DURABLE FINANCING OF THE ROMANIAN HEALTHCARE SYSTEM WITHIN THE EUROPEAN BACKGROUND

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Abstract

All healthcare systems in the world confront themselves with an obvious discrepancy between the need for medical services, and the available sustainable financial resources for covering this increasing need for healthcare. This has become a reality which has led to an intense preoccupation on the part of all-acting participants within the healthcare systems. This aim of this study is to find solutions to make financial resources more efficient, starting with the process of caring for patients, and ending with covering up the expenses within the system. Even if there are continuous reforms happening in most of the states in Europe and/or the world, we can surely state that there is no health system deemed perfect that can be copied or adapted to. This is due to the fact that each state confronts itself with different situations in the health issue, related to making financing efficient, optimizing, well allocated, and used as intended for healthcare.

Keywords: Financing, healthcare systems, sustainability, rationalizing, expenses

Introduction

Means of financing, allocation, and the use of finances intended for healthcare system, combined with organizational types specific for healthcare system, determine one's access to health services. Basically, access to healthcare occurs due to the costs of these treatments and not necessarily due to the quality of the services offered. In most states around the world, the funds necessary for healthcare are collected from the population - except for the U.S. The US is the only state in the world where healthcare is based on private health insurance. Thus, even at that, the state intervenes in cases of underprivileged individuals.

Healthcare systems must ensure the distribution of medical services' costs towards those who are ill from those who are healthy. Consequently, this depends on the financial resources that each individual has, through a solidarity mechanism (reflect). This consensus was also met inside the EU, according to "*health cannot be abandoned to market mechanisms*".

From an economic standpoint, we must take into consideration the issue of ensuring efficiency in the use of resources available to the healthcare system. However, this is achieved through the evaluation of medical services offered to the sick, considering the financing resources, as well as the costs and efficiency of the healthcare activity. Thus, this evaluation is carried out so that the level of the healthcare activity can be qualitative.

Cristina Dobos (2008) stated in an article shown in *Quality of Life* magazine, that healthcare systems are large consumers of resources, and that the last 30 years have shown a continuous increase in the level of healthcare resources. Consequently, this increase is mainly due to the aging of the population, the discovery of more efficient drugs and more advanced technology, but also more expensive, and an increase in the number of people benefiting from healthcare. Thus, financial support can be improved through a series of measures. These measures include: limiting the access to health services, reducing the quality of the services, or increasing the share of private financing (which, in turn, has consequences that are linked to limiting the access to services). Nevertheless, none of the above measures is desirable from a social point of view. From a social protection perspective, the best way to improve financial support is to increase the efficiency of the health system by lowering costs and maintaining quality and quantity. Furthermore, this is realized through avoiding the overconsumption of medical services and through allocating sufficient resources meant for prevention and health maintaining programs, with the aim of reducing possible expenses in the future.

Current analyses and impact studies show an increase in healthcare costs. Hence, at the same time, it shows a decreasing medical efficiency, generated also by the means of allocating financial resources, as well as the understanding and application of social and public politics. In this context, there will always be a preoccupation towards rationalizing medical expenses and good management of funds allocated by the government towards medical care. Thus, this is due to the fact that financial resources destined for healthcare will be limited. As a result, this will generate different ways of constraint for all the participants in the system. The level of financial limitations is directly dependent on the economic development of the country in question, on the level of involvement of the civil society, on the coherence of health policies, and on the innovative solutions to system financing. Romania is also facing major allocation issues at the time being, due to the

fact that the level of health expenses is low. Therefore, this is a consequence of the effects imposed by the economic adjustment mechanisms.

Financing Medical Services in Romania

The world health report (2000) introduces new ground in presenting for the first time, an index of national health systems' performance. Their aim was in trying to achieve three overall goals: good health, responsiveness to the expectations of the population, and fairness of financial contribution. Consequently, their success towards these goals depends crucially on how well the systems carry out four vital functions. Thus, these functions are: service provision, resource generation, financing, and stewardship. The report devotes a chapter to each of the functions, reaches a conclusion, and makes policy recommendations on each of the functions. However, it places special emphasis on stewardship, which has a profound influence on the other three (The World Health Report 2000 - Health systems: Improving performance, WHO, 2000).

