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| **To Link this Article:** http://dx.doi.org/10.6007/IJARAFMS/v2-i4/9986 DOI:10.6007/IJARAFMS /v2-i4/9986 |
| ***Received:*** *05* November *2012,* ***Revised:*** *29* November 2012*,* ***Accepted:*** *14* December 2012 |
| **Published Online:** 28 December 2012 |
| **In-Text Citation:** (Constantinescu, 2012)**To Cite this Article:** Constantinescu, D. (2012). Health Insurance Between Sectoral Supervision and Consolidated Supervision. *International Journal of Academic Research in Accounting Finance and Management Sciences*, *2*(4), 180–192. |
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| **Vol. 2, No. 4, 2012, Pg. 180 - 192** |
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**Health Insurance Between Sectoral Supervision and Consolidated Supervision**

Dan Constantinescu

Ecological University of Bucharest Romania

Email: dr.dconstantinescu@yahoo.com

**Abstract**

The quality of the services delivered on the health insurance market generates significant effects in the financial situation of the companies and of the individuals. Any perturbation in the system is of nature to contribute to the occurrence of the phenomena of economic and social crisis and, for this reason the normal functioning of the system is an essential landmark for insuring the stability of the economy and of the society, in their ensemble. The specific of the activity developed by the institutions operating on that market, the connections between the respective entities and the influences exerted on the economic and social area led to the idea that, like other segments on the financial market, the operations run on the health insurances market must be submitted by law to some specific regulations and, in the same time, to some supervising and control procedures, known as prudential supervision. Another argument in favour of the regulation and the supervision of the private health insurances is given by the fact that they make a unique combination, in its way, between the investors’ interests on this market and the necessity to the insure the social security.

**Keywords:** Health Insurance, Supervision, Control, Supervising Authority.

# General Considerations on the Supervision of the Private Health Insurances

The protection area [2] - configured by law and by subsequent norms – may be structured from the covered entities point of view may be structured as follows:

* + The insurance companies are protected against the risks caused by the quality of the insured persons and by the potential actions against them;
	+ The insured persons are protected from the managerial errors resulting from incompetence or from hazardous assumption of some excessive risks;
	+ The shareholders of the involved institutions are protected against the destructive potential of flaw management;
	+ The financial system and the business environment are protected from the afferent and collateral effects deriving from a deterioration of the economic-financial situation of the institutions in difficulty;
	+ As a whole, the society is protected against the possible instability of the financial system, but also against the occurrence of a deficit of its image.

The experience showed that there isn’t a single and optimum system of regulation and supervision. Each country may choose its own model, adequate to the national economic, social and cultural context because what theoretically is desirable may prove impossible in concrete adverse or insufficiently accommodated conditions.

Too many times, the optimum solutions on regulating and supervising the private health insurances are obtained in an ulterior stage by rendering operational the institutions dedicated to this purpose and through the secondary legislation.

A first distinction in conceiving the supervisory system is made between the proactive and the reactive models. The first approach involves detailed regulations for most of the managers’ activity from the profile insurances. The supervising and control activities must be detailed and well defined, the main purpose being to prevent the possible errors.

The second approach mainly relies on self regulation, with much less detailed procedures of supervision. It presumes that the managers from the insurances companies have a real interest in what concerns a more elaborated self regulation, and the state must intervene only in the situations when the stakeholders and insured persons’ interests diverge. Obviously, in such a situation, the sanctions and the penalties for breaking the system rules must be much more severe.

The proactive models of supervision are more frequently met I the new systems of private health insurances from the countries in development, countries that have no consistent tradition in the field of regulation, nor a corresponding security level in the financial sector.

The specialists in the field recommend that the possibility to use a reactive model needs to be considered in the countries with a significant experience of self-regulation of the financial institutes.

Obviously, choosing between a proactive model and a reactive one depends in great extend of the national context. A combined approach may be the unhappiest choice as, for instance, a reactive model applied in a country with a limited or superficial penalties system may get in crisis, most probably.

In any context, the frame of supervising the private health insurances involves four large compounds:

* The mission of supervision;
* The system functions;
* The institutional structures;
* The supervision methods.

The supervision mission is the same, regardless on the context where it develops and it refers to protecting the insured persons’ system of interests and to the protection of the system stability.

