunological disorders, lung, muscle and bone diseases, reproductive disorders, etc.), but also indirect effects such as violence, injuries, accidents, depression, etc.

In addition, the alcohol is addictive. The European Commission Report on alcohol in Europe (2006) draws attention to the increasing share of young people who consume alcohol and to the reduced age at starting alcohol consumption (12 years and a half, first drunkenness is under 14 years).

Table 2

Incidence of risk factors in the European Union (2008)

Risk factors	Alcohol Consumption/capita (litres of pure alcohol)	Proportion of smoker population Men/ women (%)	Proportion of population using safe water sources (%)	Proportion of population using improved sanitation facilities (%)	Proportion of population using solid fuels (%)	Proportion of population suffering of hypertension Men / women (%)	Proportion of population with overweight (obesity) (%)	Proportion of population diagnosed with diabetes (%)
Austria	12.4	47/45	100	100	<5	28.7/19.8	19.2	7.1/4.6
Belgium	10.8	30/22	100	100	<5	24.5/16.8	21.2	9.3/6.4
Bulgaria	10.47	48/27	100	100	14	40/31.2	22	10.4/9.9
Czech Republic	15.26	43/31	100	99/97	<5	37.3/27.7	30.5	11.5/9.1
Cyprus	8.66	...	100	100	<5	28.9/18.5	24.8	10.2/6.6
Denmark	11.06	30/28	100	100	<5	25.6/15.0	17.1	8.8/5.9
Estonia	14.32	46/23	99/97	96/94	<5	47.3/32.2	20.2	9.0/7.8
Finland	20.26	28/22	100	100	11	34.0/22.7	21.0	10.3/6.3
France	12.30	36/27	100	100	<5	29.1/18.2	16.8	7.2/4.3
Germany	12.02	33/25	100	100	<5	31.1/20.7	23.1	9.8/6.3
Greece	9.25	63/41	100/99	99/97	<5	25.1/14.6	18.8	9.5/7.9
Ireland	12.40	...	100	100/98	<5	34.9/20,7	25.7	8.4/5.6
Italy	7.44	33/19	100	...	<5	28.6/20.6	19.3	8.8/5.4
Latvia	13.20	50/22	100/96	...	5	44.5/32.7	21.5	10.4/9
Lithuania	13.08	50/22	98	95	21	44.5/34.3	23.9	11.2/9.7
Luxembourg	16.48	...	100	100	<5	28.9/17.9	24.5	9.9/8.7
Malta	7.58	30/21	100	100	<5	29.9/20.3	26.1	11.8/8.9
Netherlands	9.25	31/26	100	100	<5	28.9/17.6	18.1	6.1/4.1
Poland	10.74	36/25	100	96	<5	41.3/33.0	22.9	8.2/6.9
Portugal	...	32/16	99/100	100	<5	34.4/24.3	20.4	9.8/5.7

United Kingdom	13.85	26/23	100	100	<5	27.7/19.1	24.4	7.8/6.7
Romania	**16.15**	**46/24**	**99/...**	**88/54**	17	37.2/31.8	**18.3**	10/8.9
Slovakia	11.80	39/19	100	100/99	<5	42.1/32.5	24.9	10.6/9.2
Slovenia	12.71	30/22	100/99	100	<5	43.3/32.8	25.3	10.7/8.8
Spain	11.98	36/27	100	100	<5	27.7/18.6	24.9	11/8.8
Sweden	6.90	...	100	100	<5	29.7/19.3	18.2	8.1/6
Hungary	11.79	43/33	100	100	<5	42.7/31.3	26.2	10.6/8.5

Source: World Health Statistics 2011, WHO 2011

The analysis of those factors put Romania in a position different from the rest of the European Union. Thus, in terms of alcohol consumption (in liters of pure alcohol consumed by people aged over 15 years, within a year), places Romania on the fourth rank in the European Union, with a volume of 16.15 liters of pure alcohol, after Estonia, Czech Republic and Lithuania. However, there has to be considered the consumption habits of the population (the typology of drinks) and the environmental conditions. This is because the amount of alcohol is greater for countries that mostly consume spirit drinks (whiskey, vodka, brandy, palinka) and lower for countries where the population is consuming wine, beer, etc. Also, the consumption is different in countries with cold climates from countries with a mild climate. Whatever type of alcohol, it is a health risk factor.

Another risk factor is smoking. Tobacco is the main risk factor in terms of respiratory diseases (cancer, diabetes, cardiovascular disease, etc.). About 6 million people die annually because of smoke, of which about 600,000 are non-smokers (passive smokers).

For those countries that are available data, the share of adult male smokers differ greatly from a country to another, from 26% in the United Kingdom, or 28% in Finland to 50% in Lithuania and Latvia, reaching 63% in Greece. Romania, with a share of the male population smoking 46%, ranks 6 in the EU. Proportion of women who smoke is lower than that of men smokers in all EU countries. The ratio between women and men smokers who smoke ranges from below 50% (Lithuania, Latvia, Slovakia) to 90% (Denmark and Austria). In Romania, the weight of smoking women is 24%, representing 52% of the proportion of men smoking.