Member States of the World Health Organization (WHO) committed themselves in 2005 at Geneva, to develop their health financing systems. This was implemented so that everyone can have access to healthcare services, and should not suffer financial hardship in paying for healthcare service. Therefore, this goal was referred to as a universal coverage, which is sometimes called universal health coverage. In striving for this goal, governments encounter three fundamental questions: *1. How can such a health system be financed? 2. How can they protect people from the financial consequences of ill-health and paying for health services? 3. How can they encourage the optimum use of available resources?* Subsequently, they must also ensure that coverage is equitable and should establish reliable means to monitor and evaluate the progress. In this report, WHO outlines how countries can modify their financing systems to move more quickly towards universal coverage and to sustain those achievements. Moreover, the report synthesizes new research and lessons learnt from experiences of a set of possible actions that countries at all stages of development can consider and adapt to their own needs. It suggests ways the international community can support the efforts of low-income countries to achieve universal coverage (Resolution WHA58/2005/REC/1, Sustainable health financing, universal coverage, and social health insurance. In: 58th World Health Assembly, Geneva, 2005, WHO).

Consequently, member countries of the World Health Organization inside EU, were established in 2008 by means of the Tallinn Charter, reconfirming and adopting the above stated values, that is first related to the financing of healthcare systems as follows:

(a) There is no unique optimal approach related to the financing of the healthcare sector

(b) Financial mechanisms should redistribute resources in order to comply with the needs of the healthcare system, reduce financial blocks, and ensure protection against the financial risk of using medical assistance services within the available financial package

(c) Financial mechanisms should offer incentives for efficient organization and supply of healthcare services

(d) General allocation of resources should reach an adequate balance between medical assistance, illness prevention, and promoting health with the purpose of responding to current and future needs of the healthcare system. In addition, this also creates the following suggestions: (a) knowledge, infrastructure, technology, and above all, human resources with a mix of capacities, abilities and competencies, need planning on a large scale and a long term investments; (b) investments in the medical workforce; (c) consolidating health and research policies, and an ethical and efficient use of innovation in medical and pharmaceutical technology.

Also, in 2010, The World Health Report health systems financing, was endorsing the raise of sufficient resources for health care by granting internal financial support for universal coverage. However, this coverage includes countries with small incomes. Therefore, the international community should financially support internal efforts in order to rapidly develop access to medical services. At the same time, countries with large incomes will continuously search for funds to satisfy the growing requirements and expectations of their population. This they do by finding financing solutions and providing funds for rapidly developing technologies, which will help to increase the performance of medical services. Consequently, the report presents four recommendations for developing healthcare systems throughout the world for better financing and functionality:

1. Increasing the efficiency of revenue collection; 2. Health allocations from public budgets becoming a priority; 3. Using and identifying innovative financing methods; and 4. Assistance in the development of the healthcare system.

From the analysis of the performance concept of WHO as presented above, the performance of the Romanian health system in the international context does not occupy a prime spot. Thus, the 99th position out of 191 states was being outranked by states which have lower economic performance than Romania.

Also, several studies, reports, strategies, and analyses have been compiled related to the improvement of the Romanian healthcare system's performance. In this respect, the 2008 *Report of the Presidential Commission*

for the Analysis and Elaboration of Public Health Policies in Romania, states that improving the health of the Romanian population and the fair access to health services should be sure, efficient, prompt, and effective. Related to the financing of the healthcare system, the following main coordinates will be taken into consideration. Thus, they include: the level of financing, the sources and ways the funds are collected, and the methods of allocation in the health sector.

The above stated report proposes a series of recommendations related to the improvement of performance in financing the Romanian healthcare system: (a) increasing the financing level for the health sector in Romania; (b) developing a system for resource allocation in health based on transparent criteria and medical records, and (c) introduction and support of the payment mechanisms based on the efficiency and quality of the medical performance. Until the current year, a series of measures have been adopted that have partially increased the performance of the healthcare system. However, this has not solved the major issues that the healthcare system has been facing for a long time.

Following the National Health Strategy 2014 - 2020, approved by the Romanian Government in December 2014, a series of analyses have been done on the context and current performance of the healthcare system. Furthermore, it was also being appreciated through its direct dimensions: the capacity of responding to the needs of the beneficiary (responsiveness), financial fairness and protection, sustainability, and efficiency. In addition, the action plan for implementing the national strategy has been approved for 2014 - 2020.

Thus, in 2013, Romania ranked next to last in Europe from the perspective of the healthcare services consumer. Also, Romania was linked with the level of financial allocation for health per capita. According to European Health for All database (HFA-DB), dated July 2013, the per capita health spending was under 1000 $PPP[1]. Hence, this places Romania on the antepenultimate rank in Europe, right before Albania and Macedonia. In this context, the 2013 EHCI report (Euro Health Consumer Index, 2013), which has analyzed health cost efficiency (calculated with a formula that links the EHCI score with the allocated financial resources), presents the low efficiency in health allocation, again ranking an inferior 31st position out of 34.

