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# SOCIAL POLICIES REGARDING FINANCIAL RESOURCES WITHIN THE HEALTHCARE SYSTEM IN ROMANIA

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**Abstract:** Romania has already a historical tradition regarding the allocation of the smallest share for the healthcare system from among all EU member-states. The public expenditures with health, of 4.36% from GDP (in 2012) and total health expenditures both public and private (of 5.56% in 2012) place Romania on the last position within the European Union, rather far from the EU average. Also in PPC (purchasing power per capita) terms we are placed at the lowest level and beyond our neighbours. During the past 20 years, the experts in health policies drew attention on the need to increase health expenditures at the European average level of 7%, by demonstrating the negative impact of maintaining expenditures at the current level. The investments in population's health were theoretically acknowledged as necessary, however these were permanently postponed because they did not deliver short-term outcomes with electoral impact and because the structural reform would mean social capital costs. It is necessary to assume political responsibility for long-term planned investments and for prioritizing the needs of the system.

**Keywords:** public health expenditures, health policies, challenges, resources

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## Healthcare Policies Challenges

Currently, some issues seem to be redundant in debates about healthcare policies in all countries. First, it is the need of all healthcare systems for more efficient organisational management and for increasing the performance of the systems in terms of costs/benefits, considering the increased requirements of the population for quality and quickly available services from temporal and spatial viewpoint. The reforms of the healthcare systems are headed towards the decentralisation trend and the adoption of the public-private mix (public and private providers, the non-profit sector)

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accompanied by diversified choice opportunities of the patient regarding the services' providers. Still, these changes are faced with the resistance expressed by the organisational/institutional culture, and the one of medical professional associations to change and reforms.

A critic of consumerism is added, regarding the market of healthcare and the issue of equity and access of some groups to services. None of the healthcare systems have succeeded in completely diminishing the social inequality regarding access to services. All countries still have various groups of disadvantaged individuals. Most times, these belong to the groups of emigrants, to the poor, to those who are unemployed/uninsured, and ethnic minority segments. Health policies have a limited capacity of diminishing factors that affect the health of the population. Population health depends on a complex of factors that are not only influenced by the healthcare system, but also by other components of the social: education services (prevention) and social protection services and benefits for supporting the quality of life. The question is which are the social needs regarding health and how does the state meet these needs? The care of a poor and ill individual, for instance, for a week in a hospital brings about only temporary improvement of his/her illness, if on returning home the living conditions are inadequate to maintaining a healthy state: improper housing, hygiene, and food, the lack of resources for continuing treatment, etc. In the absence of a complex of efficient social policies, that would combine both healthcare services, but also social protection ones, the resources of the sanitary system invested in the respective citizen do not provide the expected outcome and might generate a waste of resources.

The capacity of the state to achieve an efficient mix between various types of social policies: social assistance, health, community services and house care services should be increased. The demand for long-term care within communities must lead to the reform of the healthcare and social services. There is a need for the corresponding mix of social and healthcare services within communities. A series of medical issues have a social anomaly component that needs to be solved, just as a series of social issues have also a healthcare component: alcoholism, drug dependency, child and elderly abandon, suicide attempts, etc.

Finally, we might state that we witness an over-medication of modern life. The modern times are found to have increased the dependency of individuals on healthcare institutions (Rădulescu, S. 2002). In medical units arrive all typologies of issues: from depressions, suicide attempts, unwanted and abandoned children to the homeless. Many of these issues are social in nature. Medication hides unsolved social origin, the social inequities and social anomalies. The resort to medication, the hospitalisation for depression only turn into ways of temporary hiding dysfunctional issues of the modern individual, and do not solve them. These types of issues are just partially solved or remain unsolved by social protection system and induce expenditures to the healthcare system along with social costs, as well.