 With regard to the supervision functions, the speciality studies reveal an area quite wide of the debated issues of which the following directions cannot miss [3]:

* Insurers’ certification and registration;
* Terms of qualification for getting the afferent benefits of the insurance bonuses;
* Management of the system operators;
* Insurance bonuses and regularity of their payment;
* The insured persons, the possibilities of transfer from one insurer to another;
* The variant of option on cashing the benefits (payment to the beneficiary or, respectively, to the medical services supplier);
* Conditions of access to the substitutive, complementary and supplementary insurances;
* The investments of the insurers and restrictions on actives allowance;
* The minimal capital of the insurers and the deposits to be created;
* Financial, actuarial and accountancy methods;
* Marketing activity;
* Procedures of insured persons’ information and of the interested institutions;
* Procedures of merger and of liquidation.

The other two components of the supervising framework are to be widely presented in the following subchapters.

**Main Domains of the Supervising Activity**

The speciality literature and, particularly, the World Bank documents structure the activities of regulation and supervision in four domains to be grouped two by two [6]:

* The institutional and financial control that cover the insurers way of function, since certification to their eventual dissolution, by merger or liquidation; it also includes the verification of the management quality and the persons affiliated to the insurers, the intermediate agents and their subsidiaries, as well as the procedures of investing the obtained resources by collecting the insurance bonuses;
* The control of the insured persons and benefits, referring to the procedures of adhesion and solving the insured persons’ petitions, as well as monitoring the calculation of the rights of medical care covered by the insurance contract.

The fact that the supervising authority must focus its efforts on the mentioned issues does not mean that the support-activities can be neglected. In this regard, we consider the domain of the information technology, that of the human resources and the activity of legal assistance.

The institutional and financial control is particularly important, mostly in the first years of rendering operational the private health insurances system. Afterwards, its importance in the supervising process reduces due to several reasons. First of all, the initial effort of certification of the new companies practicing health insurances reduces naturally. Secondly, the lack of initial security on the possibility that certain insurances companies fail with regard to the coverage of the health care expenses assumed by contract reduces while the system is strengthening. Third, the eventual mergers or liquidations will be more frequent in the first stage of their functioning and they will have a much lower frequency after the market stabilisation. Fourth, while the involved institutions become more familiar with the regulations, the control may become more selective. Finally, since the number and the value of the benefits payments increase, once the system is maturing, the other domains of control become a priority.

The main aspects on the institutional and financial control concern:

* Certification of the new insurers and of the specific business lines;
* Merger and insurers liquidation;
* Insurances products marketing;
* Insured persons’ and interested institutions information;
* Collecting the bonuses and the possibilities of transfer to another insurer;
* Investments supervision, including of the information sources and of the employed systems of information technology;
* Procedures of actives evaluation, especially for those covering the compulsory reserves;
* Respecting the limits of investment, if there are such, depending on the type of the investment tool, the level of risk, the issuing body etc;
* Calculation of the insured persons’ benefits;
* Evaluation of the financial and operational performances;
* Inspections, verification of the balance sheets and other ways of control.

The regular reporting system of the insurers’ investments is considered an essential element of the financial control. It is at the latitude of the supervising authority that, according to the law, to establish the periodicity of such reports (monthly, weekly, daily), as well as their informational content. It is recommended that the insurers’ reports include complete details on the investment policies, the portfolio composition, the corresponding incomes and expenses.

The actives evaluation covering the compulsory reserves has as purpose the permanent insurance on the insurers’ capacity to pay the insured persons the corresponding benefits. Most legislation in the field stipulates a system of evaluation based on the daily market prices. In other states, the insurer establishes the actives value based on a system of rules established by the supervising authority.

The existence of the investment is by itself a controversial issue as it obliges the insurers to use methods of placement that cannot optimise the report risk-profit but, in the same, they increase the level of security of the investments by diversifying the portfolio.

Usually, the limits refer to the following characteristics: type of actives, issuing bodies, risk level (established by the authority of supervision or by the private evaluation agencies) and the potential conflicts of interests.

The limits on the investments into one issuing body are of nature to prevent an excessive concentration of the placements and of the associated risk. They put the problem of defining the issuing bodies, either as individual companies, either as economic groups. If their purpose is to stimulate diversity, then the limits must be established for the economic groups, without being necessary to mention all companies forming them.

The limits of the accepted risk level have as objective to avoid those actives for which there is no acceptable estimation of the risk. Into such a context, the efficient supervision of the risk evaluation agencies becomes essential.