Healthcare systems can be sustained through various financing methods as follows: 1. financing from the state budget; 2. financing through

[1] PPP (purchasing power parity) – monetary unit that reflects the purchase power of the same goods and services in the compared countries.

social health insurance (public); 3. financing through private health insurance; 4. financing through direct payment to the health services supplier by the consumer; 5. financing through the community, others, etc. Although our country is concerned, the financing of the medical services' suppliers is ensured through public health insurance, mostly by the National Health Insurance Fund. This however, comes from the contributions of physical and legal persons, from employees, and from commercial agents. Consequently, this method of health fund collection requires the payment of a health insurance contribution from the employer and the employee. We can find a different health financing fund in European countries like Germany, Austria, Belgium, France, Luxembourg, or in The Netherlands. In Romania, until 1997, health was being financed from the revenue generated from taxes. Therefore, this represents a characteristic of the national health system found in countries such as the UK, Italy, Spain, or Denmark. Even at the time being, in the current social insurance system, Romania continues to have an important financing component to the state budget.

Currently, insurance systems in Europe as a result of joint evolution, have several key elements in common. These key elements includes: similar inputs from all contributors; the funds are administered and publically controlled; social insurance does not exclude private insurance – there is complementary private insurance in almost all the aforementioned countries; insurance bonuses are granted according to the revenue and not according to the individual risks; and contributions are being paid by the employer and the employee.

In Romania, at the time being, financing sources for public health expenditures are represented by social insurance health funds, state budget, local budgets, own incomes, and outside resources. Apart from the issues linked to the system’s low level of financing, other distortions in the system limit the service quality, fairness, and attainability. As a result, there are delays in solving population health problems. During the transition period, various population segments have appeared to be socially and economically underprivileged. Thus, this is accompanied with attainability difficulties by the medical services, due to the continuous underfinancing of the health system.

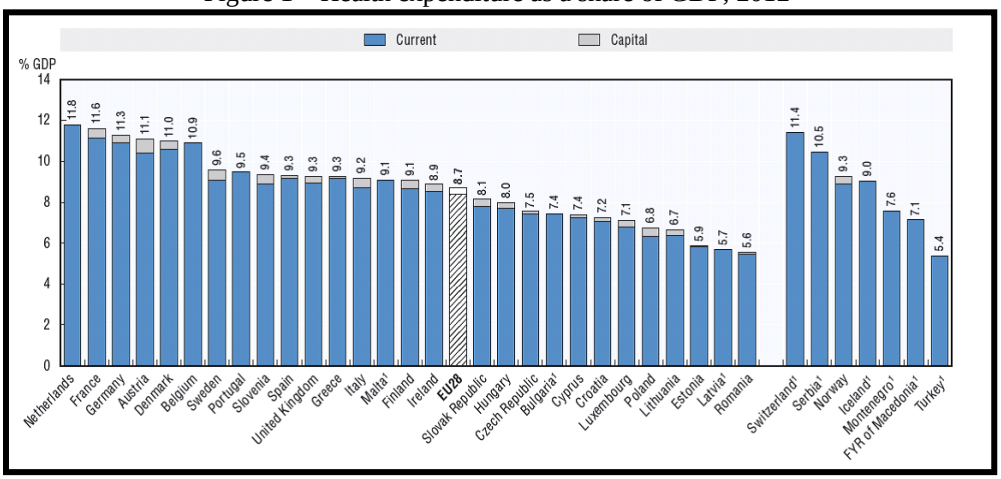
In 2012, the EU member states have allocated an average of 8.7% of GDP to health expenditures, as opposed to the year 2000, with an average of 7.3 of the GDP. The biggest increase was in 2009, when health expenditures were 9% of the GDP. Out of all the EU member states, Holland has allocated the largest percentage of the GDP towards healthcare (11, 8%). Thus, this was followed by France and Germany with a GDP of 11, 6% and 11.3%, respectively. Nevertheless, European states are much behind in comparison to the US, where health expenditures have been 16, 9 % of the GDP in 2012.

The percentage of health expenditures in the GDP was lower in Romania, Latvia, and Estonia, which was under 6%. Health expenditures in Romania ranked last of all EU countries in 2012 (Health at a glance: Europe 2014), 5,6%, of GDP, compared to the European average EU 28 – 8,7 %, even though the growth rate registered in the previous period was accelerated (Figure 1).

Outside the EU, Switzerland has allocated 11, 4% of GDP for healthcare, while Turkey has allocated 5,4% of GDP for healthcare. For a more complete understanding of the health expenditure level, as a part of the GDP, it is paramount that they are considered alongside the health expenditures per capita.

