THE FINANCE PERSPECTIVE OF THE HEALTH SYSTEMS IN THE E.U. COUNTRIES

MARIANA MAN, MARIA MĂCRIȘ *

ABSTRACT: *Health represents a factor having direct implications upon the normal carrying out of life and of economic and social activities, being perceived according to a triple perspective: political and demographic, social, and economic. Health financing is a complex process that systemically integrates the making up, collecting, allocating, and efficient use of the funds that are going to be employed by the health system. At a world wide level, after 1960, the amount of health expenditures increased so that it has doubled in most developed countries.*

KEY WORDS: *financing sources; incomes; expenditures; foundation; allocation.*

JEL CLASIFICATION: *I 15; M 41; H 75.*

1. INTRODUCTION

Health, considered from a wider perspective and representing more than a state of wellness, is a complex phenomenon with multiple implications that target both the individual and society as a whole. If, from an individual point of view, health represents a component of the system of needs, from the point of view of society it defines a much larger concept with multiple implications: economic, social, and psychological.

The goal of the hereby paper is the identification of financing opportunities as well as the analysis of resource employment so that an increase of the performance of the health care system is attained together with a proper use of the funds.

The hypotheses that represent the starting of this research have been the following ones: does the performance of the system of health care depend on the level of the incomes allocated to the system involved? Do efficient allocation and

* *Prof., Ph.D., University of Petroşani, Romania,* man_mariana2011@yahoo.com
Lecturer, Ph.D., University of Petroşani, Romania, macrismaria@yahoo.com

use of the resources determine the increase of the system's performance and, implicitly, of population's health?

In order to get familiar with the financing and resources allocation we have employed as a **research method** the statistic analysis of data, using as data sources the official reports of the national and international institutions with responsibilities in the field (The National Health Insurances Bureau, in case of Romania case study; Health World Organization, in case of international comparisons).

Epistemologically, we consider that our position related to the analyzed object of reality is positivist and grounded both upon the empiric research of the Romanian health system as a whole and upon the analysis of the place Romania detains within the European Union (EU) and world wide.

2. ECONOMIC PERSPECTIVE OF HEALTH

Health is not only a fundamental right of a human being. During the years, economists have shown through numberless studies that health is a pre-condition of economic development. The findings of its impact upon economic growth and the analysis of the various features of its connections determine the understanding of the benefits of health investments that are involved in economic policies and human development.

Researches at a micro and macro-economic level have emphasized both the relation between health and labor productivity and health's impact upon incomes and welfare.

The idea that health investments play an important part in economic growth has become evident. Theodore W. Schultz (1979) underlines the positive character of health investments, mentioning that a healthy population is a decisive production factor.

Health investments determine the development of human capital. Michael Grossman (1972) has had an important contribution owing to his inclusion of health within the field of human capital. He has drawn out a model of health demand through employing the theory of human capital and has shown that higher incomes do not always determine the improvement of health.

Fogel (1994), Barro (1996) and Sala-i-Martin (2004) have studied the relation between health and economic growth as well as between health and wealth. Accordingly, a high level of health of the human capital has a positive effect upon labor productivity and the rate of economic growth. Employees without health problems determine, at the level of a group or of an organization, the decrease of the number of days of physical or psychical incapacity, of absenteeism due to illnesses and the increase of the opportunity of improving their level of education and their performance.

Pan American Health Organization and Inter - American Development Bank have undergone a research about health impact upon long term economic growth as well as upon households productivity. The research included less developed countries and has outlined the following conclusions: there is a relation between poverty and inequality and human capital accumulation as well as between the variations of

economic growth and social development. Although life expectancy has increased, the different degrees of implementing health policies, sometimes in different areas of the same country, determine inequalities between poor and rich people (Lopez-Casasnovs et al., 2005).