Finally, the last category of limits proposes itself to avoid the conflicts of interests between the insurer and the affiliated persons, by forbidding or limiting the investments in the active issued by the companies having tight economic or affiliation relation with the insurance company. However we have to mention that not all investments into the actives issued by a company affiliated to the insurer is of nature to generate a conflict of interests, as, even in this case, the market mechanisms may generate fair prices.

We have to mention that all types of limitations generate certain difficulties in implementation and supervision. The creativity of the financial markets may lead quickly that the differentiations between the predefined categories (warranties, shares, deposits) to become irrelevant especially when various derived tools are used. This is a reason for which the supervising authority must be able to update in useful time the categories of placements depending on their concrete contents.

 The control of the insured persons and of their entitled benefits, focused in a first stage on solving the notifications and the claims of the insured persons, is to move afterwards to the supervision of the way of granting the rights of compensation afferent to the insurance contract.

In this regard, the main domains of action are:

* The insured persons procedures of affiliation and the possibilities of their transfer from one insurer to another;
* Insured persons’ information;
* Solving the insured persons and the medical care beneficiaries claims;
* Definition and control of the procedures to ask for benefits;
* Control of the way of payment of the benefits (directly to the beneficiaries or to the services suppliers).

The calculation of the corresponding benefits for the insured persons may become a very difficult problem for the supervising authority if the deposits level and other guarantees in the area of reimbursement are low. For this reason, it is necessary a more explicit regulation of the calculation methodology and the calculations must be supervised by the supervising authority both considering the principles (as regulated calculation formula) and in the control operations (by checking the calculations made by the administrators). Even in the absence of a warrantees system, a regulation on the calculation methodology of the corresponding benefits for the insured persons is necessary in the idea of increasing the transparency and the possibility of comparison between various insurance products of this kind.

The regulations on the affiliation and transfer procedures of the insured persons must cover the following aspects:

* The necessary of information for correctly justifying the individual affiliation or transfer decision;
* The role of the selling power of the health insurances products;
* Assigning the responsibilities in case of fraud or incorrect affiliation.

The current tendency is to move the responsibility to the insurers for several reasons. First of all, the regulations on the legal relation between the selling force and the insurer may be more flexible, reducing the marketing costs. Moreover, the conditions for opening subsidiaries become somehow more flexible, allowing the use in common of the space and of the staff with other activities such as – for instance – the banking ones. Not lately, the responsibility of the insurers for eventual frauds simplifies the supervision procedures of the respective authority.

Supervising the selling power may be accomplished either by a detailed training program or by a certification system. Usually, the responsibility for training is the insurer’s task, but the certifications are regulated differently from one country to another. Initially, it is preferred the direct certification of the sales staff by the supervising authority, based on the results of a centralised examination, but while the system develops, the certification is left to the insurer according to the procedures approved by the competent authority.

The insured persons’ information, based on the regular report of their incumbent benefits, must be a priority for the initiators of the private health insurance systems. The insurers are in competition to provide their services to the potential clients who are able to make the right choice if they hold correct information on the costs and the benefits. It is to be expected in a competition area to assist to a reduction of the costs and to the increase of the efficiency.

Considering the cost of issuing the regular reports, there are reserves considering their transmittal to each insured person. Usually, the insurers are required to draft a report to be presented to the public by the authority of supervision through media or internet.

The regulations must specify the content, the format and the frequency of the information sent to the insured persons. The standard formats are recommended for the standardised formats, in the idea of facilitating the comparisons between the insurers and for preventing the manipulation of the information to the interested ones. The inspections of the supervising authority must verify if the reports were regularly sent to the insured persons and if the information is accurate.

With regard to the insured persons’ notifications and claims, in first instance, it is recommended that they are addressed to the insurance company as first instance of solving them, while presenting to the supervising authority an information report in this regard. If the proposed solution is not the appropriate one or in case of conflict, the supervising authority is able to give its own solutions, by establishing the insurer’s, the intermediate agent’s or their leaders’ responsibilities,

The procedures for requesting for the benefits must be standardised with the more exact mention of the necessary justifying forms and documents.

The main problems occurring in the area of the control activity concern:

* + The wide diversity of the analysed subjects that imposes a good professional training of the inspectors and a more accurate definition of their tasks;
	+ The quality of representatives of the supervising authority imposed the inspector on field a proper tenure and behaviour, in accordance to their mandate;
	+ The intensive character of the actions of control require proper equipments and a corresponding software for the processing and structuring necessities of the gathered information;
	+ The collaboration with other departments of the supervising authority, considering that, along the regular inspections, a significant weight of the activities in the area must be dedicated to the thematic, non anticipated controls.

