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Romania

Health system review

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European Observatory on Health Systems and Policies
a partnership hosted by WHO

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PREFACE

The Health Systems in Transition (HiT) series consists of country-based reviews that provide a detailed description of a health system and of reform and policy initiatives in progress or under development in a specific country. Each review is produced by country experts in collaboration with the Observatory's staff. In order to facilitate comparisons between countries, reviews are based on a template, which is revised periodically. The template provides detailed guidelines and specific questions, definitions and examples needed to compile a report.

HiTs seek to provide relevant information to support policy-makers and analysts in the development of health systems in Europe. They are building blocks that can be used to:

- learn in detail about different approaches to the organization, financing and delivery of health services, and the role of the main actors in health systems;
- describe the institutional framework, process, content and implementation of healthcare reform programmes;
- highlight challenges and areas that require more in-depth analysis;
- provide a tool for the dissemination of information on health systems and the exchange of experiences of reform strategies between policy-makers and analysts in different countries; and
- assist other researchers in more in-depth comparative health policy analysis.

Compiling the reviews poses a number of methodological problems. In many countries there is relatively little information available on the health system and the impact of reforms. Due to the lack of a uniform data source, quantitative data on health services are based on a number of different sources, including the World Health Organization (WHO) Regional Office for Europe's European Health for All database, data from national

statistical offices, Eurostat, the Organisation for Economic Co-operation and Development (OECD) Health Data, data from the International Monetary Fund (IMF), the World Bank's World Development Indicators and any other relevant sources considered useful by the authors. Data collection methods and definitions sometimes vary but typically are consistent within each separate review.

A standardized review has certain disadvantages because the financing and delivery of healthcare differ across countries. However, it also offers advantages because it raises similar issues and questions. HiTs can be used to inform policy-makers about experiences in other countries that may be relevant to their own national situations. They can also be used to inform comparative analysis of health systems. This series is an ongoing initiative and material is updated at regular intervals.

Comments and suggestions for the further development and improvement of the HiT series are most welcome and can be sent to contact@obs.who.int.

HiTs and HiT summaries are available on the Observatory's website (http://www.healthobservatory.eu).

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The European Observatory on Health Systems and Policies is a partnership that includes the governments of Austria, Belgium, Finland, Ireland, Netherlands (Kingdom of the), Norway, Slovenia, Spain, Sweden, Switzerland, and the United Kingdom; the Veneto Region of Italy (with Agenas); the French National Union of Health Insurance Funds (UNCAM); WHO; the European Commission; the Health Foundation; the London School of Economics and Political Science (LSE); and the London School of Hygiene & Tropical Medicine (LSHTM). The partnership is hosted by the WHO Regional Office for Europe. The Observatory is composed of a Steering Committee, core management team, research policy group and staff. Its secretariat is based in Brussels and has offices in London at LSE and LSHTM and at the Technical University of Berlin. The Observatory team working on HiTs is led by Ewout van Ginneken (Director); Elias Mossialos,

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LIST OF ABBREVIATIONS

AMI	Acute myocardial infarction
AMR	Anti-microbial resistance
ANDIS	National Agency for Development of Health Infrastructure
ARPIM	Romanian Association of International Producers of Generic Drugs
CHE	Current health expenditure
CHF	Congestive heart failure
COPD	Chronic obstructive pulmonary disease
CT	Computerized tomography
DHIH	District Health Insurance Houses
DPHA	District Public Health Authorities
DRG	Diagnosis related group
EMA	European Medicines Agency
EQLS	European Quality of Life Survey
EU	European Union
FFS	Fee-for-service
GDP	Gross domestic product
GNI	Gross national income
GP	General practitioner
HTA	Health Technology Assessment
IHME	Institute for Health Metrics and Evaluation
INN	International Non-proprietary Name
INS	National Institute of Statistics
LTC	Long-term care
MRI	Magnetic resonance imaging
NAMMD	National Agency for Medicines and Medical Devices
NAQMH	National Authority for Quality Management in Healthcare
NGO	Non-governmental organization

NHIF	National Health Insurance Fund
NHIH	National Health Insurance House
NIHSM	National Institute of Health Services Management
NRRP	National Recovery and Resilience Plan
OECD	Organisation for Economic Co-operation and Development
OOP	Out-of-pocket
P4P	Pay for performance
PET	Positron emission tomography
PPP	Purchasing power parity
SDR	Standardized death rate
SHI	Social health insurance
STS	Special Telecommunication Service
VAT	Value added tax
VHI	Voluntary health insurance
WHO	World Health Organization

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ABSTRACT

This review of the Romanian health system analyses recent developments in health organization and governance, financing, healthcare provision, recent reforms and health system performance. The Romanian health system is based on a social health insurance (SHI) system. It provides a comprehensive benefits package to the 89% of the population that is covered (2023), with the remaining population having access to a minimum package of benefits. While every insured person has access to the same healthcare benefits regardless of their socioeconomic situation, there are unmet needs in access to healthcare, with large differences between income groups and between rural and urban areas, the latter driven by the unequal distribution of health workers and facilities. The Romanian population has seen increasing life expectancy (reaching 76.6 in 2023) and declining mortality rates, but the COVID-19 pandemic reversed the positive trends, increasing differences with the EU. Romania continues to have a high rate of preventable mortality, indicating a low effectiveness of public health interventions. Public sources accounted for 77.7% of health financing in 2022, with out-of-pocket (OOP) payments covering 21.4% of current health expenditure (CHE). The share of informal payments also seems to be substantial, although decreasing since 2017. The largest part of health expenditure is spent on hospital care (43.7% in 2023). The total number of hospital beds remains high, although long-term care (LTC) beds have decreased over time. Healthcare remains characterized by under-provision of primary and community care and inappropriate use of inpatient and specialized outpatient care. There are shortages of medical professionals, mainly in rural and remote areas, with a high density of medical staff in big university cities. Although the number of physicians and nurses migrating to other countries has increased in the last decades, outmigration has lessened recently due to measures to tackle this issue. Reforms in the Romanian health system have been frequently ineffective, due in part to the high degree of political instability. Since 2016, key areas of reform were related to governance, healthcare financing and provider

payment mechanisms, efficiency in spending, increased coverage and access, management and human resources. The 2023–2030 National Health Strategy outlines targeted actions to strengthen administrative capacity and improve prioritization, planning and implementation of health policies, improving health management and health system performance monitoring.

EXECUTIVE SUMMARY

With a population of 19 million people, Romania is the sixth most populous country in the European Union (EU). Its population has significantly declined over recent years, with many Romanians, including a high number of health professionals, migrating abroad. Only slightly more than half (54.6%) of the population lives in urban areas.

The health status of the Romanian population was improving until the COVID-19 pandemic started in 2020. Over 2020–2021 life expectancy fell by 2.7 years, reaching 76.6 years in 2023; the gap in life expectancy that year between women and men was 7.6 years, favouring women.

There are high gender and geographical differences in life expectancy and general mortality. Men with lower levels of educational attainment at age 30 live on average 6.4 years less than those with higher education. These differences are reflected in the socioeconomic gradient, as well as in inequities in accessing healthcare.

Circulatory diseases are the main cause of death in Romania, accounting for 53.9% of deaths in 2023. Malignant neoplasms have traditionally been the second most harmful cause and accounted for 19% of deaths in 2023. Only in 2021 did respiratory diseases (19.5%) surpass the tumours due to the COVID-19 pandemic. The infant mortality rate has decreased three-fold over the last two decades and changed little during the pandemic but remains above the EU average. Maternal mortality tripled during the COVID-19 pandemic, exceeding 28 deaths per 100 000 live births in 2021.

Morbidity and risk factors data are less reliable since no health and morbidity evaluation survey has been conducted in the last 25 years, and national disease registries are still under development. Records collected by family physicians indicate that diseases with the highest prevalence in 2020 were high blood pressure, ischaemic heart disease and diabetes mellitus, while hospital data show that the most frequent reasons for inpatient admissions were respiratory diseases, circulatory diseases and malignant tumours.

Romania's SHI system pools public resources, remaining highly centralized

The Romanian health insurance system was introduced in 1999. It is organized at two main levels – national and district (*judet*) – but remains highly centralized. There is a single National Health Insurance Fund (NHIF), and all contributions are centrally pooled. District health insurance funds buy services from healthcare providers, such as general practitioners (GPs), specialist practices, laboratories and hospitals at the local level. Patients have a free choice of provider at all levels of care, without geographical restriction.

The benefits package is determined by the Ministry of Health and the NHIH and the covered medicines are selected based on health technology assessment (HTA). There is also a minimum benefits package for those who are uninsured, with one of the highest coverages compared to other EU countries, in particular for primary care services (with a benefits package similar to the insured population) and hospital inpatient care (with free access to secondary care for those with certain diseases).

Planning capacity is insufficient, and this has been formally acknowledged. The establishment of a planning unit within the Ministry of Health and in various areas of the health system has been a priority, since the development of regional plans were ex-ante conditionalities for accessing the European Structural and Investment Funds. A new strategy for the health sector was published in 2023.

A clear strategy for improving health information systems is lacking, despite gaps in the collection and lack of interoperability of existing systems that put a substantial burden on healthcare providers. However, there are positive developments, such as in health registers and the development of the National Health Digitalization Strategy 2024–2030, currently going through the approval process, which seek to improve informatization of the health system. Basic information, such as on statutory benefits, is easily available, while information regarding access and quality, including regarding hospital waiting times, medical errors and the quality of non-hospital providers, is largely missing.

Health financing increased during the COVID-19 pandemic, but remains one of the lowest in the EU as a share of GDP

The share of gross domestic product (GDP) that Romania spends on health increased from 4.2% in 2000 to 5.7% in 2022 but remains among the lowest in the EU (8.7%) and the wider WHO European Region (8.1%). Public expenditure accounts for the largest part of CHE, amounting to 77.7% in 2022, higher than the EU average. The rest is paid for from private sources, almost all in the form of OOP payments, and with pharmaceuticals accounting for the largest share.

Informal payments to doctors and nurses appear to be still highly prevalent in Romania, but seem to have decreased since 2017, when a significant salary increase was implemented. The largest part of health expenditure is spent on hospital care (43.7% in 2023), despite political pledges to shift provision to ambulatory settings, followed by pharmaceuticals (27.5%) and outpatient care (21.1%).

To access benefits, the insured must prove their insurance status. A significant proportion of Romanians (11% in 2023) lack SHI coverage, which could be explained by the high number of Romanians living abroad but still being officially resident in Romania. Purchasers are not allowed to selectively contract with providers and must contract with all providers that comply with the existing norms and requirements. Fees are fixed, but the volumes of services are negotiated within the available budgetary limits.

Fee-for-service (FFS) and Diagnosis Related Groups (DRGs) are the main methods of paying providers. FFS is used for paying providers of public health services, primary care physicians (who also receive capitation payments and are also paid for performance) and ambulatory specialists. Hospitals are paid based on DRGs, but they also receive lump sums for health programmes, case payments for provision of day care and day fees for treating chronic cases.

Migration of health professionals to other countries has resulted in health workforce shortages

In 2023, there were 554 hospitals in Romania, including 374 public hospitals, 163 day care hospitals and 81 LTC facilities. The total number of hospital beds decreased from 889 per 100 000 population in 2000 to 675 in 2011

but increased again to 728 in 2023. The distribution of beds varies across regions, with a higher concentration in Bucharest (18.0% of all hospital beds in 2023) and fewer beds in hospitals located in the West (9.5%) and South-West (9.7%) of Romania.

Electronic reporting of patient-related primary and ambulatory care activity to the NHIH began in 1999 for reimbursement purposes and was expanded to hospitals in 2006, alongside the introduction of the DRG system. In 2008, the NHIH launched the Integrated Unique Informatics System, later extending it with the electronic prescribing information system in 2012, the electronic health card in 2015 and electronic patient records in 2021. The COVID-19 pandemic accelerated the use of digital solutions.

Although Romania no longer has the highest number of graduating physicians in the EU, the number is still well above the EU average. Despite an increasing health workforce, especially after an almost threefold salary increase in 2017 and mass hiring during COVID-19, there are still shortages, especially among physicians, in certain specialties and in some geographical regions. The number of physicians migrating to other countries increased from 42 179 in 2013 to 64 978 in 2023 (mainly to France, Greece and Germany), while the number of nurses migrating to other countries increased from 123 404 in 2013 to 190 420 in 2023 (mainly to Italy and the United Kingdom).

One of the health reforms included in the 2021–2026 National Recovery and Resilience Plan (NRRP) aims to increase health management and human resources capacity. The reform is supposed to lead to improved health management training across the health system and to better professional development opportunities.

Patients tend to seek hospital care directly, bypassing primary care

Public health services are guaranteed by the state and financed mainly from the state budget through the national public health programmes, but also from local budgets, from SHI and from other sources. The main strategic document in public health is the National Health Strategy 2023–2030.

Primary care is provided by family physicians, who are meant to act as gatekeepers and operate independently, mainly in solo practices. However, due

to the shortage of family physicians and the lack of out-of-hours primary care services, many patients bypass family doctors by calling emergency ambulance services or going directly to hospital emergency departments. Specialized ambulatory care is provided mainly by private solo practices. Most specialized physicians work in both the public and the private sectors, employed in hospitals and working out-of-hours in private settings, with or without a contract with the DHIH. The low number of ambulatory specialized services is reflected by the overutilization of hospital services.

Day care has expanded considerably over recent years, representing 64.5% of total hospital admissions reimbursed by SHI in 2022, compared to 41.6% in 2014. However, the target is that by 2030 at least 50% of the day cases treated in hospitals in 2022 will be delivered as ambulatory services.

Emergency services are overused due to patients' preferences to directly consult the emergency departments in the hospital or to call 112; in some cases, however, this is the only option available, either due to patients' uninsured status or if they live in an area without primary care services. A high percentage of ambulance calls are resolved at the patients' home, indicating an overuse of ambulance services.

Dental care is covered to a very low extent by SHI; this is the main driver of catastrophic spending among households in the richest consumption quintile and leads to an increased level of unmet need for dental care examination due to cost, especially among the poorest quintile, reaching 6.6% in 2024.

Recent reforms have been aimed at attracting health professionals

Since 2016, key areas of reform in the Romanian health system were related to governance, health care financing and provider payment, efficiency in spending, increased coverage and access, management and human resources capacity. The 2023–2030 National Health Strategy outlines targeted actions to strengthen administrative capacity and improve prioritization, planning and implementation of health policies, improving health management and health system performance monitoring.

To eliminate the problem of employers not paying SHI contributions for their workers, employees became solely responsible for paying the full amount of the contribution, amounting to 10% of their income. In 2017,

health professionals' salaries were increased more than threefold to reduce workforce emigration. In 2023, the payment model for family physicians was modified, changing the FFS ratio from 50:50 to 35:65 to encourage service provision. Additionally, a lump-sum payment was introduced for performing specific health risk assessments to promote the delivery of preventive services.

To improve population coverage, categories of people covered by SHI but exempted from paying contributions have gradually widened. At the same time uninsured individuals gained entitlement to primary care services.

Improving health management and human resources in health management was considered a cornerstone for better operation of the health system, better management of services provision and finally better coverage of population healthcare needs, and is one of the main reforms financed by the NRRP.

Romania's NRRP and funding under the EU's Cohesion Policy bring significant investments for healthcare

The overall governance of the Romanian health system has improved over the last decade, and there are plans for further improvements to be supported by the 2022–2026 NRRP, which focuses on developing management knowledge and skills across all health system levels, strengthening human resource capacity, and increasing integrity while reducing vulnerabilities and risks of corruption in the health system.

A significant share of the Romanian population (11% as of 2023) is not covered by SHI; since 2023, the uninsured population is also entitled to primary care services, including preventive, diagnostic and treatment services, and home care, and since 2024 to specialized services for early detection and treatment of diseases such as cancers, hepatitis B and C, and HIV/AIDS in pregnant women. Romania has a high share of households facing catastrophic health spending (12.5% in 2015). OOP spending on health reached 21.4% of CHE in 2022. The largest driver of catastrophic health spending for households in the poorest income quintiles is outpatient medicines, while for wealthier households it is dental care.

Healthcare quality has become a high priority in Romania over the past decade, but data on quality of care was not collected regularly until 2022 when the country started the process of OECD accession. Quality improvement was included as one of the reforms under the NRRP to address this gap.

Mortality from preventable causes in Romania was 304 per 100 000 population in 2022, the fourth highest in the EU and nearly twice the EU average of 168 per 100 000 population, highlighting the limited effectiveness of public health interventions. Mortality from treatable causes was 215 per 100 000 population in 2022, the highest among the EU countries, and more than double the EU average of 90 deaths per 100 000 population.

Funding allocations remain driven largely by political decisions rather than evidence or cost-effectiveness, contributing to persistent regional inequalities and inefficiencies in service provision.

1

Introduction

Chapter summary

- With a population of 19 million people, Romania is the sixth most populous country in the EU. Its population has significantly declined over recent years, with many Romanians, including a high number of health professionals, migrating abroad. Only slightly more than half (54.6%) of the population lives in urban areas.
- The health status of the Romanian population was improving until the COVID-19 pandemic started in 2020. Over 2020–2021, life expectancy fell by 2.7 years, reaching 76.6 years in 2023; the gap in life expectancy by gender is 7.6 years, favouring women.
- There are high gender and geographical differences in life expectancy and general mortality. Men with lower levels of educational attainment at age 30 live on average 6.4 years less than those with higher education. These differences are reflected in the socioeconomic gradient, as well as in inequities in accessing healthcare.
- Circulatory diseases are the main cause of death in Romania, accounting for 54% of deaths in 2023. Malignant neoplasms have traditionally been the second most harmful cause and accounted for 19% of deaths in 2023. Only in 2021 did respiratory diseases (19.5%) surpass the tumours due to the COVID-19 pandemic. The infant mortality rate has decreased three-fold over the last two decades and changed little during the pandemic but remains over the EU average. Maternal mortality tripled during COVID-19, exceeding 28 deaths per 100 000 live births in 2021.

- Morbidity and risk factors data are less reliable since no health and morbidity evaluation survey has been conducted in the last 25 years, and national disease registries are still under development. Records collected by family physicians indicate that diseases with the highest prevalence in 2020 were high blood pressure, ischaemic heart disease and diabetes mellitus, while hospital data show that the most frequent reasons for inpatient admissions were respiratory diseases, circulatory diseases and malignant tumours.

1.1 Geography and sociodemography

Romania is situated in the south-eastern part of central Europe. It borders the Republic of Moldova to the east, Ukraine to the north, Hungary and Serbia to the west, Bulgaria to the south and the Black Sea to the southeast (Fig. 1.1). Most of the border with Bulgaria and a large part of the border with Serbia are formed by the Danube River. The Romanian coast of the Black Sea stretches for 245 kilometres, enabling connections with countries in the Black Sea and the Mediterranean basins.

Romania's climate is temperate. Its terrain lies on three main levels, each constituting about a third of the total area: the highest level is the Carpathians (with the highest peak at 2544 metres); the middle level corresponds to the sub-Carpathians hills and plateaus; and the lowest level contains the Danube Delta and other plains.

Romania is the eighth largest country in the EU in terms of surface area, covering 238 391 square kilometres, and the sixth largest in terms of population, with 19.1 million people in 2024 (EU, 2024). The population has continuously decreased over the last two decades (see Table 1.1), which can be attributed to the negative population growth (despite a slight increase in the fertility rate and a decline in the mortality rate; see Section 1.4) and the continuously negative net migration rate.

The population in Romania is ageing, with 18.4% of the population aged 65 years or over in 2023 (see Table 1.1). The population distribution between urban and rural areas has changed little over the years, with only slightly more people in urban (54.6% of the total in 2023) areas.

Romania is among the top 20 countries in Europe with the largest population change, with a 5% decline between 2009 and 2019, and is also among

FIGURE 1.1 Map of Romania

Source: United Nations, 2024

the top 20 countries globally in terms of the size of its emigrant population, with a 3.6 million diaspora population in 2019 (IOM, 2019). Net migration remained negative until 2021, decreasing from -31 314 in 2019 to -22 219 in 2022, possibly due to the limitations imposed by the COVID-19 pandemic, but subsequently became positive, reaching 90 713 in 2023 and 84 847 in 2024, due to the incoming displaced population following the war in Ukraine (Eurostat, 2025). The group of emigrants includes a high number of health professionals, of whom increasingly more have been moving to Western Europe in recent years; some reports estimate that between 2009 and 2015 Romania lost half of its doctors (usually young doctors leaving the country for better opportunities) (IOM, 2019; Hervey, 2017). By 2017–2018 Romania had become the third largest supplier of foreign-trained doctors in OECD countries, with a 33% emigration rate (Socha-Dietrich & Dumont, 2021).

According to the latest census (2021), around 77.6% of the population in the country self-identified by ethnicity as of Romanian origin. Around 5.2% of the population born in Romania has self-identified as of Hungarian origin. The share of population self-identified as Roma accounts officially

for 2.9% of the total population (INS, 2023c). However, the exact share is unknown, partly due to people not self-reporting their Roma status to avoid stigma and discrimination. A 2019 report from the Central European University mentions Romania among the top three countries with the highest share of Roma population among EU countries (8.3%), after Bulgaria and Slovakia (Velux Foundations, 2019). As in other countries, the Roma population is characterized by higher poverty and lower education rates than the average across the Romanian population. This, together with weak protection policies, contributes to low SHI coverage among the Roma, which, according to a 2021 survey by the EU Agency for Fundamental Rights, resulted in 42% of the Roma population being uninsured (FRA, 2023) (see Section 7.2).

Other minority groups, comprising 14.2% of the Romanian population, include Ukrainians (born in Romania), Germans, Turks, Lipovans, Aromanians, Tatars, Serbs, Bulgarians, Greeks and others. As of July 2023, the number of Ukrainian refugees who arrived in Romania following the outbreak of war in February 2022 was 137 130 people, which is fewer than in neighbouring Bulgaria (162 935) and Poland (1 627 510) (UNHCR, 2023).

The country's official language is Romanian, but other languages are also spoken. In the 2021 census, around 73.6% of the population identified as Orthodox, 3.9% as Roman Catholic and 2.6% as Protestant (INS, 2023c).

TABLE 1.1 Trends in population/demographic indicators, 1995–2023 (selected years)

	1995	2000	2005	2010	2015	2023
Total population (in millions)	22.6	22.4	21.3	20.2	19.8	19.0
Population aged 0–14 (% of total)	20.6	18.6	15.9	15.8	15.7	15.8
Population aged 65 and above (% of total)	11.9	13.6	14.7	15.6	16.8	18.4
Population density (people per sq. km)	98.8	97.7	92.7	88.0	86.1	83.7[a]
Population growth (annual %)	-0.2	-0.1	-0.6	-0.6	-0.5	0.05
Fertility rate, total (births per woman)	1.3	1.3	1.4	1.6	1.6	1.8[a]
Urban population (% of total population)	53.7	53.0	53.1	53.8	53.9	54.6

Source: World Bank, 2024

Note: [a] 2020.

1.2 Economic context

Romania has seen strong overall economic growth over the past 23 years. GDP per capita increased eight-fold from US$ 5848 (adjusted for purchasing power parity (PPP)) in 2000 to US$ 47 903 in 2023. As a result, GDP per capita reached 81% of the OECD average of US$ 59 491 per capita in 2023 (World Bank, 2024).

The Romanian economy was, however, hit hard by the COVID-19 pandemic, with GDP falling by 3.7% in 2020 (Table 1.2). The government's expenditure as a share of GDP increased from 36.0% in 2019 to 41.5% in 2020, with the public deficit increasing from -4.3% in 2019 to -9.2% in 2020 and the general government gross debt increasing from 35.1% in 2019 to 46.9% in 2020. The period 2020–2023 saw some recovery, with the economy recording a growth of 3.6% in 2020 and 2.1% in 2023. The government's expenditure as a share of GDP fell slightly to 40.3%, and the deficit decreased to -6.5% in 2023 (Table 1.2).

The National Institute of Statistics (INS) annual surveys on the quality of life of Romanians found that the share of jobless households increased from 34.7% of households in 2019 (33.9% in urban areas, 35.6% in rural areas) to 42.4% in 2023 (37.2% in urban areas, 48.8% in rural areas). At the same time the share of households that declared having difficulties in paying for living necessities decreased from 77.2% in 2019 to 71.1% in 2023 (INS, 2020a, 2024a). The unemployment rate reached 5.6% in 2023, from 3.9% in 2019, mostly affecting young people aged 15–24 (21.3%) and people with low levels of education (14.2%) (World Bank, 2024). Despite this, the share of people at risk of poverty and social exclusion has been continuously falling, from 36.3% in 2019 to 35.6% in 2020 and 32% in 2023, although it remains well above the EU average of 21.4% (Eurostat, 2024).

Romania's per capita gross national income (GNI) reached US$ 12 630 in 2019, leading the World Bank to classify it as a high-income country for the first time. The economic impact of the COVID-19 pandemic led to a decline in per capita GNI to US$ 12 570 in 2020, causing the country to revert to the upper middle-income group (World Bank, 2022). However, a rebound in 2021 restored its high-income status, with a per capita GNI of US$ 14 170. By 2023 it had reached US$ 16 660 (World Bank, 2024).

Since 2008 Romania has been placed high on the Human Development Index. Its level increased from 0.806 in 2008 to 0.832 in 2019, mainly due

to increases in life expectancy, per capita GNI and years of schooling. The Human Development Index level decreased to 0.821 in 2021 due to the decrease in life expectancy during the COVID-19 pandemic, and increased to 0.827 by 2022 (UNDP, 2024).

The GINI coefficient, which measures income inequality, decreased from 34.8 in 2019 to 31 in 2023, higher than the EU average of 29.6 and Hungary (29), Poland (27) and Slovakia (21.6), but lower than Bulgaria (37.2) (Eurostat, 2024) (Table 1.2).

TABLE 1.2 Macroeconomic indicators, 1995–2023 (selected years)

	1995	2000	2005	2010	2015	2019	2020	2023
GDP per capita (current US$)	1650	1659	4618	8397	8976	12899	13047	18419
GDP per capita, PPP (current international US$)	5426	5848	9602	17352	21622	31867	34293	47903
GDP growth rate (annual %)	6.2	2.5	4.7	-3.9	3.1	4.2	-3. 7	2.2
Public expenditure (Government expenditure as % of GDP)*	34.3	38.5	33.5	39.5	36.0	36.0	41.5	40.3
Government deficit/surplus (% of GDP)*	-2.0	-4.6	-0.8	-6.9	-0.5	-4.3	-9.2	-6.5
General government gross debt (% of GDP)*	–	22.5	15.9	29.0	37.7	35.1	46.6	48.9
Unemployment, total (% of labour force)	8.0	7.0	7.2	7.0	6.8	3.91	5.0	5.6
Poverty rate (People at risk of poverty or social exclusion by age and sex as % of total population)*	–	–	–	–	44.5	36.3	35.6	32.0
Income inequality (GINI coefficient of disposable income)*	–	29.0	–	33.5	37.4	34.8	33.8	31.0

Sources: World Bank, 2024.
Note: *Eurostat (2024).

1.3 Political context

Romania is a semi-presidential parliamentary republic with a president as head of state and a prime minister as head of government. The president is directly elected for a maximum of two five-year terms (European Committee of the Regions, 2023). The former president, on his second term, remained in office following the annulment of the presidential election in November 2024 by the Constitutional Court due to a far-right candidate not obeying the electoral process, until May 2025 when a new president was elected. The parliament consists of two chambers: the Chamber of Deputies (330 members) and the Senate (136 members), both with a four-year mandate. Each chamber elects their respective presidents. After consulting with the presidents of both chambers, the president of the republic appoints the prime minister from the party that secured a parliamentary majority. The prime minister then presents the cabinet to the parliament for approval (Vlădescu et al., 2016).

Romania comprises 41 districts (known as "*judete*"), 216 towns and 2862 communes. In 2022, the smallest *judet* had 200 042 residents, while the largest had 760 774 (INS, 2023a). Large towns are declared municipalities. Given its size (1 716 961 residents), the Bucharest municipality is a separate administrative entity.

The political climate of post-communist Romania has been characterized by high instability. During its 30 years as a democracy Romania has seen 25 cabinets. With governments remaining, on average, only 1.2 years in power, implementation of major reforms across all domains (for example health, education, infrastructure, public administration, etc.) has been difficult (see Section 6.1).

No party won a majority in the December 2024 parliamentary elections. The parties from the previous ruling coalitions, the central-left Social Democratic Party, the centre-right conservative National Liberal Party and the progressive-liberal Save Romania Union (USR), gained less votes. Only the centre-right Alliance of Hungarians in Romania kept a similar vote as in the previous election. Meanwhile, the Alliance for the Union of Romanians, a nationalist, Eurosceptic, right-wing populist party founded in 2019, nearly doubled its votes from 9.1% in 2020 to 18% in 2024. Furthermore, two newly established far-right parties, S.O.S. Romania and the Party of Young People , also gained votes (Parties and Elections in Europe, 2024). Following

the election, the Social Democratic Party, the National Liberal Party and the Alliance of Hungarians in Romania, with support from the national minorities, formed a pro-European grand coalition government. Starting from June 2025, a new party, the Save Romania Union joined the coalition.

Romania is a member of the United Nations, the Council of Europe, the World Trade Organization, NATO and, since 1 January 2007, the EU. Further, the Government of Romania has ratified a range of international and regional human rights treaties, recognizing the right to health and other health-related provisions (Vlădescu et al., 2008). On 25 January 2022, the OECD Council decided to open accession discussions with Romania. The roadmap for the country's accession process was formally adopted at the OECD Council at Ministerial level in June 2022.

1.4 Health status

Romanians' health status has improved but progress up to 2019 was undone by the COVID-19 pandemic. Romania's life expectancy at birth rose steadily until 2019, but the COVID-19 pandemic caused a steep decline of nearly three years between 2019 and 2021. It began to rebound in 2022 and climbed to a new record of 76.6 years in 2023 (Eurostat, 2024). A significant gender disparity in life expectancy persists. In 2023, men in Romania had a life expectancy of 72.9 years, while women reached 80.5 years — a difference of 7.6 years. This disparity is influenced in part by men's higher exposure to risk factors such as smoking and excessive alcohol consumption (Eurostat, 2024). There are also educational inequalities in life expectancy. Between 2016 and 2017 the life expectancy gap at age 30 between higher- and lower-educated people increased from 4.9 to 6.4 years for men and from 0.2 to 0.9 years for women (last available data from Eurostat).

Furthermore, there are also geographical inequalities in life expectancy. In 2020, people in urban areas lived 3.8 years longer than those in rural areas (INSP, 2021). In 2020, there was a 7.9-year difference between districts (*județe*), ranging from 73.3 years in Tulcea to 81.2 in Vâlcea. The difference is even higher in rural districts, where a person in the Vâlcea countryside was expected to live 10.6 years longer than a person in the Tulcea countryside in 2020 (INSP, 2021). No information is collected on the socioeconomic characteristics for ethnic minorities or migrants.

