THE MANNER FINANCING INFLUENCES THE PERFORMANCE OF EUROPEAN UNION HEALTH SYSTEMS – A CASE STUDY: ROMANIA

MARIANA MAN, BOGDAN RĂVAŞ [*]

ABSTRACT: *Within the European Union, Romania detains the last place as regards the share of health allocated incomes within the Gross Domestic Product (GDP). Romania which allocates a small percent of its GDP faces a chronic financing deficit that has as a result a low performance of the system and requires the searching of solutions capable to increase the incomes to be used for health purposes.*

Irrespective of the adopted financing system, we consider that providing the funds required by the health field has been and still is an issue of governmental policies.

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

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

1. FINANCING SOURCES OF HEALTH CARE IN ROMANIA

The mechanism of financing health represents the instrument of implementing sanitary policy with a view of meeting the demands for medical assistance of the population. The term 'financing' covers the following aspects: gathering incomes in order to pay health services, allocating funds to the providers of medical services (redistribution of money), and payment of medical services.

According to the Law of Health Social Insurances no. 145 dated July 24th, 1997, published by Monitorul Oficial no. 178 dated July 13th, 1997, insured persons contribute with a part of their gross incomes to the foundation of the health fund. The persons who are unemployed should declare their taxable incomes with a view to settle their health social insurance contribution. At the same time, the employer also contributes with a certain amount to the foundation of the fund. Initially, the contribution share represented 7 % in case of the employee and 7 % in case of the

[*] *Prof., Ph.D., University of Petroşani, Romania, man_mariana2011@yahoo.com*
Lecturer, Ph.D., University of Petroşani, Romania, ravasbogdan@yahoo.com

employer. Subsequently, the 7% share representing the contribution to health social insurances due by insured persons and stipulated by the Law of Health Social Insurances no. 145/1997 decreased to 6.5%. (Order no. 147/31.10.2002 published in Monitorul oficial no. 821 dated 31.11. 2002)

There are a lot of categories of financing health services: social insurance originating in compulsory contributions; public financing (centralized or governmental) originating in taxes and fees (the State budget); private insurance (optional, owing to individual payment of insurance fees); direct payment of services by the patients; co-payment.

Funds of health social insurances

The funds of health social insurances are the main source of health financing in Romania and represent over 90% of the public health expenditures. The foundation of the funds is done owing to the contributions of natural (employees, retirees, other natural persons) and juridical persons and are used in order to pay medicines and given medical services and to cover the administration and functioning expenditures, etc.

The Law of Health Social Insurances no. 145/24.07.1997 published by M. O. no. 178/31.07. 1997, stipulates that natural and juridical persons should pay monthly money contributions; it also settles the exceptions to the law given by the law makers. Let's notice that in case of retirees, unemployed persons, and those who work according to a labor convention, the contribution for the health social insurances is retained at the moment they receive their incomes.

The foundation of the National Unique Fund of Health Social Insurances according to Order no. 150 dated 31.10. 2002 which regards the organizing and functioning of the system of health social insurances is done through: contributions of natural and juridical persons; subsidies from the State budget; interests, donations, sponsorships, and other incomes, as the law stipulates.

Contributions are collected by the Insurances Bureaus in the unique account opened for the National Health Insurances Bureau (CNAS).

Natural persons (insured persons) are obliged to pay a money contribution for health insurances which represents a 6.5% share that applies upon: salary incomes that are taxable – monthly payment; incomes originated in activities deployed by persons who exert liberal professions or who are authorized according to the law to carry out independent activities – trimester payment; agriculture and fruit tree culture incomes established according to the incomes standards for the natural persons who are not employers and do not range into letter b) – trimester payment; unemployment aids and support allocations – monthly payment; incomes originated in ceding the use of goods, in dividends and interests and in other incomes that are taxable in case they do not belong to the category of incomes stipulated by letters a)-d) – yearly payment.

The employers to whom the insured persons deploy their activity are obliged to calculate and give to the insurances bureau a 7% contribution reported to their salary fund and due in order to provide the health of their employees; they are obliged to announce the insurances bureau about all their incomes changes that may occur.

The foreign citizens who contract facultative insurances contribute to the fund with a sum that is calculated by applying the 13.5% to the value of the country's two basic minimum gross salaries for a service package settled by the standard contract.