The increase in the efficiency of the inspection, verification and control procedures presumes their structuring on programs, for each of them the following aspects are going to be mentioned:

* The objectives of the control action to be developed;
* The frequency of the control, their regular or not character, the irregular ones;
* The activities for achieving the control objectives;
* The resources allowed for the program of the control;
* The circumstances generating the beginning of the control;
* The way of putting into value the control results and the application of the disciplinary measures.

Obviously, the annual plan of control of the supervising authority consists in a quite comprehensive number of programs. Despite all these, it is recommended that each insurer is submitted to the verification, at least yearly, for each of the foreseen control programs.

An orientate option of the inspection, verification and control themes, based on the experience from the states accumulating a significant experience in the field of the private health insurances, is presented below:

* The control of the individual or collective bonuses made for each insurance products, by verifying the consistence of their information, especially with regard to noting the bonuses and the correct and in time deduction of the commissions;
* The control on the insured person’s information must verify the justifying documents used for drafting the regular reports;
* The control of the accountability practices must verify if the insurers respect exactly the regulations issued by the supervising authority with regard to recording and maintaining the actives covering the compulsory deposits;
* The control of the accession process verifies, for a sample of insured persons, the way of filling the documents of participation (not be signed in white, not to be incomplete) and, in special cases, it may include the direct monitoring of the accession process;
* The control of the documentation on the investments and the deposits made by the administrator is complementary to the financial control;
* The control of the insurers subsidiaries (subsidiaries, branches, agencies) includes visits on site for verifying the information supplied to the insured persons, of the accession procedure and of the eventual possibilities of transfer;
* The control of the procedures for solving the petitions and the claims include also the practical modality to implement them; in addition, they complete with the existing information in the supervising authority referring to the correctitude of the claims solving;
* Verifying the payment to the medical services suppliers is made in the context of the existence of some prior approved contracts by the supervision authority.

Even if, as we have already shown, the actions of inspection mainly rely on the verification of the justifying documents, the practice in the field shows that a regular review of the control programs is required. Moreover, for increasing the efficiency in the area, even it is imposed a certain conformation of the control programs to the insurers’ specificity and sometimes we have to repeat the verifications as special inspections that might follow the same procedures as the planned periodic controls.

From the range of the support activities the issue of the legal conformity remains the most significant one on the aspect of the implications it presumes.

In this regard, we have to deal with applying the sanctions to the entities and the persons involved in the system of private health insurances. From this perspective, the results of the inspections, of the verifications and of the controls may be divided into three categories:

* Acknowledging of some already solved problems, the risk of occurrence of some disfunctionalities being crossed;
* Propositions of revision of some functional aspects that are not the exactly errors, but rather directions of perfecting the activity;
* Acknowledging the errors and the irregularities to be sanctioned.

For rendering objective the system of sanctions it is necessary to create a database on the results of the controls and of the inspections. Beyond the contribution to insuring a proper, equitable and objective frame for the sanctions disposed by the supervising authority, such a tool is useful with regard to the evaluation on preset criteria of the insurers’ management.

The relations of the supervising authority with the legal instances are determined by the fact that some irregularities go over the competency of the specific authority. In such situations, that the law has to stipulate clearly, the supervision authority will manage the corresponding legal complaints. Examples of such cases include fraud, attempts to force the individual choice, fakes etc.

The legal force of the regulations is given by law. However, as way of organisation, there is still the idea that the responsible authority for drafting the regulations must be different from the supervising one. Even in this case, the supervising authority must make its own norms and regulations aiming for the procedures of follow up and control of the entities in the system. It is the reason for which the role of the experts in the legal sector is still essential.

The activity of collecting and disseminating the information on the private health insurances system is an essential part of the attribution of the supervising authority in the field and that can be made operational in a department of statistics and research.

The main structures of collected information must include:

* Aspects on the insurers’ management, the system of bonuses and benefits, the insurers’ incomes and expenses, concrete investment principles and coordinates, payment of the benefits, insurers’ performances;
* The economic information on the system of the health insurances, in relation with the statistics of the labour market, of the social security, of the capital markets on public finances, the internal and external debt;
* Information on the internal and external legislation in the field.

Collecting on rigorous criteria of the necessary information and their publication in time is a useful support for the activity of the researchers’ and of the analysts in the field and also o proof on the system transparency.