The leading causes of death in 2023 were circulatory and heart diseases (53.9% of all deaths), with 600.8 deaths per 100 000 population, a decline from 686.6 in 2022. Other causes are malignant neoplasms (19% of all deaths), with 212.2 deaths per 100 000 population in 2023. Although malignant tumours traditionally were the second leading cause of death in Romania, respiratory diseases briefly surpassed them due to the COVID-19 pandemic, accounting for 19.5% of all deaths in 2021. However, these were the third leading cause of death in 2023 (8.8%), closer to the pre-pandemic range of 4–6% of all deaths (INSP-CNSISP, 2023a).

Among cancer-related deaths, trachea, bronchus and lung cancers were the most common (19% of all malignant tumour deaths), mostly affecting men (72.7% of lung cancer deaths). Breast cancer accounted for 7% and prostate cancer for 4.5% of deaths from cancer (INSP-CNSISP, 2023a). Deaths from external causes declined until 2016 but have since remained at the same level at 43 deaths per 100 000 population, according to mortality data reported to the WHO Regional Office for Europe (WHO Regional Office for Europe, 2023). Mortality from communicable diseases has been increasing continuously since 2013 (Table 1.3). Mortality from viral hepatitis increased from 0.17 per 100 000 population in 2013 to 0.51 in 2019, while mortality from intestinal infectious diseases increased from 0.37 per 100 000 population in 2013 to 0.79 in 2019, both below the WHO European Region average. In 2023, digestive diseases accounted for 5.8% of deaths, while external causes accounted for 3.4% (INSP-CNSISP, 2023a).

The COVID-19 pandemic increased the general mortality rate from 11.7 per 1000 population in 2019 to 15.2 in 2021. This increase was due not only to COVID-19 deaths but also to indirect causes, such as deaths arising from reduced access to health services. Around 119 000 excess deaths occurred in Romania between 2020 and 2022 (OECD & European Observatory on Health Systems and Policies, 2023). Around 40% of the excess deaths in 2020 were attributable to COVID-19 (OECD & European Observatory on Health Systems and Policies, 2021).

The mortality rate decreased to 12.4 per 1000 population in 2022 and to 11.1 in 2023. Disparities persisted between urban and rural areas in 2022 (10.9 vs. 14.4) and 2023 (9.9 vs. 12.6) and between women and men in 2022 (11.5 vs. 13.3) and 2023 (10.4 vs. 11.9), though these gaps narrowed from 3.5 to 2.7 years between rural and urban areas and from 1.8 to 1.5 years between women and men (INSP-CNSISP, 2023a).

The infant mortality rate decreased threefold over the past two decades, reaching 5.8 deaths per 1000 live births in 2023, but remains above the EU average of 3.2 (INSP-CNSISP, 2023b; Eurostat, 2023). Despite a sharp decline in the maternal mortality rate over the last two decades, from 32.8 deaths per 100 000 live births in 2000 to 9.3 in 2019, Romania still has one of the highest rates in the EU and the rate increased to 13.5 in 2023 (Table 1.3). During the COVID-19 pandemic, maternal mortality even tripled, reaching 25.9 deaths per 100 000 live births in 2021 (INSP-CNSISP, 2023b), potentially the result of unsupervised prenatal care and unsafe abortions from limited access to health services.

Data on morbidity and risk factors in Romania are less reliable due to the absence of regular surveys in the past 25 years and the ongoing development of national disease registers. Available indicators are calculated using data from different sources, which may not be comparable. For example, in 2019 the diabetes prevalence rate reported to WHO, based on family physicians' records, was 3.7%, while the National Health Report from the National Institute of Public Health estimated it at 6%, based on records collected by the specialist offices for diabetes, nutrition and metabolic diseases (INSP, 2021).

According to family physicians' records, the most prevalent diseases in 2020 were high blood pressure (13.8% of the population), ischaemic heart disease (6.2%), diabetes mellitus (4.5%), chronic obstructive pulmonary disease (COPD) (2.3%) and cerebrovascular diseases (2%). According to hospital records, the most prevalent inpatient cases in 2020 were respiratory diseases (1.7% of the population), due to COVID-19 cases, circulatory diseases (1.3%), tumours (1.1%), pregnancy and delivery (1.0%) and digestive diseases (0.9%) (INSP, 2021).

In 2023, 72% of Romanians reported being in good or very good health, above the EU average of 67.8%. Meanwhile, 21.1% reported having a long-standing illness or health problem, compared to 35.1% in the EU (Eurostat, 2024).

According to the Global Burden of Disease study, the top five risk factors for mortality in 2021 were high blood pressure, diet, high cholesterol, tobacco and high body-mass index, estimated to account for 69.8% of all deaths in Romania. High systolic blood pressure alone was estimated to account for 27.1% of all deaths, compared to 17.1% in the EU, while dietary risks were thought to be responsible for 16.1% of deaths, compared to 11.7% in the EU (see Fig. 1.2).

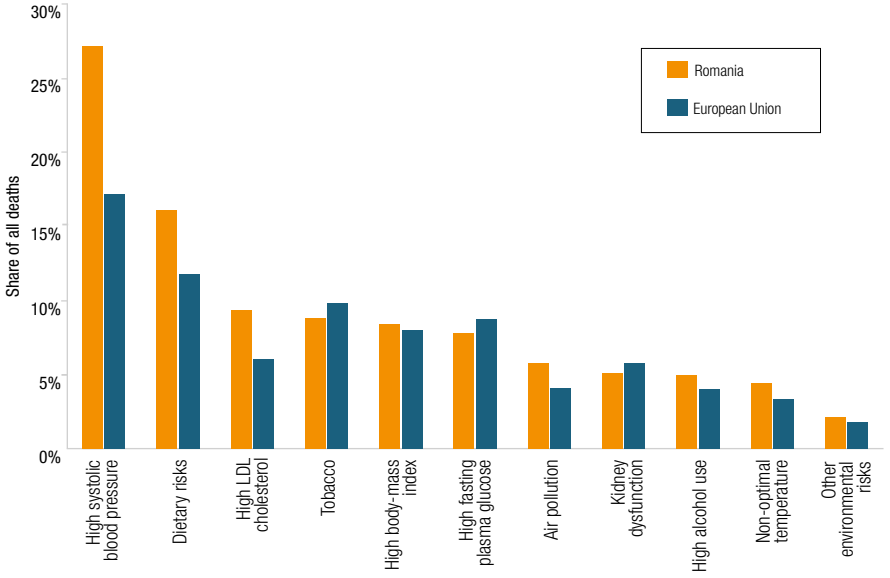
TABLE 1.3 Mortality and health indicators, 1995–2023 (selected years)

	1995	2000	2005	2010	2015	2019	2020	2023
Life expectancy (years)								
Life expectancy at birth, total	69.3	71.2	71.9	73.7	74.9	75.6	74.2	76.6
Life expectancy at birth, males	65.5	67.7	68.4	70.0	71.4	71.9	70.4	72.9
Life expectancy at birth, females	73.5	74.8	75.4	77.7	78.6	79.3	78.3	80.5
Life expectancy at 65 years, men	12.8	13.4	13.1	14.2	14.5	14.9	13.4	15.1
Life expectancy at 65 years, women	15.3	15.9	15.9	17.6	18.0	18.6	17.7	19.2
Mortality								
Mortality, SDR per 100 000 population*	n/a	1047.90	1025.40	877.90	662.32	567.83	607.09	641.22
Circulatory diseases	748	668	645	540	467	418	n.a.	n.a.
Malignant neoplasms	163	171	180	180	185	175	n.a.	n.a.
Communicable diseases (infectious and parasitic diseases)	15.2	14.6	11.7	10.4	10.8	15	n.a.	n.a.
External causes of injury and poisoning	81	64	58	53	44	43	n.a.	n.a.
All causes	1224	1098	1064	948	868	831	n.a.	n.a.
Infant mortality rate (deaths per 1 000 live births)	21.2**	18.6**	15.0**	9.8	7.3	5.4	5.2	5.8
Maternal mortality rate (deaths per 100 000 live births)**	47.8	32.8	16.7	24.0	13.1	9.3	15.9	12.8

Source: Eurostat, 2024

Notes: *WHO Regional Office for Europe, 2023; **INSP-CNSISP, 2022, 2024; n.a. = no information available; SDR = Standardized death rate.

FIGURE 1.2 Major risk factors affecting health status, 2021



Sources: IHME, 2024

Illicit drug use is a major and increasing health challenge, and recent reports indicate a growing illegal drug market in Romania (National Anti-Drug Agency, 2023). Between 2013 and 2019 drug use among adults (aged 15–64) increased in lifetime consumption (from 6.6% to 10.7%), consumption over the last year (2.5% to 6%) and consumption over the last month (1.1% to 3.9%). Usage rates were even higher among young adults (15–34), with 16.9% reporting lifetime use, 10% past-year use and 6.6% past-month use in 2019 (National Anti-Drug Agency, 2023). In contrast, an international survey found that Romanian students reported relatively low lifetime use of any illicit drug (9.5%) compared to the 17% average in the 2019 ESPAD study countries (ESPAD, 2019). Similarly, Romanian young adults (aged 15–64) reported relatively low use (11.9%) compared to the EU average (29%) in 2020 (EMCDDA, 2022).

2

Organization and governance

Chapter summary

- The Romanian SHI system was introduced in 1999, after several decades under the communist regime when the Semashko model was followed. It is organized at two main levels – national and district (*judet*) – but remains highly centralized. There is a single NHIF, and all contributions are centrally pooled.
- District health insurance funds buy services from healthcare providers, such as GPs, specialist practices, laboratories and hospitals at the local level. Patients have a free choice of provider at all levels of care, without geographical restriction.
- The basic benefits package is determined by the Ministry of Health and the NHIH, the covered medicines are selected based on HTA, and there is also a minimum benefits package for those who are uninsured.
- Planning capacity is insufficient and this has been formally acknowledged. The establishment of a planning unit within the Ministry of Health and in various areas of the health system has been a priority, since the development of regional plans were ex-ante conditionalities for accessing the European Structural and Investment Funds. A new strategy for the health sector was published in 2023.

- A clear strategy for improving health information systems is lacking, despite gaps in the collection and lack of interoperability of existing systems that put a substantial burden on healthcare providers. However, there are positive developments, such as in the area of health registers, which seek to improve informatization of the health system.
- Basic information, such as on statutory benefits, is easily available, while information regarding access and quality, including regarding hospital waiting times, medical errors and quality of non-hospital providers, is largely missing.

2.1 Historical background

The foundations of Romania's health system were laid even before the major political unions of 1859 and 1918. Under Russian occupation, Moldavia and Wallachia established Health Committees in 1831–1832 through the *Regulamentele Organice*, tasked with population health monitoring and imposing quarantines. Following the Little Union, these Committees were replaced by the Health Directorate in 1862, and the first health law of 1874 formally positioned it within the Ministry of Internal Affairs as the central health authority. By the late 19th century the system included three administrative levels, relied on state financing, and introduced early forms of social protection through an accident insurance fund (1895) and sickness funds for craft workers (1902).

After 1922 the Health Directorate was moved to the Ministry of Labour, Health and Social Protection, marking a shift toward broader social policy integration. The 1930 health law created a dedicated health and protection fund to support care for the poor, public health activities and infrastructure development. Throughout the interwar period, social and sickness insurance funds expanded their coverage to include more categories of workers, culminating in the consolidation of all these funds into a unified system in 1933.

After the accession to power of the communist regime, the health system was reorganized according to the Soviet (Semashko) model under the law for state health organization issued in 1943 (Parliament of Romania, 1943), and from 1948 to 1949 all private health providers were nationalized (Great National Assembly, 1948).

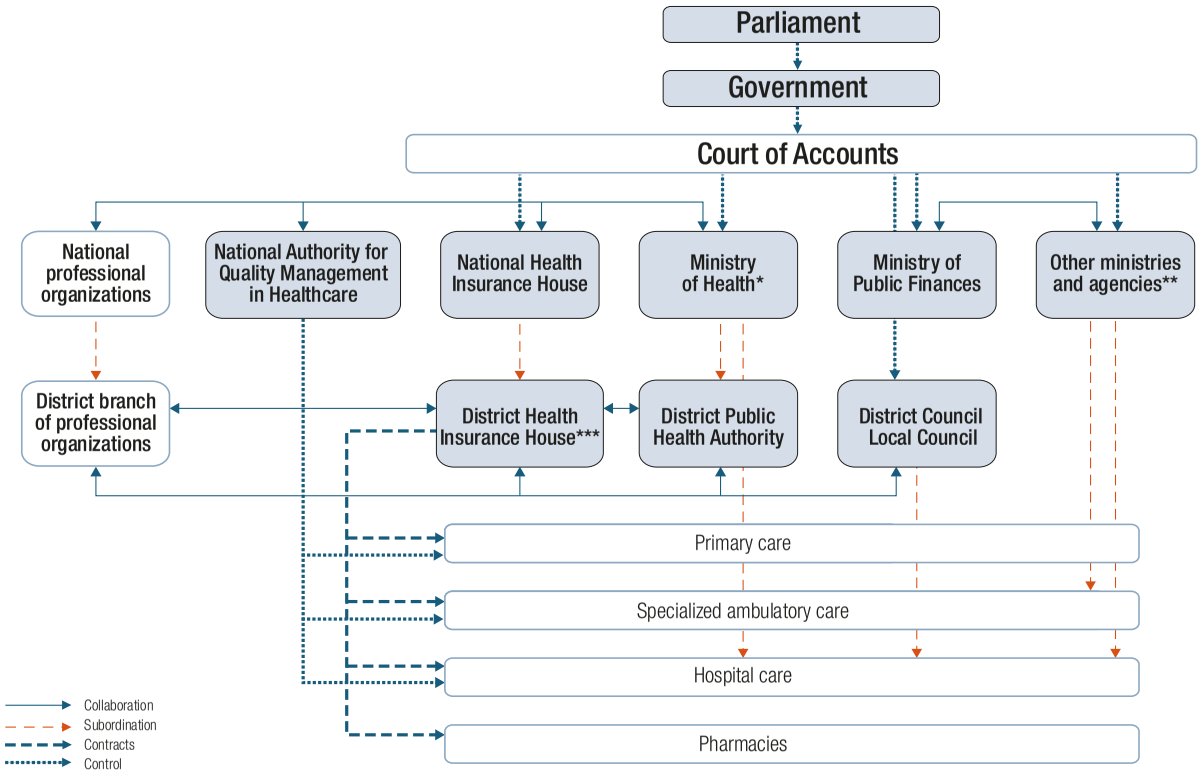
The end of the communist regime precipitated many reforms of the health system, with the fundamental change being the introduction of an SHI system in 1999. The latest major legislative act was Law no. 95 on Healthcare Reform in 2006. The reform introduced a comprehensive framework act comprising 20 titles covering almost all aspects of the health sector, including financing, organization and governance, provision of services including public health, primary care, emergency care, specialized outpatient care, hospital care, pharmaceutical care and healthcare professionals' practice, as well as the coordination of the Romanian SHI system with the SHI systems of other EU Member States. The Law has been subject to over 1300 amendments, being republished in 2015 in the Official Gazette as a revised version, and has been further modified another 215 times up to the date of writing (December 2025).

2.2 Organization

According to Law no. 95 of 2006, the Romanian health system is organized at two main levels: national and district (*judet*) (see Fig. 2.1). The national level is responsible for health policy making and implementation, administration and regulation of public funds, setting standards for ensuring the quality of the services provided. The highest authority within the health system is the Government, which performs its stewardship role through the Ministry of Health. There are also several ministries operating their own parallel health systems, by receiving allocated funds from the state budget to finance their own health facilities, funds for investments or specific health programmes. These include the Ministry of Transport, the Ministry of National Defence, the Ministry of Internal Affairs, the Ministry of Justice and the Romanian Intelligence Agency.

The SHI system is centrally administrated by the NHIH. The district level is responsible for ensuring service provision according to the rules set by the central level. There is a health insurance house covering employees of the Ministry of National Defence, the Ministry of Internal Affairs, the Ministry of Justice and the agencies related to national security. However, the parallel structures are all under contractual relationship with the district health insurance houses, as the patient, regardless of where they are employed, has the free choice of service provider and of health insurance house.

FIGURE 2.1 Overview of the health system



Source: Based on Vlădescu et al., 2008

Notes: * The Ministry of Health has several directly subordinated institutions of national importance, such as the National Institute of Public Health and the National Agency for Medicines and Medical Devices (NAMMD); **The Ministry of Transport, Ministry of National Defence, Ministry of Internal Affairs, Ministry of Justice and the Romanian Intelligence Agency; *** Including the Health Insurance House covering employees of the Ministry of National Defence, the Ministry of Internal Affairs, the Ministry of Justice and the agencies related to national security.

National authorities

The **Parliament** is the legislative authority of the country, adopting health- and healthcare-related legislation, including the budget law. The parliamentary functions in the area of health are supported by two specialty commissions: the Commission for Health and Family of the Deputies Chamber and the Commission for Health of the Senate.

The **Government** is the public authority of executive power that approves health strategies, policies and programmes. During national public health emergencies or parliamentary vacations, legislative authority is delegated to the national Government, which can issue emergency ordinances – these have the same legal force as ordinary laws. Through its ministries, the Government administrates financial resources in the public sector. The Court of Accounts exercises control over the efficient use and administration of public resources, which includes reporting to the Parliament, public institutions and authorities, as well as taxpayers.

The **Ministry of Health** is the central administrative authority in the health sector, responsible for the governance and stewardship of the system. It drafts legislative documents to be submitted to the Parliament and the Government for approval, regulates standards in the health system, including in the pharmaceutical sector, sanitary inspection and purchasing of health services. It monitors and evaluates population health status, and elaborates and coordinates the implementation of national health programmes and policies on human resources in the health sector. Further, it administrates the international technical assistance programmes supporting health reforms, ensures implementation of international agreements and collaborates with other ministries and central agencies to achieve a Health in All Policies approach.

Several important institutions with responsibilities in specific areas are subordinated to the Ministry of Health. The **National Institute of Public Health** is responsible for the surveillance of population health, health needs assessment, monitoring community health risks, health statistics and information, maintaining disease registries (their level of development varies), coordination and monitoring of preventive health programmes, health promotion and health education. The **National Agency for Medicines and Medical Devices** (NAMMD) has the responsibility for the authorization and surveillance of medicinal products for human use and medical devices, HTA of pharmaceuticals, and ensuring access to useful and accurate information on medicinal products for human use authorized for marketing in Romania. Some other

national institutions are directly subordinated to the Ministry of Health, such as the National Agency for Transplants, the National Institute of Transfusion Haematology, the Medical Science Academy and others, including 58 hospitals of different categories. The National School for Public Health, Management and Professional Development was transformed in 2022 into the National Institute for Health Services Management (NIHSM) and is subordinate to the Ministry of Health. The NIHSM is responsible for processing and validating all data used for reimbursing hospitals under the contractual arrangement with the district health insurance houses. The provision of management training for hospital managers and of continuing medical education also falls under its realm and it has an extended role in management training at all sectors and levels of the health system. In addition, its new responsibilities since 2022 include health services assessment and development of regional healthcare plans.

The **Ministry of Public Finances** approves the yearly budget of the Ministry of Health and the budget of the SHI fund, oversees the financial resources raised for and spent on healthcare, and plays a key role in decision-making on health sector reforms when they involve changes in public finances.

Other ministries – including the Ministry of Transport, the Ministry of National Defence, the Ministry of Internal Affairs, the Ministry of Justice and the Romanian Intelligence Agency – own and operate parallel structures for providing health and care services, with separate healthcare facilities (hospitals, polyclinics and dispensaries). The Ministry of National Education collaborates with the Ministry of Health on the organization of postgraduate training for health personnel and the Ministry of Labour and Social Protection finances several LTC facilities or home services providing medical and social care. Further, through the Law on community healthcare issued in 2017, the Ministry of Health, the Ministry of National Education, the Ministry of Labour and Social Protection and the Ministry of Regional Development and Public Administration collaborate to ensure the provision of integrated services at the community level.

District authorities

The Ministry of Health is represented at the district level by **41 District Public Health Authorities** (DPHAs), one in each of the 41 districts plus one in the municipality of Bucharest. The DPHAs are mainly responsible for carrying out the functions of the Ministry of Health related to population

health at the local level, including monitoring the health status of the population; developing, implementing and evaluating public health programmes; organizing health promotion and disease prevention activities; as well as controlling and evaluating healthcare provision and the functioning and organization of healthcare providers.

The **district councils** are the elected bodies of the local government with the main goal of coordinating the work of local (municipal, city and communal) councils in their geographical areas to ensure the provision of public services, such as sanitation and waste management. The 1991 local public administration law made the local councils responsible for ensuring the conditions necessary for the functioning of health facilities in their area, such as paying for utilities, maintenance and repairs. Since 2002 the district councils have administrated the grounds and the buildings of public hospitals in their respective areas and established and financed medicosocial facilities, such as nursing homes for older people and LTC facilities for chronically ill or disabled people. Between 2008 and 2010 a decentralization reform transferred some responsibilities of the Ministry of Health to the local councils, including the management and administration of 373 district, municipal, city and communal hospitals. In Bucharest, where the local administration is in charge of 19 hospitals, 451 medical offices and 157 dental offices in schools and universities, the Administration of Hospital and Medical Services Bucharest has been established as a dedicated structure to manage these new tasks.

Payers

The **NHIH** is an autonomous public institution that manages the SHI system within the constraints of the Government's health policies. It administrates the SHI fund, together with the subordinated District Health Insurance Houses (DHIHs). It draws up legislative documents to be considered by the Government, such as the Framework Contract which regulates the provision of health services, medicines and other health technologies under the SHI system, including drawing up the health benefits package and the list of covered medicines. It also develops secondary legislation related to the provision of services and provider-payment mechanisms in collaboration with the Ministry of Health, and regulations related to the functioning of the SHI system. Further, it decides on resource allocation from the NHIF to the DHIHs and supervises and coordinates their activity, having the power to issue implementing regulations that are mandatory for all DHIHs.

There are **43 DHIH**s, one in each of the 41 districts plus the Bucharest Health Insurance House and one insurance house for the employees of the Ministries of National Defence, Internal Affairs and Justice and the agencies related to national security. They are mainly responsible for concluding contracts with public and private health service providers at the local level, monitoring these contracts, keeping updated records on insured persons, and informing and assisting both the insured persons and service providers on SHI-related issues.

Provider organizations

There are five independent **professional organizations** representing and regulating their respective health professions in terms of controlling and monitoring professional practice, training and accreditation: the College of Physicians, the College of Dentists, the College of Pharmacists, the Order of Nurses and Midwives, and the Order of Biochemists, Biologists and Chemists. They are also consulted when debating the main legislative drafts, such as the Framework Contract. Additionally, the College of Physicians and the Order of Nurses and Midwives have representatives in the administrative councils of the hospitals, along with the local authority and trade union representatives. Membership in these organizations is mandatory for all health professionals who practise in Romania. They are organized at the national and district levels.

Other agencies

The **National Authority for Quality Management in Health (NAQMH)** was established in 2015 as a central public administration institution under the direct coordination of the Prime Minister. This new agency incorporated the National Commission for Hospital Accreditation, which was established in 2008. Its responsibilities include elaborating, in collaboration with the Ministry of Health, the national strategy for quality assurance in health; drafting legislative proposals to ensure harmonization with international regulations; elaborating accreditation standards, methods and procedures for healthcare providers; accrediting training and technical consultancy providers in the field of health quality management; evaluating, re-evaluating and accrediting health providers and monitoring that appropriate quality standards are in place in healthcare facilities at all levels of care; and performing research activities in the area of health

services quality. A draft for a national strategy for quality assurance in health was available for discussions in 2018 but then dropped. Aspects related to quality of health services were included in the National Health Strategy 2023–2030.

Patients have been increasingly empowered to take a proactive role in the health system through numerous **patient associations** that aim to represent their interests. These associations participate in the public debates of legislative drafts and have representatives on the administrative board of the NAQMH. There are 165 patient associations that are enrolled in the Community of Patient Associations online platform (https://www.caspa.ro/).

2.3 Decentralization and centralization

Despite attempts to decentralize the health system, it remains highly centralized, as the main national level institutions – the Ministry of Health and the NHIH – not only have regulatory roles, but also keep a tight control and approve most of the decisions of their subordinated units at the district level. The final decisions in health financing also lie at the central level, with the Ministry of Public Finances.

Despite the transfer of the administration of hospitals from the Ministry of Health to the local level between 2008 and 2010 (see Section 2.2), the Ministry retained the responsibility for approving changes to the structure of hospitals. The Ministry further has the authority to extend the scope of its influence in public health emergency situations. For example, during the COVID-19 pandemic, the Ministry coordinated hospitals administrated by the local authorities and made key decisions such as on the redeployment of hospital beds and healthcare personnel based on the daily reporting of bed occupancy in the electronic centralized operational coordinating centre that was newly established within the Ministry of Health (see Section 2.6).

2.4 Planning

Planning activities have not reached their full potential in the Romanian health system but there are initiatives, some funded by the EU, which may help to improve policy planning and implementation capacities (see Box 2.1).

BOX 2.1 Is there sufficient capacity for policy development and implementation?

Deficiencies in policy development and planning capacity in the health sector are formally acknowledged in the National Health Strategy 2023–2030, where strengthening health system governance is one of its general objectives. Specific objectives include increasing health authorities' governance capacity; increasing capacity and professionalization of health policies planning and implementation; development and implementation of planning and priority setting tools; and monitoring health system performance.

The strategy also mentions increasing capacity for human resource planning and development. This was further detailed in the specific Human Resources Development Strategy 2022–2030, which is also in line with WHO's Global Strategy on Human Resources for Health: Workforce 2030.

With WHO support, in 2022 the Ministry of Health developed five Sectoral Action Plans – for primary healthcare, public health, hospital care, ambulatory care and community care, and in 2023 initiated the development of a national Health Workforce register (James et al., 2024).

Other sectoral or specific strategies or plans are: The National Plan for Cancer Control, which was developed in 2022 in the context of Europe's Beating Cancer Plan, the National Strategy for Tuberculosis Control for the period 2022–2030 and the National Strategy for Surveillance, Control and Prevention of HIV/AIDS 2022–2030, both developed by the Ministry of Health with support from the Global Fund to Fight AIDS, Tuberculosis and Malaria and WHO, and the 2024–2030 National Strategy to Fight Cardiovascular and Cerebrovascular Diseases.

Better planning of health services driven by population needs is also required. The assessment of health needs, which now falls under the remit of the NIHSM in cooperation with other institutions, such as the National Institute of Public Health, and the subsequent development of eight Regional Masterplans for health services development can potentially support this objective. Regional plans were first elaborated in 2016 and later updated for 2021–2027 and were part of ex-ante conditionalities for accessing European Structural and Investment Funds.

The European Commission's Recovery and Resilience Facility, which aims to support Member States to mitigate the economic and social impact of the COVID-19 pandemic, presents a great opportunity for improving policy development and implementation in Romania. To access funding under this instrument, which allotted over €2 billion specifically for healthcare, Romania committed to, among other things, increase capacity to manage public health funds; increase capacity to undertake investments in health infrastructure; increase health management capacity, including within the DPHAs and DHIHs; and increase human resources in health (European Commission, 2021a).

While during recent years some general or sectoral strategies have been developed – many at the request of external financing institutions – not all of them were based on a proper needs assessment and their implementation was neither monitored nor evaluated (Vlădescu et al., 2016). National health strategies are proposed by the Ministry of Health and approved by the Government. The last published strategy is the 2023–2030 National Health Strategy "Together for Health" that was developed as one of the ex-ante conditionalities ahead of the signing of the 2021–2027 Partnership Agreement with the European Commission on funding through the European Structural and Investment Funds, in order to ensure effective and efficient use of these funds (Government of Romania, 2023a). The strategy has an implementation action plan that includes a budget estimate, financing sources, allocation of responsibilities, and monitoring indicators and reporting terms (Ministry of Health, 2023a).

2.5 Intersectorality

Protecting population health by addressing determinants of health has also been a priority for sectors other than health, especially since 2007 when Romania joined the EU and had to implement EU legislation or translate it into its national laws. Some of the key health-related responsibilities of other ministries and agencies are presented in Table 2.1.

Intersectoral collaboration is taking place at ministerial councils, committees and commissions. These have a consultative role and have been established by a Government Decision with the purpose of the development, integration, coordination and monitoring of intersectoral public policies. There exists a provision for these to be established by the Prime Minister for specific operational purposes (Government of Romania, 2019). Another form of collaboration is through the implementation of intersectoral strategies, as for example the National Strategy on Long-Term Care and Active Ageing for 2023–2030 proposed by the Ministry of Labour and Social Solidarity, and under responsibility of the Ministry of Health also (Government of Romania, 2022a).

Joint regulations are commonly issued in specific, interconnected areas. These are usually orders signed by two or more ministers. Any new legislative proposal, in any area, must be accompanied by a substantiation note that

includes a section on its social, environmental and economic impact. There is no specific requirement to assess the impact on health, but this could be included either under the social or environmental impact, if it is assessed (Parliament of Romania, 2000). A methodology for conducting health impact assessments was developed in 2019 and mainly applies to building construction projects and evaluates their impact on the environmental determinants of health. The assessments are coordinated by the National Institute of Public Health through the National Centre for Environmental Health Risk Monitoring (Ministry of Health, 2019a).

TABLE 2.1 Selected health-related responsibilities of other ministries and agencies

ENTITY / INSTITUTION	HEALTH DETERMINANTS-RELATED RESPONSIBILITIES
Ministry of Labour and Social Solidarity	• Ensuring an adequate employment level, especially among vulnerable and disadvantaged groups • Development of social protection policies • Ensuring safety and health at work • Provision of work accidents and occupational diseases insurance • Disability and work capacity assessment
Ministry of Environment, Water and Forests	• Control of industrial pollution • Control of noise and air pollution • Ensuring biological security • Waste and dangerous substances management • Climate change policies
Ministry of Agriculture and Rural Development	• Ensuring food security • Rural development policies
National Sanitary Veterinary and Food Safety Authority	• Ensuring food safety, including through pesticides monitoring • Prevention and control of transmittable animal diseases
Ministry of National Education	• Education on health and nutrition • Provision of education for children with disabilities, including home teaching or teaching in health facilities
Ministry of Transport	• Traffic safety policies
Ministry of Public Finance	• Taxation policy on alcohol, tobacco and coffee
Ministry of Internal Affairs	• National anti-drug strategy • Ensuring disasters and emergencies management and preparedness
Ministry of National Defence	• Research and development • Ensuring safety and security against biological threats

Source: Authors' own compilation

2.6 Health information systems

There is currently no policy or strategy in the field of health information, although a recent draft is under public consultation. There are several information systems with only a small degree of interoperability of existing databases, using different software, reporting formats, definitions and standards. This can be considered a burden on health data providers, as the same data often need to be reported to various systems but in different formats. The integration of all information systems was a specific objective of the National Health Strategy 2014–2020 "Health for Prosperity", but progress has been limited so far. The 2023–2030 National Health Strategy also has specific objectives related to better management of the health information system, integration and interoperability.

