

ROMANIA IN FRONT OF A NEW EUROPEAN CHALLENGE: THE FINANCING OF HEALTH SYSTEMS

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Abstract

The Global Organization of Health defines the health system as „the totality of the organizations, institutions and resources consecrated to the improvement of health.” The financing of a health system refers to the way in which the funds necessary for the development of the activity in the sanitary sector are collected and also to the modality in which these funds are allocated and then used. The chosen financing modality, combined with the type of organization of the sanitary system determines who has access to the health care, the cost of this care, the productive efficiency and not least the quality of the offered services. All these intermediary results determine in their turn the final results of any health system: the health condition of the population, the financial protection against the risks and not least the degree of satisfaction of the consumers of services. The paper proposes a compared analyze of the various financing mechanisms of health systems in Europe, to conclude on the advantages and disadvantages of each system. Concerning our country, we search the answer to the question: “Is a supplementary health insurance viable in Romania and would it reduce the costs of the patients?”

Keywords: healthcare systems, Bismarck social insurances, market mechanisms.

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1. Means of financing the healthcare systems

The healthcare system represents „ the total amount of organizations, institutions and resources used in order to improve health”.

Financing a health care system refers to the way in which the funds necessary to the development of the sanitary field activities are being collected.

The mean of financing which is chosen, combined with the type of the sanitary system organization, determines who has access to the health cares, the cost of those cares, the productive efficiency and last but not least, the quality of the services

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which are being offered. In their turn, all the intermediate results, determine the final results of any healthcare system: population health level, financial protection against risks and the level of satisfaction of the services consumers.

There are five main means of financing the healthcare systems : financing from the state budget; financing through the social health insurance; financing through the private health insurance; financing through direct payments; communion financing.

The means of financing the health care systems appear in these pure states, in which they have been described, only very rarely, most of the times them being „skinned” to the specific conditions existing in each country, and , sometimes, they even appear in a mixed form inside the same healthcare system.

Ideally speaking, it seems that the best financing solution would be that of a three leveled healthcare system:

1. for the public goods and healthcare services, which have a major impact on the level of health, the best method is financing through general taxation.

2. for necessary health cares, derived from the individual sickness risk, the best methods are public financing through special taxation or social healthcare insurance.

3. for the services which are considered non- necessary (with non-proved efficiency, luxury ones, or the ones requested by the patients), the best methods are financing through private health insurance or through direct payment.

The strategy which should be adopted by any country which wants to apply a mixed financing system, is to define the public goods, necessary goods, luxury goods in the healthcare system, this being done based on the society values and the existing funds.

FINANCING FROM THE STATE BUDGET. Through this mean of financing, the funds are collected into the state budget, and afterwards they are allocated to the sanitary system. Population coverage is general, each person contribution being dependant on their income and not on their individual risk.

There are several sources, where from the funds can result: general taxation; special taxation for healthcare; other budgetary incomes.

The general taxation result from three main sources: import/export taxation; taxation on the economic agents; salary taxation, and also on the global income.

The funds which are collected in this way, most of the times don't represent a stable source of financing the health system. The explanation is that, for some governs, health doesn't represent a main priority, and this aspect combined with the economic instability of the transition countries, leads to a crises of the funds allocated to the sanitary system.

FINANCING THROUGH HEALTH INSURANCE

Health insurance is a way in which many of the average and high income countries manage to cover the sanitary system expenses, in a significant proportion.

There are two main types of health insurance: compulsory insurance (social insurance and public insurance done by the govern), and voluntary insurance (private).

Social health insurance. There are two main differences between the social and private insurance. In the first place, the social insurance is mandatory. Each eligible

person must enlist and pay the suitable amount of money. Secondly, the premiums and benefits belonging to the social insurance are established by the existing law, this being the reason for which they can be modified more easily than the ones of the private insurance,

Financing the social health insurance system is made through obligatory contributions, usually equally paid both by the employees (under the form of a percent from the salary) and the employers. In some of the countries in order to include also the people that work outside the official sector, the contribution can be calculated as a percent from the global income of those people (e.g. Farmers).

In the health insurance system, the government contributes with funds from the State budget, in order to finance some precise objectives which are not covered by the insurances, like: health programs of national importance, rehabilitations in the health area, endowment with gears of high performance etc. The underprivileged groups that are not included in the social health insurance are also the government responsibility.