Consequently, there are countries with a high level of health expenditures related to their allocation from the GDP. In addition, they can have relatively low per capita expenditure, but the converse is also possible. As an example, Luxembourg and Croatia have spent around 7% of their GDP for healthcare in 2012, and nonetheless, the per capita expenditure was three times as much in Luxembourg in comparison to Croatia (Figure 2).

Figure 1 – Health expenditure as a share of GDP, 2012

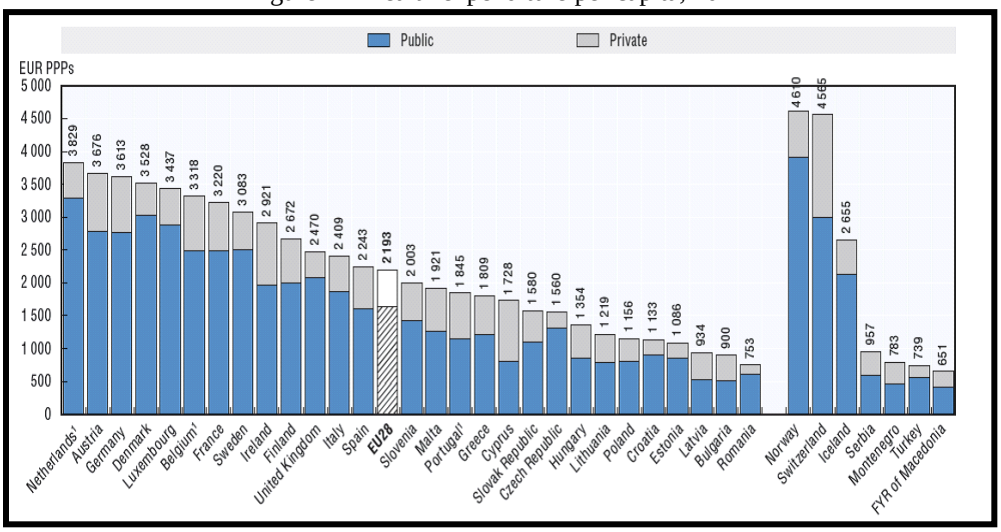


Source: OECD Health Statistics 2014, http://dx.doi.org/10.1787/health-data-en; Eurostat Statistics Database; WHO Global Health Expenditure Database.

There are higher variations of the growth levels and rates of health expenditures in Europe. One country's health expenditures and their growth rate, reflects the financing level of its healthcare service system and the quality of its medical services. Thus, we can easily measure how much a state spends on health. For instance, Norway or Switzerland have spent 4.500 euro/person, Thus, this is way above the European average with an amount of 2.193 euro/person. The antipode being Romania and Bulgaria, have spent an amount for health that is considerably under the European average, 753 euro/person and 900 euro/person, respectively (Figure 2).

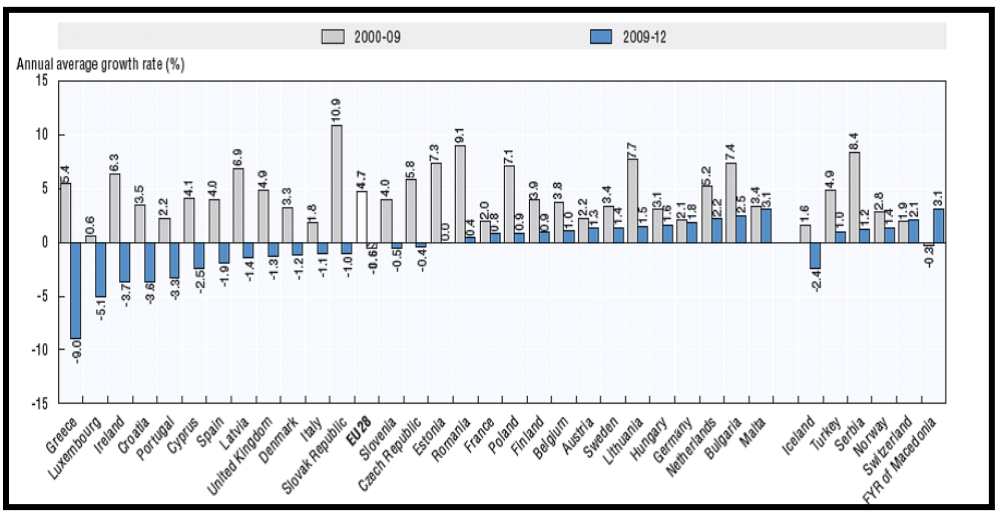
Since the beginning of the economic crisis in 2008, health expenditures have decreased in Europe, after years of continuous growth. Between 2009 and 2012, healthcare expenditures in real terms (adjusted to the inflation), have decreased by 50 % in half of the EU countries, and by another 50% in the other half of the countries. Thus, this process of decrease was slower. At an average, healthcare expenditures in the EU have decreased by 0.6% each year between 2009 and 2012, compared to an annual growth rate of 4.7% between 2000 and 2009 (Figure 3).

