One of the objectives currently followed by the member states of the European Union for the development of health financing systems that guarantee to all the citizens the access to health systems worldwide and fair and also to protect them from the financial difficulties that are associated to the payment of medical services, although the exact configuration of these services vary from one country to the other [1].

In Romania, the access to medical services is done through the public system of health insurances [2], that represents the main financing system of the health protection, by which it is provided a fair and non discriminatory access to a basic medical services to all the insured persons, containing medical services, health care services, medicines, sanitary materials, medical devices and other services to which the insured persons are entitled to and are paid from the Unique National Fund of Health Insurances (FNUASS), under the conditions of the framework contract.

Currently, the system of health insurances is governed by the principle of the obligation to pay the health insurance contribution due to the budget fund and the amount representing co-payment, the persons insured in the health insurance system in Romania, benefiting of the basic medical services package in case of disease or accident and till healing, conditioned on the payment both of the health insurance contribution and contribution in cash paid by the insured person.

But the obligatory character of the payment of the health insurance contributions have to be analysed related also to other principle, foundation of this system, namely, the one of solidarity. According to this principle, all citizens, regardless the incomes they have, have the right to medical assistance. This principle reflects the agreement met within the European Union, according to which health can not be abandoned to the market mechanisms [3] and has as foundation the idea that, due to the solidarity of the ones contributing, this system can achieved the main objective, respectively to provide medical assistance for population, including for those categories of persons that find themselves in the impossibility to contribute to the establishment of the health funds.

Therefore, the right of the insured persons to benefit in a non discriminatory manner of medical services, medicines and medical devices in the system of health insurances, is a right deriving from the principle provided by the law, according to which, within the health insurance system of Romania, the insured persons benefit of a basic medical services package in a fair and non discriminatory manner [4]. This right is correlative to the obligation to pay the contribution of health insurance, due to the fund budget and of the amount representing co-payment, due in the amount and under the conditions established by the framework contract regarding the conditions of granting medical assistance within the system of health insurance, the rest of the amount being paid by FNUASS.

The rights and obligations of the insured persons are expressly regulated by the law and are provided in the insurance contract, which is concluded between the physical person, beneficiary of medical services and the health insurance houses, directly or by employer. Under this aspect, it is mentioned that in the system of the health of Romania, two types of contracts are concluded and developed, respectively a contract of insurance and one of medical services supply. Having in view the fact that both the rights and the correlative obligations of the insured persons, are regulated by the law, by the insurance contract the contracting parties will not be able to establish by their wish other rights or obligations that exceed the legal framework by which these have been established. This way, the contract of health insurance contract is a contract resulted from the law effect, in which both parties have the legal obligation to conclude the contract.
the rights and obligations being established by the law and is different from the contract of goods insurance which conclusion takes place only if the parties by their free will understand to give birth to insurance relationships, these establishing, still by their assent, the conditions of the contract [5].

The second contract of medical services supply is being concluded between the health insurance houses and the supplies of medical services, in view to provide the rights of the persons insured within the system of health insurances.

The legal provisions establish that all the Romanian citizens with the residence in the country and also the foreign citizens and stateless persons that have requested and obtained the prolongation of the temporary staying right or have residence in Romania and make the proof of the payment of the contribution to the fund have the quality of insured persons and the rights granted by this quality. The persons that fulfil these conditions have the right to benefit of the basic medical services packages, that represents the full package of such services of the system of health insurances of Romania, from the date of initiation of the contribution payment to the fund [6].

For the situation in which the persons do not make the proof of the quality of insured person, they have the right to a minimal medical services, containing medical services only in case of the medical- surgical emergencies and of the diseases with endemo- epidemical potential, including the ones providing in the National Immunisations Program, monitoring of the pregnancy evolution and confinement, services of family planning. This way, the minimal package of medical services is granted even under the conditions of non payment of the contribution to the FNUASS budget, but under the compliance with the condition that this person should have the residence or the staying right in Romania. In the situation of loosing such the quality of insured person and the insurance rights end.

In Romania, within the health insurance system, medical services are granted also to the persons that have no obligation to make an insurance, but who have a facultative insurance [7]. We are talking about the members of the diplomatic mission accredited in Romania, the foreign citizens and stateless persons who are temporary in the country, without requesting the visa for long staying and the Romanian citizens with residence abroad who are temporary in the country. These persons benefit a defined services package and distinctly dimensioned [8] by the legislator, which includes medical services, health care services, medicines, sanitary materials, medical devices and other services to which this category of insured persons is entitled to and are paid from the fund.