As there have been stated previously, higher incomes means not necessarily better health. Revenue growth may lead to changes in other biomedical determinants that lead to a worsening of health. It is known that in developed countries the prevalence of obesity and related diseases (diabetes and hypertension) is much higher.

With an overweight population share of 18.3%, Romania ranks 23 in the European Union to obesity and the number 21 on the incidence of diabetes. With 37.2% in men and 31.8% among women Romania is in the middle in terms of hypertension.

Since the social determinants of health address the key drivers of health organizing and financing, there is paid increased attention to improving economic and social policies. The concern regarding these issues is not new. Since the 19th century, Engels (1845) and Virchow (1848) defined firstly the living conditions as determinants of health. Since then, numerous studies have demonstrated that material and social circumstances that are subject to people in their homes, at work or in society, are more important for health, than so-called “lifestyle choices” that means alcohol and tobacco consumption, fruit and vegetable based food, involvement in physical activities (Nettleton, 2006).

Social determinants are the main factors which are reflected in poor health and inequities in the world.

In the framework of WHO Regional Office there is developed a partnership between 53 states, known as the “Health 2020”. Based on this partnership, the new objectives of health policy focuses on promoting a healthier population and reduce inequities in this area, as important factors in a country development. Starting from the idea that health is an essential resource for economic sustainability, for social and human development, the approach of health determinants becomes a strong responsibility both for each state policy, but also at international level. Governance in health is a key element of “Health 2020”.

The debates of the Conference of November 21st, 2010 in the UK highlighted the need to overcome the level of paper policy and communication; the health portfolio must be enriched with new thinking, involving not only governmental agencies, but also public health institutions and associations, as the civil society. The 900 million people in Europe need a real progress, and coherent actions to allow them to live healthy in a healthy environment.

The Political Declaration of Rio de Janeiro on social determinants of health (October 21st, 2011) brought together decision makers from around the world, for a comprehensive inter-branch approach in this respect, with leitmotifs "all for fairness" and "health for all". Emphasizing the principles and provisions stated in the Constitution of WHO, as well as in statements from Alma-Ata (1978), the Ottawa Chart (1986), and during numerous international health promotion conference, reaffirmed that "health standard is one of the fundamental rights of every individual, regardless of race, religion, political, economic and social conditions".

4. CONCLUSIONS

Social determinants of health include all societal conditions in which people are born, grow, live, work and age. There is required much more speed and increased aspirations for the establishment of "Millennium Development Goals", under the powerful changes caused by global economic and financial changes.

There are five key action critical areas to address inequities in health, as follows:

- adoption of better governance for health and development by increasing attention to vulnerable and high risk areas;
- promoting participation in the development and implementation of policies, by strengthening the role of community, civil society and private sector;
- continuing to reorient the health sector to reduce inequalities, comprehensive and integrated action of primary health care;
- reinforcement the overall governance and cooperation by supporting actions under the terms of social protection, addressing the needs of each country, accelerated implementation of measures to reduce tobacco use, strengthening of North-South cooperation and South-South in the areas of technology transfer, health and pharmaceutical production;
- monitor of progresses and increase accountability by tracking indicators, ensuring transparency of results, access to information, taking into account the advice of Mother and Child Health and the exchange of good practice internationally.

Due to the economic and cultural differences between countries, the policies approach may present specific features, and the healthcare indicators may vary significantly. For example, Sweden is one of the countries that, through economic policies, reduced the unemployment, and downplayed the inequities caused by income and individual health status, taking into account numerous important determinants of health. The literature states that Americans are healthier than Canadians, and the latter are outrun by northern European nations.

Considering the risk factors, there is necessary to enforce steps to reduce their influence:

- additional fees for alcohol and tobacco, even the governments are far more interested to increase the sources for budget revenues, but to reduce alcohol and tobacco consumption. This represents an indirect way to diminish the risk of associated diseases and treatment costs. Reduction of alcohol consumption annually with a liter per capita, would reduce mortality in men by 1% in South and Central Europe, and by 3% in Northern Europe (Peter Anderson and Ben Baumberg, 2006, page 18);
- promote education in the spirit of reducing consumption of alcohol and tobacco. Promoting of these measures devolves not only to the states and the public health system, but also to other players such as school, family, civil society, NGOs and to producers, which should have to clear specify, by labeling, the risks incurred for consumers;
- people education to adopt healthy consumption habits, in order to reduce the incidence of cardiovascular diseases, obesity and diabetes.

The analysis was based on official statistics, for which we can say that in some cases (alcohol and smoking) the share of consumers for some countries may be even greater, since both alcohol and tobacco products are subject to economic underground.

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