Figure 2 – Health expenditure per capita, 2012



Source: OECD Health Statistics 2014, http://dx.doi.org/10.1787/health-data-en; Eurostat Statistics Database; WHO Global Health Expenditure Database.

Figure 3 – Annual average growth rate in per capita health expenditure, real terms, 2000 to 2012



Source: OECD Health Statistics 2014, http://dx.doi.org/10.1787/health-data-en; Eurostat Statistics Database; WHO Global Health Expenditure Database.

In the year 2000, studies done by the Romanian Academic, stated that financing healthcare expenditures is done in Romania mostly by the public sector (82% in 2008). In other EU countries, the participation of the private sector in the co-financing of healthcare expenditures is much higher compared to Romania (26% versus 18%). In this context, the growth of financing healthcare expenditures from private sector resources (introducing co-payment but not limited to), appears to be natural – a viable solution for partially solving structural problems existing in the public healthcare system. Also, the level of consolidated budgetary income in Romania is much lower compared to the EU average, representing a major constraint in the government's capacity of properly financing public services. Romania is the EU state that allocates the least funds to health from the GDP. Thus, the problem has become traditional. After 1989, all government was facing the same issue – the discrepancy between healthcare expenditures and the population's real needs. The gap has permanently increased as multinational pharmaceutical companies have appeared in Romania. Specific marketing requires that they invest in informing doctors and the entire population indirectly, on current treatment and diagnosis possibilities. That is why there is a permanent pressure to increase expenditures in health. This is a growth that no government has yet to assume, which is more than just a declaration. In addition, the healthcare system has tried to keep up with the existing level in Western countries by primarily allocating funds to clinical hospitals in university towns. Also, this is done through the investments made lately in medical emergency assistance.

In spite of low incomes, Romania has updated utility and even food prices in time, making them comparable to the prices in EU states. However, the GDP per capita is expressed according to the purchasing power, which was 44% of the euro zone average. The expenditures in 2012 in $PPP were several times lower than the EU average – there was a permanent reduction in quality services and the territorial coverage of medical services. Thus, the rural population is benefiting from far less medical personnel and infrastructure compared to the urban population.

Consequently, public health expenditures in Romania are financed through the following income categories:

1. National Social Health Insurance Fund (NSHIF) – the main income source is from the contributions of employers and employees.

2. Health Ministry (HM) – the main own income categories comes from the vice tax and the turnover tax (the claw-back tax – represents an overtax for companies in the pharmaceutical industry on the revenues obtained from sales done over the state budget allocations for drugs).

3. The state budget – the deficiencies of the National Social Health Insurance Fund are covered by allocations from the state budget, through transfers from the Health Ministry

4. Local budgets.

5. Budgets of the service suppliers from own incomes.

6. External credits.

7. Non-refundable external funds.

8. Donations and sponsorships.

Overall, the largest share is from the National Social Health Insurance Fund, of over 76 % in 2014. The National Social Health Insurance Fund is currently financed by the employees' contributions (5.5% of their income) and the employers' contributions (5.2% from the salaries' fund).

Table no. 1 – Overview of the evolution of contribution share of the NSHIF, 1999 to 2015

Year	Annual contribution share		
	Employers	**Employees**	**Total**
1999 – 2001	**7,0%**	**7,0%**	**14,0%**
2002 – 2006	**7,0%**	**6,5%**	**13,5%**
2007	**6,0%**	**6,5%**	**12,5%**
2008	**5,5%**	**5,5%**	**11,0%**
2009 – 2015	**5,2%**	**5,5%**	**10,7%**

Source: Health Insurance National Fund

Therefore, we can see that these contributions for the National Social Health Insurance Fund have decreased progressively from 14 % in 1999 to 10.7% in 2009, till this present day. It also has to be mentioned that the number of direct contributors has decreased significantly in the same period, reaching around 8.451.398 people (6.483.600 employees, 1.602.166 retired that exceed a quantum of the pension income established through law of over 160 euro, 230.463 free lancers, 135.169 of other categories of insured) in 2013 to contribute to the financing of a system from which 18 million citizens should equally benefit. This is due to the payment exemption of different population categories, without allocating equivalent funds to compensate these exemptions.