Going to one services package to other can be achieved only pursuant to the law. The basic medical services package is granted to the insured persons that have complied with the obligations of payment of the contribution to the fund budget and have paid the amount representing the co-payment, except for the persons that benefit of health insurance, without payment of the health insurance contribution and who do not have to pay the co-payment.

The failure to comply with the obligation of the payment of the health insurance contribution leads to the diminishing of the basic services package [9]. The diminution of the basic services package takes place after 3 months from the last payment of the contribution, after this date, the insured persons benefiting only of the minimal medical services package. In the situation in which the beneficiary of a minimal medical services package complies with the obligation of the contribution payment to the fund, this person shall benefit of the basic medical services package from the date when he/she makes the proof of having paid the health insurance contribution.

This way, it can be noticed that the determinant element of the opening of the right to benefit of one of the medical services, minimal or basic, is represented by the compliance with the obligation of contribution payment to the fund. In case of the persons who benefit of the medical services package for the persons who have facultative insurance, the determinant element to go to the basic medical services is given by the status of the person, respectively in order to benefit of this last benefits package, the person has to be a Romanian citizen with the residence in the country or a foreign citizen or stateless person who has requested and has obtained the prolongation of the right of temporary staying or the residence in Romania and to make the proof of having paid the contribution to the fund.

With regard to the minimal medical services package, the wording of the law text is lacunose, because it is provided that this package is granted to the persons who do not make the proof of the quality of insured person, without making any other mentions in such purpose. Therefore, it leads to the situation according to which any person being on the Romanian territory benefits of the minimal medical services package, without making the mention by who of these persons has the obligation to make an insurance. Therefore, it results that the European citizens or citizens of other states who do not fulfil the conditions of insurance in their home country can be beneficiaries of these services, the cost of these expenses is paid from the fund budget.

With regard to the regulation of the mechanism of the payment of the contribution for health insurances, the legal provisions establish in the responsibility of the legal persons or individuals who have the quality of employer, of the legal persons or individuals assimilated to the employer, and also of the individuals, who, as the case may be, the obligation of paying the health insurance contribution. In case in which the employers do not pay the contribution to the fund, the employees shall no longer benefit of the basic medical services, these practically becoming beneficiaries of the minimal medical services package. In the practice, we distinguish two situations and namely: the situation in which the employers do not pay the
compulsory contribution due by them, calculated on the salaries fund and the situation in which the employers do not pay their personal contribution and neither the one due by the employee, although, pursuant to the financial records, these last contributions have been withheld from the gross income achieved by the insured person.

The failure to pay the contribution to the fund by the employers has as consequence the loss by the employee of the quality of insured person and therefore, after 3 months from the last payment, the employee shall benefit only of the minimal medical services package, although the failure to pay the contribution can not be charged with the insured person. There is also the possibility that the employer fulfills only partial the obligation and to pay to the fund only a part of the health insurance contribution. In this situation, there is the issue that if the employees of such employer, a part of them, all or none, can be considered as insured persons.

Therefore, we have to mention that the special legal provisions regulating the quality of insured person within the health insurance system in Romania [10], condition the obtaining of the quality of insured person on the cumulative fulfilment of all the conditions provided by the law, respectively, the person should be a Romanian citizen with the residence in the country or a foreign citizen or stateless person who has requested and has obtained the prolongation of the right of temporary staying or the residence in Romania and to make the proof of having paid the contribution to the fund. Therefore, as long as the person can not make the proof of having paid the health insurance contribution, it results that these conditions are not cumulatively fulfilled and therefore, the respective persons can not make the proof of having the quality of insured person, so, they shall benefit only of the minimal medical services package.

To the extent in which the employers shall be sued by the employees in order to oblige the employers to pay the health insurance contributions that have not been paid pursuant to the legal provisions, from the date when the proof of the payment of the contributions to the fund budget is done, pursuant to a final and irrevocable court order, by which it is ruled the obligation of the employers to pay the health insurance contributions and the accessories applied for the delay period, the employees are considered insured persons and beneficiaries of the basic medical services package.

**CONCLUSIONS**

In Romania, throughout the public system of the health insurances, medical services are being granted both to persons that pay the health insurance contribution to the fund budget and both to persons who do not pay this contribution, the operation of this system being governed by the principle of solidarity. Social solidarity implies that any insured person should benefit, when necessary, in identical conditions of assistance for the defence and re-establishment of health, even if his/her material resources determined by the level of the incomes achieved, have allowed him/her a smaller contribution to the establishment of the health insurances fund.

The fulfilment of the payment of the health insurance contribution to the fund budget is one of the requirements provided by the legislator for the person to obtain the quality of insured person and which cumulative fulfilment conditions the right to benefit of the basic medical services package or the minimal medical services package, within the health insurances system.

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