High rates of life expectancy and low levels of illnesses tend to stimulate economic increase through accelerating demographic transition, promoting human capital investments, growing households' savings, augmenting foreign and population's investments which all determine the increase of social and macroeconomic stability. Investors avoid a labor market susceptible of illness and which has a limited access to health care (Alsan et al., 2004, 2006).

Muhammad Jami Husain (2009) states that in case labor productivity and income are positively correlated and in case health determines productivity increase then they should determine incomes increase.

Health and economic growth are not simple determiners of human welfare. Their interaction shows that it is not possible to provide economic growth in a world under development without settling the essential health issues; at the same time, population's health is difficultly preserved and improved without providing economic growth.

In case illnesses occur, the structure of the use of individual and public resources might change as they would be directed towards treatment and recovery; they might be totally or partly available and allocations out of the health area towards nourishing, education, and entertainment would decrease determining long term serious consequences.

Within the whole structure of the health system, it is essential to find out the best manner of efficiently employing resources, to properly re-direct the incomes taking into account their limited character, the competition among health care providers under the circumstances of ascendant trending needs.

Although health services market is a typical sample of "market failure" (Arrow, 2004), a conceptual parallelism may be drawn out between the health system, with its entire universe, and economic theory, as a result of the multiple existing resemblances, such as: resources allocation, needs, demand and offer, price, services cost, benefits, etc.

Famous economists such as David Hume (1711-1776), Lionel Robbins (1898-1984) and Paul Samuelson (1915-2009), focused upon resources scarcity, their limitation and the implications that accordingly occur. The rhythm according to which the structure, quality, and amount of economic resources change is much below the rhythm according to which the intensity, size, and structure of humankind's needs grow.

It is obvious that progress as well as maximum potential is the result of a healthy nation. In case one considers that meeting the health care needs represents a determining factor of welfare then allocated resources should provide the proper carrying out of sanitary activity. Nevertheless, health care needs that exhibit an ascendant trend are allocated a limited amount of resources irrespective of the country's level of economic development.

The evolution tendency of sanitary field expenditures is given by the evolution of the expenditures made by hospitals and the money spent for pharmaceutical products, specific sanitary stuff, and medical equipment.

Another economic aspect which should not be neglected is the health impact upon employment due to the fact that the system of health care creates new jobs. Accordingly, in Romania, during 2009, health system employees represented 2.91% of the employed population. In case one adds to this percent the employees having different specializations but working in the health field then the health care system obviously creates a significant number of jobs.

3. HEALTH FINANCING SYSTEMS

Health financing is a complex process that systemically integrates the foundation, gathering, allocation, and efficient use of the funds meant to be employed by the health system. This is the reason why the financing of health systems is considered a system and not a simple activity.

The specific character of the financing manner comes from the fact that health represents a need and not a wish, and the right to health care is a fundamental right of the individual. Besides, health can be assimilated to an intangible product which cannot be substituted.

Depending on the State's part in organizing sanitary system, Vlădescu (2004) displays three types of systems, namely:

- *Liberal systems* characterized by a voluntary adhesion to health insurances, a decentralization of sanitary policies, and a pluralist organization of medicine, governed, as far as the ambulatory field is concerned, by liberal medicine (private practice remunerated per act). A part of the hospital beds belong to the public system, the share differing from state to state;
- *National systems* that give medical assistance to the whole population and are mainly financed out of State taxes. A private system also operates at the level of insurances and medical services;
- *Intermediary systems* that combine the characteristics of the other two systems as regards the universal access, the pluralist organizing and financing (mainly owing to special dues) of the medical system, and the liberal medical practice. The public and private systems detain different shares within the functioning of the sanitary system.

Irrespective of the adopted financing system and of the organizing manner of the providers of medical services, health care is still State's responsibility.