In case of the persons who benefit from insurances without paying the contribution (those who are under term military service; those who are in medical leave, in medical leave for pregnancy and post-pregnancy or in medical leave in order to take care of the ill child until he/she reaches 7 year old; those who are deprived of liberty or are in preventive arrest; those who benefit from unemployment aids or, according to the case, from support allocation), the sums afferent to the contributions for the health social insurances are paid by the State budget, the budget of the State social insurances, and the budget of unemployment insurances as the law stipulates.

The funds that were not used at the end of the year are reported during the next year and have the same destination. With a view of balancing the deficit budgets of the health insurances offices, each insurance office pays a 7% share of its monthly incomes in the account of CNAS.

In exceptional circumstances and when objectively motivated, in order to cover the deficit of the fund budget after the reserve fund has been spent, the incomes of the fund budget are supplemented with sums that are allocated from the State budget.

State budget financing

State budget further covers the following expenditures: current expenditures of sanitary units (organized as integral or partial public institutions); investment expenditures that regard the building of medical and sanitary units as well as certain endowments in highly performing medical equipments; diagnose activity, patients' curative and recovery activity; recovery of labor capacity; expenditures of the national medical institutions.

At the same time, under special circumstances, the State budget may allocate subsidies in order to supplement the funds of the National Health Insurances Bureau and of the funds of District Health Insurances Bureau.

Special health fund

Special health fund is founded separately from the State budget and originates in certain taxes perceived upon health damaging activities deployed by juridical persons which get incomes from advertising tobacco products, cigarettes, and alcoholic beverages (a 10% share of such incomes); also, juridical persons which get incomes from selling tobacco products, cigarettes, and alcoholic beverages contribute a 1% share of such incomes. At the same time, this fund also includes a series of incomes originated in the activity of sanitary units (a share of the incomes of pay policlinics, fees for medical examinations, etc.). The resources of this health special fund are put together with the resources of the State budget for the units totally financed out of budget resources.

Population's health expenditures

Population's health expenditures are those payments for medical services or medicines other than those that belong to the field of health social insurances; at the same time, population may contract facultative, private insurances.

To the same category of population's health expenditures also belongs "co-payment". It was introduced according to Law 220, dated November 28th, 2011, and represents the "payment of the money contribution of the insured person according to

the obligation stipulated by the law in order to benefit from the medical services belonging to the package of basic services of the national health social insurances."

Co-payment's introduction in 2011 is going to bring changes both at the level of the public sanitary system and at the level of the private one. The arguments that support and motivate such an act are the following ones: the potential increase of health incomes, discouragement of unnecessary health services demand, and consequently, the unmotivated use of some limited resources, efficiency in providing services owing to assuming responsibility for the patients' interests and needs, improvement of equity through distributing the incomes gathered from those who have the necessary means towards those who do not possess financial resources in order to support the payment of sanitary services. Co-payments incomes may cover a part of the functioning costs of current programs according to which simple curative services are given. The counter-arguments which should be considered when employing co-payment regard: the covering of an extremely small part of the functioning costs of the public sanitary system, the boomerang effect that may determine a stagnant or even a descendant trend of collected incomes.

Private health insurances

Private health insurances represent another means of improving financing.

The advantages of the private health system are given by the wider access to specialized doctors and high class equipments as well as by the time spared owing to the decreased period of wait as compared with public medical services which are always agglomerated. The introduction of private health insurances has determined the increase of the efficiency of employing public funds due to the competition system and the decrease of certain important expenditures made by the public system such as the investments in the private sanitary environment.

The negative financial consequences of a precarious health represent an important risk which should be a major priority of a private insurances program (system). Under such circumstances, the practice of private health insurances should notice moral haphazard and adverse selection.

As regards the direct payment of health services by the population, one may infer that the individuals' financial vulnerability is accordingly increased. Its consequence is the decrease of the access of small incomes population to health services, and, on a long term, the burdening of the public system due to the increase of the expenditures of secondary and tertiary services.

2. STRUCTURE AND DYNAMICS OF HEALTH FINANCING INCOMES

The structure analysis of health financing incomes correlated with population's size and structure may determine another debate (Table no.1). The analysis of the structure shows the high share of health insurances contributions within health incomes ranging between 90.26% in 2008 and 93, 92% in 2009, and 76.21% in 2010. The sums received from the State budget and other administrations are under 10%, except in 2010.