The main health information system is managed by the Ministry of Health through the National Centre of Statistics and Informatics in Public Health at the National Institute of Public Health (see Section 5.1). It collects a very large volume of data from healthcare providers, via DPHAs, mainly on health services provision and utilization (such as the number of medical consultations, inpatient days, average length of stay or bed occupancy) and data on morbidity.

The National School of Public Health Management and Professional Development, which was transformed into the NIHSM in 2022, was tasked in 2003 to collect and process patient-level clinical data from hospitals, including to support updating of DRGs (see Section 3.7). From 1997 to 2007 the Integrated Unique Informatics System was developed, piloted and implemented by the NHIH. This includes data on healthcare services received by each patient, provider payment and the administration of the NHIF (for example, the running costs of the DHIHs). Data are collected and analysed by the DHIHs, aggregated, and administered at the central level. The electronic prescription informatics system was added to the Integrated Unique Informatics System in 2012, the electronic health card in 2015 and electronic patient records in 2021. There is a degree of data interoperability among the information systems under the Integrated Unique Informatics System, but in many cases providers transmit the same data more than once, in different formats.

Despite a considerable amount of data being collected, they are rarely used for systematic and comprehensive health system performance monitoring

and evaluation. There is also no feedback to the healthcare providers supplying the data and, as a result, providers cannot easily compare themselves to other providers or make decisions based on these data. A positive development, however, has been the introduction of an electronic platform (CAPESARO), in 2020, for collecting data to be used in the accreditation process of healthcare providers by the NAQMH (NAQMH, 2020). In the same year a Structural Funds-financed project was initiated by the Ministry of Health and the Authority for the Digitalization of Romania to develop an informatics system for health registries, although they are not yet fully functional at the national level (see Section 1.4).

Collected data are published annually in statistical reports and in thematic bulletins (for example, there is a bulletin on the causes of deaths). Other reports are made available upon request. The database, however, suffers from major deficiencies, with collected data frequently being incomplete and some key information missing. For example, routine data on health determinants and disease risk factors are not collected and information on the provision of services and utilization does not reflect the activity of the entire system because information on the activity of private physicians is not always collected. Further, as data are aggregated at the district level and the aggregation reflects various levels of care and population groups, access to disaggregated or individual data is difficult at the national level; for instance, it is not possible to obtain data on the activity and costs of individual providers. Also, access to disaggregated data is rather limited at the district level as not all data are publicly available. There is a lack of organized quality control and quality assurance mechanisms, and other sources that collect data on the same indicator may give different results owing to differences in methodology.

At the time of writing (December 2025), the 2024–2030 National Health Digitalization Strategy is under development, with WHO support. It aims to improve access to quality medical services, streamline the health system and support research, by integrating information technologies into all aspects of the health system (Ministry of Health, 2024).

2.7 Regulation

All regulation in the field of health is developed in the light of the Romanian Constitution that guarantees all citizens the right to healthcare. It also

obligates the state to ensure hygiene and public health and a legal framework for the organization of medical care, including regulation of medical practice and paramedical activities, a system of social security in case of sickness, accidents, recovery and maternity, as well as any other measures to protect physical and mental health.

The Parliament (see Section 2.2) is the main legislative authority and passes the main legislation governing health. Secondary legislation is issued by the Government (decisions and, in certain situations, emergency ordinances) and by the Ministry of Health, either alone or jointly with the NHIH and with other ministries (orders of the Minister and/or the NHIH President). The professional organizations as well as other institutions that represent authority in certain areas such as the NAQMH also have some regulatory responsibilities (Vlădescu et al., 2016). Since its EU accession in 2007, Romania has also been subject to European regulations, such as in the area of cross-border care, HTA and others.

2.7.1 *Regulation and governance of third-party payers*

The payer-provider split was introduced by Social Health Insurance Law no. 145/1997. The SHI system became functional in 1999 when the first framework contract regulating the purchasing of health services was issued by means of a Government Decision. Law no. 145 was replaced by Emergency Ordinance no. 150/2002 on the organization and functioning of the SHI system, and later by Law no. 95/2006 on Health Care Reform, which was republished in 2015.

The framework contract is developed by the NHIH, in consultation with the representatives of service providers, patients and civil society, and approved by the Ministry of Health and other ministries covering related domains. It is passed by a Government Decision periodically – annually before 2013 and every two years since then. The contract regulates the conditions for the provision of healthcare, medicines and medical devices, technologies and assistive devices within the SHI system, and mandates public payers to fulfil their financial obligations towards providers as specified under the services provision contracts.

The NHIH is the central authority with regulatory function in the SHI system (see Section 2.2). Besides elaborating legislative documents

for approval by the Government such as the Framework Contract, national curative programmes and lists of medicines covered by SHI, the NHIH also issues Orders implementing Government Decisions that are signed by its President, sometimes jointly with the Minister of Health. These concern methodological issues (such as the methodological norms for implementing the Framework Contract), organizational issues (such as the organization and functioning of control activity within the NHIH and at the DHIH level, and the ethical code and professional conduct of the employees of the NHIH and the DHIHs), technical issues (such as technical norms that should be used for implementing the national curative programmes, reporting documents that should be used by healthcare and medicines providers within the contracts with SHI, documents that can be used as proof of insurance status by the individuals), and pricing (such as pricing of medicines covered by the national curative programmes). The NHIH also uses Orders to establish expert commissions for the implementation of national curative programmes.

The DHIHs do not have a regulatory role. They implement legislation, rules and norms set at the higher level by concluding individual contracts with public and private health service providers and by reimbursing cross-border healthcare services. Prior to signing contracts, the DHIHs evaluate whether the providers fulfil the contractual conditions, such as in terms of health personnel, equipment, accreditation, etc. Specificities of service provision (for example, their number, type, etc.) are included in the individual contracts signed by the DHIHs with service providers. The DHIHs also have a control department that evaluates whether the contracts have been fulfilled. The DHIHs' activity is monitored and controlled by the NHIH.

Voluntary health insurance (VHI) is also covered by Law no. 95/2006 on Health Care Reform, republished in 2015, but since proper secondary legislation has not been issued so far, there are only very few payers that fall into this category.

2.7.2 *Regulation and governance of providers*

Law no. 95/2006 on Health Care Reform, republished in 2015, also applies to healthcare providers. It includes separate titles for public health, primary

healthcare, emergency care, ambulatory care, inpatient care, professional practice in the health sector, pharmaceuticals and medical devices. Since several LTC facilities are under the oversight of the Ministry of Labour and Social Protection, these are regulated by Law no. 292/2011 on social assistance.

Secondary legislation is issued by the Government, the Ministry of Health, the Ministry of Labour and Social Protection and other institutions responsible for specific areas. For example, the NHIH develops regulations and norms related to service provision, professional organizations set regulations for their respective professions, and the NAQMH issues regulations related to quality assurance and hospital accreditation. Table 2.2 provides an overview of the regulation of providers.

Primary care physicians are independent practitioners. Most of the secondary and tertiary care facilities are publicly owned and are under state administration (of the Ministry of Health, local councils, other ministries, or central agencies). The eligibility conditions for providers to enter into contracts with the DHIHs are set out in the Framework Contract and are the same for all, irrespective of whether they are public or private. Details of the contracts, such as type and volume of services, reimbursement methods and conditions, reporting requirements, etc., are included in the NHIH's Order regarding the methodological norms for implementing the Framework Contract signed jointly by the Minister of Health and the President of the NHIH.

Providers must be authorized by the DPHAs based on the criteria set by the Ministry of Health and meet adequate training and practice-licensing requirements for health professionals, as well as certain standards for equipment. Hospitals must be accredited by the NAQMH and special accreditation/authorization is also required for specific providers or activities as a precondition for signing contracts with the DHIHs (for example, from the National Accreditation Association for non-hospital laboratories, and from the National Commission for Nuclear Activities Control for radiology offices). The introduction of accreditation for other health providers at the first attempts (in 2018) faced high opposition from primary healthcare, laboratory and ambulatory services providers. The methodology for accreditation of ambulatory providers has been periodically approved and subsequently modified over 2020–2024, but at the time of writing (December 2025) the accreditation has not started yet.

TABLE 2.2 Overview of the regulation of providers

	LEGISLATION	PLANNING	LICENSING OR ACCREDITATION	PRICING OR FEE SETTING	QUALITY ASSURANCE	PURCHASING OR FINANCING
Public health services	Law no. 95/2006 on Health Care Reform, republished in 2015	Ministry of Health, National Institute for Public Health	Ministry of Health	Ministry of Health	Ministry of Health	State budget Direct payments by purchasers of services (e.g., fees for issuing authorizations for measuring environmental health determinants, etc.) EU project funding
Primary healthcare	As above	NHIH, Ministry of Health, Ministry of Finance plan the budget structure; this is subject to annual negotiations between DHIHs and providers	Ministry of Health: authorization of PHC practice Professional organizations: practice licence for physicians and nurses	NHIH and Ministry of Health	Ministry of Health	NHIH
Specialized (secondary) ambulatory care	As above	As above	Ministry of Health: authorization of ambulatory practice National Accreditation Association: accreditation of laboratories National Commission for Nuclear Activities Control: accreditation of radiology offices Professional organizations: practice licence for health professionals	NHIH and Ministry of Health	Ministry of Health	NHIH Direct payments by service users
Specialized inpatient care	As above	As above	Ministry of Health: authorization of hospitals NAQMH: accreditation of hospitals Professional organizations: practice licence for health professionals	NHIH and Ministry of Health	Ministry of Health NAQMH Internal quality assurance through the management of health services quality structure within hospitals	NHIH Ministry of Health

Urgent and emergency care	As above	As above	Ministry of Health: authorization of ambulance services Professional organizations: practice licence for health professionals	NHIH and Ministry of Health	Ministry of Health NAQMH Internal quality assurance through the management of health services quality structure within ambulance services	NHIH Ministry of Health
Dental care	As above	As above	Ministry of Health: authorization of dental practice Professional organizations: practice licence for health professionals	NHIH and Ministry of Health	Ministry of Health	Direct payments by service users NHIH (small share)
Pharmaceutical care	Law no. 95/2006 on Health Care Reform, republished in 2015; Law no. 266/2008 on pharmacy, republished in 2015	As above	Ministry of Health: authorization of pharmacies College of Pharmacists: practice licence for pharmacists	NHIH and Ministry of Health	Ministry of Health	NHIH Co-payments and direct payments (over the counter) from households
LTC	Law no. 95/2006 on Health Care Reform, republished in 2015. Law no. 292/2011 on social assistance	NHIH, Ministry of Health, Ministry of Finance plan the budget structure; this is followed by annual negotiations between DHIHs and providers Ministry of Labour and Social Protection	Ministry of Health: authorization of LTC institutions NAQMH: accreditation of hospitals Professional organizations: practice licence for health professionals	NHIH and Ministry of Health Ministry of Labour and Social Protection	Ministry of Health	NHIH Ministry of Labour and Social Protection
University education of personnel	Law no. 193/2023 on higher education and subsequent legislation	NHIH, Ministry of Health, Ministry of Finance plan the budget structure; this is followed by annual negotiations between DHIHs and providers Ministry of Labour and Social Protection	Ministry of National Education	Universities	Ministry of National Education	State budget Direct payments

Source: Authors' own compilation

The quality of health services provision is regulated by Law no. 185/2017 on quality assurance in health that nominates the Ministry of Health and the NAQMH as the institutions responsible for developing policies and strategies in this area. The NAQMH drafted the National Strategy for Quality Assurance in Health for 2018–2025, but at the time of writing (December 2025) the document has not been finalized and officially launched. The NAQMH has comprehensive responsibilities, from setting accreditation standards and evaluating providers against these standards, to raising awareness, provision of training on quality, and administration of a database on quality of services in all providers. Through a common Order issued by the Ministry of Health and the NAQMH, hospitals and ambulance services must establish an internal structure for managing health services quality (Ministry of Health & NAQMH, 2020).

Clinical practice guidelines for different specialties or diseases and therapeutic protocols are developed by the Ministry of Health in collaboration with specialty medical associations and agreed by the College of Physicians. They are approved by the Minister of Health. Each hospital must develop its own clinical protocols, based on the national guidelines, as a prerequisite for entering contracts with the DHIHs. Participation in quality improvement activities such as professional development can be recognized by the College of Physicians and points of continuous medical education are awarded to participants.

2.7.3 *Regulation of services and goods*

Basic benefits package

The benefits packages covered by the SHI system are defined by Law no. 95/2006 on Health Care Reform, republished in 2015, as follows:

- A benefits package – this is a package of publicly financed services for insured people, and includes medical services, healthcare services, pharmaceuticals, sanitary materials, medical devices and other services;
- A minimum benefits package – this package is for those who are uninsured and includes healthcare services, pharmaceuticals and sanitary materials, but only in the case of health emergencies, communicable

disease outbreaks, during pregnancy and post-partum. Primary care, family planing and community care are also covered.

Decisions on the inclusion/exclusion of the services and medical goods in the statutory benefits package are taken by the NHIH and the Ministry of Health, after consultations with different stakeholders. There are no clear inclusion or exclusion criteria. Decisions for inclusion/exclusion of pharmaceuticals in the benefits list are approved by a Government Decision based on assessments carried out by the HTA unit of the NAMMD.

HTA

HTA has been introduced following the publication of Directive 2011/24/EU on the application of patients' rights in cross-border healthcare which had to be transposed into Romanian Law. The HTA unit within the NAMMD is the national competent authority for HTA in Romania. The assessment methodology is approved by the Ministry of Health (Order no. 861/2014). It concerns solely pharmaceuticals, and it is based on a scorecard system that is largely linked to the reimbursement status in other countries. The assessed molecule receives a certain number of points for several criteria: the reimbursement status in other EU countries and the United Kingdom, a local real-world data study and a budget impact assessment. According to the obtained score the drug is listed, delisted or included on commercial arrangements-related conditions (Scîntee, Ciutan & Vlădescu, 2021).

HTA capacity is considered insufficient, precluding Romania from actively participating in joint clinical assessments at the EU level. However, there are initiatives to further develop the HTA system. A working group on HTA development was established in 2015 at the Ministry of Health with responsibility for initiating and supervising an offset of World Bank capacity development projects. The first of these projects presented three alternative models, all of them suggesting creating a pool of experts, selected among existing national experts, to increase the HTA capacity and enable inclusion of non-pharmaceuticals in the HTA process. Some of the recommendations were adopted in the new Law no. 134/2019 on the reorganization of the NAMMD. Further activities on HTA methodology are planned to be carried out under the second World Bank project, which started in July 2023, but up to the time of writing (December 2025) there is no publicly available report on their implementation.

2.7.4 *Regulation and governance of pharmaceuticals*

Pharmaceuticals are regulated by Law no. 95/2006 on Health Care Reform, republished in 2015, that appointed the NAMMD as the national competent authority. Together with the Ministry of Health, the agency is responsible for developing secondary legislation in this field. Wholesalers and pharmacies are operating under Law no. 266/2008 on pharmacy, which was also republished in the Official Gazette in 2015, as a revised version including numerous additions and modifications to its original version.

Regulation of pharmaceutical products

Law no. 95/2006 includes provisions related to pharmaceuticals market access, manufacture and importation, labelling, wholesale distribution, advertising and pharmacovigilance. The NAMMD is responsible for market authorization and surveillance of the safety of medicinal products on the market.

No medicinal product may be placed on the Romanian market without a marketing authorization issued by the NAMMD, except for pharmaceuticals that must be authorized by the European Medicines Agency (EMA) through a centralized procedure. Medicines outside the scope of the centralized procedure may be authorized with the use of EU mutual recognition and decentralized procedures. The national marketing authorization procedure takes a maximum of 210 days to complete and its results together with the evaluation report are published by the NAMMD. Every year, the NAMMD issues an index of medicinal products authorized for marketing in Romania (https://nomenclator.anm.ro/medicamente). The marketing authorizations are issued for five years, and these may be renewed indefinitely or for a further five years depending on certain pharmacovigilance criteria. Certain homoeopathic or traditional medicinal plant-based drugs are subject to simplified market authorization procedures.

The NAMMD is also responsible for authorizing and controlling local pharmaceutical producers. Any new pharmaceutical product must be registered by the Romanian State Office for Inventions and Trademarks. The NAMMD also operates the pharmacovigilance system in line with Directive 2001/83/EC on the European Commission Community code relating to medicinal products for human use and its subsequent modifications and additions.

Patent protection is governed by the Patent Law. According to this law, a supplementary patent protection certificate may be obtained for pharmaceutical products in accordance with the Council Regulation (EEC) no. 1768/92 of 18 June 1992 and Regulation (EC) no. 1610/96 of the European Parliament and of the Council of 23 July 1996.

Conditions for pharmaceutical advertising are stipulated in Law no. 95/2006. Advertising of products that do not have a valid marketing authorization, prescription-only drugs, drugs that contain psychotropic or narcotic substances or drugs covered by SHI is not permitted. Advertising should encourage the rational use of drugs and may not be misleading.

Regulation of pharmacies and wholesalers

Law no. 266/2008 and its subsequent revisions and secondary regulations provide provisions for pharmaceutical services and types of pharmacies, including online pharmacies. The Ministry of Health decides whether a new pharmacy can be established depending on the ratio of existing pharmacies and the number of residents. In urban areas the total number of pharmacies cannot exceed one pharmacy per 4000 inhabitants; in district capital cities the ratio cannot be higher than one per 3500, and in Bucharest one per 3000. The other requirements (in terms of endowments and staffing) for new pharmacies and authorizing conditions are set in the Ministry of Health Order no. 444/2019. Inspection and control of pharmacies are performed by the Ministry of Health and the NAMMD.

Prescriptions are issued electronically, by generic name (International Non-proprietary Name, INN), except in cases where there may be adverse reactions, when the prescribed medicine can affect the efficacy of other products, and for pharmaceuticals included in a cost–volume–outcome agreement. The pharmacists must inform the patient of the available generic substitutes and must dispense the cheapest drug. Online sales are allowed only for over-the-counter drugs.

Besides the existing legislation on counterfeit drugs, in 2018 Romania started the implementation of the European Drug Verification System, in accordance with Directive 2011/62/EU on preventing entry of falsified medicinal products into the legal supply chain (Dorobantu, 2018). A specific NAMMD website (www.crimemedicine.ro) provides warnings, informs on existing legislation and provides a route for the reporting of counterfeit drugs.

Since 2011 a claw-back system has been in place. Currently, the marketing authorization holders of the drugs on the reimbursement list must pay trimestral contributions of 15% of the total value of consumed pharmaceuticals for domestic drugs, 25% for foreign innovative drugs and 20% for foreign generic drugs (Law no. 53/2020). In addition, for drugs that are conditionally included on the reimbursement list, cost–volume and cost–volume–outcome agreements can be negotiated since 2015 (Law no. 95/2006).

Wholesale distribution and storage of medicinal products are allowed only for medicinal products that have a marketing authorization granted by the NAMMD or through the EU centralized procedure. Pharmacies are not allowed to conduct the wholesale of drugs.

Pricing of prescription pharmaceuticals

The pricing methodology is established by the Ministry of Health and is applied to all drugs that have a market authorization from the NAMMD or from the EC (after an evaluation by the EMA), except for the drugs authorized through EMA centralized procedures and procured centrally by the EC. Another exception was made for the drugs included in the treatment protocol for a SARS-CoV-2 infection.

The regular procedure includes that the marketing authorization holder submits to the Ministry of Health the price as suggested by the manufacturer. The price is then compared with the prices of the same product in the following reference countries: Czechia, Bulgaria, Hungary, Poland, Slovakia, Austria, Belgium, Italy, Lithuania, Spain, Greece and Germany. The price in Romania can only be lower than or equal to the lowest price among the reference prices. If the drug is not registered in any of the reference countries, then the proposed price is used as reference.

The price of a new generic cannot exceed 65% of the reference price of the original drug. The formula to calculate the maximum retail (pharmacy) price considers the manufacturer's price (ex-factory price), wholesale price and VAT (9% in Romania). The mark-ups of the wholesaler and the pharmacist depend on the price of the package and discounts; importers may give discounts to wholesalers and wholesalers may give discounts to pharmacies. The total mark-up of the wholesalers and pharmacies varies from 10% for prices up to 300 RON (around €60) and 24% for prices below 25 RON (around €5). For drugs priced at over 300 RON, the mark-up becomes a flat rate of 30 RON (around €6) for the wholesaler and 35 RON (around €7)

for the retailer. Once a year, prices can be adjusted for exchange rate fluctuations. Retail prices are published in the national catalogue of drugs (*CAtalogul NAtional al MEDicamentelor*, CANAMED), which is updated quarterly (Ministry of Health, 2023a).

Public reimbursement of pharmaceuticals

The list of reimbursed outpatient medicines, represented by their INNs, is approved by a Government Decision. Since 2014, the list is updated based on the results of the assessments performed by the HTA department of the NAMMD (see Section 2.7.3). An Order of the President of the NHIH specifies, for each approved INN, the actual commercial products that are reimbursed and their characteristics (form, dose, concentration, etc.), their reference price, the maximum reimbursed amount, and the maximum user charge (co-payment).

2.7.5 *Regulation of medical devices and aids*

Law no. 95/2006 on health reform sets the legislative framework for the use of medical devices. A special department of the NAMMD is charged with developing norms, regulations and standards in this area that need to be approved by the Ministry of Health. The NAMMD evaluates and authorizes national producers, import firms, sellers and wholesalers, and supervises the medical devices market. All authorized devices are included in the national database administered by the NAMMD (ANMDMR, 2023).

There is a list of medical devices and aids that are reimbursed within the national health insurance system. There is no HTA process supporting the decision, nor any inclusion/exclusion criteria. An Order of the President of the NHIH sets the reference price of reimbursed medical devices (purchase or hire prices). There are also set priority criteria used in compilation of the waiting lists for prioritizing patients, such as medical criteria, age, social circumstances and others. The patient applies for reimbursement approval from the DHIH based on the medical prescription. If approved, they receive the device from the provider (after showing the DHIH decision) and the provider will be reimbursed by the DHIH. Hospitals procure medical devices for their own use. The Ministry of Health can procure medical devices centrally for the hospitals under its administration.

In 2021, the National Agency for Public Procurement, together with the American Chamber of Commerce in Romania, published a guide of good practices in medical devices procurement and opened it to public debate. There is no published follow-up at the time of writing (December 2025).

2.8 Person-centred care

2.8.1 *Patient information*

The main sources of information for patients are the health services providers. They have a legal obligation to inform patients face-to-face or through other communication channels. Most of the information disseminated on the web pages of the hospitals, the NHIH and the DHIHs concerns patients' rights and their statutory benefits. Some hospitals also provide information on different aspects of health education. Information on hospital clinical outcomes is in many cases incomplete, outdated or missing (Table 2.3). Although Law no. 46/2003 on Patients' Rights stipulates that medical information should be provided to the patient in their native language, information in minority languages is only provided in the regions with larger minority populations.

Observing patients' rights, including the right to information, is included in hospital accreditation standards but accreditation reports are not publicly available and comparative information provided by the NAQMH only reveals the accreditation status (NAQMH, 2023a). Medical errors are also reported to the NAQMH (NAQMH, 2023b) with the purpose of identifying causes and taking preventive measures, but this information is not disseminated and available to the public.

2.8.2 *Patient choice*

Opting out of the statutory health insurance system is not permitted (Table 2.4). There is one single national insurance fund, and people are part of the DHIH where they pay their contributions, usually in the district where they reside (although they are not prohibited from paying contributions to a DHIH in another district). Purchasing private health insurance cover is optional (see Section 3.5).

Patients have the free choice of provider at all levels of care, without geographical restriction and not limited to providers who have concluded a contract with the DHIH in their district. Registration with a family physician is mandatory and they may be changed no sooner than after six months. Family physicians act as gatekeepers to secondary care since accessing specialist care requires a referral. Direct access to specialists is possible only for follow-up visits for certain conditions and patient groups (see Section 5.3).

There is no evidence on the number of people who exercise free choice of their DHIH or their provider; however, except for patients switching between family physicians in cities, most people are unlikely to choose a DHIH or a provider located outside their district of residence, as this would mean an additional burden of bearing the travel costs and time.

Participation in the treatment decision and other rights concerning treatment are covered by legislation, but there is no evidence on the extent to which these rights are being exercised.

2.8.3 *Patients' rights*

Patients' rights are mainly regulated by Law no. 46/2003 on Patients' Rights. Rights of specific patient sub-groups are included in special laws, such as Law no. 487/2002 on the mental health and protection of people with mental disorders, republished in 2012, and Law no. 448/2006 on the protection and promotion of the rights of disabled people, republished in 2008.

Each hospital has a structure for ensuring quality management of health services that is responsible for monitoring the implementation of patients' rights. Hospitals are also required to have a register of procedures in place for managing complaints. Implementation of the legislation on patients' rights is assessed as part of the hospital accreditation procedure.

Patients can also submit complaints online by filling out a complaint form available on a dedicated platform for collecting patient feedback on the quality of services in public hospitals hosted by the Ministry of Health (Ministry of Health, 2023f). A patient satisfaction questionnaire post-discharge and information on patients' rights and the obligations of the insured person can also be found on the platform.

Complaints may be lodged with the Commission for monitoring and professional competence for malpractice cases within the DPHAs, with the

Professional Jurisdiction Departments of the District Colleges of Physicians or with the public relations departments of the DHIHs. Patients may also seek legal redress through civil courts (Table 2.5).

TABLE 2.3 Patient information

TYPE OF INFORMATION	IS IT EASILY AVAILABLE?	COMMENTS
Information about statutory benefits	Yes	Updated legislation and the Guide for the Insured (https://cnas.ro/ghidul-asiguratului/) published by the NHIH; the guide was published in 2021
Information on hospital clinical outcomes	Yes	Published on hospital websites, but often incomplete or outdated
Information on hospital waiting times	No	No information on waiting times, but some facilities have online appointment systems
Comparative information about the quality of other providers (e.g. GPs)	No	Only a few independent websites provide information on health services and providers (e.g. www.doctorbun.ro)
Patient access to own medical record	Yes	Access to electronic medical records is still under implementation (http://www.des-cnas.ro/pub/); currently it is possible only at the provider level, upon request
Interactive web or 24/7 telephone information	No	
Information on patient satisfaction collected (systematically or occasionally)	No	Online patient satisfaction forms/questionnaires are used by hospitals at discharge; SMS sent by the Ministry of Health to patients after discharge asking about satisfaction with the services; results are not systematically published
Information on medical errors	No	Reported to the NAQMH, but not available to the public

Source: Authors' own compilation

TABLE 2.4 Patient choice

TYPE OF CHOICE	IS IT EASILY AVAILABLE?	DO PEOPLE EXERCISE CHOICE? ARE THERE ANY CONSTRAINTS (E.G. CHOICE IN THE REGION BUT NOT COUNTRYWIDE)? OTHER COMMENTS
Choices around coverage		
Choice of being covered or not	No	Social health insurance is compulsory
Choice of public or private coverage	No	Public coverage is compulsory; private coverage is voluntary; they are not exclusive
Choice of purchasing organization	No	There is only one purchaser in the national SHI system, but people can choose their DHIH
Choices of provider		
Choice of primary care practitioner	Yes	Changing provider is possible after six months
Direct access to specialists	No	Exceptions are follow-up consultations for certain chronic conditions
Choice of hospital	Yes	Free choice
Choice to have treatment abroad	Yes	Requires previous authorization from the NHIH or the Ministry of Health
Choices of treatment		
Participation in treatment decisions	Yes	Stated by the Law no. 46/2003 on Patients' Rights
Right to informed consent	Yes	Stated by the Law no. 46/2003 on Patients' Rights
Right to request a second opinion	Yes	Stated by the Law no. 46/2003 on Patients' Rights
Right to information about alternative treatments	Yes	Stated by the Law no. 46/2003 on Patients' Rights

Source: Authors' own compilation

TABLE 2.5 Patients' rights

	YES/NO	COMMENTS
Protection of patient rights		
Does a formal definition of patients' rights exist at national level?	Yes	Law no. 46/2003 on Patients' Rights sets the rights (healthcare, respect, medical information, consent, confidentiality, privacy, including the right to erasure, rights in the area of reproduction) and regulates each of these areas
Are patients' rights included in specific legislation or in more than one law?	Yes	Law no. 46/2003 on Patients' Rights and the Ministry of Health Order no. 1410/2016 approving the application of norms Law no. 487/2002 on mental health and protection of people with mental disorders, republished in 2012
Does the legislation conform with WHO's patients' rights framework?	Yes	
Patient complaints avenues		
Are hospitals required to have a designated desk responsible for collecting and resolving patient complaints?	Yes	Hospitals are required to have a complaints management procedure, and a complaints' register
Is a health-specific Ombudsperson responsible for investigating and resolving patient complaints about health services?	No	There is no health-specific Ombudsperson; the Ombudsperson investigates and resolves patient complaints about health services without having a deputy or a specialized team in the area of health
Other complaint avenues?	Yes	DPHAs; District Colleges of Physicians; DHIHs
Liability/compensation		
Is liability insurance required for physicians and/or other medical professionals?	Yes	Liability insurance is mandatory for all providers (public and private) and is requested by the professional organization when issuing the practice licence
Can legal redress be sought through the courts in the case of medical error?	Yes	
Is there a basis for no-fault compensation?	Yes	Civil courts decide on the no-fault compensation
If a tort system exists, can patients obtain damage awards for economic and non-economic losses?	Yes	Courts decide the value of the awards for both economic and non-economic losses
Can class action suits be taken against health care providers, pharmaceutical companies, etc?	No	

Source: Authors' own compilation

2.8.4 *Patients and cross-border healthcare*

Like all EU citizens, Romanians have the right to access, and to be reimbursed for, healthcare received in any EU country under Directive 2011/24/EU on the application of patients' rights in cross-border healthcare. This was transposed into Romanian legislation mainly through Title XIX Cross-border healthcare of Law no. 95/2006, republished in 2015.

Unplanned healthcare can be accessed by Romanians in any EU Member State since 2007 by using the European Health Insurance Card. Planned care can be accessed with previous authorization from the NHIH or the Ministry of Health.

The health services previously authorized and reimbursed by SHI are approved by Government Decision no. 304/2014. The main conditions for issuing the authorization are insurance status, specialist referral and inclusion of the recommended service in the benefits package covered by the NHIH. The costs can be reimbursed up to the cost of the equivalent services in Romania.

For accessing health services and treatments that are not included in the benefits package covered by the NHIH and cannot be provided in Romania, pre-authorization is needed from the DPHA and the procedure for authorization is regulated in the Ministry of Health Order no. 50/2004. The costs of these services are paid for by the Ministry of Health through the DPHAs.

Patients can receive health services in non-EU countries, pursuant to bilateral agreements between Romania and these countries. These have been in place since before Romania joined the EU and there are currently 22 bilateral agreements in place that cover healthcare.