The functioning principles of a sanitary system to which most OECD countries have adhered, irrespective of the type of financing they have decided upon, are the following ones: universal and equitable access to a minimum package of health services; macro-economic efficiency: the costs of health assistance should not overpass a decent percent of the country's resources (7-9 % out of GDP); micro-economic efficiency: the range of services provided should guarantee, in exchange of a minimal cost, good results at the level of patients' health and satisfaction; patients' right to choose; autonomy of health services providers; incomes' protection: patients should

not pay medical services that are too expensive as compared with their incomes; the prices of such services should be connected to their payment capacity which implies the preventing of those circumstances when the cost of a treatment could threaten the normal existence of an individual or of a family; State's involvement on medical services market and its responsibility for its own citizens' sanitary assistance. (Vlădescu, 2004)

Sanitary policies are founded upon the above principles; what differs is the manner they are implemented from one country to another.

During the last century four main conceptual systems of organizing and financing health care have been outlined: Semasko type system – centralized; American system – based upon private health insurances; Beveridge type English system; Bismark type German system.

Semasko system (soviet) takes its name from a doctor who never practiced but who conceived a system of health care in former USSR. The system implied the existence of public property institutions or State property institutions as well as a single network of medical services. It is a centralized system with a single type of financing (the public one) which entirely comes out of the State budget. Accordingly, all sanitary needs as well as all categories of expenditures - current and capital ones - are covered.

The system proved to be viable in former USSR; it was perfectly adapted to war conditions through directing money resources towards certain objectives (objective sanitary management). It determined the eradication of several illnesses in the former soviet area and the settling of certain concepts of sanitary hygiene among population. After World War II the system perfectly operated mainly implying the reconstruction and revitalizing of the entire medical system.

The American system is based, to a large extent, upon private health insurances. Such sums are not considered compulsory contributions as social insurances are. The health system provides an inequitable access of people to this extremely important population service, especially due to the extremely high cost of health care.

The American State finances only two health programs: MEDICARE Program, for those who are over 65 year old and have terminal illnesses and MEDICAID Program, for those persons whose incomes are below poverty margin.

Besides the above categories of persons and those who contract private health insurances, a large number of persons in the USA do not have any health insurances (unemployed persons, temporary workers, small incomes persons). Such circumstances have determined the initiation of certain measures concerning health care reform that targets the foundation of national organisms capable of identifying various sources of constituting a health budget; for instance, companies may provide health insurances for their employees.

The English system is a combination between the American system based upon private insurances and the Russian one relying upon the State's intervening in economic and sanitary environment.

All individuals are offered free medical care; the State entirely finances health care owing to the National Health Service. It is a system that relies upon financial resources coming out of taxes. The patients do not pay anything but are obliged to

enlist to a doctor who is remunerated by NHS according to the contract drawn out with this organism. The budget financing of the health system represents 85% while the rest comes from other funds or from patients (for instance, medication is partly paid by the patients).

The German system introduced the contributive system based upon compulsory contributions equally made by employees and companies. The money is not given to the State budget but is administered by the health bureaus of the lands whose primary obligation is to provide a high standard of population health.

The patients do not pay anything for being seen by doctors and for treatments due to the fact that the insurance bureaus have contracts with the health providers – doctors, specialists, pharmacies – and pay those expenditures.

When compared, budget financing represents 25% while contributions financing represents 75%.

The above system relies upon a large autonomy, is specialized, and allows competition. Such a system, with certain specific features, is encountered in Germany, Belgium, Luxembourg, The Netherlands, France etc. In Germany, during 1987, 93% of the country's population compulsorily contributed to illnesses insurances bureaus (the rest had private insurances).

Irrespective of the adopted financing system, we consider that providing the funds to be used for health care has always been and still is an important issue of governmental policies.

4. MEANS OF FINANCING HEALTH IN E.U. COUNTRIES

Concern for structuring and modernizing the systems of health insurances with a view to improve them at the level of their amount and of the quality of the health services provided for the population as well as at the level of costs can be encountered in most developed countries and in less developed ones.