Table 1. Structure of health financing incomes (%)

	2007	**2008**	**2009**	**2010**
TOTAL INCOMES, out of which:	100	100	100	100
I. INSURANCES CONTRIBUTIONS:	93.46	90.26	93.92	76.21
1.Employers' contributions	46.80	44.50	46.72	37.79
2.Insured persons' contributions	46.66	45.76	47.20	38.42
3.Non-fiscal incomes	0.46	0.46	0.10	0.05
VARIOUS INCOMES	0.02	0.00	0.01	0.02
IV. SUBSIDIES	6.08	9.28	5.97	23.74
SUBSIDIES FROM STATE BUDGET	1.54	2.08	2.28	20.96
SUBSIDIES FROM OTHER ADMINISTRATIONS, out of which:	4.55	7.19	3.70	2.78
Health insurances contributions for the persons who benefit from social aids	0.11	0.11	0.09	0.10
Sums allocated out of the Ministry's of Public Health own in comes	4.39	7.07	3.59	2.67

Source: Yearly reports of CNAS

A few questions are raised: *Are such circumstances normal? Did the Romanian State intervene with health subsidies in 2010 in order to cover the financing needs? To what extent is this structure of incomes going to determine the under financing of the sanitary field?*

In order to be able to answer such questions we are going to start from the premise that health services are provided for "all Romanian citizens residing in the country as well as for the foreign citizens and no - country individuals who have demanded and obtained the prolonging of the temporary residence right or who reside in Romania and give the evidence of paying their contribution to the fund; to them one should add the categories of persons who benefit from insurance without paying the contribution" (Law 95/2006 art. 211). According to the same law, the insured person pays a monthly money contribution for health insurances, except those insured persons that benefit from insurance without paying the contribution (as a percent share that is applied upon the incomes).

The natural and juridical persons for whom the insured persons work are obliged to calculate and pay to the fund a contribution whose percent is settled by the law upon the salary fund and due in order to provide the health of the unit's employees. The contributions shares both for insured persons and for employers are settled by the State budget. The contribution due by the persons for whom the payment of the contributions is done out of other sources is going to be paid to the fund as follows: by the State budget; by the budget of State social insurances in case of retirees; by the budget of unemployment insurances, in case of unemployed persons.

When considering the stipulations of the same law, one may observe that most beneficiaries of medical services should contribute, directly or indirectly, to the fund of health insurances. While all employed persons pay these contributions, in case of the other categories of persons for which the State budget and other budgets should contribute to the Unique National Health Insurances Fund, the paid sums are much under the required level.

In 2009, employed population represented 43.12 % and provided 93.92% of the incomes of the fund due to the contributions paid by the insured persons and their employers. Retired persons represented only 26.54% while the incomes from the State budget, either the direct ones or through the Health Ministry, represented only 5.87%. Considering that the State's consolidated budget should have paid the sum afferent to the contributions of retired persons, one may infer that a diminishing of health funds occurs. The under - financing of health is the result of certain circumstances that perpetuated during a long period of time (between 2005 and 2009).

In 2010, the share of the contribution of employed persons decreased to 76.21%, while the contributions paid from the State budget and other administrations increased (23.74%). While retired persons represented 25.68% of the population, unemployed persons 3.33% and the beneficiaries of social aids 1.23% (categories for which the fund should have received sums), the 23.74 percent of incomes is not sufficient. But the sums received as subsidies do not cover only the health insurances contributions that should be paid to the fund by the categories of persons stipulated by the law; they should also cover certain sums which are meant for the health programs directly financed by the Health Ministry.

In order to provide the funds required with a view of supplying proper health services, the increase of the sums the fund consists in is imperative. A means of increasing such sums may be the growth of the contribution share for health insurances. Such a fact would determine an increase of the fiscal burden which is going to influence economic activity; and although on a short term incomes would increase, on a long term they might diminish. The second manner of increasing health incomes is "co-payment", namely the additional payment made by the consumer of medical services; yet, this supporting method of financing sanitary system should not be seen as a miracle element as it only represents a small percent of the cost of medical services which is not covered by the basic insurance.