3

Financing

Chapter summary

- The share of gross domestic product (GDP) that Romania spends on health increased from 4.2% in 2000 to 5.7% in 2022 but remains among the lowest in the EU (8.7%) and the wider WHO European Region (8.1%).
- Public expenditure accounted for the largest part of CHE over the last twenty years, amounting to 77.7% in 2022, higher than the EU average. The rest is paid for from private sources, with almost all of them being in the form of OOP payments, and with pharmaceuticals accounting for the largest share of private spending.
- Informal payments to doctors and nurses appear to be highly prevalent but decreasing since 2017, when a significant salary increase was implemented.
- The largest part of health expenditure is spent on hospital care (43.7% in 2023), despite political pledges to shift provision to ambulatory settings, followed by pharmaceuticals (27.5%) and outpatient care (21.1%).
- To access benefits, the insured must prove their insurance status. A significant proportion of Romanians (11% in 2023) lack SHI coverage, which is partly due to the high number of Romanians living abroad but still recorded as residents in Romania.
- Purchasers are not allowed to selectively contract with providers and must contract with all providers that comply with the existing norms

and requirements. Fees are fixed, but the volumes of services are negotiated within the available budgetary limits.

- FFS and DRGs are the main methods of paying providers, with the former used for paying public health providers, primary care physicians (who also receive capitation payments and are paid for performance) and ambulatory specialists. Hospitals are paid based on DRGs, but they also receive lump sums for health programmes, case payments for provision of day care and day fees for treating chronic cases.

3.1 Health expenditure

The share of GDP spent on health increased from 4.2% in 2000 to 5.7% in 2022 (Table 3.1). Still, Romania remains among the countries with the lowest percentage of GDP spent on health among both EU countries (8.7%) and the wider WHO European Region (8.1%) (Fig. 3.1). This share has also been consistently lower than in the neighbouring countries (Fig. 3.2).

The situation looks similar in terms of per capita health expenditure, although the increase here was more substantial, from US$ PPP 246 in 2000 to US$ PPP 2472 in 2022. Despite this surge, Romania still spends half of the EU average (US$ PPP 5196), ranking last amongst all EU countries (Fig. 3.3).

Public expenditure accounted for the largest part of CHE over the last twenty years, amounting to 77.7% in 2022, which was slightly above the EU average (74.8%) and higher than in Poland (73.2%) and Hungary (72.3%), but less than in Slovakia (79.9%) (Fig. 3.4). Public expenditure on health accounted for 11.2% of general government expenditure in 2022, which was higher than in Poland (10.7%) and Hungary (9.9%), but less than in Slovakia (14.6%) and the EU average (14.6%) (Fig. 3.5).

Private expenditure has slightly increased as a share of health spending, from 20.7% in 2000 to 22.3% in 2022 (Table 3.1). OOP payments represent the largest part of private health expenditure – 96.6% in 2022. The share of OOP spending in CHE – 21.4% in 2022 – was above the EU average of 14.3%, Slovakia (19.3%) and Poland (18.8%) but lower than in Hungary (24.3%) (World Bank, 2025). A more recent study using a different methodology estimated OOP spending as 30% of CHE in 2023 (Garofil, 2024). Private insurance accounts for a very small share of private health expenditure, having increased from 0.37% in 2010 to 2.6% in 2022 (Table 3.1).

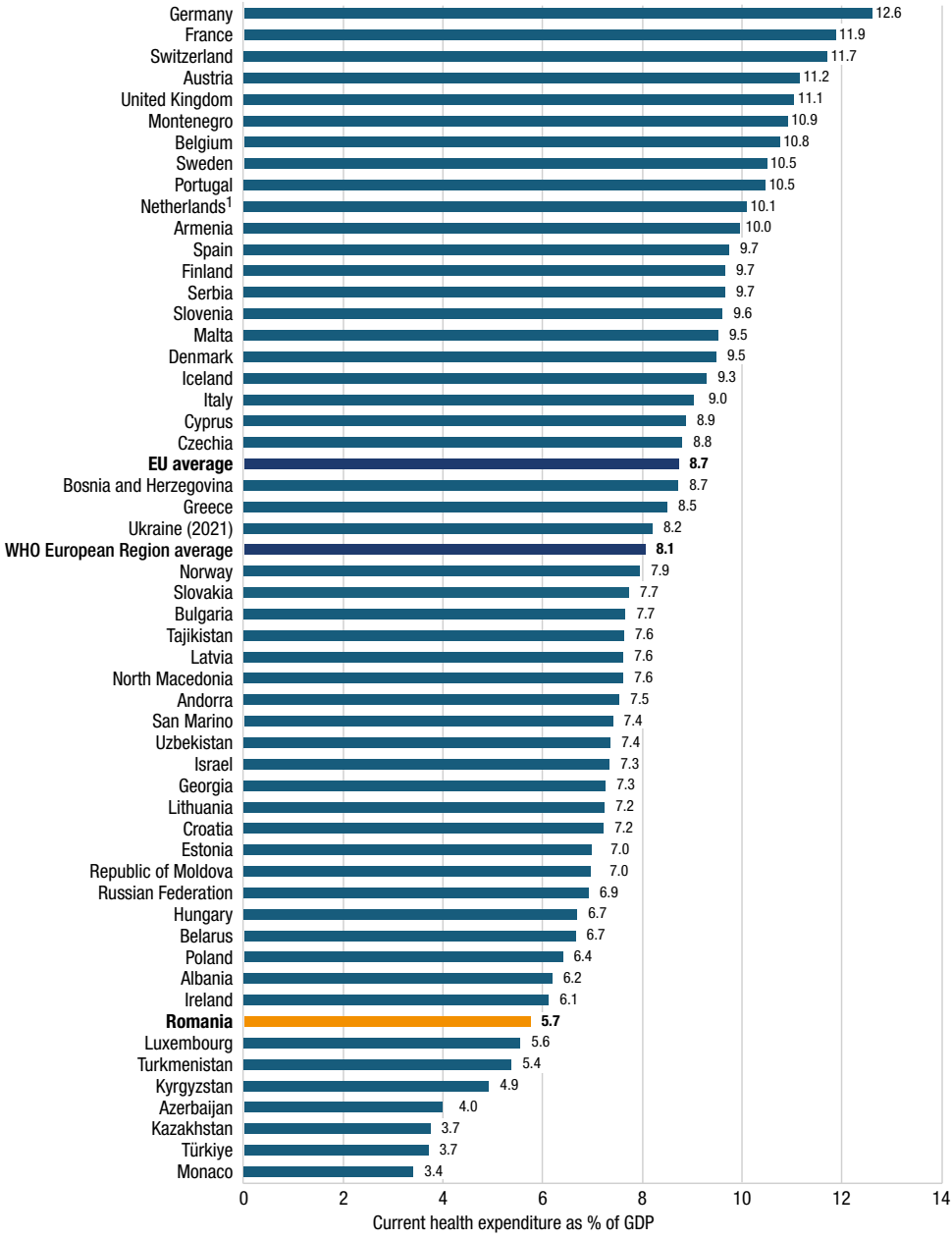
TABLE 3.1 Trends in health expenditure in Romania, 2000 to 2022 (selected years)

EXPENDITURE	2000	2005	2010	2015	2022
CHE per capita in International US$ PPP	246	529	976	1 066	2 472
CHE as % of GDP	4.2	5.5	5.6	4.9	5.7
Public expenditure on health as % of current expenditure on health	79.3	79.8	79.9	77.9	77.7
Public expenditure on health per capita in International US$ PPP	195	422	780	831	1 920
Private expenditure on health as % of current expenditure on health	20.7	19.8	20.0	22.1	22.3
Public expenditure on health as % of general government expenditure	8.7	13.2	11.4	10.7	11.2
Government health spending as % of GDP	3.3	4.4	4.5	3.9	4.5
OOP payments as % of current expenditure on health	19.4	18.5	19.6	21.3	21.4
OOP payments as % of private expenditure on health	–	93.4*	98.1*	96.8**	96.6***
Private insurance as % of private expenditure on health	–	0.4*	0.37*	1.27**	2.6***

Sources: World Bank, 2025

Note: *INS, 2012; **INS, 2018; ***INS, 2025a.

FIGURE 3.1 CHE as a share (%) of GDP in the WHO European Region, 2022

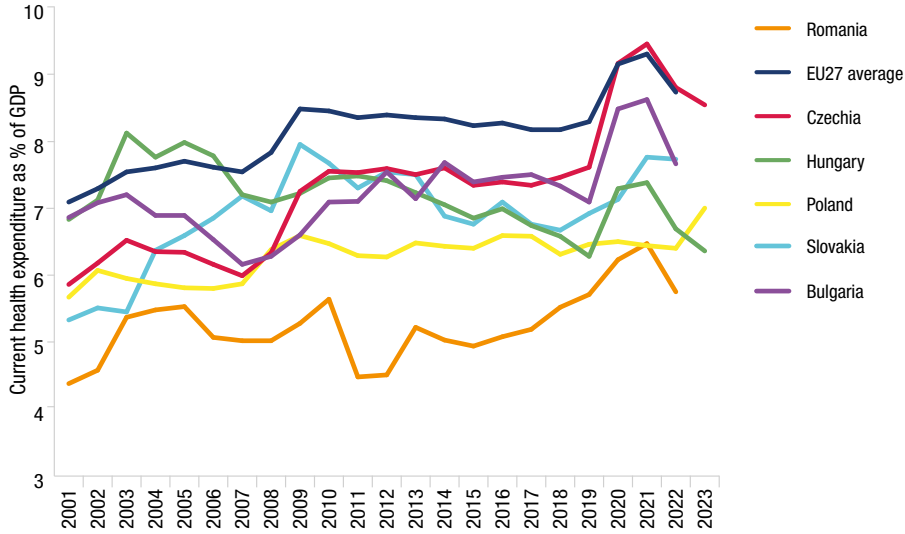


Source: WHO, 2025

Note: data for Ukraine are from 2021.

1 Note that Netherlands (Kingdom of the) comprises six overseas countries and territories and the European mainland area. As data for this review refers only to the latter, the review refers to it as the Netherlands throughout.

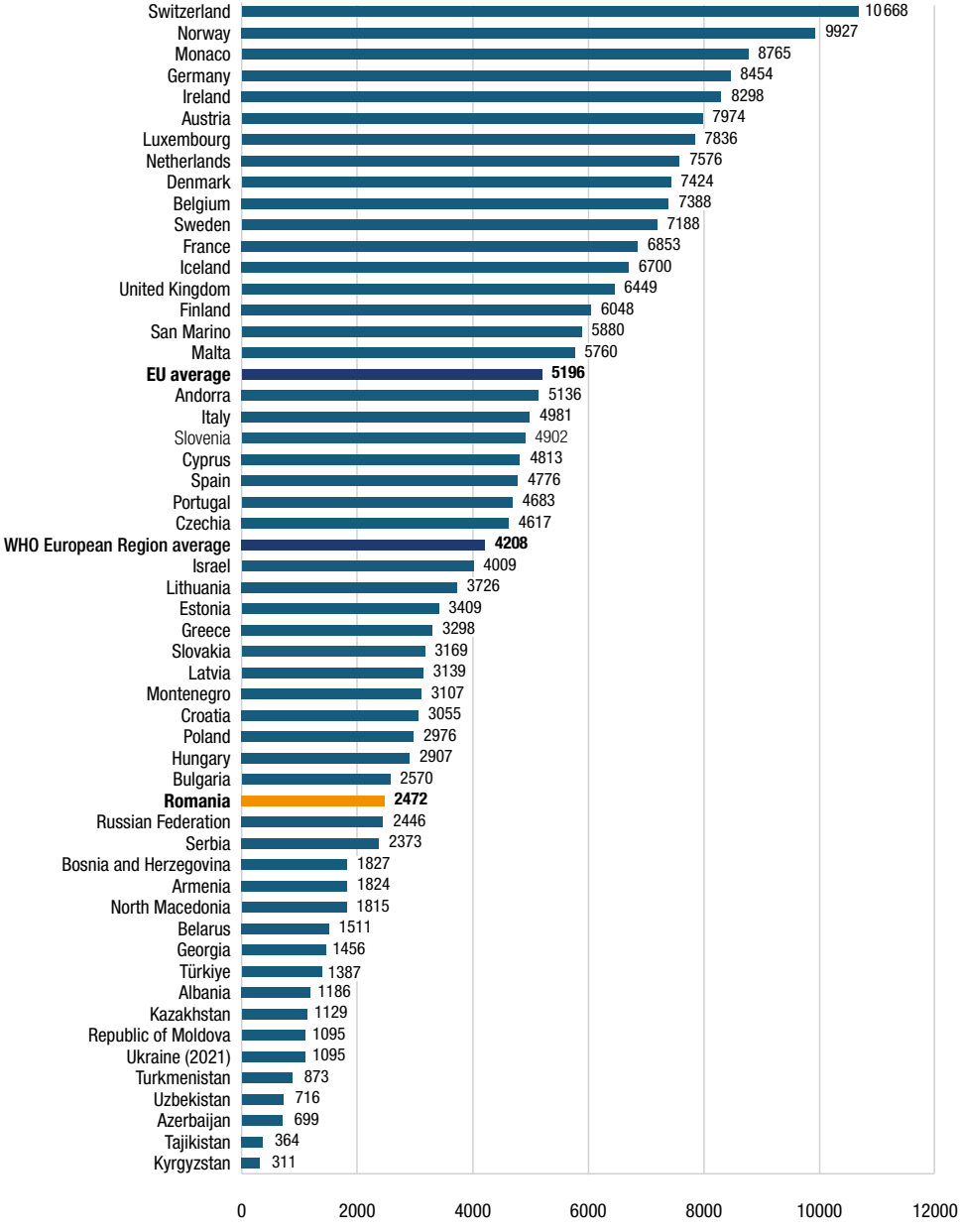
FIGURE 3.2 Trends in CHE as a share (%) of GDP in Romania and selected countries, 2000–2023



Source: WHO, 2025

The largest part of health expenditure in 2023 was spent on hospital care (43.7%), followed by pharmaceuticals (27.5%) and outpatient care (20.1%) (Table 3.2). Spending on hospital care and pharmaceuticals is traditionally high in the Romanian health system. While shifting the provision of healthcare from hospitals to ambulatory care has been declared a policy goal, hospital expenditure as a share of CHE increased by more than 10 percentage points over the past nine years, from 35.6% in 2011. Spending on pharmaceuticals as a share of CHE has seen a decreasing trend (from 38.7% in 2011), but the actual spending almost doubled, from 10 billion RON (around €2 billion) in 2011 to over 20 billion RON (around €4 billion) in 2022. A high increase was registered in 2020 for non-durable medical supplies (including personal protective equipment), due to the COVID-19 pandemic, as expenditure doubled from 526 million RON (around €105.2 million) in 2019 (3.5% from expenditure on pharmaceuticals) to 1082 million RON (€216.4 million) in 2020 (7% from expenditure on pharmaceuticals). In 2022 expenditure on non-durable medical supplies was 736 million RON (€147 million), representing 4% from expenditure on pharmaceuticals (INS, 2020b, 2024b).

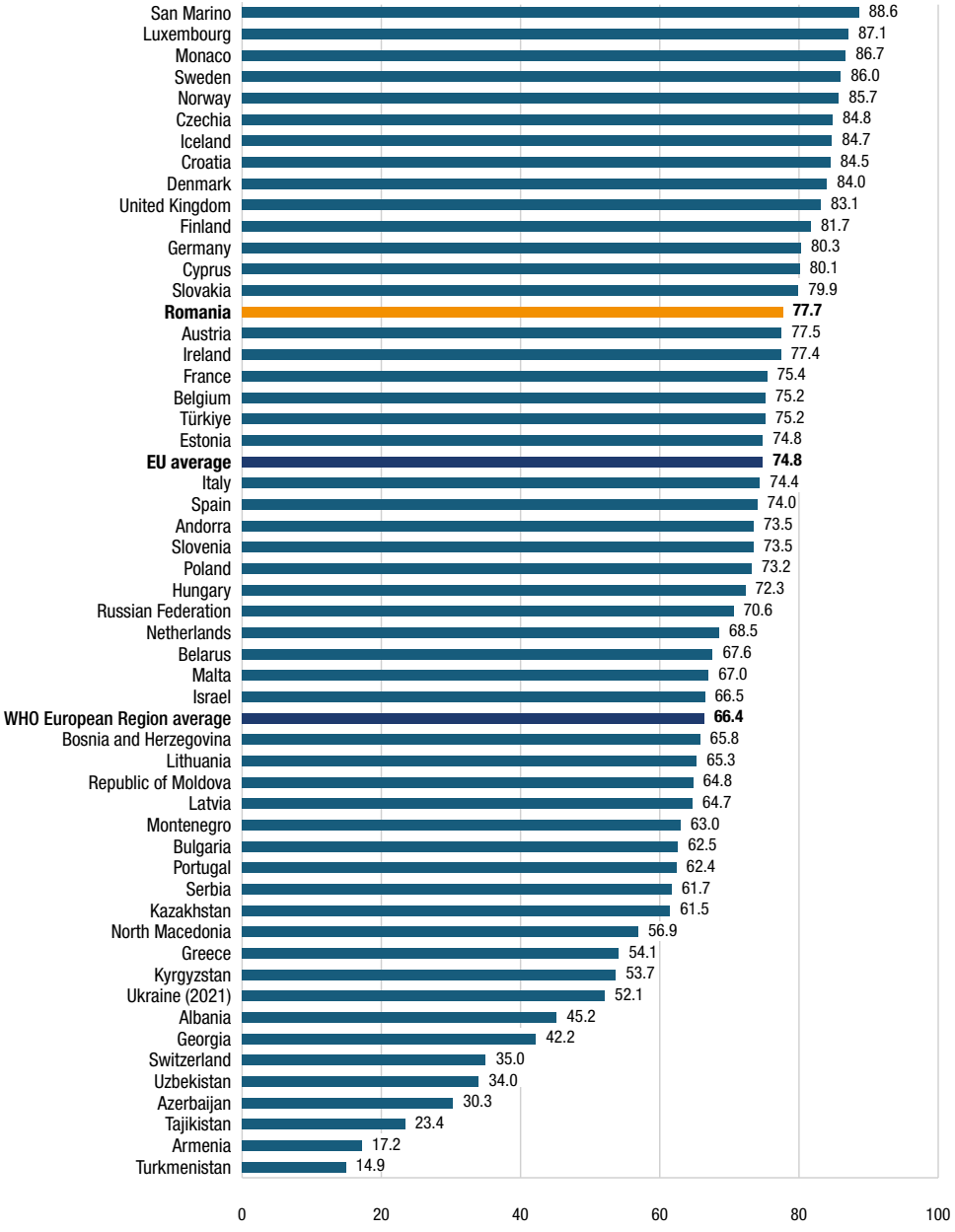
FIGURE 3.3 CHE in US$ PPP per capita in the WHO European Region, 2022



Source: WHO, 2025

Note: data for Ukraine are from 2021.

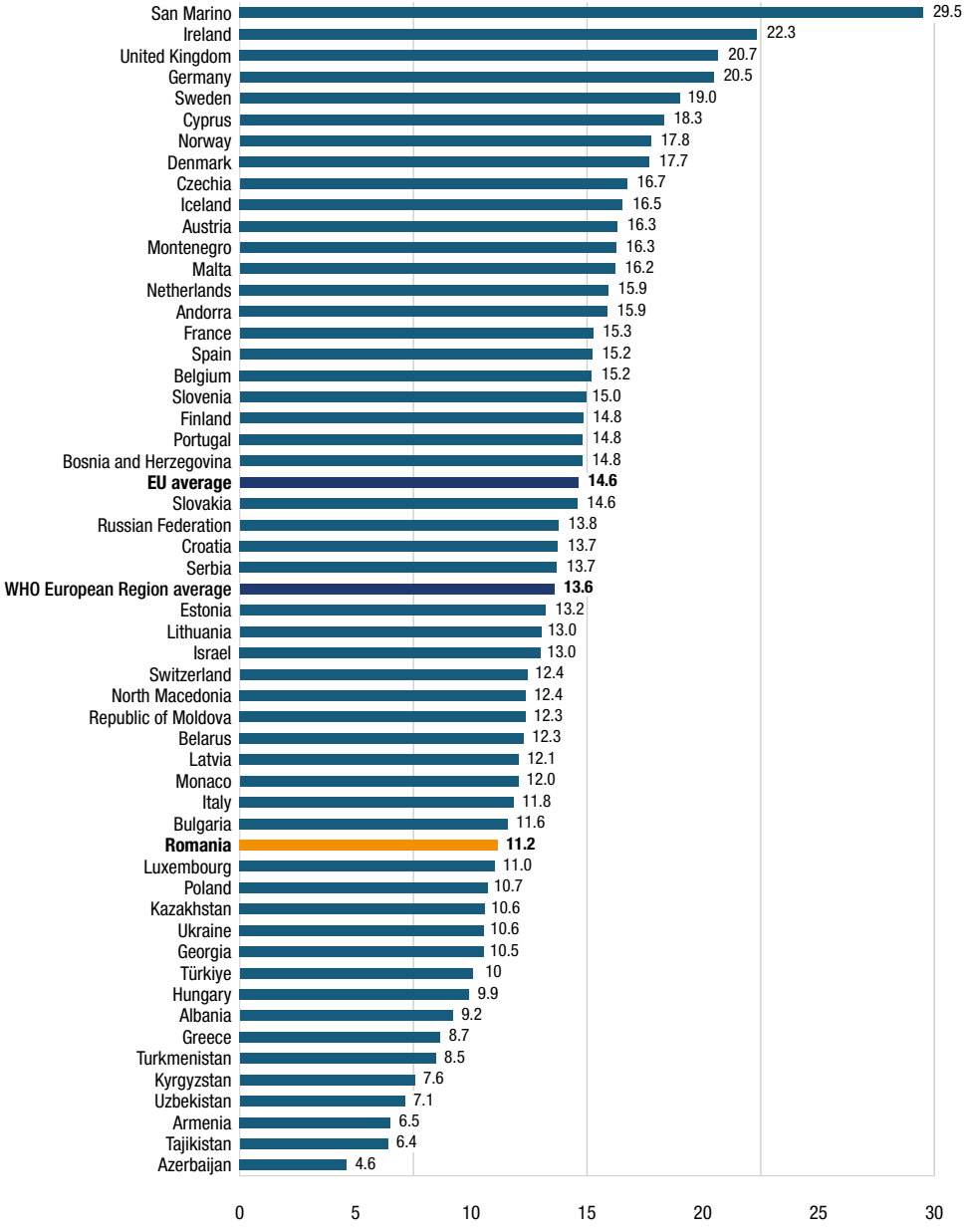
FIGURE 3.4 Public expenditure on health as a share (%) of CHE in the WHO European Region, 2022



Source: WHO, 2025

Note: data for Ukraine are from 2021.

FIGURE 3.5 Public expenditure on health as a share (%) of general government expenditure in the WHO European Region, 2022



Source: WHO, 2025

Note: data for Ukraine are from 2021.

TABLE 3.2 Expenditure on health (as % of CHE) according to function and type of financing, 2023

	INPATIENT CARE	OUTPATIENT CARE[a]	LTC	PHARMACEUTICALS[b]	PUBLIC HEALTH	ADMINISTRATION	OTHER SERVICES[c]	TOTAL
General government	7.6	0.7	0.7	–	0.1	2.6	2.7	14.4
Mandatory health insurance	35.7	11.3	–	13.2	–	0.4	1.3	61.9
Private OOP	0.3	7.7	0.7	14.3	–	–	–	23.0
Private insurance	0.1	0.3	–	0.0	–	0.1	0.1	0.6
Other sources[d]	0.0	0.1	0.0	–	–	–	0.0	0.1
Total expenditure	43.7	20.1	1.4	27.5	0.1	3.1	4.1	100.0

Source: INS, 2025a

Notes: [a] includes home care, laboratory and imaging services; [b] includes materials and devices; [c] includes transportation, healthcare provided by other sectors, day care and other unclassified costs; [d] non-profit service households and enterprise financing.

3.2 Sources of revenue and financial flows

In 2023 the main sources of health financing in Romania were the NHIF (61.9% of CHE), state and local budgets (14.4%), OOP payments (23.0%) and VHI (0.6%) (see Table 3.2).

The NHIF accounts for the largest share of public funding (77.7% in 2022). NHIF's financing comprises individual health insurance contributions (the contribution rate is set at 10% of individuals' incomes and is collected by the Ministry of Finance); labour insurance contributions paid by employers to cover financial compensations due to illness (the contribution rate is set at 2.25% of gross salaries); subsidies from the state budget to cover deficits; and transfers from the Ministry of Health for specific purposes (such as to partially cover drug co-payments for low-income pensioners, payments for family physicians in continuity care centres to cover their share of on-duty calls, or increases in health personnel salaries). In the 2023 NHIH budget, the share of individual contributions was 71.8% and the share of state subsidies was 18.3% (NHIH, 2024a). The money is spent through the 43 DHIHs according to pre-approved budgets (see Section 2.2) and is used for purchasing health services and for paying for statutory sick pay, maternity leave and disability-related absences. Payment for such compensations historically represented up to 6% of total NHIH expenditure, but during the COVID-19 pandemic reached 7.2% in 2020 and 7.6% in 2021 (NHIH, 2022a).

Financing from the state budget is channelled through the Ministry of Health and other ministries with their own (parallel) health systems (see Section 2.2) and transferred to the DPHAs, other subordinate institutions and the NHIH. The Ministry of Health pays for the implementation of preventive national health programmes, medical equipment, and infrastructure investments, research and teaching activities. It also contributes to the budgets for ambulance emergency services and for several other directly subordinated institutions, including the National Institute of Public Health, the National Institute for Sports Medicine, the National Institute for Blood Transfusion and the National Transplant Agency, among others. The Ministry also pays for intensive care units, medical and dental offices at schools, and salaries of staff employed in public offices providing sport medicine, family planning, HIV/AIDS, tuberculosis, mental health and legal medicine services.

Financing from local budgets has been traditionally used to pay for maintenance, repairs and inpatient meals in health facilities in their area (mainly hospitals), covering less than 1% of CHE. More recently, they have also been used to pay for equipment and infrastructure investments, health promotion and disease prevention programmes, health services for socio-economically deprived populations, some of the costs of running medical and dental school offices, and to co-finance EU Structural Funds projects.

Household OOP payments, which is the largest source of private funding (96.6% of total private expenditure on health in 2022; Table 3.1), are mainly used to pay for services provided by private providers (especially for dental care, where there is insufficient public cover) and for over-the-counter drugs, and to cover co-payments for drugs, dental care, spa treatments and rehabilitation within the statutory system. Informal payments are still used, especially in hospitals, but their extent is not reported or made available (see Section 3.4.3).

Spending on VHI has seen a continuous upward trend, from 40 million RON (around €8 million) in 2011 to 474 million RON (€94.8 million) in 2022 – a large increase (see Section 3.5). During this period, the share of VHI in private health expenditure increased from 0.6% to 2.6% (and from 0.1% to 0.6% as a share of CHE) (Table 3.1; INS, 2020b, 2024b).

In the years 2020 and 2021 health revenue increased substantially in response to the COVID-19 pandemic. Additional funding came from different sources (see information archived in the Observatory's COVID-19 Health System Response Monitor, https://eurohealthobservatory.who.int/monitors/hsrm/), including:

- funding from the European Commission, consisting of unspent pre-financing resources from the European Structural and Investment Funds from 2019 (around €483 million) and from 2020 (around €637 million), which was allocated for the procurement of personal protective equipment, tests and medical equipment, medical and social home services for older people, hygiene products for vulnerable groups, and to cover the bonuses paid to the health workforce dealing with COVID-19 cases, and also for other purposes, such as for sustaining small- and medium-sized enterprises;
- additional state budget funding, obtained by implementing several legislative budget corrections, which was spent to cover treatment of

COVID-19 cases and for purchasing equipment, health workforce bonuses and preventive measures;
- funding from the National Reserve Fund, which was directed to the Ministry of Health to cover the cost of testing, treatment and control of the outbreak, but also to cover other things such as immunizations against flu, HIV/AIDS treatment, blood collection and transplants; and
- donations, which also included in-kind contributions such as personal protective equipment, disinfectants, tests, etc.

Overall, government health spending increased from 50 660.0 million RON (€10 132 million) (which represented 4.8% of GDP) in 2019 to 55 527.7 million RON (€11 105.54 million) (5.2% of GDP) in 2020, and to 63 298.2 million RON (€12 659.64 million) (5.4% of GDP) in 2021. The increasing trend was maintained in 2022 and 2023, reaching 66 414.3 million RON (€13 282.86 million) in 2022 and 71 960 million RON (€14 392 million) in 2023, but this counted for only 4.7% of GDP in 2022 and 4.5% of GDP in 2023 (Ministry of Finance, 2020, 2021, 2022, 2023). SHI expenditure increased from 41.8 million RON (€8.3 million) in 2019 to 45.2 million RON (€9 million) in 2020, 49.8 million RON (€10 million) in 2021, to 54.9 million RON (€11 million) in 2022, reaching 59.7 million RON (€12 million) in 2023 (NHIH, 2024c).

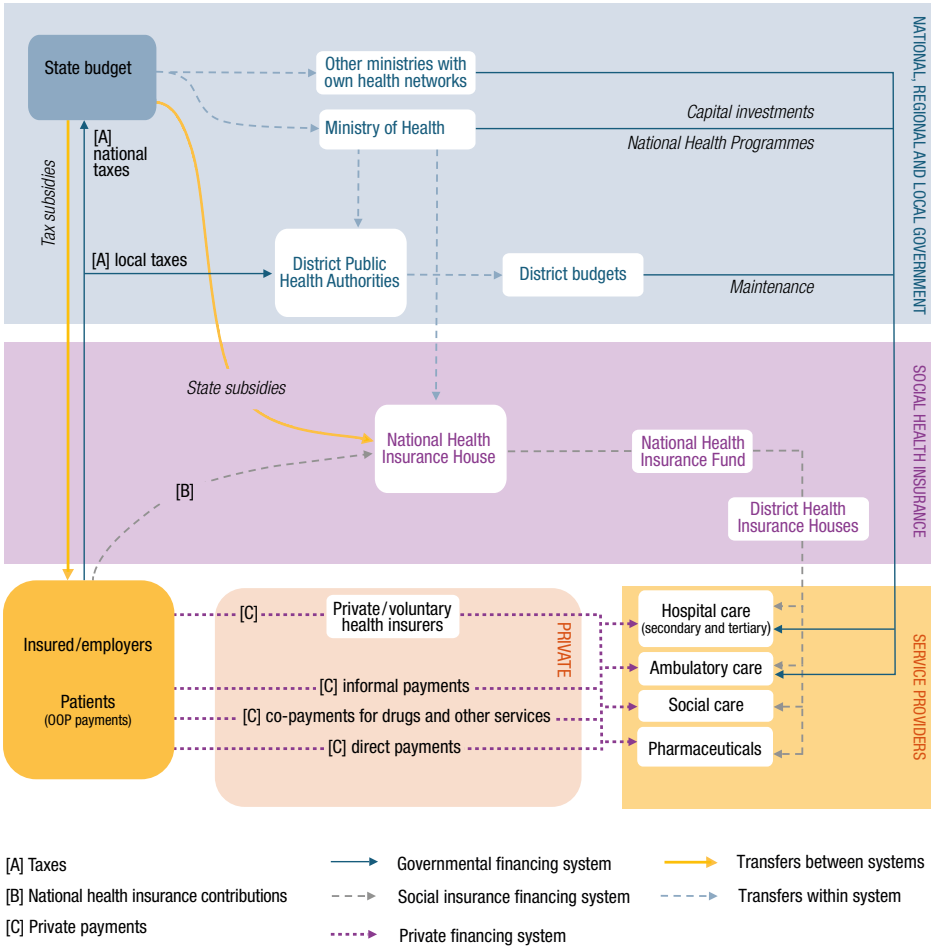
3.3 Overview of the statutory financing system

3.3.1 *Coverage*

Breadth: who is covered?