Reforms of the health care systems have been also made by the states where the manner of organizing health insurances represented a referential for the other health systems (the German system, the English system).

In **Germany**, the Bismark type system of medical insurance founded in 1883 has witnessed several changes; at present it is financed through the system of social security whose budget relies upon the compulsory contributions of employees (50%) and of employers (50%).

The principles that represent the foundation of organizing and financing the German health system regard social solidarity, decentralization, and self-management. According to this system the whole population benefits from insurances: Compulsory public insurances 85%; Private insurances 10%; Central public financing 5%. The funds to be employed by the health system come from: compulsory and voluntary contributions (co-payments were introduced after 1980 in order to prevent the excessive use of public medical services); taxes and fees; insurance bonuses. Insurances are made by the Funds of Medical Insurances which have to finance the activities in the field.

Although the German system of health insurances represents a standard in health care insurances, its reformation has been required in order to better use resources. After 1986 they have shifted to the global financing of hospitals with a view to properly administer costs; accordingly, primary assistance has been separated from ambulatory treatment and from hospital care. Such facts have determined a decrease of the number of hospital beds and a more efficient use of hospital beds. Hospitals are administered by municipalities (50%), by non-profit organizations (30%), and the rest are private.

The financing of the system of health insurances in **Great Britain** is done out of public sources (taxes and fees), and the whole population benefits from the services. The foundation of the system was established by Beveridge in 1942 and during the years it has become one of the reference systems as regards the manner it provides health care to the population.

Financing is provided by public funds (83%) and other sources, ranging among the states that provide a small percent of private medical services. Nevertheless, after the 90s, in order to determine competition among the providers of sanitary assistance and to decrease the costs, the Sanitary National Service (SNS) has reformed the management of the system defining three types of sanitary authorities: Regional Sanitary Authorities, District Sanitary Authorities, and Medical and Sanitary Services Authorities. Accordingly, they also stimulate the liberalization of the patient's option to choose the provider of medical services.

The British SNS has witnessed numberless reforms. Let's notice the 1999 SNS reform which stated the following functioning principles (Dobson, 1999): existence of a national service, similar services across the country with national standards of quality and performance; local responsibility that regard the implementation of national standards; partnerships both among the SNS units and between these units and other institutions with a view to better meet patients' needs; increased efficiency through focusing upon performance and decreasing bureaucracy; quality as a supreme argument in the process of decision taking at all levels of the system; increase of the population's confidence in SNS as a public, open system conceived so that to reflect the needs of the population.

The principles formulated by NHS Constitution in 2008 are the following ones: SNS gives a comprehensive service, available for all persons, irrespective of sex, race, disabilities or social orientation; access to the services of the national health system is based upon clinical needs and not upon the individual's capacity to pay; SNS targets the maintaining of high standards of excellence and professionalism; the services given by SNS show the needs and preferences of the patients and of their families; SNS is not confined to organizational barriers and functions according to partnership grounds with other organizations that serve the interests of the patients, of the local communities, and of the whole population; SNS pledges itself to give the highest value in exchange of the money paid by the contributors and the most efficient use of resources; SNS is responsible before the public, communities, and the patients it serves.

In **France** the health system combines the public field with the private one. Initially, the system was founded upon compulsory health insurances; later they have

introduced voluntary insurances too. The French sanitary system is administered by the Regional Health Agency which equally coordinates, at a regional level, all the institutions and parties on the health services market. There is a powerful competition environment among public sanitary units, between the private ones and the non-profit ones, administered by associations and religious congregations.