After 2006, alongside general fiscal revenues, an important health budget source was the excises. Thus, this was accomplished by introducing vice tax on alcohol and tobacco, and through the modification of the Health Law starting from 2010. The turnover tax was introduced (claw-back tax) for companies who have a license to market drugs for drugs that are included in the national health programs and the drugs insured for walking cases. Furthermore, this is done with or without personal contribution based on medical prescription, in the social health insurance system, and for the drugs insured for the hospital treatment. The income from the claw back tax is

according to the law owned income of the Health Ministry. By this way, the Romanian Health Ministry has a significant budget for financing those public health services that are not funded by the National Social Health Insurance Fund.

The funds allocated by the ministries and agencies with their own health network, like the National Defense Ministry, the Internal Affairs and Administration Ministry, the Transportation Ministry, and the Intelligence Service, are also from the state's budget, with figures far below that of the National Social Health Insurance Fund and the Health Ministry.

Consequently, the same can be said about the local authorities' budgets, where health expenditure is one of the poorest budgetary categories. This is because of the current structure of the healthcare system, due to the influence and the low responsibility of the local segment of public authorities.

Another important income source of the healthcare system is represented by the population's private expenditure. Therefore, this can be done through private healthcare insurance, or by direct payment of the health services. In Romania, private health insurance has an insignificant percentage wise in the total number of private expenditures. This is because they are being linked to the lack of sufficiently in stimulating fiscal frame, and the lack of private suppliers, especially for hospitals with the biggest expenditure of the healthcare sector.

In this context, the share of direct payers out of their own pocket is growing. Therefore, this expenses increases, thereby raising the financial vulnerability of the population. It is estimated that the total number of private health expenditure in Romania is almost a quarter of the total health budget, which is one of the lowest direct contributions in the EU. The consequence of this reality is the decrease in access to necessary healthcare services, especially for the population with low incomes.

Table no. 2 – Overview of total revenue evolution of the National Social Health Insurance Fund (NSHIF), 1999 to 2014 -million lei-

Indicator name	Achieved 1999	Achieved 2000	Achieved 2001	Achieved 2002	Achieved 2003	Achieved 2004	Achieved 2005	Achieved 2006
Total revenue	1.838,6	2.845,6	4.173,4	5.480,1	5.512,7	6.877,4	8.474,4	10.757,2
Indicator name	Achieved 2007	Achieved 2008	Achieved 2009	Achieved 2010	Achieved 2011	Achieved 2012	Achieved 2013	Achieved 2014
Total revenue	13.080,6	15.780,5	14.623,6	17.258,7	17.820, 9	19.049,5	23.089,8	22.868,5

Source: http://www.cnas.ro/informații-publice/bugetul-fnuass/evoluția-fnuass

There have been permanent attempts to boost healthcare allocations, through the aid of law proposals meant to protect the budget of the Health

Ministry from the reallocations done by the Finance Ministry and the Parliament towards other fields of interest, which are apparently less primary. Thus, after 2006, the social health insurance system was introduced. The largest financing part of this system is being done from an individual contribution related to the employee's income (7%) and from a similar quota (7%) related to the gross salary, paid by the employer.

Therefore, the effects were visible straight away. In 1999, the first collection of healthcare insurance was done, and in the year after that, the amounts that were gathered reached 5.2% from the GDP, as opposed to 3.2% in 2006, 3.1% in 2008, 3.3% in 2010, 2.9% in 2012, and 3.7% in 2013. However, this represents the maximum level allocated annually according to the data below:

Table no. 3 – GDP health allocation in Romania, 2004 to 2014

Billion lei

INDICATOR	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
GDP	248	289	345	416	515	501	524	558	587	629	669
NSHIF	6,9	8,5	10,8	13,0	15,8	14,6	17,3	17,8	19,1	23,1	22,9
% GDP	2,9 %	3,0 %	3,2 %	3,2 %	3,1 %	2,9 %	3,3 %	3,1 %	3,3 %	3,7 %	3,4 %

Source: National Statistics Institute, National Social Health Insurance Fund

It can be observed that from 2004 and until 2014, the revenue of the healthcare system has increased 3.3 times in 2014, compared to 2004. Moreover, this was as a result of improving the financing mechanism of the healthcare system, increasing the collection of contributions for social health insurance, improving and clarifying the legal frame of the system, additional allocations from the state budget for national health programs, investments in constructions and independent facilities, entering external credits for purchasing hi-tech medical equipment, stimulating the growth of own revenue by specific activities, attracting amounts from local budgets for current and capital repairs of medical infrastructure, and for health related actions locally.