The most important source of founding the incomes required by the sanitary system is the Unique National Health Insurance Fund administered by the National Health Insurances Bureau. The income sources of the Unique National Health Insurance Fund are the following ones: contributions of natural persons (insured persons) and of juridical persons (employers); subsidies from the State budget and from other administrations; interests, donations, sponsorships, incomes from the exploitation of the patrimony of CNAS and of insurances bureaus as well as other incomes, according to the law.

The foundation of the incomes of health fund depends on three main factors: the number of contributors, the share of contribution, and the degree of funds collecting.

The analysis of Table no. 2 shows an increase of the incomes, from one year to another, except in 2009. Due to the fact that beginning with 2009, as a result of the economic crisis, the number of direct contributors (employees and employers) has decreased, a diminishing of the contribution of health social insurances can be noticed. The decrease of the number of contributors adds to the diminishing of the contribution share from 6% to 5.5%, namely 5.2%, a fact that undoubtedly determined the decrease of the incomes collected by the fund.

Table 2. Dynamics of health financing incomes according to categories of resources (%)

Indices	2008/2007	2009/2008	2010/2009
TOTAL INCOMES, out of which:	120.64	92.67	118.02
I. INSURANCES CONTRIBUTIONS:	116.51	96.43	95.76
1. Employers contributions	114.70	97.30	95.46
2. Employees contributions	118.33	95.59	96.06
3. non-fiscal incomes	121.71	20.32	50.52
VOLUNTEER TRANSFERS, Other than subsidies	130.81	47.49	263.94
IV. SUBSIDIES	183.97	59.68	468.98
SUBSIDIES FROM THE STATE BUDGET	163.54	101.26	1086.32
Subsidies received from FNUAS' budget	220.11	118.52	1482.71
SUBSIDIES FROM OTHER ADMINISTRATIONS	190.88	47.63	88.82
Health insurances contributions for the persons who benefit from social aids	117.35	80.08	132.60
Sums allocated out of the Public Health Ministry's own funds	194.06	47.08	87.75

Source: Yearly reports of CNAS

One may notice an important increase of the State budget subsidies in 2010 as compared with 2009; a fact suggesting that in order to provide the stability of the system of Health Insurances State's intervening was required.

3. STRUCTURE AND DYNAMICS OF HEALTH EXPENDITURES

As to the structure of health expenditures (Table 3.), one may notice the tremendous share (about 95%) of health expenses, namely of medical services, medicines and medical devices providing. No significant changes occur from year to year.

The largest share within health expenditures is detained by the Medical services in hospital type sanitary units (between 45.21% in 2008 and 48.76% in 2006). Such a fact is quite normal due to the diversity and complexity of the insured services. Worldwide, the share of hospital services expenditures ranges between 40 – 60%, Romania being included within this margin.

The next shares are detained by pharmaceutical products expenditures, specific sanitary stuff, and medical devices (28 - 31%) and by ambulatory medical services (shares ranging between 10.4% and 15.75%).

If one takes into account the fact that the providing of population health includes three components – prevention, treatment, and recovery – it means that most funds are spent in order to treat; prevention and recovery are neglected.

Accordingly, in 2008, when the "Program of evaluating population's health" was ended, one could see an increase of the share of ambulatory medical assistance expenditures (family doctors and polyclinics) together with a decrease of the share of hospital expenditures. Such facts show that a lot of persons who were aware of the

existence of certain illnesses went to their family doctor or to the specialist in order to cure these illnesses.

Table 3. Structure of health expenditures during the period 2006-2010 (%)