Table 1. Share of financing funds within GDP – 2008

	GDP /capita	% Health expense within GDP	% Public funds	% Private funds	% Health expenditures within public budget	Health expenditures /capita ($ exchange course)	Health expenditures /capita ($ PPT)
Austria	36680	10.5	73.7	20.9	15.8	5201	4150
Belgium	34760	11.1	66.8	25.3	14.8	5243	4096
Bulgaria	11950	7.1	57.8	37.7	11.2	482	974
Czech Republic	22790	7.1	80.1	17.5	13.3	1469	1830
Cyprus	…	6	41	56.3	5.8	1909	18838
Denmark	37280	9.9	80.1	15.5	15.3	6133	3814
Estonia	19280	6.1	77.8	20.6	11.9	1074	1325
Finland	35660	8.8	70.7	24.5	12.6	4481	3299
France	34400	11.2	75.9	21.4	16	4966	3851
Germany	35900	10.5	74.6	22	18	4720	3922
Greece	28470	10.1	60.9	39.1	13	3110	3010
Ireland	37350	8.7	76.9	23.1	16	5253	3796
Italy	30250	8.7	76.3	23.7	13.6	3343	2836
Lithonia	16740	6.6	60	40	10.2	979	1206
Lithuania	18210	6.6	68.3	27.4	12.8	931	1318
Luxembourg	64320	6.8	74.8	15.9	13.7	7998	5996
Malta	…	7.3	75.2	24.8	12.3	1374	4197
The Netherlands	41670	9.9	75.3	16.5	16.2	5243	4233
Poland	17310	7	67.4	26	10.9	971	1271
Portugal	22080	10.6	67.4	28.5	15.4	2434	2578
United Kingdom	36130	8.7	82.6	17.4	15.1	3771	3222
Romania	**13500**	**5.4**	**78.9**	**18**	**11.8**	**517**	**840**
Slovakia	21300	8	67.1	28.1	15.4	1395	1849
Slovenia	26910	8.3	68.6	26.2	12.9	2238	2420
Spain	31130	9	69.7	26.9	15.2	3132	2941
Sweden	38180	9.4	78.1	16.8	13.8	4858	3622
Hungary	17790	7.2	68.9	28.5	10.2	1119	1506

Source: World Health Statistics 2011, WHO 2011

As in most states, sanitary system has been adjusted over the years, witnessing several stages (MEDAS Project): the period of Global Endowment (1983-1991) when

DRG (diagnosis regular groups) were introduced; the period of Administration (1991-2005) when Regional Hospitalization Agencies (1996) and Responsibility Centers were founded; the period after 2005, Strategic and Performance Management, "Hospital 2007 and the new hospital management"; the system of quantifying hospitals' activity was also founded.

Within all the states of the European Union, except Cyprus, financing out of public funds represents the majority (57.8% Bulgaria and 82.6% Great Britain).

The financing of the sanitary system mostly comes from taxes paid by employers and employees, the insurances system covering 74% of the population (Eurostat, 2009).

Irrespective of the financing system adopted, the health system is allocated a certain percent of GDP which depends on the governmental policy at a precise moment, on the degree of development of the country, and on the development and complexity of the existent system of health care (Table 1.).

At a first analysis, one may notice that within the European Union, Romania detains the last place as regards the share of the incomes allocated to health within its Gross Domestic Product: only 5.4% when compared to developed countries that allocate over 10% of their GDP to health (Austria 10.5%, Belgium 11.1%, France 11.2%, Germany 10.1 %, Greece 10.1% and Portugal 10.6%). In case one also analyzes GDP's level per capita expressed in US Dollars according to the prices of the buying power ($ PPT), disparities increase due to the fact that at a high level of GDP/capita the allocated percent is much higher. Due to such circumstances the incomes allocated per capita in Romania are over 4 times lower than those allocated by the developed countries and 1.5 – 2 times lower than those of the countries that entered the European Union during the last period.

The small share within GDP of health allocated incomes together with the decreased level of GDP/capita obviously determines the under-financing of the system of health care; such facts determine on a medium and long term a degradation of the health condition of the individuals and implicitly an increase of the expenditures of the sanitary field.