The consequences of over-medication of the modern world are reflected directly in the healthcare system. The over-medication trend has led to an increase in the healthcare costs and to higher numbers of medical documents. In this category are included, next to the above-mentioned (and which pertain to social anomaly) also medical acts that are

not justified from the medical viewpoint but pertain to the psychological-social sphere: Caesarean section on demand, aesthetical surgery, etc. Most medical systems impose costs that are not covered by the system, auxiliary ones, paid out of the pocket by the patient for these medical interventions. Another challenge of the healthcare systems refers to the excess paradox. According to a report from 2000, in the US, 1/5 of the hospitalisation days, 1/4 of the procedures, and 2/5 of medication weren't necessary (Bodenheimer S., Grumbach K., 2004). The need of a more efficient management of the financial resources emerges in the context of healthcare costs on increase in all European countries, on the background of growing life expectancy and population ageing, including here also the technological and medication advance in the medical field.

The analysis of the healthcare policy must be studied within the social context, but also according to the historical background of national health policy. In Romania, the policy adopted on the background of some reduced financial resources granted to the health and education system marginal positions for financing. At the same time, the reform policy of the healthcare system lacked enough daring to achieve major reforms, as in the other former communist countries, reforms that succeeded in improving the quality of services. The social, political, and ideological history of each state, and the role of trade unions or of some professional organisations have modelled the evolution of the systems. The professionals' associations within the British healthcare system, for instance, have played an important role in structuring the national system by determining the health needs and establishing priorities for expenditures within the system, as the British government attempted for the last 20 years to re-establish control by a series of organisational mechanisms.

Comparing health systems is useful for understanding the common issues faced by many of them, such as the increase in the requirements of the population and the growing costs with health on one hand, and the trends of meeting these requirements shown by the systems on the other hand. Even though the various European systems have known different historical developments, thereby reflecting varied social, political and cultural priorities, now they all are faced with similar contexts: population ageing, and the prevalence of the state in financing and providing services.

International comparisons about health systems face some difficulties: 1. the constitutive parts of the healthcare are different from one country to another; 2. The means of financing are diverse as sources and constitutive parts; 3. the borders between formal and informal care are hard to demarcate; 4. national data are not always directly comparable; 5. errors might appear in comparing countries with dissimilar social, demographic and political structure. The primary analysis of the share of expenditures with health in GDP is an indicator very often used, but this analysis must be supported also by the analysis of the quantitative and qualitative differences. In ample comparative studies, such as the OECD Health Data Survey, where several social indicators are analysed, such as GDP, the health public expenditures as share of social expenditures, the mortality rates or income inequalities, tend to ignore countries from the viewpoint of socio-cultural and political specifics.

How can costs be diminished? Eliminating services that are not strictly necessary is one way of diminishing costs. The reduction of the costs for managing the system is yet another alternative. There is an administrative excess within most of the systems. The advantage of high bureaucracies within the state system is that they provide jobs, in general, and particularly jobs for women. Cuts might imply unemployment in the field. The shift towards care as social component of the services that are rather more social than medical is also another alternative: house assistance, counselling for rehabilitation, child and elderly care. Thus, house care against hospitalisation, whenever possible.

If healthcare costs increase continuously in this manner, there are two options regarding the systems: diminishing the quality of the services (the systems identify perverse mechanisms to regulate deficits) or allocating new funds for health by bringing damages to other components of the social services: education, public administration, etc. In general, the public does not want to pay new taxes and whenever costs increase, the access decreases, and the most affected categories are poor individuals, elderly, people without insurance (unfortunately, those with low standards of living are more likely to be ill than those with high living standards).

The inertia of all policies and of the budgetary allotments are things that must be considered, annual budget operates based on historical data. Innovation, implementation of new measures, and sudden increases in financing are hindered by system bottlenecks. Even though policies might change gradually, in small steps, the policy instruments show inertia. Policies must prove internal and transversal coherence, activities resulting from the policy should be logically inter-correlated and coherent. Horizontal coherence is shown by the coherence between public policy areas. A factor that substantiates the health policies is the path dependency. This refers to the continuity of the public policies in the health field and to the importance of the options. The path dependency explains the stability of options and the resistance to change.