The beginning of the economic and financial crisis has shown a decrease of public revenue in health by 3.4% in 2009. In the background of shrinking economic activities that lead to a decrease in contribution, it takes into account the financing needs of the healthcare system. However, this has been on an increase path once the limits for the compensated drugs were eliminated. Also, between 2010 to 2014, we see a growth of revenue in the public healthcare system, with an average of 18% on a yearly basis.

Significant revenue increase has also been registered: 1. after the introduction of the claw back tax in 2010, for companies that had drugs' marketing authorizations in Romania, for the drugs which were included in

the national health programs, for the drugs insured for the walking cases, with or without personal contribution based on medical prescription in the social health insurance system, and for the drugs insured for hospital treatment; 2. after the introduction of law modifications on the Fiscal Code in 2011, which helped to issue taxing decisions for the registered sole traders activities between 2006 – 2010. Also, this is for companies having debts on the social health insurance fund. According to the protocols made with the National Agency for Fiscal Administration, and due to the various endeavors related to the obligations towards the national social health insurance fund of miscellaneous categories of people, revenues have been cashed from freelancers, agriculturalists, and from people who do not earn salaries.

The revenues of the NSHIF consist of current revenues from taxes on assets and services, employees' and employers' insurance contributions, property revenues, interest revenues, various miscellaneous revenues, donations and sponsorships, state budget grants, grants from other administrations, and sums from the EU.

Table 4 – The evolution and structure of the NSHIF revenues, 2012 to 2014

-Million lei-

Indicator name	**Realized 2012**	**%**	**Realized 2013**	**%**	**Realized 2014**	**%**
Total revenue, split as follows:	**19.049,5**	**100,00**	**23.089,8**	**100,00**	**22.868,5**	**100,00**
I. Current revenue	**16.794,2**	**88,16**	**16.579,2**	**71,80**	**19.011,2**	**83,13**
I.A. Assets and services taxes	1.811,6	9,51	1.063,9	4,61	1.521,1	6,65
I.B. Insurance contributions:	14.966,2	78,56	15.455,4	66,94	17.465,5	76,37
I.B1. Employers' contributions	*7.255,7*	*38,09*	*7.679,9*	*33,26*	*8.244*	36,05
I.B2. Employees' contributions	*7.710,5*	*40,47*	*7.775,5*	*33,68*	*9.221,5*	40,32
I.C. Non-fiscal revenues	16,4	0,09	59,9	0,25	24,6	0,11
II. Grants	**2.255,3**	**11,84**	**6.435,9**	**27,87**	**3.842,2**	**16,80**
II.1 State budget grants	*1.398,2*	*7,34*	*5.875,9*	*25,45*	*3.637,3*	*15,91*
II.2 Grants from other administrations	*857,1*	*4,50*	*560*	*2,42*	*204,9*	*0,89*
III. Sums from the EU in the account of made payments	**0**	**0**	**74,7**	**0,33**	**15,1**	**0,07**

Source: National Social Health Insurance Fund

We can see from table no. 4 that the revenues of the NSHIF consisted of current revenues from taxes on assets and services, employees' and employers' insurance contributions, contributions from legal entities and

registered sole traders, state budget grants, donations and sponsorships, interests, revenues from using the heritage of the NSHIF, sums from the Public Health own revenue, as well as from other revenues within the law limits

The revenues from the contribution of legal entities and registered sole traders which hire personnel with salaries, the revenues from employees' contribution, as well as contributions for vacations and indemnities from legal entities and registered sole traders, have represented the most important share from the total revenue obtained in the stated period. On an average, a percentage of over 73%, are registering a growth of over 7.35% in 2014 compared to 2013, and a growth of 5.85% compared to 2012. This was as a result of maintaining a high degree of NSHIF revenue collection from employee contribution, as well as a growth in the number of legal entities that have contributed to NSHIF. Moreover, this is accomplished by applying the 5.2% quota on gross revenue realized by freelancers, registered sole traders, etc.

Significant revenues have been the state budget grants which is received with an average of over 18% from the total revenue realized in the studied period. Revenues that have increased considerably in 2013 compared to 2012, with over 185%, were allocated for supporting the Romanian healthcare system through external loans. Considering the on-going financial crisis in Romania and maintaining the decreased collection degree of NSHIF revenue from employees' and employers' contribution, on-going growth of unemployment rate and underground economy, 'under the table' work, public and private work field dismissals, the decrease in population revenue, the closing and bankruptcy of multiple companies, and the migration of the young population towards other countries, have decreased considerably with over 40% in 2014. Thus, this was as a result of own revenue deflation of the Health Ministry.

During the studied period, the sums collected from assets' and services' taxes were 1.521.045 thousand lei, 8.00% from the total revenue, and a percentage of 42.96% less than in 2013.