One may state that worldwide, during the period 1960-1990, the amount of health expenditures doubled in most developed countries. According to UNCTAD Report of Human Development in 1998, the share of total health expenditures within GDP in the countries members of OCDE increased from 4.5% in 1960 to 9.7% in 1991; in North America from 5.3% to 13.0%; in the European Union from 4.1% to 8.2%. Under development countries also registered, on the whole, a doubling of the share of health public expenditures within total GDP (from 1% in 1960 to 2% in 1990), but with important differences among countries.

As regards the Index of Human Development, Romania ranks 50 among 187 countries (HDI values and rank changes in the 2011 Human Development Report), witnessing an ascending trend during the period 1990-2011 (Table 2.).

During the last decades, Romania has undergone various sanitary reforms, abandoning the centralized, monopolist, and rigid system, and adopting an intermediary system relying on pluralist financing sources.

Most researches that deal with the financing of Romanian medical system (Tănăsescu, 2001; Vlădescu, 2004; Vulcu, 2002) identify the following aspects: foundation of incomes, allocation of resources and spending health funds. One cannot speak about the manner of distributing funds without approaching the ways they are collected.

Table 2. Evolution of basic pointers of Human Development Index

Years	Life hope at birth	Probable school years	Average duration of school period	National income per capita (2005 PPP$)	HDI
1980	69.6	12.3	7.9	0	0
1985	69.6	12.3	8.6	0	0
1990	69.4	12.4	9.0	7.803	0.700
1995	69.4	10.9	9.5	7.150	0.687
2000	70.5	12.0	9.9	6.759	0.704
2005	72.4	13.5	10.1	9.270	0.748
2010	73.8	14.9	10.4	10.863	0.779
2011	74.0	14.9	10.4	11.046	0.781

Source: HDI values and rank changes in the 2011 Human Development Report

5. CONCLUSION

One may notice that the countries with a developed sanitary system which allocate an important percent of their GDP to this field (England, Germany, France, Sweden) have also implemented the permanent reformation of the financing system or of the manner of organizing this field; all these have had as an objective the shift from "covering the whole population with health services" to the "providing of cost efficient health care" without affecting the quality of medical services or the principles that represent the foundation of the health insurances system.

It is obvious that progress as well as maximum potential is the result of a healthy nation. In case one considers that meeting the health care needs represents a determining factor of welfare then allocated resources should provide the proper carrying out of sanitary activity. Nevertheless, health care needs that exhibit an ascendant trend are allocated a limited amount of resources irrespective of the country's level of economic development.

A variant of increasing the incomes meant for health is given by "co-payment", namely the additional payment made by the consumer of medical services; yet, this type of financing sanitary system should not be seen as a salutary element as it only represents a small percent of the cost of medical services which is not covered by the basic insurance.

Taking into account the high costs afferent to the treatment and recovery segments, it is necessary to pay a special attention to prevention in order to support the sanitary system on a long term.

The small share within GDP of health allocated incomes together with the decreased level of GDP/capita obviously determines the under-financing of the system

of health care; such facts determine on a medium and long term a degradation of the health condition of the individuals and implicitly an increase of the expenditures of the sanitary field.

As to the second hypothesis, according to which the efficient distribution and use of resources determines the increase of the system's performance and implicitly of the population's health, it requires, in order to become valid, an analysis of health costs of each type of medical assistance due to the fact that the administration of health costs has become a global issue. The rhythm of expenditures has over-passed the rhythm of economic growth as an effect of demographic increase and structural changes that involve population's aging (especially in developed countries where they speak about the "fourth age", namely the persons over 80), of the increase of the individuals' expectations from medical and social assistance, of the coming forth of highly technological medical services, of epidemiological changes (from the typology of illnesses dominated by infections towards a typology dominated by non-transmissible illnesses, such as cancer, heart illnesses), of the increase of the segment of population overexposed to risks (smoking, alcohol, pollution, sedentary life, improper foods).