*“The budget is an historical issue and budgetary allocations are made almost exclusively based on historical criteria. How much was allocated the previous year, as much shall be allotted this year. A growth or decrease indicator is used which is multiplied with what was the previous year. If the money runs out, on rectifying the budget something is added to it. But this is not the issue only of the Ministry of Health, but it is our operating way by and large. It is very hard to bring about something new, to push things towards something more important because you are hindered by this historical ballast. The budgets are anyway made very late very often”* (director, the Ministry of Health, November 2014)<sup>1</sup>.

The mechanisms determining one option are increasingly more restrictive as they are circumscribed to longer periods of time. These should deal with costs related to investments, to learning effects, to coordination and anticipative capacities. The change presumes investments in the capacity of foreseeing new behaviours, the changes in expectations and organisational stress. On the other hand, the mandates of those elected are on short-term and, thus they are pushed to opt for the least costly solution from the social and electoral costs viewpoint. A completely new solution has often immediate costs of implementation into practice and of learning, but shows advantages

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<sup>1</sup> Interviews made by this article’s author, within the OPHDR project “Pluri- and interdisciplinary doctoral and post-doctoral programmes”.

on long-term along with risks, and therefore it is not an option for political decision factors (Pierson P., 2000).

## Public Health Expenditures in Romania

Romania has already had a historical tradition in allotting the lowest share of all EU countries for the healthcare system. Public expenditures with health are 4.36% of GDP (in 2012) and total health expenditures both public and private (5.56% in 2012) place Romania on the last position within the European Union at a distance to the EU average. Also, in terms of PPC (Purchasing Power per Capita), we register the lowest level and behind our neighbours.

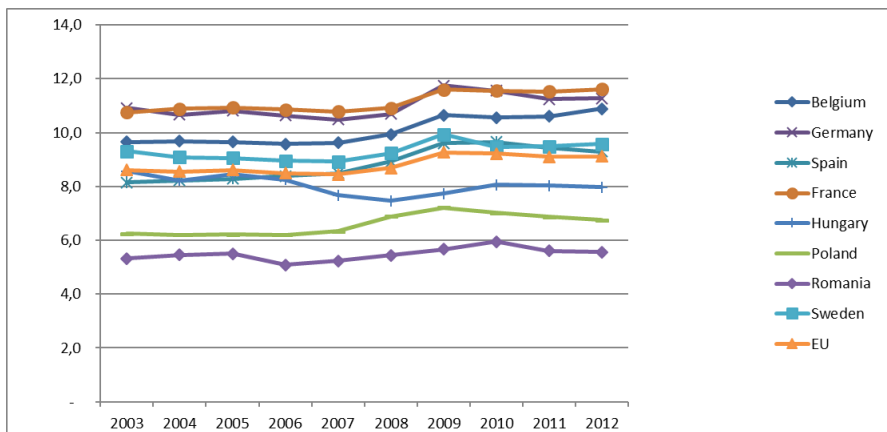
During the last 20 years, the Romanian experts in health policies drew attention to the need of increasing health expenditures to be closer to the European average, respectively 7%, by indicating the negative impact of maintaining expenditures at the current level. The investments in population health was theoretically acknowledged as necessary, but it was permanently postponed because it does not show short-term outcomes with electoral impact and because the structural reform would mean social capital costs. It is necessary to assume political responsibility for planned long-term investments and for prioritising the needs of the system.

**Table 1:** Public health expenditures – current EU level and targets for Romania 2035

Indicator	Current EU level	Romania's targets 2035
Public health expenditures as % of GDP	EU-18 average: 7,4 %	7 %

Source: Targets established by the IQLR team.

**Figure 1:** Total health expenditures (public and private) as share of GDP



Source: Eurostat, 2015.

Between 1990 and 2010, the expenditures with health increased quicker than the GDP in all OECD countries (except for Finland). The increases in pharmaceuticals' expenditures were even higher than the increases in healthcare. At the same time, the public expectations grew regarding services, as there is a well-informed population (the medical industry and the internet boom contributed to an increased degree of information).