TYPES OF SOCIAL HEALTH INSURANCE: There are two main types of social health insurance from the point of view of the funds administration:

- Social health insurance administrated by the government, through governmental agencies;
- Social health insurance administrated by public or private insurance companies,
- Social health insurance administrated through governmental agencies;

Social health insurance administrated by the government, through governmental agencies:

In this case, the government is the one that establishes the contribution level together with the offered services.

The health unities that are included in the insurance plan can belong exclusively to the government property, or these can be mixed, both private or governmental, in the first case the insured person having the possibility of choosing. It is obviously that the first model, the one of the State monopoly against the services contractors, has indeed many disadvantages, like birocrtatism and lack of liberty from the beneficiary side, causing diminution of the quality of the medical act.

The major disadvantage of this kind of system is tied with the political pressures. The political pressures is affecting the allocation of the resources, together with the payment ways done by the medical services contractors. On the other hand, the politicians may promise in exchange of the electoral support, unrealistic packets of services which will be a burden for the next generations. We encounter these kind of health insurance systems in the Latin America countries.

Social health insurance administrated by public or private insurance companies (Bismarck model):

In this situation, the task of the government is to declare mandatory insurance for all the eligible people. The citizens have the liberty of choosing among several

insurance funds, either public or private. In many countries these kinds of funds are named “sickness funds”, and can be organized also by trade unions.

The organization for offering health care may vary accordingly to the different social insurance plan. For example in Japan, most of the specialists from the tertiary assistance are represented by the employees of the hospitals, while in Germany and France, the payments are done separately by the insurance funds for doctors, and hospitals. This leads to a scanty integration for the hospital services, and a weak coordination among doctors and hospitals, causing diminution in efficiency.

The advantages of this kind of system, in comparison to the one of the social health insurance administrated by the governments would be the following: non-interference of the politics, the decrease of the birocrtatism, competition among the insurance funds, causing a quality increase in the medical act.

However, the encountered issues are tied with the apparition of the adverse selection, the insurance funds trying to draw the healthy people in the area of the sick people and the young people in the area of the old ones. We encounter this kind of the Bismarck model heath insurance in Germany, France, Japan, Benelux, Austria, and soon in Romania.

Voluntary, Public social insurance: The private health insurance is offered by non- profit insurance companies or for profit, on the base of individuals or groups.

In what concerns the individual medical insurance it is calculated accordingly to the sickness risk. The amplification of the contribution also depends on the packet of services that is offered, plus the administrative expenses, plus profit. The last two ones represent 40- 50% from the insurance. The high administrative costs are explained by the high marketing costs, needed for selling the insurance to as many individuals as possible,

The private insurance may be also offered to groups of individuals, usually employees of the same employer or members of unions.

In the last years it could be noticed an increase in the interest for the private insurances, seen as a mean of the income increase for health. However, implementing this kind of system in the health care market, raises a series of problems like: does the insurance be thought as for individuals or as for groups of individuals? Should the insurance societies be for profit or non profit?

The most important aspects are tied by the government role. Its important task is to establish the legislative framework without which an insurance society cannot work. The executive may also imply in a series of problems like: creating some back up funds for the insurance companies similar to the ones from the bank system with the aim of preventing any kind of fraud.

What is absolutely clear is the fact that the option of the private insurances doesn't stop the government from the responsibility of involving in the financing health system. On the contrary the private insurance raises a lot of legislative and management problems.

As a conclusion it may be said that the private insurances are representing indeed an extra source of income for heath. Implementing the private insurances are

requiring precise regulations and an attentive and constant supervision, and most of the countries cannot respect these kind of requirements.

It is significant the fact that the only state in the world that has a private health system based on private insurances is USA. However, even here the government offers medical care to the disadvantaged groups through two programs: Medicaid, for the poor ones and Medicare for the old people and handicapped people. The last program covers around 38 mil people. 15% from the Americans don't have medical insurance.

Financing through direct payments: There are several types of direct payments: total payment of the services; co-payment (an established sum for each medical visit); co-insurance (a certain percent from the visit cost)

The total direct payment of the medical services is done in the private area, while the co-payment and co-insurance are done in the public area.

The positive effects of these payment ways might be: the reduce of the non necessary services, quality increase of the services, efficiency increase.