**The Institutional Structure of the Supervising System**

The most significant influential factors marking the institutional structure of the private health insurances supervising system may be structured in four categories:

* The system of political and administrative organisation of the state: federal or unitary, centralised or decentralised;
* The characteristics of the private health insurances system: individual / collective; substitutive, complementary, supplementary;
* The structure of the market: insurers’ number, types of delivered products, concentration on the market (financial conglomerates, oligopolies);
* The way of approach of the regulation and the supervision: qualitative, prudential, quantitative, self-supervision, reactive, proactive.

Firstly the issue of the level of institutional coverage must be solved in organising the supervising authority, starting from the fact the insurers’ regulating (setting up the rules) and supervision (imposing the rules) is distinct functions. They may be assigned to the same institution or may form the object of activity of some distinct institutions. Using a single institution presumes the existence of a preset control procedure that avoids the eventual interpretations on the regulators options. The second option allows the supervisors to act without internal institutional influences.

The experience of the states that introduced the system of the private health insurances shows that a combination of both alternatives is possible and it corresponds in greater extent to the mission of the supervising framework. Consequently, in most countries, where there is already set an insurances supervising authority, part of the regulating activity was achieved by the respective institution, while in some other part (usually the primary legislation), other authorities initiated it, such as – for instance – the ministries of health or of labour and social security.

The organisational structure of the supervising authority must reflect the four various domains of activity, that were presented in the previous subchapter: the institutional control, the financial one, the insure persons’ issue and the benefits payment.

The division responsible with the control of the health insurances must have at least four functions that are in charge with the four mentioned forms of control: institutional (performances certification and evaluation), financial (limits of investment, adding value to the placements, deposits), the insured persons’ (subscription, transfers, notification) and of benefits (direct or to the services suppliers). Another division should comprise the reporting system, the statistics and the activity of research, including the sector of publications. A third division must be in charge with the legal aspects, including a department on giving sanctions and one specialised in legal consultancy (with activities of petitions distribution and solving). Finally, a division afferent to the support services must be in charge with the problems on the information technology, of administration and human resources issues.

As for the statute of the supervising authority, it has to protect is from the eventual political pressured. Though, as functionality, it resembles to the other forms of regulation of the state, the main purpose of the supervision of the health insurances has always to be to long term protect the insurers’ stability and insured persons’ rights security.

As long as the secondary or tertiary level regulations may have an effect of scope on the insurers’ investments, it is expected that the supervising authority to be submitted to a significant lobby. To avoid or, at least, to minimise the dimension of such pressures, it is recommended that the specific authority is autonomous and independent from the government structures and its top management to be established in a transparent process, preferably by parliamentary procedures and to have a limited mandate.

The functional autonomy does not confer the health insurances supervising authority the role of supreme instance in the field, reason for which its decisions and actions can be submitted to a reviewing process, either of administrative nature, either by the courts of law.

Moreover, the activity of the supervising authorities is submitted to a regular analysis in the empowered bodies for supervising the supervisors. They can be: the parliament, the ministries, the prim ministers or the president, the national auditing institution, bodies of the insuring industry, the public opinion, in the informing policies through the regular reports and from publishing the profile information on the internet.

A widely debated issue refers to the possibility of integrating the supervision of the various institutions from the banking-financial system, including of those related to the private health insurances.

The arguments of the supporters of the integration idea mainly refer to the following aspects:

* The unitary coverage of the activities developed by the financial conglomerates;
* Avoiding some overlaps in the activity of the supervising bodies;
* Increased consistency of the intersectoral supervision;
* Optimising the information flow;
* Scale and purpose economies, including by dissemination of the previous experience.

There are other opinions according to which the level of integration of the supervising activity should rely on the scope of the similitude between various segments of the financial market. In this context, it is proposed the common supervision of the market of insurances and private retirement funds, starting from the following considerations:

* + On the aspect of their duration and their possibilities of investment, the placements performed by the insurances companies are likely to those performed by the retirement funds
	+ Similitude starting from the dimension of (social) “insurance” concerning the retirement funds;
	+ The insurance companies offers of some products that conceptually are close to the idea of a private retirement fee: life insurances with the bonuses reimbursement, annuities, insurance on term in case of surviving etc;
	+ Of the experience of the countries institutionalising the system of private pensions, we noticed that the main market operators (funds managers) are organised either as subsidiaries of some insurances groups, or as a joint-venture where the insurances companies hold a significant even a control position on the market.