The EU countries do not spend similar shares of the GDP for healthcare services (the Eastern European states which accessed EU after 2000 have smaller expenditures as they have less resources available, while Spain, Greece and Portugal have a history of regions that ignored health and welfare for a period), but all developed countries grant an important role to health.

The financing in all European health systems has as source mostly the public system, by 70 to 80%, while the private market has only a minor role to play. The social role played by the state in ensuring intergenerational and intergroup solidarity (by protecting social groups at risk) remains one of the important pillars in the EU member-states.

The factors triggering costs' increases with health for the last decades are the demographic changes, the population ageing (because of increased life expectancy and of fertility decline). Thus, the dependency rate of those aged 65 years and over on the younger working age population increased and will continue to increase in the future, putting pressure on the European social protection systems: pension, health and social assistance systems and this means increased pressures for the year 2035 (OECD, 2014).

The importance of the public function of the state is diminished in Romania against other EU countries due to the low share of social public expenditures as percentage of GDP (34.9% in Romania, against the 49.1% average in EU-18). The social function of the states needs to be strengthened by increasing all social public expenditures and public health expenditures.

**Table 2:** The relevance of the social function of the state

		<b>Romania targets 2035</b>
State relevance: Governmental expenditures as % of GDP	EU-18 - 49,1 %	maximum - 49,1%
	EU-8 - 41,4 %	average - 45,2
	<b>Romania - 34,9 %</b>	minimum - 41,4
Relevance of the social function of the state: Social public expenditures as % of GDP	EU-18 – 20,3 %	maximum - 20,3 %
	EU-8 – 14 %	average - 17,1
	<b>Romania – 11,5 % (2013)</b>	minimum - 14

*Source: Targets established by the IQLR research team for the Strategy 2035 of the Romanian Academy*

## Increasing the Financing Level in Health

A favourable forecast of GDP increase for the year 2035, as shown in the optimistic variant scenarios of the economists within the Romanian Academy, would mean

additional resources for social expenditures, including for health, but some elements specific to the year 2035 against the year 2015 should not be omitted, as they will require additional resources next to the GDP growth: a more elderly population, a decrease in the active population contributing to the Health Insurance Fund, the continuing developments in medicine, technology, procedures and medication all of these implying most probably increasingly costs for practicing the medical act at modern European standards, and last but not least, a population with accumulated health issues in time, without present adequate prevention. To these should be added, probably, a more informed and critical population regarding the acceptance of a medical act performed in any conditions.

The public financing of the system does not refer first to allocated incomes and expenditures from the state budget (resulting from taxation and covering public health programmes, salaries of those within the system etc.), but to collecting the compulsory social insurance bonuses (how they are collecting, the taxation base) and the way in which all available public resources are used: efficient use (cost-benefit), where are they necessary (identifying the needs), equitable financing (distribution between regions, social groups). As result, we deal with identifying mechanisms by which the resources that enter the system might be supplemented, but also with mechanisms for more efficient use of the existing resources.

Increasing the level of collecting and the taxation base for social health insurance bonuses against the current level would lead to an increase in the financing of the system. The currently collected amounts do not cover the needs of the system. The collected amount turns into a problem whenever the population contributing to the system is diminished against the population benefitting from the services.

In Romania, the numbers of employed population contributing to public taxes system, including to the social insurance and health insurance system diminished after 1990 due to early retirement, work on the black market, emigration of a part of the labour force and to large portions of the population involved in subsistence agriculture without paying any contributions to the public system, or involved in daily labour without legal forms (including in agriculture), and to other ways legally accepted in the past years for avoiding payment of social contributions and to the lacking social responsibility regarding the contribution to the system. Not long time ago, alternative forms to the labour contract were still used (such as civil conventions, copyright contract, authorised person form of contract), by part of those intending to avoid contributing to the social insurance and health insurance system and who resorted to such solutions as primary and not supplementary employment forms, as they were free of charges to National Fund of Social Health Insurances, according to the law.