Index	**2006**	**2007**	**2008**	**2009**	**2010**
Total expenditures	100	100	100	100	100
I. Health expenditures	95.26	95.56	95.40	93.96	94.07
a) Medical stuff and services:	93.62	93.44	93.94	92.64	91.99
Pharmaceutical products, specific sanitary stuff, and medical devices out of which:	31.57	31.19	29.43	28.02	29.04
Medicines with or without personal contribution	19.73	20.34	18.60	14.28	16.94
Medicines and materials for high risk chronic diseases employed by curative national programs	7.67	7.11	7.65	9.89	8.28
Hem dialysis and peritoneal dialysis medical services	3.67	3.09	2.51	3.22	3.33
Medical devices and equipments	0.51	0.65	0.67	0.62	0.50
Ambulatory medical services:	10.40	12.78	15.5	12.39	10.49
Primary medical assistance	4.54	5.81	8.76	7.24	6.29
Medical assistance for clinical and para - clinical specializations	4.77	5.87	5.97	4.23	3.45
Other categories of medical assistance	1.09	1.10	1.02	0.92	0.76
Emergency services	2.84	2.87	3.34	4.05	3.73
Medical services in hospital type sanitary units:	48.76	46.53	45.21	47.93	48.51
General hospitals	48.18	46.09	44.79	47.51	48.13
Other hospital type units (recovery)	0.57	0.44	0.42	0.43	0.37
Medical care at home	0.04	0.08	0.12	0.12	0.16
b) Fund administration expenditures:	1.64	2.12	1.50	1.24	1.39
Medical service given in a state member of the European Union	0.00	0.00	0.09	0.12	0.06
II. Insurances and Social Assistance Expenditures	4.74	4.44	4.60	6.04	5.93

Source: CNAS's reports during 2007-2010

As to the share of recovery expenditures, they represent an amount under 1%. Consequently, recovery is the responsibility of the patient (insured persons), financially speaking, as the health fund insignificantly contributes. We consider that such circumstances are not normal due to the fact that health providing also includes this component having significant long term effects on population's health.

Public health expenditures are meant for the maintaining and functioning of sanitary institutions (hospitals, dispensaries, polyclinics, etc.) as well as for financing certain illnesses preventing programs, accident avoiding programs, and sanitary education. The report of health expenditures in Romania, according to the National Health Insurances Bureau (CNAS) is displayed by Table 4.

Health care financial resources are used both in order to make investments in this field (building of sanitary units, their endowment with modern medical equipments, devices, and instruments, adequate transport means) and especially in order to provide current maintaining and normal functioning of the hospitals,

dispensaries (salaries and other rights of the employees, sanitary stuff, medicines, food for patients, repairs, etc.).

Table 4. Health expenditures during the period 2006 – 2010 (thousand lei)

Index	2006	2007	2008	2009	2010
Total expenditures, out of which:	**10170503.1**	**12859102.8**	**16636256**	**15274758**	**17507384**
I. Health expenditures, out of which:	**9688279.0**	**12288469.3**	**15870567**	**14351730**	**16469661**
a) Medical stuff and services:	**9521157.5**	**12015375.5**	**15628563**	**14150624**	**16104663**
Pharmaceutical products, specific sanitary stuff, and medical devices out of which:	3210979.5	4010708.9	4896301	4279614	5084210
Medicines with or without personal contribution	2006519.9	2616142.9	3094919	2181869	2965416
Medicines and materials for high risk chronic diseases employed by curative national programs	779774.1	913745.4	1272527	1511241	1448987
Hem dialysis and peritoneal dialysis medical services	373077.1	397164.8	417979	491286	582725
Medical devices and equipments	51608.4	83655.8	110876	95218	87083
Ambulatory medical services:	1057925.8	1642870.6	2620102	1892435	1836807
Primary medical assistance	462035.7	746726.2	1456956	1105264	1100946
Medical assistance for clinical and para-clinical specializations	484689.9	754262.2	993847	646689	603477
Other categories of medical assistance	111200.3	141882.2	169299	140482	132384
Pre-hospital emergency services and sanitary transport	289062.6	368620.6	556083	618756	653718
Medical services in hospital type sanitary units:	4958674.7	5982948.1	7522036	7321761	8491999
General hospitals	4900573.9	5926597.4	7452125	7256536	8427017
Other hospital type units	58100.8	56350.7	69912	65226	64982
Medical care at home	4514.9	10172.3	19279	19080	28144
b) Fund administration expenditures, out of which :	**167121.5**	**273093.8**	**249972**	**189692**	**242854**
Medical service given in a state member of the European Union	200.0	54.9	14761	18977	9785
II. Insurances and Social Assistance Expenditures	**482224.1**	**570633.6**	**765690**	**923028**	**1037723**

Source: CNAS's reports during 2007-2010

The amounts allocated for the various categories of expenditures and their evolution depend on sanitary policy and on the evolution of the prices of medicines and medical services. The dynamic analysis of health expenditures shows that they have an ascendant tendency from year to year, except in 2009 when a 8.18% decrease was registered.