The problems that are encountered are tied with the fact that the poor individuals or the old ones, the ones that receive the medical services might reduce the consumption if the needed care due to payment impossibility.

The researches show the fact that introducing the direct payments hasn't lead to a significant increase of the health funds, increase which is estimated to less than 10%. More than this, no improvements could be done in the quality of the medical services.

In conclusion there are many possible negative effects of this way of financing. It is important to be understood the limit of the method, the impact and especially the context of each country.

Communion financing: It is a method that may be applied in the rural area. It is based on the fact that the members of a community should pay in advance a contribution with the scope of obtaining a packet of medical services, when these will be needed. The contribution covers a part from the costs, the rest being offered by the government. Contributions may be obtained also from the local industry where this exists. The Communion financing proposes most of the times to cover the primary care costs, the drug costs and also a part from the hospitalization costs.

The communion financing is based on two principles: cooperation among the community members and trust among them. This method may be encouraged and sustained by the government through legislative initiatives, technical and financial assistance. Ideally is that the organization of the communion financing to be independent from the local and central authorities.

Other methods of financing: There are new methods of financing, like Managed competition, Managed care, and health costs. Etc.

Managed competition means mandatory insurance for the individuals, with the liberty of choosing the insurance company which will negotiate with the contractors the best conditions for the offered care payments.

The payment of the contributions will be depending on the income (for covering an unique care packet) toward a national (central) fund of insurances, which will pay to the insurance companies funds as per individual, depending on the sickness risk. Fucks shows that although some of the countries have tried this kind of financing (Dekker in Holland, Clinton in USA), we cannot reach to the conclusions about the advantages and disadvantages of this method.

Managed care is a new concept that integrates financing with the offering of health care and which implies services in an integrated, responsible and competitive system, and the insured person negotiates with the contractor. The Contractor is the organization of HMO Type Health Maintenance Organization from USA. These organizations request contributions that have the same characteristics with the ones from the private health insurances (tied with risk, for the individuals contributions, or communion for the group contributions.)

Usually these contributions are less than the ones from the private insurances, because it limits the access to certain contractors and it appears the sharing of the financial risk with the contractor through capitation contracts and global budgets.

Financing through health accounts is a financing health care method which is based on mandatory payment of a monthly contribution in a personal health account. In case of some diseases, the money from this account may be used for purchasing from the market some cares which are needed. The money from these accounts can be used only for the health payments, can be donated to the family members for being used in the health care or taken when retirement (but keeping a minimal level into the account). The system is applied in Singapore under the name of Medisave, being completed by other two plans: Medishield for catastrophic events and Medifund, which pays minimal services for the inhabitants that have no other insurance.

2. Health insurance financing in the EU countries

2.1 General aspects

Health insurance financing and organization in the EU countries follow the institutional, political and national socio-economical customs. These carries out a series of social objectives in financing and efficient medical services using an approachable price.

For financing a health system it is needed to collect money from the population for getting in contact with the contractors of the medical services.

The main objective of the systems is the one of distributing the costs of the medical services among the sick people and the healthy ones and of modulating them depending on the resources that each individual possesses.

This mechanism reflects the consensus which is encountered in the UE according to which health cannot be abandoned in favor of the market mechanisms.

Each country has developed its own financing mechanisms.

Along the history, there have been remarked different types of social insurances. The most important ones are: the Bismark social insurance model, Beveridge social

insurance model, insurance systems in a continuous flow (Pay-as- you- Go) and insurance systems with funds capitalization.

In order to analyze them we may group the mentioned models as per below:

2.2. The Bismarck social insurance model versus the beveridge social insurance model

The Bismarck social insurance model, was named after Otto von Bismark, the chancellor of the second Reich. This one has introduced for the first time in Europe a legal system of social insurances. The Chancellor is considered the creator of the first German modern State through institutional- organizing reforms initiated as a reply to the problems caused by the industrialized process in Europe.

Social protection in Europe, becomes at the end of the 18th century, as a consequence of a strong economical recession, an issue of State interest, before this being limited to a rudimentary model of social insurance based on charity and voluntaries.

The State implication has been reduced in most of the European countries . In 1881, Bismarck introduced for the first time a mandatory State social insurance model, adding in 1883 the payments for sickness cases, in 1884 the insurances against work accidents and in 1889 a comprehensive plan of age and disabled pensions.