The statutory health financing system is regulated by Law no. 95/2006 on Health Care Reform, republished in 2015 after numerous modifications and additions. SHI is mandatory and meant to cover all Romanian citizens and foreigners with permanent residence in Romania, EU/EEA/Swiss citizens with temporary residence for more than three months who are not insured in another EU or EEA Member State or Switzerland, cross-border workers living in another EU or EEA Member State or Switzerland, Romanian pensioners who are permanent residents in another EU Member

FIGURE 3.6 Financial flows



Source: Authors' own compilation

Note: Financial flows related to rehabilitation care have not been included in this figure because their collection and administration are overseen by the Ministry of Labour and Social Solidarity and its subordinate institutions.

State or in EEA or Switzerland or in another country that has concluded a bilateral agreement with Romania that regulates social security and healthcare (Parliament of Romania, 2015a).

The high number of Romanians living or working abroad but still with residence in Romania could be the reason behind the high share of the population that is not covered by the NHIH: 11% in 2023 (calculated based on the number of insured reported by the NHIH and the number of residents reported by the INS (INS, 2025b). Eurostat data shows that almost a fifth (18.6%) of working-age Romanians were living or working in another EU country in 2020 (Eurostat, 2023).

The insured population is entitled to benefits as contributing payers (that is, working residents paying SHI payroll contributions) or as being included in one of the categories of the insured who are exempt from paying contributions. Until recently, there were 19 such categories: children under 18 years old, and students under 26 years old who have no income; young people under 26 years old who come from child protection institutions and have no income; dependent spouses and parents of an insured person; war veterans and their widows and victims of political persecutions between 1945 and 1989; people with disabilities; people without income with chronic conditions covered by national health programmes; women during pregnancy and post-partum; pensioners; people on sick leave due to occupational illness or injury; registered unemployed people; people on parental or adoption leave; people receiving social benefits, which includes all those with an income below the minimum wage; people under arrest or detention; asylum seekers and victims of human trafficking; Romanian citizens who are victims of human trafficking, for up to 12 months; monks, nuns and other people living and working in monasteries; volunteers working in emergency services; stem cell donors for a 10-year period after donation; and household employees.

Construction workers and agriculture and food industry workers with monthly gross income under 10 000 RON (€2000) were exempted initially from 2019, but in 2023 this facility was suspended for economic reasons (Law no. 227/2015b, Law no. 296/2023). The austerity reform packages implemented in 2025 reduced drastically the number of exempted categories almost by half, with only 10 categories remaining exempted: children under 18 years old and students under 26 years old; young people under 26 years old who come from child protection institutions and have no income; women during pregnancy and post-partum; pensioners with under 3000 Ron (€600)

income; people with disabilities; patients without income enrolled by national health programmes for cancers; people under arrest or detention; victims of human trafficking, for up to 12 months; volunteers working in emergency services; and stem cell donors for a 10-year period after donation (Parliament of Romania, 2025).

To access the benefits, the insured person must show confirmation of their insurance status at the point of service delivery. This can be an electronic confirmation generated by the Electronic Information Health Insurance Platform on the basis of a valid health insurance card or the 13-digit national identification number, a paper confirmation issued by the DHIH for people who lack or do not want to have an electronic health insurance card or the national ID, or a birth certificate for children under 14 years old. If the person is unable to prove their insurance status, they will only have access to the minimum benefits package (see "Scope: what is covered?" below).

Access to healthcare for asylum seekers is regulated by Law no. 122/2006 on Asylum in Romania, according to which asylum seekers have access to free medical care provided by the staff employed at the accommodation centres of the General Inspectorate for Immigration and to hospital emergency services in cases of life-threatening conditions.

In 2022, for the people fleeing the war in Ukraine, Romania implemented the EU's Temporary Protection Directive that provides refugees the right to a residence permit, access to the labour market and full access to healthcare and education for their children (Government of Romania, 2022e).

Scope: what is covered?

All insured people, regardless of whether they are obliged to pay contributions or are exempt, are entitled to a standard, relatively comprehensive benefits package compared to those in other health insurance systems, which includes a wide range of health services, pharmaceuticals and medical devices. Statutory benefits are approved by Government Decision (known as the Framework Contract) and detailed by the Order regarding the methodological norms for implementing the Government Decision (see Section 2.7.1), which was co-signed by the Minister of Health and the President of the NHIH and includes (for each category of providers) the types and volumes of services that are reimbursed within the statutory health insurance.

Statutory primary care services include emergency care, preventive services and health education, a general check-up every three years for people

aged over 18 years old, monitoring of people with chronic conditions, antenatal care, family planning and home visits for people with limited mobility and for women after delivery.

Statutory outpatient specialist care services include diagnostic consultations, palliative or home care, monitoring of discharged patients (two follow-up visits) and of patients with chronic conditions (four visits per trimester per insured patient), different diagnostic, therapeutic or minor surgery procedures, rehabilitation services, non-medical services (psychology, kinesitherapy, logopaedic services) and breast and uterine cancer screening. The list of reimbursed services includes 108 laboratory exams, 165 imagistic diagnostic procedures and 25 dental services (some of them only partially covered).

Besides treatment of acute cases, statutory inpatient care services include LTC, spa treatment, hospital rehabilitation treatment, physical therapy, massage and medical gymnastics programmes.

There is a positive list of covered outpatient medicines (see Section 5.6). In addition, SHI covers specific medical devices to correct eyesight and hearing, prosthetic limbs, continence and oxygen therapy devices and other prescribed specialized medical products.

Emergency care is fully covered, irrespective of insurance status.

Other benefits covered by the statutory health insurance include treatment abroad (see Section 2.8.4), home care, speech therapy, psychological counselling, kinesitherapy for certain beneficiaries, cash benefits during sickness leave, hospital accommodation for people accompanying children up to 3 years of age and patients with a severe disability, and transportation related to medical treatment.

There is a negative list of health services that are not covered by the statutory health insurance. These include occupational illness and injury (which are covered by the Insurance Fund for Work Accidents and Professional Diseases), some expensive hospital technology requiring services, certain dental services, in vitro fertilization, cosmetic surgery for people over 18 years of age (except for breast reconstruction after mastectomy), and medical services obtained without a referral.

Uninsured people have been entitled to a minimum package of services covering emergency care, services related to epidemic-prone/infectious diseases, care during pregnancy and childbirth, family planning and community care (Parliament of Romania, 2015a). Since 2023 they have received the same benefits package of primary care services as the insured population. However,

they still have to pay OOP for lab tests and imaging investigations and for outpatient medicines prescribed by the family doctor. In July 2024 the benefits package for the uninsured population was further adjusted, including services (lab tests and specialist visits) that ensure early detection and early treatment for several serious diseases such as cancers, hepatitis B and C, and HIV/AIDS in pregnant women (Ministry of Health & NHIH, 2023). Patients with confirmed diagnostics will afterwards be included, for treatment, under the national health programmes. The role of HTA in deciding upon inclusion of goods and services in the benefits package is limited to pharmaceuticals (see Section 2.7.3), while decisions regarding all other goods and services are taken by the NHIH and the Ministry of Health, based on consultations with different actors.

Depth: how much of the benefit cost is covered?

Statutory user charges are applied to several goods and services included in the benefits package (see Section 3.4.1).

For about one third of outpatient medicines, the national health insurance does not reimburse the full reference price, and the patient must pay a certain percentage (10% or 50% or 80%). Additionally, patients must pay the difference between the reference price and the retail price. Pharmaceuticals account for the largest share (66.3% in 2021) of OOP spending (INS, 2024b).

Cost-sharing is also applied to balneotherapy and rehabilitation services. Patients pay a fixed contribution of 52 RON per day (about €10) for stays up to 21 days, and 100% of the fee for stays over 21 days, with the exception of military veterans and revolution fighters (that is, those who fought during the 1989 revolution). For certain public dental care services, the patient must pay 40% of the price, except for children under 18 years old, students up to 26 years old, military veterans and revolution fighters.

Since 2013 hospitals have also been charging a small co-payment – up to 10 RON (€2) per day – for hospital admissions, with the aim to reduce hospital admissions and to increase hospitals' incomes. Exempt from this charge are children under 18 years old, students up to 26 years old, patients without income who are covered by the national health programmes, pregnant women, pensioners with a monthly income under 900 RON (approximately €180), Romanian victims of human trafficking, detainees and prisoners without income, and stem cell donors with no incomes when admitted for the donation procedures.

BOX 3.1 Key gaps in coverage

The high number of Romanians living or working abroad but still with residence in Romania could be the reason behind the high share of the population that is not covered by the NHIH: 11% in 2023 (calculated based on the number of insured reported by the NHIH and the number of residents reported by the INS (INS, 2025b)) are not insured by the national health insurance, meaning that they can access only the minimum benefits package (see Section 3.3.1). This could be because of the high number of Romanians living or working abroad but still registered (or with residence) in Romania, and because some unemployed people are not registered for unemployment or social security benefits, with both groups having unpaid national health insurance contributions.

Despite the comprehensiveness of the statutory benefits package, 5.2% of Romanians said they did not receive the medical care they needed in 2023 due to high cost, distance to the facility or waiting times. Although this is much lower than its 2011 peak (12.2% in 2011), it increased compared to previous year (4.9% in 2022) and is more than twice the EU average (2.4% in 2023) (Eurostat, 2025). There are also variations by income groups. Only 1% of those in the highest income group reported unmet medical needs, while 7.2% of those in the lowest income group did (Eurostat, 2025). Since no data on waiting times for elective care are available, it is difficult to identify where the most pressing needs exist. The latest Eurostat data show a sharp decrease in unmet need for medical services reaching 2.2% in 2024, below the EU 27 (in 2020) average of 2.5%, with 0.6% of those in the highest income group and 3.6% of those in the lowest income group (Eurostat, 2025).

A recent study on financial protection in Romania (Scîntee, Mosca & Vlădescu, 2022) shows that in 2015 dental care, where most of the services are paid OOP, resulted in financial hardship for richer households and in unmet needs for poorer households, while outpatient medicines were by far the largest driver of financial hardship in poorer households (see also Section 7.3). According to OECD data, Romania spent 63% of total OOP expenditure on pharmaceuticals in 2021, which was 2.6 times higher than the EU average of 24%. This limits access to essential medicines and represents an important barrier to drugs coverage (OECD & European Observatory on Health Systems and Policies, 2023).

Private facilities may charge patients for the difference between their own fees and the national health insurance reimbursement level. New regulations introduced in 2021 (amending Law no. 95/2006) improve transparency in this area by obliging all private NHIH-contracted hospitals to publish their fees online.

Extra billing is also allowed in public NHIH-contracted hospitals for superior accommodation (up to three beds per room with a private toilet, bath facilities, domestic appliances such as TV and fridge, and better meals). The cap of 300 RON per day (approximately €60) set in 2013 was lifted in 2018, allowing hospitals to offer superior accommodation at any price, as long as standard accommodation is guaranteed for all patients who need to be admitted. Since 2023 the cap of 300 RON per day for extra-billing of superior accommodation was reintroduced.

3.3.2 *Collection*

Contributions pooled by the NHIF

The revenues of the NHIF consist of contributions paid by the insured population, allocations from the work insurance contribution paid by the employers (40% of this contribution is allocated to the NHIF to cover sick leave payments and the rest is channelled to the state budget for other purposes), contributions paid by the marketing authorization holders for pharmaceuticals (as claw-back taxes and as part of cost–volume–result arrangements), state budget subventions and transfers, and other sources (for example, donations) (Law no. 95/2006 on Health Reform).

The contribution rate is set in Law no. 227/2015 on the Fiscal Code, with subsequent modifications and additions. It represents 10% of the gross monthly salary. Since 2018, when salaries were increased by an amount equal to the employer's due contribution at that time, health insurance contributions have been fully borne by the individuals. However, it is the employer who pays contributions on behalf of the employees, including transferring contributions to the NHIF. Besides salaries and similar incomes, SHI contributions are levied on incomes from self-employment or other commercial activity, intellectual property rights, rents, agricultural activities, investments and other sources defined by law (Law no. 227/2015).

The contribution for non-salary incomes is 10% of net income. The contribution is limited between a minimum of 10% from 6 gross monthly minimum wages per year – 24 300 RON (€4860) and a maximum of 10% from 60 gross monthly minimum wages per year – 243 000 RON (€48 600). The gross monthly minimum wage in 2025 was 4050 RON (approximately €810). The various existing exemptions (see Section 3.3.1) make health insurance contribution a progressive source of health financing (Box 3.2). People with no taxable incomes may opt to pay 10% of six gross monthly minimum wages (representing 2430 RON/€486 in 2025) for 12-months' insurance coverage.

All health insurance contributions are collected by the National Agency for Fiscal Administration, under the Ministry of Public Finances.

BOX 3.2 Is health financing fair?

SHI contributions are proportionate to income, with the contribution rate fixed at 10%. The various exemptions from contributions for economically deprived populations constitute an element of fairness and progressivity, making contribution payments related to people's ability to pay and, hence, placing less burden on poorer households.

However, SHI contributions account for only 61.1% and not all of health financing. OOP payments are the second source of health financing, reaching 21.4% of total health financing in 2022 (Table 3.1). OOP payments are mainly used to cover cost-sharing for outpatient medicines, direct payments to private dental or healthcare providers and for informal payments. Even though some population categories are exempt from co-payments (for example, children, students, Romanian victims of human trafficking, among others; many other categories with low or no income are not exempted), OOP payments are not linked to income, which makes them regressive. They affect the poorest households the most, increasing financial hardship and obstructing access to healthcare.

Financial hardship linked to OOP payments is high in Romania compared to many EU countries (see Section 3.4 and Section 7.3), leading to catastrophic health spending. In 2015 catastrophic spending affected 12.5% of households and was heavily concentrated among the poorest of them. Also, despite improvements, unmet health needs (5.2% in 2023) remain above the EU average (see Section 7.2).

General government budget

The general government budget contributes to health financing through sums allocated to the Ministry of Health, to other ministries and agencies with their own health systems, and through subsidies to the NHIF (Fig. 3.6). In 2023 government expenditure represented 14.4% of the total budget on health (see Table 3.2).

The government budget is made up of revenues from numerous taxes, duties and payment obligations, collected by the National Agency for Fiscal Administration, under the responsibility of the Ministry of Finance. These revenues include excise duties raised from the production, distribution and sale of alcohol and tobacco products, but this money is not specifically earmarked for health. One exception was the so-called "tax on vice" that was collected between 2006 and 2018 with the purpose of reducing alcohol and tobacco consumption and raising funds for health. The money was designated to health infrastructure development, national health programmes and health promotion. Both the level of taxation and the level of collection are low compared to other EU countries, which translates into relatively low spending on health in Romania (see Section 3.1).

3.3.3 *Pooling and allocation of funds*

Allocation from collection agencies to pooling agencies

The main collection agency for all taxes, contributions and other financial duties levied at the national level is the National Agency for Fiscal Administration, with its regional and local divisions. All collected sums constitute the revenue of the national public budget. The national public budget is composed of the state budget, the social insurance budget and the local budgets. Every year the government drafts, under the coordination of the Ministry of Finance, the state and social insurance budgets, which must then be approved by the national parliament through the State Budget Law and the Social Insurance Budget Law. The State Budget Law also includes the NHIF budget.

All social health contributions collected by the National Agency for Fiscal Administration are pooled into the NHIF and are administered by the NHIH. The latter allocates the money to its district branches (DHIHs) for purchasing services. The allocation is based on historical expenditure.

However, if changes are required (for example, more family doctors are contracted to improve access in an isolated area or new hospital services are contracted), the budget is adjusted during the financial year. Up to 3% of the budget may be spent on fund administration and 1% of the total annual NHIF budget may be retained as a reserve, if the previous deficits are covered and subsidies from the state budget are not needed.

The state budget is allocated among all ministries and other national authorities. State funding for health is earmarked for specific purposes before the money is distributed to the Ministry of Health and to the other ministries with their own health systems. Funds that are allocated to one spending category cannot be transferred to another. The Ministry of Health allocates funds to the DPHAs or directly to its subordinated units (that is, hospitals, institutes of public health) in accordance with the approved budget. Allocations to the DPHAs are based on proposals made by the representatives of the DPHAs and rely heavily on historical allocations.

Local authorities collect local taxes and include this revenue in their local budgets, which are set under the Local Public Finance Law. Local funding for health is predefined by spending category in the local budgets and transferred to the medical institutions or projects that are administered by the local authority.

Allocating resources to purchasers

The 43 DHIHs (see Section 2.3) purchase services on behalf of the insured population in their respective geographical areas or on behalf of any patient who chooses a provider that is contracted with them, since patients have a free choice of service provider and purchaser (see Section 2.8.2). Each DHIH drafts its own budget based on the methodology set out by the NHIH, which considers historical allocations and the NHIF's overall budget (see Box 3.3). This determines the allocation for each type of health service the DHIHs must purchase. DHIH budgets are approved by the NHIH's President. Implementation of these budgets does not allow for any adjustments at the purchaser level without prior approval from the NHIH.

BOX 3.3 Are resources put where they are most effective?

As resource allocation at the state budget level has been traditionally based on political negotiations, and further allocation of the budget to purchasers of health services is mainly based on historical precedents, rather than on needs assessments or any resource allocation formula, the resources are not used in the most effective way (see also Section 7.6.1).

The allocation of resources between different types of providers or levels of care (primary healthcare vs. hospital services vs. LTC, etc.) is also based on a political decision. Except for pharmaceuticals, where HTA is in use (Section 2.7.3), evidence about effectiveness, including cost–effectiveness, is not used in allocation decisions.

Recent positive developments in the purchasing of services include increasing payment of primary care providers working in remote areas and introducing pay-for-performance (P4P) and adjusting the DRG payment formula for different categories of hospitals, depending on their competency level. These adjustments are implicitly included in the allocation of funds to the purchasers. Resource allocation is frequently adjusted retrospectively, based on actual expenditure, which helps preserve existing spending patterns and obstructs real changes to resource allocation.

3.3.4 *Purchasing and purchaser-provider relations*

Purchasing of services is mainly regulated by the Framework Contract (see Section 2.7). The DHIHs contract services based on the NHIH's general contracting methodology, their approved (by the NHIH's President; see Section 3.3.3) budgets, which specify resources that are allocated for each service type, including the approved number of hospital beds to be contracted per district, and norms regarding the catchment population size that apply to certain providers (such as specialist offices and pharmacies). A designated purchasing commission within the DHIH negotiates and signs contracts for each service type. Purchasers are not allowed to selectively contract with providers and must contract with all providers that comply with the existing norms and requirements. Fees are specified in the Framework Contract and cannot be negotiated. The Framework Contract and its implementation norms also include provisions related to the direct payments that contracted providers are allowed to charge (see Section 3.4). The volumes of services

provided are negotiated within the limits of the available budgets and are based on the provisions of the Framework Contract and its implementation norms that set volume thresholds to counter supplier-induced demand.

The implementation of the purchasing contracts is monitored by special departments at both the NHIH and DHIH levels. Other departments in these institutions periodically monitor providers in order to check compliance with the terms of their contracts for provision of services. Sanctions for each type of violation or failure to meet the obligations under the contract, for both the DHIHs and service providers, are set in the Framework Contract.

3.4 OOP payments

OOP payments have historically accounted for most private and a significant share of overall health expenditure in Romania. Despite having decreased from 24.3% in 2011 to 18.9% in 2019, they increased again to 21.4% in 2022 and remain higher than the EU average of 14.3% (World Bank, 2025). According to INS data, the share of OOP in 2023 was 23.0% (see Table 3.2).

According to National Health Accounts data, user charges represented 16.7% of OOP expenditure in 2022 (INS, 2024b). The remaining share of OOP spending was made up by direct spending on goods and services that were not included in the statutory health insurance benefits package or covered by the national health programmes; services accessed from (uncontracted) private providers; services accessed by uninsured patients; and donations or sponsorships. The exact share of each of these spending categories is not available. The total extent of OOP spending is uncertain, due to poor access to data on privately provided services delivered outside the DHIHs' contracts. The size of informal payments is also not known.

OOP payments in Romania pose a higher risk of household impoverishment due to catastrophic health spending compared to many EU countries (see Section 7.3).

3.4.1 *Cost-sharing (user charges)*

Cost-sharing for pharmaceuticals was introduced in 1992 by a Government Decision and takes the form of co-insurance. Since then, the list of medicines and the percentage of the price paid by users have been frequently changed.

Currently, patients pay 10%, 50% or 80% of the reference price (that is, the lowest-priced product of the cluster) for different medicines (see Section 3.3.1). Most prescribed outpatient medicines (over 70% in 2020) are fully (that is, 100%) covered. These include medicines for specific diseases, medicines included in the national health programmes, and medicines for children under 18 years old, students under 26 years old and pregnant women. The first Law on Social Health Insurance in 1997 linked statutory coverage to the reference price, with the difference between the reference price and the retail price being paid by the patient. If the patients prefer a more expensive product, they will have to pay the difference between the price of the preferred drug and the price of the lowest-priced drug in the cluster, in addition to paying a percentage of the reference price. There is only one exemption from cost-sharing for pharmaceuticals: retired people with a monthly income under 1830 RON (€366) pay 10% of the reference price for drugs to which 50% cost-sharing is applied (with the other 40% being subsidized by the Ministry of Health) (Government of Romania, 2023b).

Patients also pay 40% of the statutory fees for some dental services, and a fixed contribution of 52 RON per day (about €10) for inpatient stays over 21 days in spa treatment and rehabilitation facilities.

Co-payments for hospital admission were introduced in the legislation in 2002, with the purpose of reducing inappropriate demand for health services and raising revenue for hospitals, but this was not implemented until 2013 owing to the lack of secondary legislation. Since then, patients must pay 5–10 RON (less than €2) at discharge, except for emergency, legal psychiatry (psychiatric services for prisoners and detainees who require psychiatric service, and any other psychiatric evaluations required by the authorities), and palliative care admissions. Children under 18 years old, students under 26 years old, people without income who are covered by national health programmes, pregnant women, retired people with a monthly income under 900 RON (€180), Romanian victims of human trafficking, detainees and prisoners without income, and stem cell donors with no incomes when admitted for the donation procedures are exempted from co-payments for hospital admission.

Extra billing is used for superior accommodation in public hospitals, while in private facilities people pay OOP for any difference between the NHIH and private fees.

Table 3.3 provides a summary of user charges applied in the statutory health system in Romania.

TABLE 3.3 User charges for health services

HEALTH SERVICE	TYPE OF USER CHARGE IN PLACE	EXEMPTIONS AND/OR REDUCED RATES	CAP ON OOP SPENDING	OTHER PROTECTION MECHANISMS
Primary care	None	–	–	
Outpatient specialist visit	None in public facilities. Extra (balance) billing in private facilities	No	No	
Outpatient prescription drugs	10%, 50%, 80% of the reference price for certain drugs; the difference between the retail price and the reference price for drugs that are more expensive than the lowest-priced product in their group	Retired people with a monthly income under 1830 RON (€366) pay 10% of the reference price for drugs to which 50% cost-sharing is applied (with the rest subsidized by the Ministry of Health)	No	Medicines for specific diseases, medicines included in the national health programmes, medicines for children under 18 years old, students under 26 years old and pregnant women are covered 100%
Inpatient stay	Fixed co-payment of 5–10 RON per hospital admission. Extra billing for superior accommodation. Extra (balance) billing in private facilities	Exemption from co-payments for children under 18 years old; students under 26 years old; people without income who are covered by national health programmes; pregnant women; retired people with a monthly income under 900 RON (€180); Romanian victims of human trafficking; detainees and prisoners without income; and stem cell donors with no incomes when admitted for the donation procedures.	300 RON (€60) per day cap for extra billing for superior accommodation;	Co-payment is not required in the palliative care ward, for legal psychiatry services and for cases admitted as emergencies.
Dental care	40% of the price for certain services	In public facilities only: children under 18 years old, students under 26 years old, military veterans and revolution fighters	No	
Medical devices	Difference between the reference price and the retail price	No	No	Some medical devices are provided within the national health programmes and are covered 100%
Spa treatment and rehabilitation	Fixed contribution of 52 RON per day (about €10) for inpatient stays over 21 days in spa treatment and rehabilitation facilities. Extra billing for superior accommodation	Exemption from co-payments for military veterans and revolution fighters	300 RON (€60) per day cap for extra billing for superior accommodation	

Source: Authors' own compilation

3.4.2 *Direct payments*

Services that require payment of the full fee are those that are not covered by the statutory health insurance and are included on the negative list (see Section 3.3.1), or are not covered by other schemes (that is, work accidents and occupational diseases insurance); services that have been accessed without a referral; services accessed from private providers who are not contracted with a DHIH; and services provided to uninsured people. According to National Health Accounts data, these represented 83.2% of OOP expenditure in 2022 (INS, 2024b), but the actual amount is uncertain, due to incomplete data on private providers.

3.4.3 *Informal payments*

Informal payments continue to exist in Romania, despite several measures taken to eliminate them, such as strengthening the legislation in this area and increasing the salaries of health personnel. Eurobarometer data for 2019 place Romania as the EU country with the highest share of respondents (19% compared to the EU average of 5%) who reported having made an extra payment or a gift to a nurse or doctor or donated to the hospital in the previous 12 months. The values decreased by 1% in 2022, reaching 18% for Romania and 4% for the EU average, and further decreased by half for Romania by 2023 reaching 9%, and by 1% for the EU reaching 3%. The 2024 report found that 7% of survey respondents in Romania who had visited a public provider in the previous 12 months reported having been asked or expected to give a gift, favour or extra money for the received care, while the EU average remained 3% (European Commission, 2020, 2022, 2023, 2024). This is much lower compared to 2013, when this share was 28% (the EU average was 5%) (European Commission, 2014a). The real magnitude of informal payments is not known.

3.5 VHI

VHI plays a marginal but increasing role in the financing of healthcare in Romania, with its share in health spending increasing from 0.1% in 2011 to

0.6% in 2022, and from 0.6% to 2.5% as a share of private expenditure during the same period (INS, 2024b). The number of private health insurance contracts increased from 275 904 in 2017 to 382 261 in 2021 and decreased to 220 334 (42% less than in the previous year) in 2022. The estimated number of contracts for 2023 was 231 108 (Financial Supervisory Authority, 2021, 2022), and VHI now covers around 1% of the population. Still, the VHI market is growing, registering an increase of around 35% in 2022 compared to the previous year. It holds a 4.1% share of the total gross written premiums of the life insurance market (Financial Supervisory Authority, 2022).

Provision of VHI is regulated by Law no. 95/2006 on Health Care Reform and by Law no. 136/1995 on Insurance and Re-insurance in Romania. Private insurance companies are authorized and regulated by the Financial Supervisory Authority under the provisions of Emergency Ordinance no. 93/2012 on the Establishment, Organization and Functioning of the Financial Supervisory Authority. The insured are reimbursed for the services that are stipulated in the insurance contract. A generic VHI benefits package that all voluntary insurers should offer is supposed to be approved by a Governmental Decision, and maximum fees for services covered by VHI that are provided by public providers by an Order of the Ministry of Health, but these have not been issued yet.

Any person entitled to the basic benefits package provided by the statutory health insurance scheme is eligible to purchase VHI. People who purchase VHI cover are typically under the age of 45 years, have higher education and higher incomes, either from paid employment (typically working for a multinational or large national corporation) or are self-employed and live in an urban area (Vlădescu et al., 2016). Complementary VHI covers user charges in the statutory health insurance scheme, while supplementary VHI covers partially or entirely those services not available or not covered within the statutory health insurance, such as choice of a preferred physician or access to a second opinion, or superior hospital accommodation. VHI may also be purchased by employers and offered as a benefit to attract and retain employees. Up to 2000 RON (€400) spent on VHI can be deducted annually from taxable income (Law no. 227/2015). VHI cover cannot be a substitute for statutory cover, that is, it is not possible to opt out of the statutory scheme when purchasing VHI.

3.6 Other financing

3.6.1 *Parallel health systems*

The Ministry of Transport, the Ministry of National Defence, the Ministry of Internal Affairs, the Ministry of Justice and the Romanian Intelligence Agency operate their own parallel health systems, for their employees and families, with separate healthcare facilities (hospitals, polyclinics and dispensaries). However, since there is a free choice of insurer and provider, anyone can be enrolled in and access providers within these systems.

There is also an insurance house for the employees of the Ministries of National Defence, Internal Affairs and Justice and the agencies related to national security (see Section 2.2), but the contributions raised from its insured populations are transferred into the NHIF.

The parallel health systems are funded from the state budget through allocations towards the respective ministries and the Intelligence Agency, which cover investments in the facilities and various health programmes. The services provided under these systems are financed by the NHIF.

3.6.2 *External sources of funds*

Romania is a beneficiary of the European Structural and Investment Funds. Within the 2021–2027 Programme, Romania is receiving a budget of over €5.8 billion through the Health Operational Programme. This funding aims to improve access to quality healthcare through infrastructure development, such as by building new regional hospitals, purchasing new equipment, refurbishing existing primary healthcare and ambulatory facilities, building community care centres, improving long-term, recovery and palliative care, providing screening and other early disease detection measures, improving digitalization of the healthcare system, and improving the information management system (Structural Fund, 2022).

Another important source of EU funding is the European Commission's Recovery and Resilience Facility, which aims to support Member States in mitigating the economic and social impact of the COVID-19 pandemic. Romania's NRRP, with a total budget of €14.2 billion in grants and €14.9 billion in loans, includes three main reform goals in the health sector: increased

capacity for the management of public health funds; increased capacity to undertake investments in health infrastructure; and increased capacity for health management and human resources in health. By 2026, €470 million is expected to be spent on developing an integrated e-Health system connecting over 25 000 healthcare providers, and €2 billion on strengthening the resilience of the health system, by investing in modern hospital infrastructure to ensure patient safety and reduce the risk of healthcare-associated infections in hospital settings (MIPE, 2021).

Romania's health sector also benefits from funding from the World Bank, which in 2014 approved a loan of €250 million to support the Health Sector Reform Project – Improving Health System Quality and Efficiency that focused on two components: Strengthening Health Service Delivery and Public Health Sector Governance and Stewardship Improvement. The project was initially meant to end in 2020 but was extended until 2024, with Strengthening of the Public Health Emergency Response to COVID-19 added as a new component (Ministry of Health, 2021).