Even the supporters of specialising the supervising institutions on the markets where the respective ones are empowered come with justified arguments:

* By the social security compound, the health insurances are self established products, even if their financial characteristics are likely to other products;
* The supervising mechanisms of coordination of the various market mechanisms can often be heavy and quite costing;
* The reform of the health insurance system is a rather complex and duration process and involves specialised institutions;

Another practical reason is that the people are rather suspicious on the transparency and the efficiency of the already existing supervising authorities. The reform if the health insurance system has a popular support as it proposes radical changes in this system and that the previous failures from other segments of the financial market are related in the common thinking with potential problems on the regulating authorities (the image deficit).

Of course in the situation of the functioning of some specialises supervising entities for each market segment, the intersectoral flows impose forming some mechanisms of coordination between the respective authorities. They can have several forms:

* Forums or joint coordination commissions;
* Including in the leadership of some members of other supervising authorities;
* Protocols on the coordination or the division of the activities, the bureaucracy reduction and of the costs for industry, join operations etc;
* Integration of the database;
* Legal provisions or understandings on the information distribution;
* Regular meeting at the leadership level or on experts’ categories.

Funding the supervising authority for the health insurances allows two ways of approach. The first relies on government sources, through transfers from the public budget and the second on contributions and taxes paid by the insurers. The second option may reduce the political pressure of other government structure, especially when the supervising authority has the competence to collect their own incomes, under sanctioning clauses.

The logic according to which the supervised entities must fund the supervisor’s activity resides in the fact that the supervision of the health insurances, being a public service, those benefiting of it should also be those who pay. Moreover, such an approach leads to increasing the flexibility in budget management and avoids the eventual constraints applicable to the institutions funded from the public budget.

However, there are opinions that funding the supervising authority from private sources implies the risk of its dependence to the interests of the market operators (captured agencies) and leads to increasing the costs for the affiliated persons.

Insurance with human resources of the supervising authority is delicate issue, mostly in the period of introduction of the private health insurances system, as the professionals with relevant experience in the field are quite few in number. From this reason, the supervising authority must develop an intensive training program for having quickly the necessary staff, in better qualification terms.

We don’t have to omit the fact that, in the terms of a relatively low number of professionals and due to the lack of time for training the future experts, the insurers are in competition with the supervisors. To attract and maintain qualified human resources, the supervision authority must grant competitive salaries and a motivating system of afferent benefits, usually superior to those from the governmental apparatus and at least at the level of those from the profile industry.

Obviously, in a first stage, there are to be recruited experienced experts from related areas: from the health insurances institutions, from the sanitary system or from the supervisors from other sectors of the financial market. In this context, we cannot leave aside the fact that the recruiting institutions tend to get rid first of all from the less performing employees or of the non motivated ones.

In turn, the human resources policy must be flexible which means that the supervising authority should operate as a private company, hiring and dismissing employees according to the common law, without the bureaucratic system imposed to the public institutions. Of course, this is easier to accomplish in the terms of a financial autonomy.

The private health supervising authorities may borrow the model of the local political management of the states where they function. Consequently, in the countries where a unipersonal leadership is practiced, several authors consider that the responsibility and the efficiency assume that the respective authorities are run by a single president/ director, with full powers to coordinate both the regulating segment and the actual supervision. In such a context, a council or a supervising committee of the supervising institution has only consultative role and it is useful only in the measure where it does not limit to the decision-making manager’s authority.

The occidental democracies where the political tradition consecrated the role of the group management grant increased powers to the leading councils or committees, even if the particularities of organisational culture generate elements of variation on: the name, the members’ number, the hierarchy relations, the range of attributions etc.

Of course, the above considerations have an accentuated theoretic character, the private health system concept and rendering it operational being relatively recent in several countries, reason for which the practical experience did not succeed to create a coherent and articulated point of view.

**Conclusions**

It can be seen that the choice between sectoral supervision and consolidated supervision is hard to do. Each of these models operates successfully in some countries and each shows both advantages and disadvantages.

Consolidated supervision seems more appropriate developed financial markets, but can work equally well in the markets of the freshly established countries. So while most European countries consolidated supervision practice, it would be premature to speak of a European model in this respect.

Setting up a European model of supervision would soon be made ​​on the basis of generally accepted principles, such as the independence supervisors or appropriate financing system. At that, the de Larosiere report adds complementarity of EU supervisory structures with national bodies.

The fact is that, regardless of the arguments in support of one or other of supervision models, their implementation is an attribute of each state, and preference for one or another model is ultimately a political decision.

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