The most important observation for this system is the one that it has mandatory character, associated to the work contracts.

The system is supported by: the employer, employee and State. The administration of the system has been done through some territorial structures, “ aid agencies”. This social insurance system covered a relatively small category of the population, mostly addressing to the factories workers.

Occidental Europe then took over the bismarch system, this one becoming the alternate model for the beverage insurance system or Anglo- Saxon, system that is characterized by scanty and fixed benefits, financed from the State budget, from taxex and general duties, representing a minimum level of protection often combined with private insurance systems.

Beveridge Social Insurances: Lord Beveridge published in 1942 a report about the situation of the british society, in which he suggested to adopt a system of paid pensions from duties and general taxes, from the State budget, having a constatnt level for all the beneficiaries.

In the Berveridge system, the significant social actors – unions, employers – are not involved in the structure and the administration of the system. The continental system represents a comprehensive protection, ofthen undoubled by the private systems, with benefits in proportion with the contribution, namely incomes.

To have a better observation of the differences between the two insurance systems, there were grouped in the below table their main characteristics.

	Bismarck social insurances	Beveridge social insurances
Finiancing source	<i>Social insurances Fund – the individuals contributions are constituted in a distics fund</i>	<i>State Budget – financing is done through taxes and general suties</i>
Social insurance administration funds	<i>The fund is more often administrated in a tripartite regime: state, liable to payduties, beneficiaries, through representations of certain asociations Unemployment: state – union – employers Pensions: State- pensioners-employers Health:state- doctors- unions</i>	<i>Administration is done only by the State</i>
Benefits level	<i>The benefits are in relation with the incomes, namely the level of the contribution</i>	<i>Benefits are constant, and low as a level</i>
The importance of the private insurances	<i>Low</i>	<i>High</i>

2.3. Mandatory systems in a continuous flow (PAY-AS-YOU-GO) versus mandatory systems with funds capitalization

Systems with funds capitalization: the contributions are invested in different economical activities that bring profit

The main advantage of these systems is that fact that these don't depend either upon the dependence rate or the demographic evolution; these funds will always have money to pay the pensions.

These system also have disadvantages, namely they cannot face the unexpected post-pension inflation, and the payment of the benefit i in relation to unexpected inflation is almost impossible, which causes a decrease in the real incomes from the pension.

Pay-As-You-Go systems (exceptions: the different system of pensions associated with the contribution, in Sweden and Japan): this systems means pension payment from the money paid by the liable to pay duties, namely employees.

These systems have the advantage that they protect the pensions from inflation, can increase the pensions as a real value in relation to the economical boom and the eligibility criteria for an integrated pension can be anytime modified, adjusted in a certain way that it adjusts the benefits to the current economical situation.

The main problem of these systems is represented by the strong connection of dependency rate and also the fact that it may face payment incapacity.

The Health systems from UE are financed through public or direct contributions. There are three main financing systems in UE. The first one (known under the name if the Beveridge model), is characterized through public financing based on duties.

The second system (Bismarck model), the financing through mandatory insurances. The third system is done through private financing, using volunteer insurances.

Health financing systems of the UE countries:

Countries	The dominant financing system	The complementary main financing sources
<i>Finland, Greece, Ireland, Italy, Sweden,, Spain, Great Britain</i>	<i>Public: fiscality</i>	<i>Private volunteer insurance, direct payment</i>
<i>Denmark, Portugal</i>	<i>Public: fiscality</i>	<i>Direct payment</i>
<i>Austria, Belgium,, France, Germany, Luxemburg</i>	<i>Public: Mandatory social insurance</i>	<i>Private volunteer insurance, direct payment, fiscality</i>
<i>Holland</i>	<i>Mix between the mandatory social insurances and private volunteer social insurances</i>	<i>Direct payment, fiscality</i>

Patients participation contribute in a varied proportion to the medical care financing in all the UE countries.

Most of the UE countries apply exoneration dispositions from taking part all the costs of the small income categories and other disadvantages groups.

The mandatory insurances together with the volunteer insurances are administrated by the social agencies, organisms that collect contributions accordingly to the incomes in order to distribute them under the form of benefits in the moment that medical services are needed, are at the repayment of the expenses.

The financing method used in hospitals is different from one country to the other, the main forms being: the daily cost of the hospitalization, the group cost of clinic diagnose.