3.6.3 *Other sources of financing*

National Insurance Fund for Work Accidents and Occupational Diseases

Established and regulated by Law no. 346/2002, the National Insurance Fund for Work Accidents and Occupational Diseases is funded by contributions paid by employers. This fund pays for medical care in case of work accidents and occupational diseases, including for treatments to recover work capacity, and to pay for allowances during temporary work incapacity, and for invalidity and death benefits following a work accident. According to the law, all employed persons, including apprentices, are covered by the insurance, except for those working in the national defence, public order, national intelligence and justice sectors.

Social benefits are funded by the Ministry of Labour and Social Solidarity. These consist of allowances for poor persons and for persons with special needs (beneficiaries can include children and families, older people, people with disabilities, homeless, people suffering from abuse, people with addictions and patients with chronic diseases), as well as services such as accommodation, meals, etc., provided in medicosocial and residential centres, day care centres and home care. Law no. 191/2022 abolished placement

centres for children, and these services are being replaced by placing children in families, for adoption and under care provided by NGOs.

Voluntary and charitable financing

Existing legislation supports voluntary financing of healthcare through Government Emergency Ordinance no. 2/2015 that stipulates that at least 40% of donations made by the state companies should be spent on health, 40% on education, social and sport activities and no more than 20% on other purposes.

Patronage and sponsorship are not tax-deductible, but since 2021 private firms/microenterprises have been granted a fiscal credit of up to 0.75% of turnover or 20% of the corporate profit/income tax due, whichever is lower. In addition, taxpayers may allocate 3.5% of their income tax contributions to an NGO or religious organization of their choice, many of them providers or supporting providers of health services (Pop & Birz, 2022).

3.7 Payment mechanisms

3.7.1 *Paying for health services*

Public health services

There are different providers payment mechanisms in the Romanian health system (see Table 3.4). Providers of public health services (see Section 5.1) are paid through global budgets from the state or the local budget. They can also charge direct payments for the services provided (for example, authorizations given by the DPHAs, water and air analyses done by the laboratories of the National Institute of Public Health, etc.). The cost of vaccines is covered by the Ministry of Health through centralized procurement, but the cost of providing the immunization service is paid for by the DPHA to the family physician through FFS. Activities provided within preventive national health programmes are financed from the state budget, through the Ministry of Health. Drugs and medical supplies provided within the curative national health programmes are paid for by the NHIF.

Primary healthcare

Primary healthcare services provided by family physicians (who mainly work in solo practices) were paid by a mix of age- and gender-adjusted

capitation (50%) and FFS (50%) until 2023; since then, the ratio has changed to 35% per capita and 65% FFS, both quantified in "points", with each category of points having a specific financial value (applicable nationwide) that is updated by the NHIH every quarter. As well, since 2023 family physicians have been paid for performance. This is a yearly lump sum, paid for the achievement of specific indicators in the previous year (such as the number of people over 40 or 60 years of age being assessed for specific health risks). As the new legislation applies from July 2023, the first performance payments have been made in 2025, based on activity in the year 2024. The maximum number of enrolled patients is 2200. When the number of patients exceeds this threshold, which means that the number of points exceeds the 18 700 limit per year, the number of points for which a claim can be made is diminished, except in areas with family physician shortages. The number of per capita points is increased by 5% for institutionalized children, by 100% for practices located in remote areas with less than 10 000 inhabitants, and by 200% for practices in the Danube Delta. The number of points is also adjusted for the provider's professional degree (Ministry of Health & NHIH, 2021, 2023).

Family physicians are allowed to charge direct payments for services not included in the benefits package (for example, electrocardiogram, echography, among other different types of services for which they are accredited, as well as different types of administrative medical documents). They are also allowed to sign contracts with the DPHAs, VHI firms and other institutions for provision of services within their area of competence, for research activity or for teaching purposes (Law no. 95/2006).

Specialized ambulatory care

Specialized services provided in ambulatory settings (including in hospital outpatient departments), including dental services, palliative services, laboratory and imaging services, are paid on an FFS basis. They are attributed a specific number of points or a monetary value, and a list of services with their corresponding number of points or monetary value is issued periodically by the Common Order on the implementation of the Framework Contract (see Section 2.8.1). The total number of reported points should correspond to 28 services per day on average, considering 15 minutes as the average consultation time. For psychiatry and palliative care the total number of reported points is 14 services per day on average, with an average consultation

time of 30 minutes. The average services number per day for neurology and physical medicine and rehabilitation is 21, with an average consultation time of 20 minutes. This means that, for clinical specialties, the average number of points reported daily is 150, 153 for psychiatry and palliative care and 154 for neurology and physical medicine and rehabilitation. For all services that are reported in addition to the numbers above, the number of points for which a claim can be made is diminished. The number of points is further adjusted to reflect the conditions in which the providers work and their professional degree, similarly to primary healthcare providers (see above).

Ambulatory care providers may also charge patients directly (which is the case for most dental practices) or may enter into contracts with other entities for provision of certain services, that is, with the DPHAs for services performed under the national health programmes coordinated by the Ministry of Health (for example, dialysis for patients with chronic kidney diseases), with universities for medical education or research, and with local authorities and private insurers. Similar payment mechanisms are applied for services provided under these contracts.

Inpatient care

Hospitals receive prospective payments consisting of a mix of payment methods. For acute cases the hospitals are paid based on the DRG system, which was implemented nationwide in 2003 (Chiriac et al., 2011).

Initially, the American and then the Australian classification systems were used, with the latter providing a starting point for the development of the Romanian system (RO-DRG), which was implemented from 2010 onwards. Compared to the Australian DRG system, the RO-DRG has a few new DRGs, it includes new definitions for co-morbidities and complications, and has different grouping limits for some cases. The system is periodically updated (Scîntee & Vlădescu, 2015). Data collection and validation are performed by the National Institute of Health Services Management. Hospitals receive day fees for the treatment of chronic cases – these are negotiated up to a maximum value established by the Common Order on the Implementation of the Framework Contract. For the provision of day care, hospitals receive a case payment – with the fees also set by the Common Order. Hospitals also receive lump sum payments for participation in the provision of curative national public health programmes (covering drugs and medical supplies), FFS payments for services

provided by the outpatient departments and laboratory/imaging services (see above) or for home care.

Additional funding comes from the Ministry of Health, DPHAs or the local authorities, for example to cover investments and maintenance, running costs of emergency units, and for services provided within the preventive national health programmes. Further, besides the co-payment requested at discharge, hospitals may also charge patients directly for superior accommodation (public hospitals) or for any difference between the NHIH fees and their own fees (private hospitals) (see Section 3.4.1).

Pharmaceutical care

Prescribed pharmaceuticals are covered by the NHIF, in different shares of their reference price, according to special lists approved periodically by a Government Decision. The price difference is paid by the patients. Many over-the-counter pharmaceuticals are paid directly by the patients (see Section 3.4.1 and Section 2.7.4).

3.7.2 *Paying health workers*

Physicians working as independent professionals (family physicians, specialists working in their own offices, dentists) derive income from the revenues earned by their practices, through contracts with the DHIHs, other contracts or directly from patient charges (see Section 3.4). Physicians employed in hospitals, ambulatory practices or public health institutions receive a salary.

Nurses and midwives are also paid a salary. Since 2014, nurses and midwives may also work in solo practices, in which case their incomes are derived from the income of the practice.

As a measure to address shortages of human resources for health, in 2018 the salaries of physicians and nurses were increased by between 70% and 172%, depending on their eligibility to different bonuses. The basic salary increased three times (Ministry of Health, 2018). According to national statistics, between 2018 and 2021 the number of physicians increased by 8000 and the number of nurses by 12 400, following the return from abroad of some health professionals, as well as a reduction in the number of graduates leaving the country (INS, 2023a).

TABLE 3.4 Provider payment mechanisms

PROVIDERS PAYERS	MINISTRY OF HEALTH	OTHER MINISTRIES	DISTRICT HEALTH AUTHORITY	LOCAL AUTHORITIES	SHI FUNDS	PRIVATE/ VOLUNTARY HEALTH INSURERS	DIRECT PAYMENTS
GPs			FFS		35% C 65% FFS P4P	FFS	FFS
Ambulatory specialists*			FFS		FFS	FFS	FFS
Other ambulatory provision**			FFS		FFS	FFS	
Acute hospitals			LS		DRG	FFS	
Day care					FFS		
Other hospitals					PD		User charge
Dentists					FFS		FFS User charge
Pharmacies					CV		User charge Direct payment
Public health services	Budgets						FFS
Social care		Budgets***					

Source: Authors' own compilation

Notes: *Including hospital outpatient services; **For example, laboratory and medical imaging; ***Ministry of Labour and Social Protection; FFS: fee-for-service; C: capitation; P4P: payment for performance; DRG: diagnostic-related groups; PD: per-diem; LS: lump sum; CV: cost–volume contracts.

Public health professionals working for the DPHAs are paid as civil servants and receive lower salaries compared to other physicians. Salaries of other professionals working in public health are lower than salaries of public health professionals who are trained as medical doctors and much lower than the salaries in the private sector. This is why other professionals (such as economists, information technology specialists, engineers, sociologists, etc.) are not attracted to work in the public health sector.

Pharmacists employed in hospital pharmacies are paid a salary. Community pharmacies generate revenue through sales and employ salaried staff. Salary negotiation takes place only in the private sector on an individual basis, where the salary level is guided by the market. In the public sector, salary negotiation occurs at the national level between the trade union and government representatives, and the level is set by a Government Decision (Vlădescu et al., 2016).

4

Physical and human resources

Chapter summary

- In 2023 there were 554 hospitals in Romania, including 374 public hospitals, 163 day-care facilities and 81 LTC facilities.
- The total number of hospital beds decreased from 889.4 per 100 000 population in 2000 to 674.6 in 2011 but increased again to 728.4 in 2023. The distribution of beds varies across regions, with a higher concentration in Bucharest (18.0% of all hospital beds in 2023) and fewer beds in hospitals located in the West (9.5%) and South-West (9.7%) of Romania.
- Electronic reporting for patient-related primary and ambulatory care activity to the NHIH began in 1999 for reimbursement purposes and was expanded to hospitals in 2006, alongside the introduction of the DRG system.
- In 2008 the NHIH launched the Integrated Unique Informatics System, later extending it with the electronic prescribing information system in 2012, the electronic health card in 2015, and electronic patient records in 2021. The COVID-19 pandemic accelerated the use of digital solutions.
- Although Romania no longer has the highest number of graduating physicians in the EU, the number is still well above the EU average. Despite an increasing health workforce, especially after an almost three-fold salary increase in 2017 and mass hiring during

COVID-19, there are still shortages, especially among physicians, in certain specialties and some geographical regions.

- The number of physicians migrating to other countries increased from 42 179 in 2013 to 64 978 in 2023 (mainly to France, Greece and Germany), while the number of nurses migrating to other countries increased from 123 404 in 2013 to 190 420 in 2023 (mainly to Italy and the United Kingdom).
- One of the health reforms included in the 2021–2026 NRRP aims to increase health management and human resources capacity. The reform is supposed to lead to improved health management training across the health system and better professional development opportunities.

4.1 Physical resources

4.1.1 *Infrastructure, capital stock and investments*

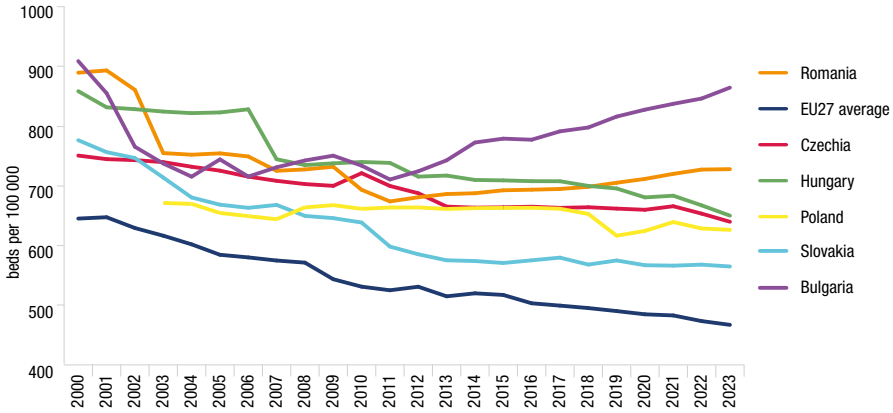
Infrastructure

In 2023 there were 554 hospitals evenly distributed across the regions in Romania (Box 4.1), including 374 public hospitals (67.5%). Additionally, there were 163 day-care facilities and 81 LTC facilities (INS, 2024c). Despite policy efforts to shift care from inpatient to ambulatory and community care settings, the total number of hospitals has increased from 447 in 2002, driven by a rise in private hospitals, from five in 2002 to 180 in 2023 (INS, 2024c). The closure of 67 underperforming public hospitals in 2011 temporarily reduced the total number from 503 in 2010 to 464 in 2011. However, 97 small private hospitals opened that same year, and more than half of the closed hospitals later reopened (Scîntee et al., 2018). The aim was to convert acute care beds, which were considered too numerous, into LTC beds for older people, people with disabilities and socioeconomically disadvantaged people.

The hospital bed rate in Romania decreased from 889 per 100 000 population in 2000 to 675 in 2011 but increased again to 728 in 2023. Romania has the third-highest number in the EU after Bulgaria (864) and Germany (766), and well above the EU27 average in 2023 (469). Among Central European countries, only Bulgaria had a higher rate than Romania, while Hungary (651), Czechia (641), Poland (627) and Slovakia (566) had lower rates of hospital beds in 2023 (Fig. 4.1).

Since 2011, the number of curative beds has increased from 504 per 100 000 population to 549 in 2023. On the other hand, the number of LTC beds in hospitals has decreased from 118 in 2011 to 108 in 2023, while the total number of beds in nursing homes and other residential LTC facilities increased from 137 in 2013 to 233 in 2023 (Eurostat, 2025).

FIGURE 4.1 Total beds per 100 000 population in Romania and selected countries, 2000–2023



Source: Eurostat, 2025

BOX 4.1 Are health facilities appropriately distributed?

A 2020 study shows that hospitals are relatively evenly distributed across regions, providing good geographical access, as over 80% of the population can reach a hospital within 30 minutes of driving. However, some areas, like the Danube Delta and remote mountain regions, remain hard to reach, with 0.1% of the population unable to access a hospital due to road infrastructure. Only 30% of the population can reach a highly specialized hospital within a 30-minute drive (Dumitrache et al., 2020).

National statistics from 2023 show a regional variation in hospital bed distribution, with a higher concentration in Bucharest (17.9% of all hospital beds) and fewer beds in the West (9.5%) and South-West (9.7%) (INS, 2023b).

In 2023 almost 91% of public hospitals are located in urban areas, while 48% of the population lives in rural areas, with 24.8% of the rural population over 60 years old. Many rural residents struggle with transport costs and limited access to basic primary care (INS, 2023b, 2025b). Other health facilities are also concentrated in urban areas, including 99.8% of school dental offices, 98.3% of school medical offices, 95.4% of laboratories, 94.5% of specialist offices, 85.7% of dental offices, 65.6% of pharmacies and 60.2% of family physician practices (2023 data) (INS, 2023b).

Current capital stock

There are different hospital types in Romania (Table 4.1). Hospitals are classified according to their competency level, ranging from I to V, with category I including hospitals that provide medical services of the highest complexity. Equipment capacity and staff specialization criteria set the competency level (Ministry of Health, 2010). Hospitals can also be classified according to ownership, resulting in public, private and mixed-ownership hospitals. Public hospitals are under the administration of local authorities, except for 58 hospitals administered by the Ministry of Health (Government of Romania, 2010).

Several evaluation reports since 2003 have highlighted the need to restructure and reorganize hospital services, improve the classification and separation of care levels, and establish regional hospital networks (Government of Romania, 2011). In response, the government approved the National Strategy for Hospital Rationalization in 2011 (Scîntee et al., 2018).

In 2004 a hospital law that Parliament never passed included the construction of eight new regional hospitals (Dumitrescu, 2022). The Regional Operational Programme 2014–2020 later included three of the eight hospitals, with construction starting in 2019. The National Agency for Development of Health Infrastructure (ANDIS), a newly established agency under the Ministry of Health, oversees the construction of these three emergency regional hospitals in Iași, Cluj and Craiova. ANDIS was established with the NRRP to manage major public health infrastructure projects (Government of Romania, 2022b).

In 2016 the government approved the first regional health plans as they were one of the ex-ante conditionalities for the 2014–2020 Partnership Agreement with the European Commission on funding through the European Structural and Investment Funds (European Commission, 2014b).

Hospital infrastructure investments have been on the health policy agenda for decades, yet the infrastructure remains poor. Most facilities were built in or before the 1970s, resulting in deteriorated and poorly maintained buildings, often scattered across multiple locations, which do not meet modern codes and standards, such as outdated electrical installation and poor conditions for patient safety. For example, there are frequent hospital fires, especially during the COVID-19 pandemic, affecting (already) overburdened hospitals; an estimated 11 fires were caused by, or were difficult to fight due to, these improper conditions (G4Media.ro, 2021).

TABLE 4.1 Hospital types in Romania

HOSPITAL TYPE	DEFINITION
Republican hospitals	Highest degree of competence, including all specialties, academic and research activities
Clinical hospitals	Provide teaching, research and continuing medical education, either contracted with or owned by universities
Institutes and clinical medical centres	Provide teaching and research, as well as either technical coordination of the activities in a specific domain or a methodological role for the entire medical specialty
Emergency regional hospitals	Treat complex cases that cannot be treated in local or district hospitals
District hospitals	Located in each district's capital, they serve the entire district, have complex organizational structures with an emergency unit, and treat patients who cannot be treated in local hospitals
Emergency hospitals	Emergency hospitals have complex organizational structures, are well equipped, have an emergency unit (sometimes with a mobile emergency unit), and serve a large catchment area
General hospitals	Have at least two of the main medical specialties: internal medicine, paediatrics, obstetrics-gynaecology, general surgery
Specialty hospitals	Provide services in a certain medical specialty, such as paediatrics, psychiatry, tuberculosis or infectious diseases
Health centres	Provide both inpatient and ambulatory care in at least two specialties for a large catchment area (including several villages)
Local hospitals	Provide general hospital services of moderate complexity for their catchment areas
Medico-social care units	Subordinated to the local public administration and provide services to patients with medical and social needs
Long-term hospitals for chronic diseases	Treat patients with chronic diseases, who can stay for longer periods of time
Sanatoriums	Treat tuberculosis
Preventoriums	Provide rehabilitation and spa treatments

Source: Authors' own compilation based on Healthcare Reform Law no. 95/2006

Regulation of capital investment

The Ministry of Health's investment programme is part of the Governmental Fiscal-Budgetary Strategy. The current strategy for 2025–2027 builds on previous strategies and focuses on two main health investment measures: 1) developing and modernizing health infrastructure, and 2) procuring

medical equipment and ambulances. These align with medium-term strategic health priorities, including rebuilding fire-damaged hospitals, developing community care centres, refurbishing ambulatory health practices, and developing LTC centres for older people (Ministry of Finance, 2025b). Besides government funds, these investments are also financed by the NRRP, other European funds and World Bank projects (Ministry of Finance, 2025b).

The overall health investment approach has been considered as chaotic, lacking synergies and intersectoral collaboration, and missing needs-based assessments to ensure equitable distribution of capital across the country and levels of care (Ministry of Health, 2023a). Furthermore, the effectiveness of the previous 2014–2020 Health Strategy suggests low capacity for implementing infrastructure projects (Ministry of Health, 2023a). Consequently, one objective of the National Health Strategy 2023–2030 is to improve quality of care through health infrastructure investments. This aims to increase planning, managing and implementing capacity through viable partnerships and by pooling all available funding sources to achieve the national investment targets. Additionally, the NRRP includes funding to renovate and equip 3000 primary care practices, build and/or renovate and equip 200 integrated community centres, and construct and/or equip at least 25 new public health units/hospitals (European Commission, 2021a).

Investment funding

Capital investments are funded through state or local budgets based on the annual investment plans of healthcare facilities, pre-approved by the Ministry of Health or the corresponding local council. Additional funding can come from external programmes such as those from the World Bank, the EU Structural Funds and the NRRP (implemented between 2021 and 2026). Healthcare institutions can also cover capital investments through their revenues and donations. Until 2014 hospitals could not use funds from the NHIH for capital investments. However, a legislative change in February 2014 (Law no. 95/2006) allowed hospitals to allocate money from their contract for investments in infrastructure and medical equipment, but only after covering all operating expenditures, such as salaries and medication (Vlădescu et al., 2016).

Romania's Law on Public-Private Partnerships was issued in 2010, but implementation has been obstructed by numerous legal limitations and

technical problems (Vlădescu et al., 2016). Despite legislative efforts to address these issues and improve implementation, public-private partnerships are still limited.

4.1.2 *Medical equipment*

Equipment infrastructure

Medical equipment in Romania is mainly financed by the Ministry of Health but also by local authorities, donations and externally funded projects. Since 2014 hospitals can purchase medical equipment with money from the DHIH for contracted health services. The latest substantial investment in medical equipment (around €315 million for the period 2022–2026) is funded through the NRRP. This investment covers equipment for 3000 family physician practices, 200 integrated community centres, 119 family planning offices, 12 neonatal intensive care mobile units and 10 cancer screening mobile units (Ministry of Finance, 2025a).

There are no detailed publicly accessible data on the type and number of medical equipment in Romania. However, aggregate data indicate that in 2024 there were 586 CT scanners, with 55.4% of them in public medical facilities and 44.5% in private facilities, and 349 MRI units, with 37.5% in public medical facilities and 62.4% in the private system (INS, 2025d). According to Eurostat data for 2023, Romania ranks mid-range among EU countries in MRI and CT scanner availability per 100 000 population, with 1.64 MRI units and 2.76 CT scanners, twice as high as in Hungary (see Table 4.2).

TABLE 4.2 Items of functioning diagnostic imaging technologies (MRI units, CT scanners) per 100 000 population in Romania, 2023

	ROMANIA	LOWEST AND HIGHEST IN EU
MRI units	1.64	0.58 (Hungary) – 3.91 (Greece)
CT scan	2.76	1.12 (Hungary) – 5.06 (Greece)

Source: Eurostat, 2025

However, Romania ranks among the lowest in the EU when considering the number of examinations. It has the second-lowest number of MRI examinations with 4335 per 100 000 population, ahead of only Bulgaria (2397), while Austria has the highest (16 808). Romania also recorded the second-lowest number of CT scans in the EU with 8257 per 100 000 inhabitants, after Finland (6757), while Latvia reported the highest number with 25 462 (Eurostat, 2025). Additionally, Romania is among the lowest in the EU regarding other equipment per 100 000 population, including gamma cameras, PET scanners, radiation therapy equipment and mammographs (Eurostat, 2025).

4.1.3 *Information technology and eHealth*

The share of households with internet access in Romania increased from 80.89% in 2018 to 94.57% in 2024 (Eurostat, 2025). Internet availability is higher in urban areas (96.04%) than in rural areas (88.12%) (2023 data; Statista, 2025).

A three-month survey in 2022 found that only 33.8% of internet users aged 16–74 years searched for health-related information, with women (41.2%) searching more than men (26.5%). A small share (32.2%) used internet-connected wearable devices, such as watches, fitness trackers and personal safety GPS trackers, while 3.2% used patient health monitoring devices (2024 data; INS, 2024d).

Electronic reporting for patient-related primary and ambulatory care activity to the NHIH began in 1999 for reimbursement purposes and was expanded to hospitals in 2006, alongside the introduction of the DRG system (see Section 3.7.1). In 2008 the NHIH introduced the Integrated Unique Informatics System, which harmonized previous reporting systems. It includes data on the insured population, received healthcare services, provider payments and the administration of the health insurance fund. Over time, it expanded to include the electronic prescribing information system in 2012, the electronic health card in 2015 and electronic patient records in 2021 (see Section 2.6).

Electronic appointment booking systems are rarely used, and only in some private ambulatory care facilities. An electronic reporting system for immunizations is also linked to the National Electronic Vaccination Registry.

The COVID-19 pandemic accelerated digital adoption in Romania. Family physicians and specialists could provide telephone/online consultations without verifying the electronic NHI card, usually required for health insurance reimbursement. This measure remains in place for patients with chronic conditions. During the COVID-19 pandemic Romania introduced 'Coronaforms', an application that collected test data and enabled public health authorities (DPHAs) to issue isolation orders to patients and their family physicians. A special COVID-19 module was also added to the National Electronic Vaccination Registry to register fully vaccinated people and those awaiting a second dose (Fahy & Williams, 2021).

Romania has committed to further digital health investments under the NRRP, allocating €470 million to develop an integrated eHealth system. This system aims to connect over 25 000 healthcare providers and develop telemedicine systems (MIPE, 2023). To support this, the Ministry of Health, with WHO support, has developed a National Digital Health Strategy 2024–2030 (Ministry of Health, 2024). Published for public debate in November 2024, it is currently under revision. The published draft includes four strategic objectives: 1. improving governance and policies for health digitalization; 2. developing digital competencies for the public and providers; 3. improving the infrastructure to support data and integrated e-health services; and 4. accelerate innovation, research and the use of digitalization in health.

4.2 Human resources

4.2.1 *Planning and registration of human resources*

Romania has a National Strategy for Human Resources in Health Development for 2022–2030. Based on this strategy and WHO technical support, sectoral action plans for primary and community care, public health, hospitals and ambulatory specialist care have been developed and implemented since 2023.

Health professionals register with their respective professional associations, such as the College of Physicians, College of Dentists or Order of Nurses and Midwives, and apply for a practice licence. This licence is

renewed annually based on a continuing professional development system that requires a set number of education points.

Health professionals educated within the EU/EEA can obtain a licence by meeting the requirements of the EU directives on the recognition of professional qualifications (Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005). For health professionals educated outside the EU/EEA, the Romanian Ministry of Education assesses their basic medical education, and the Ministry of Health and the respective professional association assess their specialty education.

4.2.2 *Trends in the health workforce*

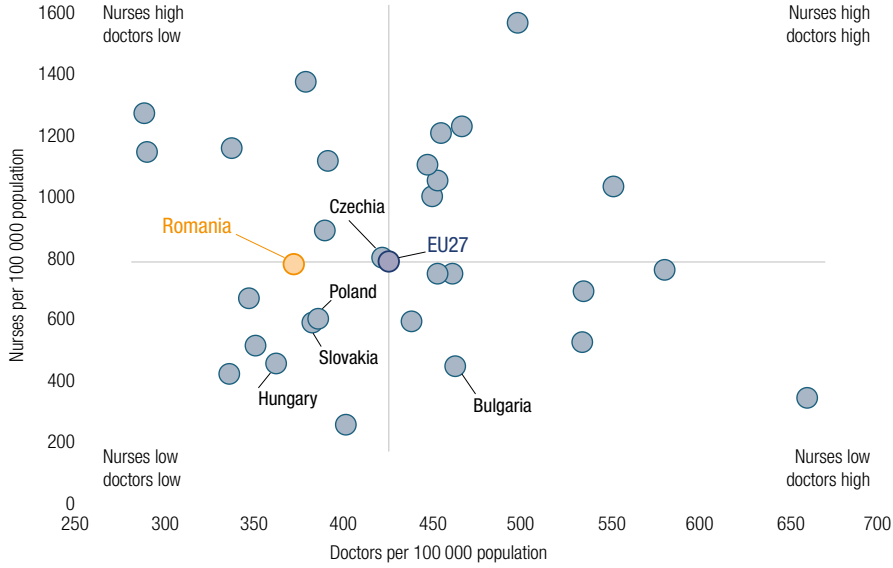
In 2023 Romania's health workforce comprised 376 188 professionals, including physicians (19.3%), dentists (5.6%), pharmacists (5.7%), allied health professionals (physiotherapists, biologists, physicists, chemists and others) (2%), nurses with university education (5.3%), nurses without university education (37.6%), and auxiliary staff (20.2%) (INS, 2024f). Health workers are distributed according to where health facilities are located (Box 4.2).

Distinguishing between physicians working in hospitals and ambulatory care and between public and private sectors is challenging. Many hospital-based physicians also practise in ambulatory care, and public-sector physicians may also work privately after hours. In 2023 Romania had 203 full-time equivalent hospital-based practising physicians per 100 000 population, higher than in Slovakia (197), Estonia (185) and Hungary (140) (Eurostat, 2025), indicating a higher workload in Romania.

Compared to other countries, there were 772 practising nurses per 100 000 population in 2023, which was below the EU average (784) but higher than other Central and South-Eastern European countries, such as Estonia (664), Slovakia (579), Poland (589) and Hungary (451). A starker difference was observed in the number of practising physicians in Romania, which was much lower than the EU average (372 vs. 425 per 100 000 population) and also lower than in Slovakia (382) and Poland (386), but higher than in Estonia (348) and Hungary (362) (Fig. 4.2).

Despite an increasing number of practising physicians (Fig. 4.3) and nurses (Fig. 4.4) in Romania, shortages persist, particularly among physicians in certain specialties and in some regions. The rise in workforce numbers may be explained by reduced migration following significant salary increases in 2017 and mass hiring during the COVID-19 pandemic.

FIGURE 4.2 Practising nurses and physicians per 100 000 population, 2023



Source: Eurostat, 2025

Notes: For physicians, data for Greece and Portugal refer to those who are licensed to practise, and for Slovakia, Montenegro and North Macedonia data refer to those who are professionally active. Data for Denmark and Sweden is from 2020, Finland 2018, and Luxembourg and Poland 2017. For nurses, data for France, Portugal and Slovakia refer to those who are professionally active, and for Belgium, Latvia, the Netherlands, Romania, Finland and Serbia – definition may be different from the EU.

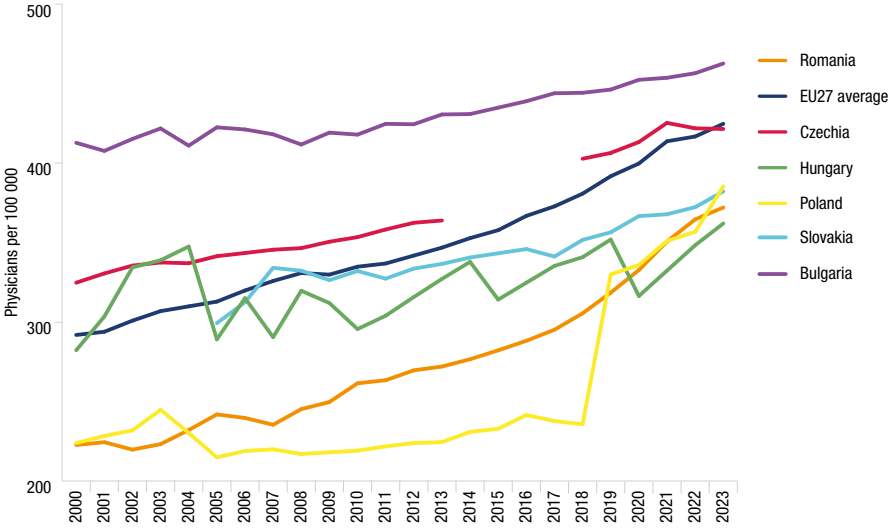
BOX 4.2 Are health workers appropriately distributed?