The allocation of the amounts necessary to finance public sources is stated in Law no. 95/2006, related to the health reform, with ulterior modifications and additions. This law is not always very clear, and it seldom establishes several financing resources for the same action or health program. However, these overlaps are the result of experiencing insufficient financing in the past and imprecise budget planning. Hence, this was such that any potential financing resource is mentioned hoping that the expenditure needs will be covered eventually. From an allocation efficiency standpoint, this practice is disadvantageous because it allows any responsible

party into the system. In addition, it absent oneself from responsibility and invokes the accountability of other involved parties.

In Romania, the immediately visible problem of the healthcare system is underfinancing. Thus, the health expenditure level ranked last amongst other EU countries, as shown in figure 1 and 2.

Conclusion

From the above studied and presented data, we can see that all European healthcare systems discuss the progress direction of health services profitably and efficiently, However, this is aimed towards the achievement of a durable social development. Fiscal pressure makes developed countries question to face the issue of new financial resources of a more efficient management or alternative ways to organize services. In all EU countries, the governments are involved in financing medical care. In addition, most member states use a combined system between social insurance contributions and direct governmental health financing.

In Romania, financing health expenditures is mostly done by the public sector, of over 80%, compared to other EU states, where the participation of the private sector in healthcare co-financing is much higher than in Romania. In this context, the growth of financing healthcare from private sector resources appears to be natural by identifying additional sums to be drawn– a viable solution partially solving structural problems existing in the public health sector. The level of consolidated budgetary revenue in Romania is much lower compared to the EU average, representing a major constraint for the government to be able to properly finance public services. Thus, allocating public resources in Romania for financing the public health sector is poorly done compared to other EU countries. Consequently, public health expenditures in Romania ranks last out of all EU countries.

The health expenditure structure which depends on the medical goods and services supplier, indicates a higher orientation towards the tertiary segment in the case of Romania compared to other countries. Furthermore, medical issues are being solved through long term hospital treatment, due to an insufficiently developed system where primary and secondary medicine is concerned.

For the development of the healthcare system in Romania, alongside its reform, restructuring health expenditures should be based on a purpose. Thus, this was such that resources are more oriented towards ambulatory medical assistance, preventive programs or medical care, interdisciplinary teamwork, and accent on filtering by family doctors. The level, alongside with the evolution of indicators that characterize the access to medical personnel, available hospital beds, or technology, suggest the inefficiency of healthcare polities related to unfairness and improvement on the coverage of

medical services. Therefore, an evaluation of the efficient use of public health resources of a group of European countries, places Romania under the optimal efficiency curve.

Considering that the health of the population is a national priority, the responsibility of the healthcare system provider is attributed to the government, as the general administrator. In addition, the administration of the system must be permanent and must ensure the supervision of the functionality of the entire system. Hence, this is done by identifying viable functioning solutions and measures for drawing additional funds for a better financing, as follows: annual allocation from the GDP must be a minimum of 6-7%, short and medium term drawing of European funds, stimulating the growth of private health insurance share, identifying new contributors to the healthcare insurance system, implementing new parafiscal taxes for legal entities or registered sole traders that favor or generate negative effects on the health of the population, improving contribution collection ways, developing public and private partnership, increasing the financing of medical services for primary and secondary medicine, stimulating private investments in the healthcare system, increasing the control capacity related to revenue cashing methods in the healthcare system, supporting the participation of private insurers in the health insurance system, raising awareness and involvement in local communities by additional allocation from the local budgets for medical units from the area of responsibility and not in the least, and the diversifying and the use of new financing methods for medical services that are based on the performance and quality of services offered to the patients. Furthermore, financing and organizing the healthcare system follow the institutional, political, national, and socio-economical traditions. In addition, it materializes into a series of social objectives related to financing and health services offers. Thus, it is efficient and has an acceptable price. In most EU countries, a significant part of medical service expenditures is ensured by the private sector or financed by private funds. Financing a healthcare system appertains to the method in which necessary funds for healthcare activities are collected, as well as the methods these funds are allocated and then used.

The chosen financing form, combined with the organization type of the medical system, determines who has access to healthcare, the cost of healthcare, the productive efficiency, and last but not least, the quality of the given healthcare services. Thus, all these intermediary results, in turn, determine the final results pertaining to any healthcare system: population health, financial protection against risks, and last but not least, the satisfaction degree of the service consumers.

Derived from the right to healthcare, the access to health services according to the needs of the patients is a fundamental right. Being one of

the recognized rights, it has a special significance. Therefore, respecting this right constitutes a priority towards other objectives of promoting general welfare. This is being sacrificed only when and if the cost would be extremely high and would surpass the society's capacity.

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