2.4. Health systems financing of the UE countries

Health Systems financing of the UE countries

Country	Organisation Method	Financing
AUSTRIA	<i>Mandatory health insurance, covering a complete plan of services</i>	<i>It is encountered into the legal health insurance regime, but the contribution to the private insurance is significant</i>
BELGIUM	<i>Mandatory health insurance for major risks</i>	<i>Health insurance payments completed through important subventions of the State</i>
DENMARK	<i>The national health service financed through duties</i>	<i>System financed with 85% through duties, the rest coming from the patients participation at the costs</i>
FINLAND	<i>Serviciu național de sănătate, progressive retirement of the State and power decisiontransferater on local level</i>	<i>Central and local financing, completed by the national system of health insurances and costs participation</i>
FRANCE	<i>Mandatory health insurance covering the crasi-total population</i>	<i>Insurance agencies payments and cost participation.</i>
GERMANY	<i>High number of health insurance agencies, an important private sector</i>	<i>Mandatory and volunteer payments of health system m, only 21% are generated through taxes</i>
GREECE	<i>Mandatory health insurance, national health service, an important private sector</i>	<i>The private sector is substantial, and there is an important market that functions in parallel.</i>
IRLAND	<i>national health service and complementary volunteer health system</i>	<i>Financing is dominated by taxes; a small part comes from insurances</i>
ITALY	<i>national health service on the principle of mandatory health insurance</i>	<i>Financing and social payments are almost in equal parts</i>
LUXEMBURG	<i>Mandatory health insurance</i>	<i>Social contributions completed through subventions from the State (27%)</i>

HOLLAND	<i>A complex system of public and private insurances, but that tends to a national system,</i>	<i>Social contributions completed through volunteer and private insurance</i>
PORTUGAL	<i>national health service on the principle of duties and mandatory health insurance</i>	<i>Payment and social contributions. Marginal private sector</i>
SPAIN	<i>National health service of the low developed State. Fiscality is mixed with the health insurance</i>	<i>Financing dominated by taxes; a small part coming from social contributions</i>
SWEDEN	<i>national health service strong decentralized, local democratic control</i>	<i>Local financing completed with public funds and employers' contributions at the national social insurance system</i>
GREAT BRITAIN	<i>national health service financed through duties</i>	<i>Financing dominated by taxes. Small private sector</i>

3. Health financing system in Romania

3.1. History .General characteristics

The financing of the Romanian health system has known in the last 15 years, from the conceptual point of view, three main stages:

1. The mandatory insurance plan through general taxes;
2. The mandatory insurance plan through general duties and health taxes;
3. The health insurance plan through general and health duties;

Before 1989 and till 1992, the Romanian financing care system was based on mandatory insurances, under the form of a financing through general taxes. The State was collecting through the Finance Ministry all the denel taxes and duties. From these amounts, then the Government and the Parliament decided which amount should be allocated to the Health Ministry that was in fact the tertiary pay maker, because it was the main credit chief account.

It must be highlighted the fact that the Health Ministry was the only contactor of health care through sanitary institutions (hospitals, institutions), which lead to the existence of an integrated health system, with the main role represented by the Health Ministry and its territorial organisms.

This method of financing lead to two important consequences:

1. The population perception that the health care is a process which is not payable and that this is the State responsibility;
2. Lack of exact definition of the health care that the citizens had, causing the perception that any kind of care may be offered if there are the necessary resources.

The collected fund and administrated every year by the Health Ministry represented about 3% from the Romanian GDP, with small variations in plus or minus from one year to the other. This kind of financing still exists nowadays, representing about 15% from the total amounts expended for the healthcare system.

A particular case of the financing through general duties was the one **from 1995-1997**, when a parts from the sanitary expenses were covered by funds coming from the local budgets and not from the state budget.

Starting with 1992, it appeared a new method of financing in the Romanian sanitary system, namely the Special Fund for Health. This Fund had the role of completing the financial resources that the Health Ministry had through allocation from the State budget. The goal of this special Fund was to compensate the drugs

price done ambulatorium. The Financing through this special Fund added to the existed one through direct allocation from the State budget, representing 20% from the total amounts expended for the health care system financing.