Almost the entire population was eligible for medical services in 2010, but only a quarter of it paid to the National Fund of Social Health Insurances. In the same year, consequently, 10.7 million citizens were exempted from paying or did not pay (World Bank, 2011). The inclusion of pensioners with incomes to 740 lei and including also those with legal contractual labour forms other than the labour contract (copyright, civil convention) for the last years increased contributions to the Fund.

The amount of the contribution to the system (employee and employer) is of 10.7%, but still too small for covering the needs of the system under the conditions of exempting various social groups from the contribution and as compared with other European countries: Hungary and Slovenia 14%, the Czech R. 13,5%, Germany 14.9%. Nevertheless, this contribution is a burden for the Romanian contributor, as the level of incomes in Romania is low as compared with the ones in other European countries, and because the level of co-payments/out-of-pocket payments (additionally to the services provided based on the insurance) is high against the level of the households' incomes.

Increasing gradually the minimum/average salary level in Romania, up to the year 2035 would diminish the felt burden of the contribution and would also increase the financing level for the system. As the contribution, has been currently diminished, its increase can no longer be done without bringing about social reactions save by making use of windows of opportunity created during social crises.

**Table 3:** Targets for Romania 2035 - Minimum and average salary

	<b>Present</b>	<b>Targets Romania 2035</b>
Minimum salary (Euro)	EU-18 – 951	maximum – 951 Euro
	EU-8 - 393	average - 672
	<b>Romania – 217,5</b>	minimum - 393
Average salary (Euro)	EU-18 – 2.305	maximum - 2.305 Euro
	EU-8 - 655	average - 1.480
	<b>Romania - 346</b>	minimum - 655

*Source: Targets determined by the IQLR team*

The state maintained a rather strong social component regarding access to services, but to the detriment of the services' quality that could have been provided at optimum standards only in few centres, on the background of insufficient resources. The access of individuals from areas without ambulatory services' coverage was focused mainly on the endowed hospitals from university centres, implying high costs for the system (costs with hospitals are currently of about 50% from the budget, and primary assistance is underfinanced, with a share of only 7%), as the prevention medicine continues to be underdeveloped. Ambulatory and preventive treatments are less costly than in hospital treatment.

The current social policy in the healthcare field puts into discussion some principles of social solidarity. Those who have not contributed can, if necessary, quickly re-enter into the system and benefit of medical services by paying the insurance for the last 6 months, at a level of 5.5% of the minimum salary. Therefore, the social policy is favourable, theoretically, to the access to services, but attention should be drawn to the fact that it might lead to rational calculated risk behaviours of the youths without legal employment forms: they would pay, only if necessary. Other categories of beneficiaries are as well exempted from payment: for instance, home-wives if their spouses pay contributions.



The principles of the current welfare state affirm that health cannot be abandoned to the market mechanisms, and that the inter-generational social solidarity youths-elderly, healthy-ill, rich-poor should be maintained but many payment exemptions for various categories might pose some questions about the equity within the system for those monthly contributing.

Special attention should be granted to the increasing private expenditures. Public health expenditures in Romania are of 82% and private expenditures are of 18%. The share of private expenditures is lower in Romania as compared with other countries (27% in Lithuania, 28% Poland, 29% Hungary, 28% Slovakia, in 2008) and under the European average (of 26%). We refer, mainly, to the lower share of the incomes attracted from private sources, which diminishes thus the total level of health expenditures in Romania.

The higher level of expenditures with health services within EU is done not only from public sources, even though these are the majority, as already shown. The difference is given by the level of the higher private expenditures. For instance, in Poland, the public funds expenditures were of 4.43% of GDP in 2013, but there was an increase to 6.75% of GDP by the additional allocation of private expenditures. In conclusion, it is necessary to invest more private financial resources for healthcare in Romania, by continuing the further development of the private system as competitive alternative for those who dispose of a satisfactory level of incomes which allows for access to this type of healthcare. Additionally, the fiscal facilities along with legislative regulations for the swifter development of complementary private insurances as developed in most EU member-states would allow also for access to the private network at bearable costs.