The evolution tendency of sanitary field expenditures is the result of the evolution of the expenditures made by hospital type sanitary units (hospitals) and by the expenditures with pharmaceutical products, specific sanitary stuff, and medical devices.

Significant deviations from the average tendency are displayed by *Ambulatory medical services* which during the period 2006-2008 increased over the average level (155.29% as compared with 126.44% in 2007, namely 159.48% as compared with

129.37% in 2008); afterwards, during the period 2008-2010 their decreasing tendency was higher than the average (72.23% as compared with 91.82% in 2009, namely 97.06% as compared with 114.62% in 2010). These significant differences are explained owing to the fact that during the 2nd semester of 2007 and the 1st semester of 2008 the "Program of evaluating population's health" was carried on; the program determined the supplementing of the funds allocated for ambulatory medical assistance. Another possible explanation of these differences is given by the changes of the State's sanitary policy concerning the discouraging of giving hospital medical care when this could be done in ambulatory.

Table 5. Dynamics of health expenditures during the period 2006-2010 (%)

Index	**2007/2006**	**2008/2007**	**2009/2008**	**2010/2009**
Total expenditures, out of which:	126.44	129.37	91.82	114.62
I. Health expenditures	126.84	129.15	90.43	114.76
a) Medical stuff and services:	126.20	130.07	90.54	113.81
Pharmaceutical products, specific sanitary stuff, and medical devices out of which:	124.91	122.08	87.41	118.80
Ambulatory medical services:	155.29	159.48	72.23	97.06
Pre-hospital emergency services and sanitary transport	127.52	150.86	111.27	105.65
Medical services in hospital type sanitary units	120.66	125.72	97.34	115.98
b) Fund administration expenditures	163.41	91.53	75.89	128.03
Medical service given in a state member of the European Union	27.45	26887.07	128.56	51.56
II. Insurances and Social Assistance Expenditures	118.33	134.18	120.55	112.43

Source: CNAS's reports during 2007-2010

Another case displaying major differences is that of the pre-hospital emergency services and of sanitary transport; the circumstances can be explained owing to the fact that in case patients faced malfunctioning of ambulatory medical services, they resorted to emergency medical services.

A peculiar case is the one of the "Medical services given in a state member of the European Union" which witnessed a spectacular increase in 2008 as compared with 2007 (268.87 times). Such an increase is due to the fact that Romania as an EU member has started to discount medical services given abroad to insured persons (E112 form). In 2008 the number of those who benefitted from such services increased.

4. CONCLUSION

A general conclusion of the research is that, irrespective of the financing system adopted and of the development level of the country, sanitary policies in the field of health try to settle a fundamental issue: the balance between the financial resources allocated to health and the continually increasing expenditures of the sanitary field.

As the research shows, the performance of the system of health care depends on the level of the incomes allocated to the system is perfectly valid due to the fact that the countries which allocate a higher percent of their GDP, through their sanitary policy, have acquired a performing system shown by the decrease of the following indices: "life hope at birth" or "rate of child mortality".

Romania which allocates a small percent of its GDP confronts with a chronic deficit of financing that determines a decreased performance of the system and the search of solutions capable to increase the incomes meant for health.

One of the variants is given by the "private health insurances" in case we consider the fact that Romania is placed under the level of the other countries as regards the share of the private insurances funds in the total amounts allocated for health (18% as compared with 21% in France, 22% in Germany, 26% in Poland). If one notices the decreased level of the population's incomes then private insurances are only a palliative of the growth of health financing resources.

A second 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.

The 2011 introduction of co-payment is going to bring changes both at the level of the public sanitary system and at the level of the private one. The arguments that support and motivate the co-payment are the following ones: potential increase of the incomes to be used by the health system, discouraging unnecessary demands of health services and, accordingly, the unmotivated use of limited resources, efficiency of services supply through assumed responsibility for the patients' interests and needs, improvement of equity through distributing the incomes obtained from those who possess the means towards those who do not possess financial resources in order to support their demand for health services. Co-payments incomes may cover a part of the functioning costs of current programs according to which simple curing services are given. The counter-arguments that should be noticed when employing co-payment regard the covering of a very small part of the functioning costs of the public sanitary system, the boomerang effect according to which collected incomes might not grow – on the contrary, they might diminish. In fact, co-payment represents a masked self financing scheme of the health system and an increase of fiscality.

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