The effects if introducing the special health Funds were:

1. Increase of the collected resources for the healthcare financing
2. Making sensitive the employers to the fact that the paid amounts, contribute in a direct way to the health care offered to the employees; a special tax has been added to the already existent taxes level for each employer;

Starting with 1998, as a consequence for adopting the special health care insurance law, the main financing is done through collecting some special taxes, dedicated to health that come directly or indirectly from employers, employees, pensioners, unemployed. This financing mechanism was doubled by the Insurance Agencies that are public institutions that are not subordinated to the Health Ministry.

The effects of these financing methods were:

1. showing clearly the fact that money used in health care are coming from each citizen;
2. separation of the one that finances the health system (companies insurances) by the one that offer health services (Health Ministry in most of the cases) and establishing some contracts among the partners;
3. fiscality increase for employees from 2 % to 5 % and then to 7 %.

Introducing the financing through social insurances didn't stop the financing through genral taxes, but it brought to the definition (more or less clear) of the sanitary activity area that would be covered by the two principal financing methods: health social insurances and public insurance administrated by Health Ministry.

What needs to be mentioned is that, from the collected funds point of view, the introduction of the social health insurance in 1998 hasn't increased the funds, the total amount of money allocated to the health system being 3% of the GDP. Once the social health insurance have been fully introduced, starting with 1999, and once the contribution increased from 5% to 7%, the total amount of money allocated to the health system has increased, which led to a total of 4% of the GDP.

It is important to say that the three means of financing which have been described above, are not the only ones which existed or still exist inside the Romanian healthcare system. They are the ones which dominated the financing of the system, and which are the base of the public insurance scheme. Besides these three means, there are other ways in which the healthcare system attracts important sums of money: direct payment of certain services (stomatological, ambulatory special services, etc).

In 1997, Romania introduced a new health insurance system, through 145/1997 law, a system which is based on a modified version of the Bismark model. Today, some structures from the following models, coexist inside the Romanian healthcare system (primarily taking into account the mean by which it is being financed)

- model – social state insurance (state treasury)

- the Beveridge model – the “filter” role principle (role belonging to the family doctors – which are freely chosen by the patients, and financed through taxes)
- The Bismark model – the social health insurance system (based on mandatory insurance premiums, dependant on income)

To sum up, a national healthcare system has functioned in Romania until 1997, a system based on the collection of funds through taxes.

The Social Health Insurance Law was adopted in 1997, which marked the transition to a new system, the social health insurance system. This system started functioning beginning with 1999.

In Romania, there are two main sources for the health funds : the social health insurance funds, which are being completed with money from the state budget.

Financing through social health insurance. The gathering of funds for the social health insurance is regulated by the Social Health Insurance Law, in the Financing chapter and consists in the employer's and employees' equal percent contribution (7%). The funds are used for paying the medical services suppliers, although lately, it has been observed that the health insurance is being used for objectives which normally should have been paid from the state budget (national health programs, payment of certain salary rights).

Financing from the state budget. Apart from the social health insurance system, there also is a system of direct taxation (taxation on income, on profit) and of indirect taxation (VAT, excises). The money coming from the budget are managed by the Health Ministry.

The destination of the money coming from the budget: the construction or repairing of sanitary institutions; performant medical equipment acquisition; diagnosis, curative, rehabilitation activities, recovery of work capacity).

Apart from those two means of collecting funds for the health system (social health insurance, state budget), there can be other sources of money: direct payments from the patients to the medical services suppliers (private clinics, costs of certain services which are not discounted by the Insurance houses and which are included in the Frame Contract); co-payments, voluntary contributions, in the future, once the private insurance houses appear.

The problems which appear in the Romanian system are mainly caused by the difficulties which appear when collecting the funds. Because there is a lack of clear legal stipulations, the district houses have difficulties in collecting the funds, and one of the factors is the existence of some big industrial units, which are in debit, not only to the state budget, but also to the social health insurance funds.

Another problem is the mandatory deposit of the funds to the Treasury, with an interest of only 10%. Not being able to receive a bigger interest, as the ones in the banking market, together with a high inflation, lead to a decrease of the real amounts which get to the sanitary system. Another important source of loss of the funds belonging to the health system is the underground economy.

3.2 Strengths and weaknesses of the romanian healthcare system

The Romanian healthcare service system, up until 1989, which hasn't encountered drastic modification even after 1990, was inspired (towards the end of the '40 and in the '50) by the soviet model (Semasko), but it also had similitudes with the systems existing in some countries in the West of Europe – Great Britain, and some nordic countries.