## **Identifying Costs within the System. More Efficient Use of Resources**

One issue of all healthcare systems in the world is the inflation of services that are not necessary, but for which settlements through the system are not limited. Technological advance was one of the reasons for increased costs, but studies show that technologies could be inappropriately used in some instances. Some of services are at optimum used for some patients, but poorly and inadequately used for other patients. Reducing unnecessary services might be one way of diminishing costs within the system.

Diminishing the management costs of the system is another alternative. The transition towards care as social component of the services is yet another option for diminishing costs: home care, counselling for psychological-social and medical rehabilitation, and caring for children and elderly. As result, home-care against hospitalisation in the cases where it is applicable and individual labour contracts with settlement through National Fund of Social Health Insurances for physicians, nurses and caretakers that provide for medical services at home.

In the system, there were a series of financial drains. These occurred either because of negligence, or due to corruption and system regulations that allowed to the staff with management positions to use legal 'escapes' for maximising costs in their own interest.

The reduction of the corruption within the system and an efficient management of the resources are primordial from this perspective.

It is necessary to identify the costs within the system. At national level, no unitary assessment of the hospitalised assistance was ever made, to highlight the financing needs, and thus it cannot be stated with certainty which are the necessary costs within the hospital sector in performing medical acts.

As shown by a study realised by National School of Public Health and Sanitary Management, it is necessary to *“better define the types of services, the way and the qualitative level at which these should be delivered, as well as the corresponding financing level. If in a private healthcare system these elements are self-understood, because first defined is the service, and thereafter the costs of supplying it and subsequently the determination of the price, within the public system the principle of universality and gratuity in accessing services makes this approach to come second, if it is ever considered or never.*

*Hence, it is necessary to standardise all care on types of patients, respectively developing protocols of medical practice. Once developed and used, these might represent the basis for identifying and computing the costs for “standard” usual care, providing a realistic image about the resources used for treating the pathology within Romanian hospitals”* (Haraga, Turlea, 2009: 12)

Cost control must be regulated by assumed policies and that can protect vulnerable groups. Otherwise, the system will regulate itself, because the financial ceilings that ensure free services are consumed and then damages cannot be controlled and, moreover, the costs for the services end by being paid out of the pocket by the patient. It is far better to have a strategy and a hierarchy, and to acknowledge that one cannot provide any type of service, in any area, at optimal standards based on the level of the current resources. In this way, one can control far better collateral social costs, and avoid impossibility of evaluating damages, because one doesn't have a cost-control evaluation within the system.

*“The ways of settling accounts for a service are extremely random in Romania nowadays, and contain 99% incompetence, and 1% ill-intention. They must go in parallel with the intentions of the healthcare system, for the respective service to be used. If me, as society, am interested more about uterine cancer, then the settlement of accounts for screening should be higher, so that physicians attract and motivate patients to perform the check. Things should be done like this. Also, these account settlements should consider social priorities. In our case, account settlements are made, by and large, to ensure a number of evaluated patients, that is “to give something” to the patients that paid insurance, but without considering the complexity of procedures for the patients who should get something out of it, and the quality of services they finally benefit of.*

*For instance, in Great Britain, if you are in a hospital, say for obstetrics-gynaecology, the respective hospital receives from the Fund a certain amount of money. They state that from this amount of money we pay this and that, and we can ensure 10 births. The 11<sup>th</sup> birth is no longer ensured, because there is no money left. In our case, it is just the reverse. We say that, for you to be functioning, respectively to get your salaries and all the necessary things, you must ensure in the first month a number of 10 births and in the second month, you should be able to ensure 12 births. In the third month, the decision is made that you can ensure 20 births. Hence, there is no connection with working hours and used materials and with reality. So, how decisions are made? I have no idea. Everything started initially with this DRG (Diagnostic Related Groups) system which budgeted what happened according to a foreign*