REFERENCES:

[1]. Arrow, K. (2004) *Uncertainty and the welfare economics of medical care*, Bulletin of the World Health Organization, [Online] 2004:82(2), Available at: http://www.who.int/bulletin/volumes/82/2/PHCBP.pdf

[2]. Barro, R.J.; Sala-i-Martin, X. (2003) *Economic Growth,* Mc.Graw-Hill, New York

[3]. Cucui, I.; Man, M. (2004) *Costurile şi controlul de gestiune*, Economică Publishing House, Bucharest

[4]. Grossman, M. (1972) *The Demand For Health: A Theoretical And Empirical Investigation*, National Bureau of Economic Research, New York,

[5]. Husain, M.J. (2009) *Contribution of health to economic development: A survey and overview*, Economics - The Open Access, Open Assessment E-Journal, Discussion Paper no. 40

[6]. López-Casasnovas, G.; Rivera, B.; Currais, L. (2005**)** *Health and economic growth – Findings and policy implications,* MIT Press, London, England

[7]. Man, M. (2008) *Raționalizarea Contabilității Manageriale*, ARVES Publishing House, Craiova

[8]. Măcriş, M. (2009) *Contabilitatea Instituțiilor Publice,* Universitas Publishing House, Petroşani

[9]. Măcriş, M. (2011) *Bazele Economiei*, Universitas Publishing House, Petroşani

[10]. Mincă, D.G.; Marcu, M.G. (2004) *Sănătate publică şi management sanitar*, Carol Davila University Publishing House, Bucharest

[11]. Oprea, C.; Man, M.; Nedelcu, M. (2008) *Contabilitate Managerială*, Didactica şi Pedagogică Publishing House, Bucharest

[12]. Răvaş, B. (2011) *Relevanța informației contabile în măsurarea performanțelor unităților de turism*, Universitas Publishing House, Petroşani

[13]. Sandier, S.; Paris, V.; Polton, D. (2004) *Health Care Systems in Transition,* WHO, Copenhagen, Vol. 6, No. 2

[14]. Schultz, T.W. (1993) *The economics of being poor*, Blackwell, London

[15]. Tănăsescu, P. (2001) *Managementul financiar al activității sanitare,* Tribuna Economică Publishing House

[16]. Tulchinsky, T.; Varavikova, E. (2003) *Noua sănătate publică*, Ulysse Publishing House, Chişinău

[17]. Vlădescu, C. (2004) *Sănătate publică şi management sanitar*, Cartea Universitară Publishing House, Bucureşti

[18]. Vulcu, L. (2002) *Tratat de sănătate publică*, Constant Publishing House, Sibiu

[19]. Young, D.W. (2003) *Management accounting in health care organizations*, Yossey-Bass Publishing House, San Francisco

[20]. Casa Naţională de Asigurări de Sănătate (2006) Raport de activitate pentru anul 2006 [Online] www.cnas.ro/pdf/Prezentare_Raport_2006v1.ppt

[21]. Monitorul Oficial al României (1997) *Legea nr 145/1997, Legea Asigurărilor Sociale de Sănătate*, nr. 178/ 31 iulie 1997

[22]. Monitorul Oficial al României (2006) *Legea nr 95/2006 privind reforma în domeniul sănătăţii*, nr. 372/ 28 aprilie 2006

[23]. Monitorul Oficial al României (2011) *Legea nr 220/2011 pentru modificarea şi completarea legii nr. 95/2006 privind reforma în domeniul sănătăţii,* nr. 851/ 30 noiembrie 2011

[24]. Organisation mondiale de la Santé, *Le Financement Des Systèmes De Sante- Le chemin vers une couverture universelle,* ISBN 978-92-4-068481-2 [Online]

[25]. PNUD (2011) *Raport privind dezvoltarea umană*

[26]. *** (2010) *The NHS Constitution, the NHS belongs to all*, England

[27]. http://www.who.int/research/en/