The principles of the system, many of which were in accordance to the recommendations made by the World Health Organisation, were based on the state vision, prophylaxis, the unity of the way the whole system was managed, planification, gratuitousness and large accessibility to medical assistance, the scientific character of the sanitary politic and the conscious participation of population in defending their own health.

- It is important to understand that the health services are just a subsystem of the sanitary system and it refers to the institutions and the preponderant medical services which these institution offer.

In its essence, the healthcare service system has been and still is a system organized and financed by the state, being made up of a network of sanitary institutions which belong to the state, managed in a centralized structure, which is led by the Health Ministry. The financing is made through general taxes and duties through the state budget, and the doctors are employees of the state.

- Critical examination of financing, organization and functioning of the healthcare services system points that, besides its shortcomings, there are also a series of advantages. This is a very important perspective for what medical assistance plans to be in the future, and this perspective has been more and more present in the specialty works elaborated especially by the academic area, of the eastern experts and consultants, which were called to propose changing solutions.

From this point of view, the system which functioned in Romania had a series of positive elements, which have been more obvious especially in the rapid economic growth periods.

- The system has been developed on the equality principles, and it ensured access to vast health services for the whole population. The access to the system hasn't been influenced by the payment capacity of the patient. The advantage of payment absence in the moment of utilization has slowly eroded when the income of the medical proffesion became more and more inadequate, and the sums asked for or suplimentary received from the patients by the medical personnel became to be acceptable from a social point of view, or even considered the right of the personnel.

- The financing and organization of the system have permitted an efficient control of the costs. The proportion in GDP of the costs for healthcare was relatively low. "The price" of a certain limitation was the lack, or limitation of access to certain services, especially the ones which required greater expenses for equipment or materials (for example, renal dialyses, cardiovascular surgery, transplants, articular prosthesis, computerised scans). The system functioned with low structures and administrative costs.

- The services infrastructure has been extensively developed, so that a good network of small medical units, polyclinics and hospitals existed. Unlike other former socialist countries, the network of primary medical assistance has been developed from the organizational point of view, but neglected from the endowment one. It is here where the most inequalities were obvious, inequalities regarding the medical personnel, regarding the economic development between districts, between urban/rural etc. When the dispensaries became part of the hospitals, the competition for resources was won by the quality medical services, to general medicine detriment. This had a negative impact on the systems efficiency, because the cases which could be solved at a primary level in the hospitals, overcrowding them, and consuming their resources.

- Population medical assistance assurance with beds was good, even more oversized than the actual needs, and than the possibilities of covering the costs and than the existence of the beds in other eastern countries. The hospitals consume over 70% of the budget allocated to health protection and solve only 20% of the population's sanitary needs.

- There has been sufficient qualified medical personnel and a quality medical education. In this domain too, if we take into account the density of the doctors reported to the GDP, Romania has a convenient position. The political interference has led to disfunctions in the forming of the medical personnel, especially in the '80 (the cessation of qualification of the specialist doctors and their access into cities, elimination of the the qualification which took place after highschool, for the medium workers)

By the middle '70 there have been registered obvious improvements of the health state, this being shown by the increasing of the life duration, the eradication or reduction of a lot of transmissible diseases, reduction of infantile deaths, the initiation of national programs concerning the cardiovascular diseases, cancer, tuberculosis, mental and dental health. The medical services had a great role in these improvements.

In spite of the disadvantages, the healthcare services system had a series of negative aspects, which starting with the '80 have become more and more visible, and so, the health state of the population and the medical assistance deteriorated.

After the revolution, some of the characteristics of the sanitary system have become discordant to the requirements of a democratic society, of a new type of state, and when the market economy emerged, in the transition period, a series of negative aspect became more and more acute.

The healthcare system which functioned in the past and which is still dominant in Romania, at a closer look, has a series of weaknesses and disadvantages. Probably the main conceptual limit was the misunderstanding of the fact that health is a "business of the whole society", which means incorporating it into the economic and social development, as a target or as a variable. This is the point from which resulted the second fatal consequence, this being to credit the sanitary services with the responsibility and possibility of improving the health state of the population, when

the ascribable part of the sector doesn't represent more than 10-15% anywhere. The logical result was the blaming the doctors and the sanitary system for all the discontents generated by the deterioration of the health state, which in fact was the result of a mixture of factors (economical, social, behavioral, biological, environmental)

- Excessive medical norms of health, influenced by the manner of management of the services, highly reduced the chance for an intersectorial approach, which took into account all the factors with influence on health.