*system. Someone there calculated the priorities and what needs to be budgeted. Thereafter, the system was transposed in Romania, where physicians remained open-mouthed because apparently banal procedures as were very well paid. And other things, regarded as apparently important weren't paid at all. Usual thinks were related, let's say, to the cholesterol level. Higher levels mean that at a given time an infarct or cerebral vascular accident is to be expected. If you don't die, you shall be very expensive for the medical system. Therefore, it is very important to do something about this little issue. Hence, it received a lot of points and lots of money. Things which were very important for us, like arthritis which implies pain and suffering and hardships but which never can be healed had less importance for the society and from here the discrepancy. That is, if we talk about my specialty, rheumatology, were patients are spending endless days in hospital and who were most of the hospitalised cases.*

*This is the reason for which physicians began to rebel, as they did not understand why some things are better paid and others less and then someone began to adjust, but adjustments were favouring own interests. If someone was a gynaecologist with a position within the ministry, the adjustment meant an increase for everything that was gynaecology, and reductions for all the rest. It didn't matter that neurology hospitals were screaming with patients suffering from cerebral accidents. The important thing was that the money went for gynaecology and everything was running well. It went on and on, in this style.*

*Solutions: the first and which is not applicable, is to tell people the truth. They should get something for the money they contribute with. At present, each of us lives with the impression that we can get anything because of the contributed money. Few are aware that the money they contribute with support yet another 4 to 5 individuals who do not pay at all. They too believe they can obtain anything, because it's their right. The co-payment formula was introduced, but it deviated from its straight line. (physician in Bucharest hospital, November 2014)<sup>1</sup>.*

The under-financing of the system is the reason why the ceilings are quickly used up, so that three out of four poor patients pay out of the pocket the required medical assistance, 62% of the poor population needing medication pay for it from their own money and thus, services are under-used by the poor. Thus, the benefits of subsidising the system are focused in favour of the rich and middle-class (World Bank, 2011).

The healthcare system does not provide currently a proper protection of the vulnerable groups. According to the World Bank, differences exist in accessing healthcare services between the population in the lowest and the highest quintile of income: in the case of chronic diseases, about 40% from the persons with incomes in the lowest quintile which claim to be affected by a chronic illness do not request assistance/care, as compared with 17% of those in the highest quintile.

According to the same report, in the period of economic growth (1996-2008), the access of the population to healthcare services increased from 61% to 71% in total. The global increase of access was due exclusively to the favourable evolution for the population segment with the highest incomes (from 65% to 80%) while for the poorest quintile no progress was recorded related to the access to services.

The more adequate use of the financial resources within the healthcare system means:

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<sup>1</sup> Interviews made by this article's author, within the OPHDR project "Pluri- and inter-disciplinary doctoral and post-doctoral programmes".

- Identifying correctly the points where action should be undertaken based on data gathered in a unitary and credible manner;
- Investing in disadvantaged regions regarding entities/endowments as these have higher morbidity rates; there are not only inequities between regions, but also between disadvantaged socio-economic categories regarding the access to services;
- Gathering data in a unitary manner within the system and instituting a single unit at national level for gathering/supplying data in an integrated way (single national register);
- Computing within the system the right price of the procedures in correlation with the instituted therapeutic/protocol guides;
- Diminishing the number of cases treated within the tertiary, hospital system which implies high costs and strengthening primary and preventive medicine;
- Assuming political accountability for diminishing inefficient costs;
- Penal accountability for false statements in reporting expenditures for “inflated/unrealistic” DRG expenditures;
- Fighting corruption within the system for reducing the financial resources’ drain from the system to various companies based on contracts with “dedication”, at visibly higher prices;
- Efficient investments in the healthcare system by timely providing for/planning the necessary of consumables and the number of required physicians. If these cannot be ensured, then the investment is inefficient and non-functional.
- Even though it is a tough decision from the viewpoint of population’s access to services, closing hospitals that are much under the imposed national standards because they don’t have either the equipment or required staff must be put on the discussion table.