The distribution of health workers follows the location of health facilities. In 2023, 97.6% of physicians, 89.2% of dentists, 89.2% of nurses and 84.5% of pharmacists were working in urban areas. There was also substantial variation between districts. The physician density in 2023 ranged from 1047 per 100 000 population in Bucharest, followed by districts with the main university centres, such as Timiș (877.0), Cluj (645.0) and Iași (630.0), to just 123 per 100 000 population in Giurgiu (INS, 2025b). The unequal distribution of health workers, as well as health facilities, is explained by the differences in economic development between rural/urban areas and between different regions in the country. While financial incentives for family physicians who work in deprived areas are in place, they still prefer to live in cities where there are better schools, better living conditions and other facilities.

The greatest shortage is among family physicians, with an estimated shortage of 2187 family physicians in 2020. Additionally, 40% of practising family physicians were around retirement age. In February 2020, 328 localities (that is, a commune or village) had no family physician, and over 1400 localities had insufficient coverage of primary healthcare services (FNPMF, 2020). By 2025 the NHIH reported a reduced, but still high, deficit of 1516 family physicians and 174 localities with no family physician (NHIH, 2025b).

Other medical specialties, such as epidemiology, public health and hygiene, also face shortages. These are perceived as less prestigious or desirable among young physicians.

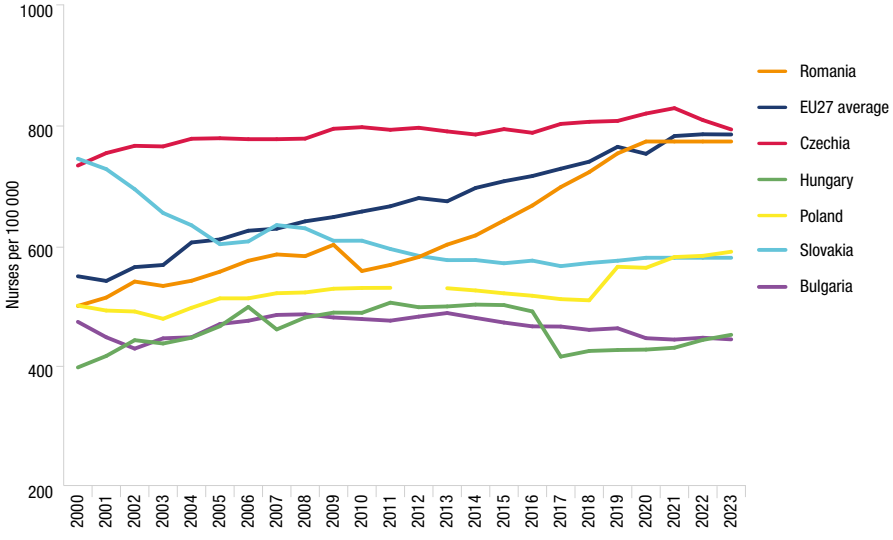
FIGURE 4.3 Number of practising physicians per 100 000 population in Romania and selected countries, 2000–2023



Source: Eurostat, 2025

Note: For Slovakia, the data refer to physicians who are professionally active.

FIGURE 4.4 Number of practising nurses per 100 000 population in Romania and selected countries, 2000–2023



Source: Eurostat, 2025

Note: For Slovakia, the data refer to nurses who are professionally active.

4.2.3 *Professional mobility of health workers*

The discrepancy between Romania having one of the highest numbers of graduate physicians (see Section 4.2.1), while facing workforce shortages (see Section 4.2.2) is mainly due to high levels of workforce migration. The number of physicians leaving the country increased from 42 179 in 2013 to 64 978 in 2023 and the number of nurses leaving increased from 123 404 in 2013 to 190 420 in 2023 (Eurostat, 2025). Of those who migrated in 2023, 63 793 physicians and 190 298 nurses had been trained in Romania, indicating that some left to study abroad and never returned (Eurostat, 2025).

In response to low salaries, one of the main declared reasons for leaving the country, the government substantially increased wages for medical personnel starting in 2018. The net salary between 2017 and 2018 of a junior physician increased 162%, from about €344 to €902, and 131% for a senior physician, from €913 to €2112 (Government of Romania, 2018). Although some media reports mention cases of physicians returning, there is no publicly available evidence on the effect of this measure. On the contrary, the 2023 survey of physicians below 35 years of age by the College of Physicians found that 40.3% of physicians considered leaving Romania, with 17.2% expressing a firm intention to migrate (Medichub, 2023). In 2023 most physicians migrated to France, Greece and Germany, while nurses primarily migrated to Italy and the United Kingdom (OECD, 2025).

4.2.4 *Training of health personnel*

Basic training for physicians lasts six years and five years for dentists and pharmacists. After graduating from medical school, physicians must pass a national exam to enter specialty training, which varies in length from four years (for example, public health, ophthalmology), five years for most specialties, to six years (for example, neurosurgery). Residency programmes for dentists and pharmacists last three years. Only a small number of residency positions are pre-allocated to medical institutions. To mitigate physician shortages, in general and in underserved areas, the Minister of Health has suggested extending the number of pre-allocated residency positions (Digi24.ro, 2025). After completing their residency, physicians can start

working, but most do not have a job directly after their residency. During their residency, they are paid by the Ministry of Health.

Nurses are mainly trained in private schools as general nurses or in specialized fields such as pharmacy, balneology and physical rehabilitation, radiology and imaging, nutrition and dietetics, laboratory work or public health and hygiene. These last three years (that is, 4600 hours). Some schools also offer training for specific roles, such as caregivers for older people, occupational therapists and rehabilitation coaches. Around 12% of nurses receive university-based training, completing either a four-year programme (240 credits) to become a general nurse or midwife, or a three-year programme (180 credits) to become a balneology, radiology or nutrition nurse (INS, 2025b). Despite the fact that the overall number of nurses per capita is around the EU average, the training pathway through private postgraduate schools (3 years) is considered suboptimal, and the state is trying to increase the percentage of university-trained nurses. After graduation, general nurses can further specialize in one of five specialties (see Section 4.2.1) or receive workplace-based training in one of the 18 other specialties to enhance their skills (Ministry of Health, 2019b). The current 2022–2030 Strategy for health workforce development envisages the increase in the share of university-based trained nurses and improved training programmes for nurses.

The Ministry of Education sets standards for basic medical education, while the Ministry of Health oversees specialization and continuing education standards. Continuing professional development is mandatory for annual relicensing by the professional colleges.

The country has six medical and pharmaceutical universities and seven other medical faculties, none imposing *numerus clausus* for medical training. Consequently, Romania had the highest number of graduating physicians in the EU from 2013 until 2021, when Latvia surpassed it. In 2023 Romania (28.05) placed third, after Bulgaria (30.61) and Malta (32.0), for graduating physicians per 100 000 population. However, the share in Romania was 1.8 times higher than the EU average of 15.21 (Eurostat, 2025).

4.2.5 *Physicians' career paths*

Specialized physicians can apply for the title of senior physician ("medic primar") after five years of practice. The Ministry of Health awards this title

after applicants pass a special exam. In each specialty, there are several areas in which a physician can undergo specific training and pass an exam to obtain a certified competency (called "Atestat"). These competencies may involve acquiring new medical or non-medical skills in a particular area (such as palliative care, health management), the use of specific technologies (such as bronchial endoscopy), or performing particular interventions (such as gynaecological laparoscopic surgery, or specific organ or tissue transplant).

To become the head of a hospital department or ward, physicians must obtain competency in health services management and pass a selection process. Hospital manager positions are open to university graduates in medicine, economics or law, provided they complete a hospital management course. One health reform included in the 2021–2026 NRRP (see Section 2.4 and Section 3.6.2) focuses on increasing health management and human resource capacity. It aims to improve management training across the health system and professional development opportunities.

Physician mobility between hospitals is limited, but some have begun offering services in multiple hospitals due to workforce shortages. Additionally, hospitals near the southern border have started employing physicians from Bulgaria.

4.2.6 *Other health workers' career paths*

The Ministry of Health, in collaboration with the Order of Nurses and Midwives, establishes the training requirements, employment criteria and career development options for nurses. As with physicians, completing a hospital management course is required to become the head of a hospital department or ward (for pharmacists, biologists and physicists) or a hospital care director (for nurses).

5

Provision of services

Chapter summary

- Public health is guaranteed by the state and financed mainly from the state budget through the national public health programmes, but also from local budgets, from health insurance and from other sources. The main strategic document in the area of public health is the National Health Strategy 2023–2030.
- Primary care is provided by family physicians, who are meant to act as gatekeepers and operate independently, mainly in solo practices. However, due to the shortage of family physicians and the lack of continuous primary care services, many patients bypass family doctors by calling emergency ambulance services or going directly to hospital emergency departments.
- Specialized ambulatory care is provided mainly by private individual medical offices. Most of the specialized physicians work both in the public and private sectors, employed in hospitals and working out-of-hours in private settings, with or without a contract with the DHIH. The low number of ambulatory specialized services is reflected by the overutilization of hospital services.
- Day care has expanded considerably over recent years, representing 64.5% of total hospital admissions reimbursed by health insurance in 2022, compared to 41.6% in 2014. However, the target is that until 2030 at least 50% of the day cases treated in hospitals in 2022 will be delivered as ambulatory services.

- Emergency services are overused due to patients' preferences to directly consult the emergency departments in the hospital or to call 112; in some cases, however, this is the only option available, either due to uninsured status or as residents in an area without primary care services. A high percentage of ambulance calls are resolved at the patients' home, indicating an overuse of ambulance services.
- Dental care is covered to a very low extent by health insurance; this is the main driver of catastrophic spending among households in the richest consumption quintile and leads to an increased level of unmet need for dental care examination due to cost, especially among the poorest quintile, reaching 6.6% in 2024.

5.1 Public health

Public health is regulated by Title I of Law no. 95/2006 on Healthcare Reform with subsequent modifications and additions. The scope of public health functions covered includes: prevention, surveillance and control of both communicable and noncommunicable diseases, monitoring health status and health determinants, health promotion and disease prevention, occupational health, environmental health, developing and implementing public health legislation, ensuring proper public health policies and management, and the provision of specific public health services (such as school health, preparedness for emergencies, family planning, screening, pre- and postnatal care, transfusion safety, and others). The responsibility for public health is shared among the Ministry of Health, the DPHAs, the NHIH, the health authorities under other ministries and institutions with their own health networks (for example, National Defence, Internal Affairs, Justice, Transport and Infrastructure, Intelligence Services, Special Telecommunication Services), and the local administrative authorities. Public health is guaranteed by the state and financed mainly from the state budget through the national public health programmes, but also from local budgets, from health insurance and from other sources. The main strategic document in the area of public health is the National Health Strategy 2023–2030, which includes public health as one of the three main priority areas of the Romanian health system and sets as general objectives: ensuring sustainability and resilience of the public health system, increasing healthy life years and quality of life, and reducing

morbidity and mortality due to communicable diseases with major individual and societal impact.

The National Institute of Public Health provides technical assistance (including the provision of data, expertise and training, as well as the development of methodologies, tools and monitoring indicators) on public health and related matters to the Ministry of Health and other ministries. It comprises four national specialized centres – the National Centre for Communicable Diseases Surveillance and Control, the National Centre of Environmental Community Risk Monitoring, the National Centre for Non-Communicable Diseases Surveillance and the National Centre for Statistics in Public Health – and six regional public health centres, located in Cluj, Craiova, Galați, Iași, Târgu Mureș and Timișoara. It also includes a National Public Health Laboratory which deals with seroepidemiology diagnosis, water quality surveillance, environment and food chemistry and microbiology, radiation monitoring and occupational health.

The National Institute of Public Health coordinates five national preventive health programmes: the national immunization programme; the national surveillance and control of communicable diseases programme, including the surveillance of healthcare and antimicrobial resistance (AMR)-associated infections and surveillance of antibiotic use, NAAT/RT-PCR (Nucleic Acid Amplification Tests/Reverse transcription polymerase chain reaction) testing; the national programme for monitoring environmental and occupational risk factors; the national programme for cervix cancer screening; and the national programme for health promotion and health education (Ministry of Health, 2022).

The 42 DPHAs, which represent the Ministry of Health at the local level (see Section 2.3), are responsible for the provision of public health services locally, including amongst other roles monitoring the health of the population and health determinants, identification of public health needs of communities, performing controls of health institutions, and coordinating the implementation of national public health programmes at the local level, as well as carrying out sanitary inspection and health promotion activities.

Public health activities are also performed as part of medical care services contracted by the DHIHs. They are mainly carried out by family physicians and include: early detection of diseases through preventive check-ups, family planning, antenatal and postnatal care, and health education and prevention. Family physicians also perform public health services under the national

preventive public health programmes, which are contracted by the DPHAs, such as immunization and the screening programme for cervical cancer (Ministry of Health, 2022).

Preventive services were first regulated by a dedicated law in 2020 – Law no. 152/2020 on the organization and financing of health promotion and disease prevention services, revised in 2023 and renamed Law no. 152/2020 on health promotion and disease prevention. According to this law, health promotion and disease prevention are defined as a set of intersectoral actions coordinated by the Government and authorized institutions and implemented by health institutions together with individuals, families and communities, directed to the increase of life expectancy and the reduction of avoidable deaths, as well as to the improvement of health status and quality of life. Health promotion and disease prevention activities should follow a four-year National Action Plan developed, implemented and financed by the Ministry of Health (Parliament of Romania, 2020). Since this is a legislative provision introduced in September 2023, at the time of writing (December 2025), the plan, which should be based on needs assessment and priority setting, has not been developed yet. Some preventive services, such as health promotion campaigns, health education, monitoring of health risks, reduction of health risks impact, prevention and control of communicable diseases, early detection of chronic diseases, and others, are provided irrespective of the above-mentioned plan, as they are legal attributions of different institutions or have been introduced by other legislative documents. The plan is expected to better coordinate and monitor these services and to add new models of delivering preventive services.

Public health interventions to address major risk factors (such as drinking, smoking, unhealthy diet and lack of exercise) are among the tasks of the Ministry of Health and DPHAs, or are included in several national public health programmes, such as the national programme for health promotion and health education coordinated by the National Institute of Public Health which includes interventions for inducing a healthy diet and exercise, and for prevention of alcohol consumption, the national sub-programme for prevention and control of tobacco consumption (Ministry of Health, 2022). Preventive medical check-ups according to population group (by age and/or diagnosis) are included in the benefits package and are provided by family physicians and paid for by health insurance. However, public health interventions to address risk factors are not very effective in Romania (Box 5.1).

BOX 5.1 Are public health interventions making a difference?

In 2022 there were 304 preventable deaths per 100 000 population in Romania, which was almost double the EU average (168 per 100 000). Also, more than one in three deaths recorded in Romania in 2021 could be attributed to behavioural and environmental risk factors (OECD & European Observatory on Health Systems and Policies, 2025). This suggests that public health interventions to address these risk factors are not very effective in Romania. One example of poor accessibility and adequacy of public health interventions is the health promotion programme in schools, which was launched in 2002 and introduced health education as an optional class. The Minister of Education declared in 2023 that under 10% of pupils attended this class, and the reason claimed by schools is the lack of specialized teachers (Edupedu.ro, 2023). The Minister of Education called for better collaboration with the Ministry of Health not only in health education curricula development but also in delivering these classes (Edupedu.ro, 2023).

Further, interventions regarding immunizations seem ineffective, as vaccination rates are well under WHO targets (for example, in 2023 the vaccination rate for polio was 78.5% compared to the 80% WHO target; for measles, mumps and rubella (MMR) it was 78% compared to 95%, for tetanus boosters it was 78.5% compared to 95%, and for influenza (in people aged 65 years and over) it was 23% against the WHO target of 75% (ISNP-CNSCBT, 2025)). Among the main barriers to access vaccination is the lack of proper information on vaccination utility, vaccine safety and vaccination services availability, as well as insufficient vaccination services. Some isolated measures were taken in 2022 (including authorized pharmacists among the vaccinators for influenza) and 2023 (making certain vaccines available in community pharmacies). A holistic intervention approach was introduced through the National Vaccination Strategy for 2023–2030 approved by Government Decision no. 1006/2023.

There are also several NGOs that are well-known for their programmes in fighting the unhealthy behaviours listed above, and others. These are, for example, the Romanian Association for Health Promotion, the Alliance for Fighting Alcoholism and Addictions, the Romanian Association for Education in Diabetes, the Anti-AIDS Romanian Association, the Romanian Alliance for Suicide Prevention, the Romanian Harm Reduction Network, and others.

Some of the national public health programmes include screening activities at population level (for cervical cancer, breast cancer, colorectal cancer,

prostate cancer and hepatitis infection) or in specific groups (screening for HIV/AIDS infection in pregnant women and persons at risk, screening for phenylketonuria, congenital hypothyroidism, cystic fibrosis and hearing deficiencies in new-borns and retinopathy in premature newborns). These programmes are implemented mainly by hospitals and several other health services providers nominated by the Ministry of Health (Ministry of Health, 2022).

The national programme for monitoring determinants of living and working environments includes actions towards preventing environmental-related diseases, such as surveillance of water and air quality, control of cosmetics, biocides and other non-chemical substances, monitoring the management of medical waste, prevention of radiation-associated diseases, occupational-related diseases, and prevention of food-related and nutrition diseases. This programme is coordinated by the National Centre of Environmental Community Risk Monitoring of the National Institute of Public Health. The Centre is divided into specialized departments that are in charge of supervision and monitoring in their respective areas of competence: environmental health, food and nutrition, waste management, toxicology and occupational health. They conduct studies and research, develop regulations, monitor methodologies and professional guidelines, provide training, administer the national risks registry and the national occupational diseases registry, and ensure the implementation of the International Health Regulations (2005) (WHO, 2008).

Occupational health is also regulated by Law no. 319/2006 on Occupational Health and Safety. The Ministry of Labour and Social Protection, in collaboration with the Ministry of Health, is responsible for developing the national policy and strategy on occupational health and safety. The last occupational health and safety strategy covered the period 2018–2020, and the National strategy for green workplaces 2018–2025 is still in action. Employers have the legal responsibility to provide occupational health services for their employees, such as periodical medical check-ups, the evaluation of occupational risks and prophylactic medical services by contracting private occupational health offices or employing an in-house occupational health specialist. They also have an obligation to ensure a healthy and safe working environment.

The National Centre for Communicable Disease Surveillance and Control (NCCDSC) of the National Institute of Public Health coordinates

the national network of epidemiologic surveillance and communicable diseases control and is the National Competent Body interacting with the European Centre for Disease Prevention and Control (ECDC). Data are collected through the DPHAs based on a methodology developed by the NCCDSC and approved by the Ministry of Health, validated and further reported to the epidemiological surveillance system. For HIV/AIDS and tuberculosis there are separate surveillance networks, coordinated by the Institute for Infectious Diseases "Matei Balș" for HIV/AIDS and the Institute of Pneumology "Marius Nasta", respectively; collected data for these diseases are also sent to the NCCDSC.

The Centre also coordinates the national immunization programme, including the estimation of vaccine needs, monthly monitoring of vaccine stocks, biannual evaluation of vaccine coverage, coordination of the surveillance of postvaccination adverse reactions, training of vaccinators, administration of the National Electronic Vaccination Registry, and printing and distribution of vaccine books. Vaccination is performed by family doctors, except for those vaccines administered at birth in neonatal departments, in tuberculosis outpatient clinics, in health units hosting abandoned children, in vaccination centres set up in case of epidemics, and for those vaccines against influenza that can be also administered by authorized pharmacists.

5.2 Patient pathways

The patient's first contact with the health system is usually through the family physician with whom they are registered (see Fig. 5.1). The consultation is free of charge if it is not above the number of monthly visits included in the basic benefits package (see Section 3.3.1). In case of an emergency, patients rely on ambulance services and/or hospital emergency departments. In many cases, emergency services are used in non-urgent cases and, because the legislation does not allow these services to refuse a person before they have been medically examined, these services are generally overused (see Section 5.5).

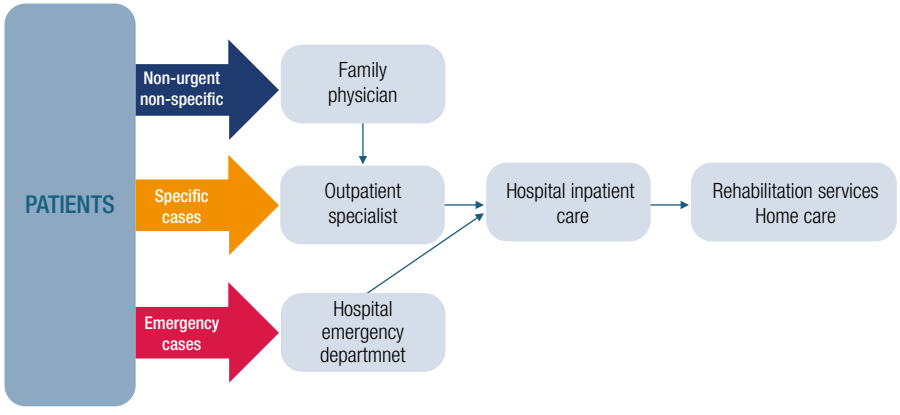
The family physician may refer the patient for laboratory or other tests. If the medical condition is beyond the competency of the family physician, the patient is referred to a specialist in an ambulatory care setting or to the hospital. A referral to access specialist services is not needed for 63 conditions and patient groups, including cardiac failure of class III–IV on the New York

Health Association scale, tuberculosis, selected mental health problems, high-risk pregnancies, hepatitis, patients after transplantation, patients with rare diseases, and others. After receiving specialist care, the family physician is informed via letter (sent directly or through the patient) about the patient's health status and the completed and prescribed treatments.

If ambulatory treatment at a specialist is prescribed, the patient shares the cost in different percentages, from 0% to 100% according to the type of medicine (see Section 3.4.1). Patients with chronic conditions are followed up either by a specialist in the ambulatory care setting or by the family physician; this includes patients with hypertension (high blood pressure), dyslipidaemia, diabetes type 2, asthma and other obstructive respiratory diseases, and renal chronic diseases. The family physician carries out home visits to patients with restricted mobility; in isolated areas where there is a community health service, the patient may also be visited by a community nurse.

Family physicians or specialists in both hospital and ambulatory care settings may refer the patient to physiotherapy and rehabilitation services (see Section 5.7), or prescribe home care services, health aids or therapeutic appliances, as necessary. Such care is free of charge if it is provided by a healthcare provider who is under a contract with a DHIH. If the patient prefers to use a non-contracted provider, the cost of the visit or hospitalization will be borne by the patient. At each point of the care pathway, except for medical emergencies, the patient must present their National Health Insurance Card to receive care free of charge.

FIGURE 5.1 Patient pathway



Source: Authors' own compilation

5.3 Primary care

Primary care is provided by family physicians, who act as gatekeepers and operate independently, mainly in solo practices. Some family physicians work in group practices, in primary healthcare offices located in health centres, or in medical offices located in schools and universities. While family physicians are paid by SHI based on service contracts (see Section 3.7.1), school and university physicians are hired by local councils or by the education institution and have their salaries paid from the state budget. The primary healthcare practices are contracted by the DHIHs to provide health services for the patients enrolled on their lists. The minimum number of registered patients required for concluding a contract with a DHIH is 800 and the maximum number is 2200. A higher number is allowed, but this is discouraged by the formula of capitation payment (see Section 3.7.1). Also, in areas with low primary care services coverage due to insufficient family physicians, contracts may be closed for less than 800 enrolled patients following an analysis performed by a specially appointed commission of representatives from the DHIH, the DPHA and the District College of Physicians.

The main services provided by family physicians include: first aid interventions; preventive services, including periodical check-ups according to age, ante- and postnatal care, evaluation of risks, family planning; consultations, diagnosis and treatment in the physician's competency area; providing referrals to a specialist service; monitoring of chronic diseases; and home visits (see Section 3.3.1). Until January 2023 the uninsured population was entitled only to a minimum benefits package limited to health services for life-threatening emergencies, epidemic-prone/infectious diseases, care during pregnancy and childbirth, family planning and community care. After January 2023 every individual has been entitled to the same extended package of primary healthcare services, and the cost for primary healthcare services provided to uninsured persons is covered from the state budget (Government of Romania, 2022c). Primary care practices can also conclude service contracts with other entities, for example they might be contracted by DPHAs for the provision of certain health services performed under national public health programmes, such as immunization (see Section 5.1), with local authorities for the provision of community care services, or with universities for medical education or research.

Individuals can freely choose their family physician (no geographic restrictions) and have the right to change the physician after six months (see

Section 2.8.2). To access the specialized services they are entitled to, provided they are insured, they need a referral from their primary care doctor, except in those cases when certain aforementioned conditions have been already diagnosed by the specialist (see Section 5.2). In any case the specialist has to inform the family physician through a medical letter at least once a year on the evolution of the medical condition and changes in medication.

The gatekeeping role of the family physician is suboptimal in Romania, with many patients bypassing family doctors by calling emergency ambulance services and going directly to hospital emergency departments (see Section 5.5). The shortage of continuous primary care services contributes to this patient behaviour, as family physicians are not required to ensure provision of out-of-hours care (see Box 5.2). One measure to overcome this problem was the establishment of continuity care centres. These are agreements among physicians to perform on-duty calls for all their patients and are paid from the state budget. Despite the increase in the number of these centres (from 192 in 2012 to 373 in 2023), they are still insufficient (Ministry of Health, 2023b). Also, they are not uniformly distributed (for example, districts with similar population sizes of over 600 000 inhabitants have different numbers of continuity care centres: Timiș – 30, Constanța – 3, Prahova – 0) (Ministry of Health, 2023b). Another reason for directly accessing emergency services is the lack of family physicians in certain areas. An Ombudsman report on the availability of primary healthcare services in rural and deprived or remote areas shows that in 2021 there were 212 localities with no family physician and numerous localities with an insufficient number, as illustrated by 665 vacancies across the health system (Office of the Ombudsman, 2021). In a response to family physician shortages, in 2019 family physicians were allowed to open up to two practices in different localities, in addition to their main practice, and since 2022 in the same locality, if they are located in areas with a shortage.[2]

Since 2014 there has been a clear national strategic objective of enhancing primary healthcare and rationalizing the use of hospital services. To this end, besides the above-mentioned interventions, the volume and types of services provided by family physicians were increased. Starting in 2021, family physicians have been allowed to provide and to be reimbursed for additional services if they have the necessary training and devices. Starting

2 See HSPM update https://eurohealthobservatory.who.int/monitors/health-systems-monitor/updates/hspm/romania-2016/increasing-access-to-primary-health-care.

in 2023, the FFS share was increased to 65% and additional payments were introduced for health promotion and disease prevention services (see Section 3.7) (Government of Romania, 2023c).

BOX 5.2 What are the key strengths and weaknesses of primary care?

Despite all the measures to enhance primary healthcare, there is still a long way to go until the balance of care will shift more towards preventive and primary services and away from inpatient care. The main difficulty is to cover underserved areas across the country due to the general scarcity of resources resulting from an increasing trend of physicians migrating to other countries (see Section 4.2), the unattractiveness of working in rural and isolated areas, and also from the lower degree of attractiveness of family medicine compared to other specialties as perceived by many physicians. This makes access to primary care difficult and inequitable.

A solution to increase access was given by Emergency Ordinance no. 18/2017 on Community Care and its subsequent secondary legislation that created the legal framework for developing and operating community care centres, especially in deprived areas. Simultaneously several EU-financed projects have trained community care nurses and health mediators to work in the integrated community care centres, beside a social worker and a school councillor. In January 2020 there were 1754 community nurses. They collaborate in various ways with family physicians; however, in almost 4% of the centres the community care nurse attended the patients at their direct request (for example, a patient immobilized at home or with a chronic condition) without guidance from or close collaboration with a family physician (Ciurea et al., 2020).

The National Health Strategy 2023–2030 envisages the existence of a primary healthcare team coordinated by the family physician in each community centre, with diversified competencies and skills, setting as targets until 2030 investment in at least 200 integrated community centres and at least 33% of family physicians coordinating community care (Government of Romania, 2023c).

Family physicians have a very powerful professional body that successfully influenced decisions for numerous incremental reforms over the years, such as flexible conditions for contracting services in remote rural areas (that is, increased allowed numbers of registered patients, flexible working hours), and enlarging the type of services (for example, spirometry, electrocardiogram). The Romanian National Society of Family Medicine, which is the main professional association of family doctors, dedicates many efforts to improving family physicians' education and training, including through international training and research projects with the World Organization of Family Doctors and other European partners.

5.4 Specialized care

5.4.1 *Specialized ambulatory care*

Specialized ambulatory care is provided mainly by private individual medical offices, and is also organized as specialized medical centres, specialized ambulatory centres, polyclinics, and centres for diagnosis and treatment, as well as by hospital outpatient departments. The majority of hospital outpatient departments in 2023 were public (93%) (349 out of 374), while other types of specialist ambulatory care providers were mainly private: 869 out of 906 specialized medical centres (96%), 119 out of 156 specialized ambulatory centres (76%), 76 out of 79 polyclinics (96%), and 16 out of 22 centres for diagnosis and treatment (73%) (INS, 2025b). Most specialized physicians work in both the public and private sectors, employed in hospitals and working out-of-hours in private settings, with or without a contract with the DHIH.

Insured patients have free access to a specialized ambulatory care provider under contract with a DHIH, by referral from their family physician, which is not needed for 63 conditions and patient groups who are undergoing certain treatment and monitoring regimes (see Section 5.2) for receiving specialized ambulatory medical services included in the benefits package.

The insufficient number of ambulatory specialized services is reflected by the overutilization of hospital services (see Section 5.4.3). Also, Romania had the highest level of hospital admissions due to diabetes in 2019, 334 cases per 100 000 population compared to the EU average of 139 cases (22 EU countries with available data), and 360 cases of asthma and COPD admissions per 100 000 population compared to the EU average of 210 cases (OECD & European Union, 2022).

The National Health Strategy 2023–2030 aims to develop the specialized ambulatory services, setting as a target to decrease by 30% avoidable hospitalizations and to treat at least 50% of current hospital day cases in ambulatory settings (Government of Romania, 2023c).

5.4.2 *Day care*

Day care includes admissions for an interval of up to 12 hours and emergencies that require medical supervision for up to 12 hours before discharge, day surgery cases discharged on the same day and cases that need daily contact (for diagnosis, monitoring or treatment) of less than 12 hours per visit.

Day care is provided in hospitals and healthcare centres under contracts with the DHIHs. In 2022 day care cases represented 64.5% of total hospital admissions reimbursed by health insurance, which is 1.5 times higher compared to 41.6% in 2014 (NHIH, 2022b; Vlădescu et al., 2016).