- Rigid planification, together with the centralized and commanding system, have suffocated the initiatives and responsibility in managing the health services and especially in adapting them to the sanitary needs, which are always changing. The centralized model, by imposing rigid norms and standard, most of the times arbitrary ones, through an administrative manner, has been an obstacle in the way of adapting the services to the local needs of the people, which are different from one zone to another. These norms have led to an inefficient mixture of abundance and wastage in some regions, and absence in others.

The normative planification was ineffective and inefficient. Although it was hardly tried to reduce the lack of balance throughout administrative methods, and through equal distribution of personnel and medical infrastructure, the result was a failure. Even today, we may notice that the system hasn't managed to reduce territorial inequality, neither at the health state level, nor in assuring doctors and beds for all the population who needed them.

Financing based on historical criteria, without taking into account the different sanitary needs of the population, has emphasized the differences between the districts.

- Subfinancing of the services has determined a delay in the introduction of new technologies, necessary in diagnosis and treatment of actual pathology, and this delay also generated losses in assuring daily use medicines and sanitary materials. All these have discouraged the preoccupation of the health services towards the medical care quality insurance and evaluation.

- The lack of a coherent politic system in the health domain after 1990, was also favoured by the inheritance of a deficit in the capacity of systematical analyses and strategy development, all these in the conditions of an insufficient qualification in the public health management and the healthcare services.

4. Conclusions

To create a performed health system has represented a major objective of the State organisms since 1990 when the Health Ministry set up a reform process with the objective of fulfilling the fundamental goal: improving the health situation of the population, efficiency increase in using the resources, of change in the relationship between doctor and patient and increase of the satisfaction level of all the beneficiaries and all the contractors of medical services.

The beginning of the Sanitary Reform meant the reorganization of the health service and of the financing health services system.

For doctors, the essence of the reform means an increase of the incomes in order to reach a decent level and to cover the huge responsibility of a medical activity done with seriosity. This fact could have been fulfilled on 1st april 2008 when through the normative paper packet regarding the salary of the medical staff, it was approved a new plan of salary through which the doctors incomes and of the auxiliary employees from the health system was increased.

For the population, the sanitary reform means stop promising sanitary services that cannot be covered from the existent money, and eventually to receive sanitaru services accordingly to the needs.

But there is one question: what is the dimension of the allocated budget for the Romanian sanitary system in comparison to the medium budget of the UE countries?

For establishing this dimension we start from the Romania GDP, which in comparison to the mediul GDP of the west center of the UE, represents 1/3. the allocated Romanian health system represents the 10th part from what it produces, namely 3.3% from GDP of the west center UE, which is very little in comparison to the other UE countries.

In the UE, the public expenses for helath are 8% from the GDP for the west center, and in what concerns the allocated amount per inhabitant in the West Europe is of 3000Euros and in the Est- communism countries this amount varies from 700 to 900 euros. In Romania, the amount allocated per inhabitant is around 400 euros.

On the other hand, it may be noticed a significant increase of the GDP percent allocated to health in Romania, from 3.6% in 2004 to 4% in 2007 and to 6% in 2008.

In conclusion we may appreciate:

- ◆ the way a health system is financed determines the available amount of money, who bears the financial burden, who administrates the fund, and if the costs inflation may be controlled.

- ◆ the capacity of mobilize funds is in strong relation to the income per inhabitant;

- ◆ the same financing method cannot be applied to the whole countries. The health systems are different from one country to the other, especially depending in its socio-economical development;

- ◆ unproportional distribution of the available funds, lack of coordination among the different sources of financing, together with the inadecvate attention paid to the costs and to the efficiency, represent major problems that are faced by the health system fianancing from the countries that are in transiy;

- ◆ most of the actual fianancing systems are not “pure”. Most of the countries have mixed varied methods of financing, depending on its specific and health objectives,

- ◆ none of the financing method is ideak and cannot offer a magic solution that may solve the problems of the health financing, especially in the low developed countries;

♦ the long objective is to establish a common politics for all the UE countries based on values and common principles to ensure a better health for the inhabitants

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