*“Currently we are dealing with a major dispersion and lacking strategy regarding the few physicians and financial resources available to Romania in many medical entities. Everything begins with the impossibility of assuming politically such reforms that bear a political price.” (Director, the Ministry of Health).*

Among the most considerable shortcomings mentioned by interviewed ones are counted: the lack of a monitoring system for the quality of the healthcare services; the lack of information about the actual costs of the system; the chronic under-financing of some fields within the healthcare system; the impossibility of drafting a development strategy for hospitals which is both coherent and on long-term; the professionals leaving the system.

*“They say let’s not make decisions that would cost us politically. Closing a hospital means to pay the political price, even if for the future this means that you increase the level and quality of services in the respective area. And thus, because we run from paying the political price we waste money uselessly.*

*Neither hospitals ranked higher have physicians, nor lower ranked ones. Let's get realistic: any hospital with 5 physicians is not a hospital. A hospital must have line-shifts of minimum 5 physicians. You cannot have line-shifts with 2 people. Things aren't done properly and this has direct consequences for the patient. But one does not acknowledge these facts. I believe that the society might understand that certain reforms are essential, if actual discussion and efficient information took place.”* (Director, the Ministry of Health).

## Conclusions

Medicine is part of a historic complex related to power, according to the theory of social conflict (Radulescu, 2002). The medical system is a dominant and power institution, the product of tensions and disagreements between groups with different interests thus, the social system begins to function better in favour of privileged groups. Healthcare institutions, pharmacies and physicians are ruled by two contradicting motivations: own financial profit or interests of any other kind on one hand, and expenditures deduction and health ensuring, on the other.

It is necessary to put a halt to the interests of some groups and to conflicts of interest. It might be cynical, but market economy and power structures operate in health and once marketing has been implemented in providing healthcare, the issue of social equity and of the morale has lost ground. The most eloquent case is the one of pharmaceutical companies and of the pharmaceuticals' suppliers where everything means maximising financial profits and therefore promotion campaigns are made for the products targeted at patients and at physicians, which even “corrupt” the physicians within the system by incentives, such as paying their attendance at congresses or offering them bonuses just to prescribe certain drugs.

The Control Body of the Ministry of Health mentions instances where understandings exist between physicians and pharmacies, and the physician indicates to the patient only some pharmacies, under the pretext that he/she can find only there the prescribed medication. Some physicians hide the conflict of interest they find themselves in: they work with private clinics or laboratories to which they direct the patients identified in the public system.

Increasing the financing of the system regarding healthcare should be a priority. Under the conditions of the crisis, in the period 2008-2011, all European member-states adopted pragmatic measure- packages to face the financial crisis, albeit reconsidering the role of the state and of its social functions were not considered. The measures aimed at restricting/controlling expenditures within the administration. The states with mature market economies considered measures for reducing taxation to stimulate economic growth.

In the healthcare sector, as well, as result of the necessity to diminish budgetary deficits, the governments are continuously faced with difficult political options in the immediate future. In case of economic growth stagnation, governments might be forced to diminish the increases in public expenditures for health, and certain healthcare fields, or to increase taxes or contributions to social insurances for reducing deficits. On the other hand, improving the efficiency of the expenditures in the healthcare sector might

contribute to keeping these pressures under control, for instance by evaluating more rigorously healthcare technologies, or using on a larger scale information and communication technologies (OECD, 2014).

Planned strategy decisions are required but not reactive answers. Not everything that governments undertake is the outcome of a policy and, as example, we might refer to the legislative ambiguities and improvisations of the law 95/2006 which regulates the entire healthcare system. This law was subsequently altered countless times. Moreover, healthcare needs to be stripped of political colours. Healthcare turns much too often into an object of political combat. Each electoral campaign, parties come up with the issue of the population health and the possibilities of the state to guarantee these expenditures. Appointing the management of the large medical entities for hospitals in the large urban area, public health directorates at county level, and thus everything turns into politics with consequences on the management quality.

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