The list of day care services and procedures has continuously been extended since its introduction in 2014, including 115 diagnostics and 142 procedures paid by case, and 211 services with individual fees, in 2023 (Ministry of Health & NHIH, 2023). Still, many of these cases are fit for ambulatory care; among the targets of the National Health Strategy 2023–2030 is that until 2030 at least 50% of the day cases treated in 2022 in the hospitals will be delivered as ambulatory services (see Section 5.4.1) (Government of Romania, 2023c).

5.4.3 *Inpatient care*

Inpatient care was provided in 554 hospitals in 2023, out of which 180 were private (32%), accounting for 3 477 249 admissions in total (INS, 2025b). Hospitals are evenly distributed at national level but are located mainly in urban areas (see Section 4.1). In order to be functional, the hospitals need a sanitary authorization issued by the DPHA, and to be eligible for contracting services with the SHI they should be accredited every five years by the NAQMH. Hospitals need to have a health services quality management structure to internally ensure and monitor the quality of health services provided (see Section 2.7). A physician coordinating this structure is in charge of reporting to the NAQMH all adverse events related to healthcare in the hospital. The main events reported in 2022 were falls (40%), non-compliance with measures for prevention and control of healthcare-associated infections (18.5%), and errors in drugs utilization (11%). Only 37% of facilities registered with the reporting system have reported such events in 2022 (NAQMH, 2022).

The fact that there is no specific strategy for quality improvement is an important issue for the National Health Strategy 2023–2030, which envisages the creation of a 'fund for quality' dedicated to creating financial incentives for quality improvement, and the development of a quality monitoring and evaluation system. Currently, there is no official quality assurance report available. Also, the strategy includes measures to ensure integration and continuity of health services between primary and secondary care; better planning of health services to decrease the avoidable hospitalization rates; and reclassification of hospitals and resizing the national number of hospital beds, reallocating beds from acute care to long-term and palliative care (see Box 5.3 and Box 5.4 for further information).

BOX 5.3 Are efforts to improve integration of care working?

The 2014–2020 National Health Strategy did not attain its goals of reducing the number of hospital facilities and providing integrated services in order to improve coordination of treatment. Healthcare is still fragmented; in many cases, patients are not guided to the right healthcare provider once a diagnostic is set and are not further advised about post-acute care after discharge. The nurse navigator role has been introduced to the system, though not widely.

The 2023–2030 National Health Strategy has been pursuing the same objective of providing integrated and coordinated health services. Among the envisaged measures to attain this objective are: establishing integrated networks of service providers including different levels of care focused on specific diseases representing public health priorities; establishing regional reference networks among different hospital categories with specific patient pathways for critical and complex cases; pilot schemes by the health insurance funds on contracting of vertical and regionally integrated services with networks/partnerships/consortia of providers, based on specific population tailored needs, clinical guidelines and pathways; and implementing and monitoring the planned discharge mechanism and integration of hospital services with social and other post-discharge necessary services. For implementing these measures, the Action plan for the implementation of the 2023–2030 National Health Strategy includes measures to resize the current hospital sector, to redefine the types of hospitals and their role, and to create post-discharge services facilities (Ministry of Health, 2023a).

BOX 5.4 What do patients think of the care they receive?

Data collected by the European Quality of Life Survey (EQLS) in 2016 show that patient-reported quality of health services in Romania was below the EU average, both for family doctors and health centre services (7.1 compared to 7.3), and for hospital and specialist services (6.2 compared to 6.9) (OECD & European Union, 2020). A Eurofound report, based on 2016 EQLS data, includes Romania among the countries with generally low performance on all quality dimensions, along with Croatia, Cyprus and Greece (Eurofound, 2019). While Romania currently does not collect these data on a regular basis, there are plans to do so since it has joined the Patient-Reported Indicator Surveys (PaRIS), as part of the OECD accession process started in 2022 (see Section 7.4); first data from Romania will be included in the PaRIS report for 2024. Patient satisfaction reviews are collected at discharge by each hospital (see Section 2.8), but there is no national survey or publicly available summary of the data.

The general perception, enhanced by mass media, is that healthcare in Romania is of poor quality. Patients evaluate inpatient care received at the moment of discharge, but these questionnaires are processed at hospital level; there is no aggregate result at national level. A Ministry of Health questionnaire electronically distributed to discharged patients surveys the situation monthly. For example, in February 2025, 21% of respondents were unsatisfied or very unsatisfied with the hospital services received, at a 14.3% response rate (DATA.GOV.RO, 2025). A study testing hospital accreditation as a sign of healthcare services quality for patients in Romania revealed a lack of awareness of hospital accreditation status among patients, even though hospitals display their status both online and onsite (Druică et al., 2020).

Starting in 2016, the Ministry of Health has developed regional plans and masterplans based on the evaluation of healthcare needs, setting regional targets for all sectors of care related to coverage by healthcare professionals, number of services provided, and number of beds for each type of care, among others. Initiated as one of the European Commission ex-ante conditionalities under the perspective of signing the 2014–2020 Partnership Agreement on funding through the European Structural and Investment Funds, three regional masterplans were updated before starting the construction of the three new regional hospitals in 2021 (see Section 4.1); the rest of five regional

masterplans were finished in 2023 as part of an EC-financed project with the objective of enhancing health system planning capacity.

Romania has the third highest number of hospital beds per 100 000 population in the EU in 2023 (see Section 4.1.1), with 7.3 beds per 1000 people in 2022, after Bulgaria and Germany with 8.2 and 7.7 hospital beds per 1000 population, while the EU27 average was 4.7 hospital beds per 1000 population. Romania also ranks above the EU26 average on the number of hospital discharges, with 162 per 1000 population compared to 155 per 1000 population in 2022 (OECD & European Union, 2024). The situation differed during the COVID-19 pandemic, when the hospital discharge rate in 2020 decreased in Romania to 130 per 1000 population, below the EU average of 144 per 1000 population (OECD & European Union, 2022).

5.5 Urgent and emergency care

Every person in Romania is entitled to emergency care provided in public facilities free of charge, financed from the state budget through the Ministry of Health and the Ministry of Internal Affairs. There are also private emergency services, which by law need to clearly state in their advertising that calling is not free and that the services are provided for a fee.

Pre-hospital public emergency care is organized at the national level as an integrated system of institutions under the Ministry of Health, the Ministry of Internal Affairs, local authorities and the Special Telecommunication Service (STS), which operates the single European emergency call number (112) (Box 5.5). The STS has a military status and provides communication facilities to the Presidency, the Government and other bodies of national interest. It transfers emergency calls to the appropriate services: ambulance services; the Romanian Mobile Emergency Service for Resuscitation and Extrication; the police; the fire brigade; the gendarmerie, which is a specific service under the Ministry of Internal Affairs, with military status; and the mountain rescue service (Special Telecommunication Service, 2022). Ambulance services are coordinated by the Ministry of Health and DPHAs, while the Romanian Mobile Emergency Service for Resuscitation and Extrication, established in 1990, is coordinated by the Ministry of Internal Affairs.

Emergency responses use a three-coloured code system, with different types of ambulances dispatched depending on the code:

- red code cases refer to major life-threatening emergencies and involve the dispatch of highly equipped ambulances, with intensive care equipment and a qualified medical doctor;
- yellow code cases include emergencies with life-threatening potential and involve the dispatch of an ambulance with equipment for emergency interventions, including a defibrillator, and with a qualified medical doctor or a nursing staff member;
- green code cases refer to non-emergency cases and involve ambulances with first aid equipment and medical or nursing staff, depending on the case – for example, a nurse for a patient with a non-acute medical condition who needs a transfer to a hospital, or a physician if patient consultation is required.

At hospital level, emergency care is provided in emergency departments with specially trained staff and financed by the Ministry of Health. Some hospitals are classified as emergency hospitals of different levels (that is, district or regional) depending on their technical endowment, organizational structure, competencies and resources to treat complex cases (see Section 4.1). The hospital emergency departments can be accessed directly by the patients and by the ambulance.

A telemedicine emergency system was developed through a World Bank-financed programme. This system connects ambulances with 131 emergency departments in the hospitals, allowing early specialized advice on medical treatment for the patient. These services function in the remote mountain areas of the country as well as in the Danube Delta, cutting down the response time.

Emergency services are overused due to patients' preference to directly consult the emergency departments in the hospital or to call 112; in some cases, also, utilizing the emergency services is the only option available, due to uninsured status or living in an area without primary care services (see Section 5.2). Even though, since 2023, the uninsured receive the same primary care services as the insured population (see Section 5.3), they are required to pay for further investigation and care services. If they seek care at a hospital emergency department, however, they are entitled to all necessary

investigations until it is proved that they can be safely discharged. A high percentage of ambulance call-outs are resolved at the patient's home and do not require admission to a hospital, possibly indicating an overuse of ambulance services either due to easy access or due to the shortcomings in primary care. The numbers of actual medical emergencies are also high, due to neglected regular check-ups of patients with chronic conditions or to delays in disease detection.

BOX 5.5 Patient pathway in an emergency care episode

A patient in an emergency care episode calls 112 or is taken in a private car to the emergency department of a hospital. In the case of an emergency call, the 112 operator decides which service to call, ambulance or SMURD, in accordance with the emergency's severity.

Upon arrival, the patient is documented through an individual emergency file opened in the triage room, which is filled further and signed by all physicians who provide care to the patient. This is separate from the pre-hospital emergency file of the patient filled by the ambulance/SMURD team with the patient characteristics and administered treatment, but a copy of the pre-hospital emergency file is attached to the hospital emergency file. The patient is further investigated through laboratory and imaging tests and seen by hospital specialists (other than emergency specialists) if needed.

After receiving emergency care services, patients who need further care are admitted to the hospital or referred to a higher competency hospital. Those who do not need further inpatient services are admitted as day cases for supervision for up to 12 hours or are discharged. Patients requiring follow-up ambulatory care are referred for follow-up with their family doctor.

Minor emergencies are also handled by family physicians at the continuity care centres.

5.6 Pharmaceutical care

In 2023 Good Manufacturing Practice certificates were issued to 46 local pharmaceutical manufacturers, as well as 170 manufacturing authorizations and 32 import licences (many of which also have local production facilities) (NAMMD, 2024). The top 10 pharmaceutical manufacturers covered 51.1% of the local market in 2024, and the top 20 covered 68.1%. The highest market shares were held by Sun Pharma (including Terapia) (10.1%) and Zentiva (including Labormed and Alvogen) (9.1%) (Cegedim, 2025).

In terms of pharmaceutical market value, in 2024 the top 10 companies represented 37.8% and the top 20, 57.5%. The total value of the pharmaceutical market in 2024 was 34.10 billion RON (€6.8 billion). The main share that year was represented by outpatient prescriptions (61%), followed by over-the-counter drugs (23%) (Cegedim, 2025). Generics accounted for the highest share of outpatient prescribed medicines (60% in 2020) but represented only 26.6% of outpatient reimbursed spending (APMGR, 2022). Due to the low price and high claw-back tax over 2500 generics, almost 500 innovative drugs disappeared from the market over the last five years (Box 5.6).

In 2022 there were 473 pharmaceutical wholesalers authorized by the NAMMD and 8135 community pharmacies, almost doubling the number from 2002 (4269). There is one pharmacy to 2342 residents, on average, but pharmacies are not evenly distributed among districts, ranging from one pharmacy per 1481 residents (Dolj district), to one pharmacy per 5687 residents (Galați district) (INS, 2024d). The pharmacies are mainly located in urban areas since there are no requirements regarding the geographical distribution of pharmacies; prescribing has been done electronically since 2012.

Some measures have improved access to pharmacies. Until 2017, some drugs covered by statutory health insurance could only be disbursed after an authorization process: the patient prepared an application, containing a medical report from the specialist physician, proof of identity and documents evidencing their insurance status, and submitted it to the relevant commission (responsible for the particular disease) at the NHIH or DHIH level. The commission reviewed the application and, if the decision was positive, issued an authorization which the patient submitted to the pharmacy together with the prescription in order to receive the drugs. The new process eliminates the stage of seeking authorization from the disease-specific commissions, and hence drugs are released by pharmacies to the patient based

only on the prescription from the specialist physician (HSPM, 2017). Since 2021, community pharmacies have been allowed to disburse medicines and medical products to any patient enrolled in the NHIH programmes, based on a prescription issued by any physician in contract with statutory health insurance. Previously, pharmacies would not get reimbursed if the prescribing physician was not in a contractual relationship with the same DHIH as the pharmacy, which obstructed access to treatment. For example, a patient who chose to see a physician outside their hometown would then also need to visit a pharmacy in the same location (HSPM, 2021).

The pharmaceutical market volume decreased by 1.7% in 2024 compared to 2023. The pharmaceutical market value has risen by 13.8% in 2024 compared to 2023 (Cegedim, 2025). Outpatient medicines expenditure is usually the second highest after hospital expenditure (see Section 3.1). For patients, outpatient medicines are the largest driver of financial hardship, mainly due to over-the-counter drugs that represent a significant share of outpatient medicines (66% in 2018). High use of over-the-counter drugs is a consequence of auto-medication, as TV drugs advertising is very common, and might be the patients' preference over the travel and waiting time to consult a family physician. Around 34% of OOP expenditure on outpatient medicines are co-payments (see Section 3.4). Patients also bear the difference between the reference price and the retail price (see Section 3.3). Although pharmacists are required to point out the cheapest alternative for the INNs on the prescription, anecdotal evidence suggests that patients choose the more expensive ones as they perceive them to be of better quality, either guided by the marketing of pharmaceutical companies, or by the pharmacists' dispensing behaviour (Scîntee, Mosca & Vlădescu, 2022).

Expenditure on retail pharmaceuticals per capita in 2022 was €398 PPP, well below the EU average of €500 PPP, placing Romania 21st among the 27 countries, due to the low cost of medicines in Romania compared to other countries (however, not when considering the average salary in Romania). At the same time, Romania was the country with the second highest expenditure for over-the-counter medicines at €156 PPP per capita, after Poland (€181 PPP per capita) (OECD, 2024). The high expenditure on over-the-counter medicines is – amongst other factors – due to widespread self-medication when in pain or experiencing symptoms, as well as due to many TV commercials for various kinds of over-the-counter medicines, including, for example, painkillers.

Medicine prices are high in the national context, but the lowest among the EU countries, leading to the problem of parallel exports and consequently resulting in a shortage of certain drugs (for example, cancer drugs). The mechanism behind this is that since prices of individual drugs vary between EU Member States, traders can buy pharmaceuticals in any EU/EEA country and then, under strictly regulated conditions, move medicines to the destination market. So, they can buy from the distributors in Romania at a lower price – creating shortages of those medicines on the Romanian market – and sell them for a higher price in other countries. Over the last decade there were several temporary bans on the export of different medicines.

BOX 5.6 Is there waste in pharmaceutical spending?

Romania uses external reference pricing, considering the lowest price of the twelve reference countries, reaching 35% below the originator price, which, combined with a government claw-back tax, results in a massive shortage of generic medicines on the market. Lowering the price to make them more affordable for patients, alongside a claw-back tax claimed by producers, has resulted in the withdrawal from the market of over 2500 generic drugs in 2018–2022 (APMGR, 2022). As a measure to stimulate the use of generics, the claw-back tax has been differentiated by Law no. 53/2020: 25% of the retail price for innovative drugs, 20% for generics and 15% for locally produced drugs.

Waste in pharmaceutical spending is also generated by the low planning capacity of some hospitals, as there were several public disclosures of hospitals that had to destroy expired excess medicines. Also, a clear procedure to allow patients to return unused medicines to pharmacies is not in place.

Another waste in pharmaceutical spending is created by the irrational use of certain drugs, such as antibiotics and antifungal medicines. To decrease the use of these drugs, the Ministry of Health issued an order in 2024 which increases the volume of information to be filled by the physician on the prescription; further, the pharmacist should report to an information system following this order. The intention of these provisions is to better monitor and control the prescribed amount and pattern of antibiotics.

5.7 Rehabilitation/intermediate care

Ambulatory rehabilitation care is reimbursed by SHI for 16 medical conditions. A total of 46 procedures are reimbursed in ambulatory medical practices, provided they have the required equipment and facilities, plus eight procedures that can be provided only in medical spas. An insured patient is entitled to 21 days per year of rehabilitation care, except patients with stroke, cerebral paralysis, lymphoedema secondary to axillary lymphadenectomy, patients with adnexectomy, and patients with large burns who are allowed 42 days of rehabilitation services within the interval of 4 months after discharge. The care is reimbursed based on the existence of a rehabilitation care plan developed by the specialist physician, and no more than four procedures per day.

Inpatient rehabilitation care in the hospitals is paid by variable day fees, according to pathology and hospital competency. Inpatient rehabilitation care provided in sanatoria (that is, medical spa centres) is reimbursed by health insurance for up to 14–21 days per year per insured person, and includes a minimum of four procedures per day, for a minimum of five days a week. Reimbursement is granted under the condition that a referral from a specialist or family physician exists. Hospitalization over the limit of 21 days is paid OOP by the patient. In 2023 there were 11 sanatoria, out of which six were public and five were private.

SHI also covers ambulatory intermediate care provided by psychologists, psychotherapists, speech therapists and physiotherapists, at the recommendation of, and based on a rehabilitation care plan developed by, the rehabilitation specialist physician.

Overall, access to rehabilitation and intermediate care is considered inadequate, due to long waiting lists and lack of integration with other forms of care, including social care.

5.8 Long-term care

LTC is provided mainly under the Ministry of Labour and Social Solidarity, which coordinates and finances 642 public LTC institutions (2024 data) through the National Authority for the Protection of the Rights of Persons with Disabilities (NAPRPD) (increased from 634 in 2023). There are also

104 private LTC institutions contracted with the NAPRPD. Out of all 746 existing institutions in 2024, 668 were residential centres (572 public and 96 private) and 78 were day care centres (70 public and 8 private) (ANPDPD, 2024). Residential centres provide care for adults with chronic conditions, for persons with disabilities and for older people; some are centres for social reintegration through occupational therapy or through neuropsychiatric rehabilitation. The total number of persons with disabilities registered with the National Authority for the Protection of the Rights of Persons with Disabilities by the end of 2024 was 960 428, out of whom 944 280 (98.32%) were not in residential institutions (ANPDPD, 2024).

The insufficient capacity for LTC has been officially recognized. An initiative launched in 2011 to close 67 acute care hospitals and transform them into LTC facilities has failed, as 36 reopened later and only 20 of them became nursing homes for older people (see Section 4.1).

Community care has been introduced by the 2017 Community Care Law, which set the legal framework for establishing integrated community care centres to offer medical, social and educational services by trained workers to deprived populations. In 2020 there were 1791 community nurses and 459 health mediators, unevenly distributed across the districts (INSP, 2021).

The Romanian Government approved in December 2022 the National Strategy on Long-Term Care and Active Ageing for 2023–2030. This strategy intends to improve access to adequate, person-centred, LTC services for dependent older people, and at the same time is based on the principle of supporting older people to live an independent and active life.

5.9 Services for informal carers

There are no officially available statistics on the total number of informal carers, though it is the dominant form of LTC, especially informal care provided outside the household by relatives, friends or other persons. According to OECD data (OECD, 2023a), the share of informal carers among the population aged 50 and over in 2019 was 7% in Romania, which is among the lowest, before the Slovak Republic and Latvia, and almost half the OECD average of 13%. Regarding care intensity, 5% of the survey respondents provided care daily, while 2% did so on a weekly basis. Only 10% of informal carers are employed outside the informal care they provide, and 70% are women (OECD, 2023a).

In 2019, 61.7% of older people with LTC needs received informal care, while 3.1% received professional care. Supporting informal care is on the Government's policy agenda, with additional training, financing, counselling and available respite services provided (Government of Romania, 2022d). The current legislation establishes entitlement to support services, respite care and counselling, but these services are extremely scarce and underdeveloped.

Persons with a certified severe disability can apply to the local authority either for a place in a residential institution, which are, however, usually hard to secure and very long waiting lists exist, for a personal assistant contracted by the local authorities, or for a cash allowance if the disability certificate recommends the help of a personal assistant.

Personal assistants contracted by the local authority have to follow care plans prescribed by specialists and must inform the local authority within 48 hours about every change in the physical, mental and social status of the disabled person they look after. To become a personal assistant, a person must be over 18 years old, have no criminal record, have at least a primary school degree (with exceptions in the case of relatives) and possess full mental and physical capacity. Personal assistants must participate in training sessions organized by the local authority at least once every two years. A personal assistant is entitled to a basic salary, equivalent to the salary of a social worker with intermediate education paid for eight hours of work per day and up to 40 hours per week, annual leave under the same conditions as all persons working in public institutions and, under certain circumstances, free urban and interurban public transportation.

5.10 Palliative care

Palliative care was initiated in Romania after 1990 by various NGOs, with international financial support. Increasing capacity for palliative care has been put on the health policy agenda in the last decade and was supported by several internationally financed (World Bank, European Commission) projects. The legal framework was established by Ministry of Health Order no. 253/2018 on approving the Regulation on the Organization, Functioning and Authorization of Palliative Care Services and National Authority of Quality Management in Health Order no. 353/2019 on approving Standards for Ambulatory Palliative Services Accreditation.

Palliative care was offered in Romania in 2019 through 87 hospitals, nine home care services, seven outpatient units, three day centres and one phone call centre. There are 94 providers in total, as nine of them offer more than one type of care. Inpatient care is predominant: in 2019, 90% of the 32 960 patients were assisted in hospitals, 5.2% received home care and 4.8% were outpatients. While over 50% of inpatient providers are palliative care wards in public hospitals, outpatient and home care services are provided mainly by non-governmental and private institutions. The coverage of palliative care services is uneven across different geographical areas: 11 out of 42 districts have no provider of palliative care services (Moșoiu et al., 2021).

The workforce providing palliative care receive special training. Physicians qualified in different specialties need to undergo 18 months' training and pass an exam to obtain the competency in palliative care (called "Atestat", see Section 4.2.5). There were seven accredited training centres in 2019 and 610 trained physicians, but only 172 of them were employed in palliative care units. Nurses are required to undergo at least 120 hours of training in palliative care, and social workers, psychologists, counsellors and other staff in the multidisciplinary palliative care teams are required to have at least 60 hours' training. Very few centres and services have a fully multidisciplinary team and the need for palliative care is far from being covered, with 18.7% of eligible patients receiving palliative care services in 2019 (Moșoiu et al., 2021).

An EU-financed project implemented between 2020 and 2023 designed a National Plan for gradual development of palliative care and a National Programme for development of palliative care services, training over 800 medical staff and 100 health services managers and setting up eight pilot centres for the delivery of palliative care. Based on its outcomes, in 2024 a National Health Programme on palliative care was announced, with the aim to improve the quality of life of patients with progressive chronic diseases in advanced stages and in terminal stages by providing palliative care services at home, in outpatient palliative care services or through specialized palliative care mobile teams. The programme will be financed by the National Health Insurance.

5.11 Mental healthcare

Mental health is regulated by Mental Health Law no. 487/2002, revised in 2012 to adapt it to the European Convention for Human Rights and

Fundamental Freedoms, and completed in 2019 and 2024 with provisions regarding conditions for involuntary admissions, and in 2023 with provisions regarding prevention of post-partum depression. Currently, there is no separate mental health strategy, but the National Health Strategy 2024–2030 includes among its objectives the development of a mental health network and increasing response capacity to mental health problems at the community level.

The last available Mental Health Atlas data for Romania are from 2017, showing 34 mental hospitals with 82.47 beds per 100 000 population and 78 psychiatry wards in general hospitals with 55.04 beds per 100 000 population, which was far above the median values for the European region of 34.2 beds per 100 000 population in mental hospitals and 12.3 beds per 100 000 population in psychiatric wards in general hospitals (WHO, 2017, 2018). Ambulatory services were provided by 116 hospital outpatient facilities, 16 other ambulatory settings and 41 community mental health centres. The mental health workforce was below the WHO European region levels: 26.92 per 100 000 population, compared to a median number of mental health workers of 50 per 100 000 population (WHO, 2017, 2018).

There are specialized services for children and adolescents: 22 inpatient facilities, 24 outpatient facilities, and 39 other outpatient services (for example, day care). Also, physicians can specialize in child psychiatry, and there are 0.56 child psychiatrists per 100 000 population (WHO, 2017). There is no specialization in geriatric psychiatry. Psychiatrists take gerontopsychiatry courses during their specialization programme. There are only a few psychiatrists with supplementary post-specialization training in gerontopsychiatry in continuing medical education programmes, but this is not a requirement to treat older adults as a psychiatrist.

As in many other countries, during the COVID-19 pandemic a new format of delivering services emerged: telemedicine. Since the pandemic there has been a decrease in the provision of mental health services in both hospitals and outpatient settings (Cummings et al., 2023).

There is no dedicated mental health budget, except for two national mental health programmes:

- a mental health promotion programme coordinated by the National Centre for Mental Health and Anti-drug Fight, aimed at promoting mental health through occupational therapy, increasing children

and adolescents' access to mental health programmes for developing social and emotional abilities, and increasing the competency level of health staff dealing with autism patients; and
- a national programme to ensure specific treatment and metabolites of narcotics testing in patients with drug addiction.

Drug consumption is an increasing problem in Romania (see Section 1.4). The 2022–2026 National Strategy has a collaborative multisectoral approach, with the health sector having shared responsibilities in the prevention of drug use, delivering healthcare and social reintegration services to users.

5.12 Dental care

Dental care is provided through a network of 16 946 dental offices, out of which 16 911 are private (99.8%), 444 are private medical dentist civil societies, 487 are public dentist offices in schools and 35 are public dentist offices in universities (2023 data; INS, 2024d).

In 2023 there were 11.1 dentists per 100 000 population, an increase from 10.4 in 2021 (INS, 2024d). Most of them work in private practices and charge a direct payment. Very few have contracts with the statutory district health insurance, as dental coverage is limited in scope and a very small amount of SHI expenditures on health services is allocated to dental care – 0.5% in 2023. The NHIH benefits package includes about 25 dental services (see Section 3.3.1). For some of these services, a 40% of fee co-payment is charged, except for children up to 18 years old, students up to 26 years, those who have been formerly persecuted for political reasons, military veterans and revolution fighters, who have services fully covered in public facilities (see Section 3.3.1).

As a result, dental care is the main driver of catastrophic spending among households in the richest consumption quintile (37.21% of OOP spending in 2015). Among the poorest quintile OOP spending on dental care is 1.34%, which explains the high unmet dental care need (Scîntee, Mosca & Vlădescu, 2022). Although unmet need for dental examination due to costs has fallen from 8.3% in 2015 to 3.7% in 2024, it remains well above the EU average of 2.9% in 2023. There is also a big gap between the richest and the poorest quintiles: 2.2% compared to 6.6% (Eurostat, 2025).

Romania does not have a specific dental care strategy. Dental care-related objectives are included in the 2024–2030 National Health Strategy, including dental and oral hygiene in school curricula, and improving the dental health of children and vulnerable populations through the provision of preventive services.

6

Principal health reforms

Chapter summary

- Since 2016, key areas of reform in the Romanian health system have been related to governance, healthcare financing and provider payment, efficiency in spending, increased coverage and access, management and human resources capacity.
- The 2023–2030 National Health Strategy outlines targeted actions to strengthen administrative capacity and improve prioritization, planning and implementation of health policies, improving health management and health system performance monitoring.
- To eliminate the problem of employers not paying SHI contributions for their workers, employees became solely responsible for paying the full amount of the contribution, which became 10% of their income.
- In 2017 health professionals' salaries were increased more than threefold to reduce workforce emigration. In 2023 the payment model for family physicians was modified, changing the FFS ratio from 50:50 to 35:65 to encourage service provision. Additionally, a lump-sum payment was introduced for performing specific health risk assessments to promote the delivery of preventive services.
- To improve population coverage, categories of people covered by SHI but exempted from paying contributions have gradually widened. At the same time, uninsured individuals gained entitlement to primary healthcare services. The austerity reform packages implemented in 2025 have drastically narrowed back the number of exempted categories.

- Improving health management and human resources in health management was considered a cornerstone for better operating of the health system, better management of services provision and finally better coverage of population healthcare needs, and is one of the main reforms financed by the NRRP.

6.1 Analysis of recent reforms

Reforms up to 2015 were covered in earlier editions of the Romania Health System Review (Vlădescu et al., 2016). Since 2016, the main strategy guiding health policy in Romania was the 2014–2020 National Health Strategy (Ministry of Health, 2016). The main financial support came through the European Structural and Investment Funds via the 2014–2020 Partnership Agreement with the European Commission (European Commission, 2014b). Since 2021, Romania has benefited from the EU Recovery and Resilience Fund, which offered significant opportunities for investment in health sector transformation (European Commission, 2021b). The reforms after 2016 mainly revolved around governance, financing, efficiency in spending, increased coverage and access, and improved management and human resources capacity (see Table 6.1).

Governance

A major push for improving health system governance in Romania stemmed from ex-ante conditionalities tied to the European Structural and Investment Funds, requiring a strategic health policy framework, including a monitoring and review system. Therefore, the government developed the National Health Strategy 2014–2020 and a subsequent monitoring plan. In 2016 the national strategy was followed by regional masterplans for health services. In 2023 these were updated through the National Health Strategy 2023–2030 (Government of Romania, 2023d) and revised regional masterplans for health services (Ministry of Health, 2023c), both supported by an EU-funded project initiated in 2019 to support national and local planning and coordination capacities.

Implementation challenges, mainly due to political instability and insufficient administrative capacity, meant that the 2014–2020 strategy fell short of expectations. Consequently, the 2023–2030 strategy prioritizes governance

improvements, such as capacity building, better prioritization, planning and implementation of health policies, and improving health management and health system performance monitoring (Government of Romania, 2023d).

Palliative care reforms have revolved around improving organization and service delivery. In 2017 a Ministry of Health order introduced palliative care into nurse specialization, followed by 2018 legislation that divided palliative care services into three complexity levels, established care standards and defined eligible patient groups. These changes led to an increase in providers (from 69 in 2015 to 94 in 2019), the development of palliative ambulatory care, day care and a helpline, and an increase in the number of palliative care hospital beds (from 1779 in 2016 to 1985 in 2019) (Ministry of Health, 2016; Moșoiu et al., 2021).

Weak governance in health infrastructure development also led to the development of ANDIS in 2022, one of the reforms funded by the Resilience and Recovery Facility. The Ministry of Health-affiliated agency manages large-scale health infrastructure projects and provides technical support to local authorities. Its first project is overseeing the construction of three regional emergency hospitals in Cluj, Craiova and Iași, which is expected to be completed by 2028.

Financing – revenue collection

Romania has historically faced challenges in revenue collection, with many of the largest employers not paying their contributions on time (see Section 3). To improve the revenue collection of SHI contributions, a reform in 2018 made employees solely responsible for paying the full amount (10% of their income), while increasing wages simultaneously. Employers remained responsible for retaining and transferring the contribution to the NHIF.

To increase transparency of OOP payments and encourage the use of VHI, a new regulation in 2021 required private providers to publish estimated OOP costs (balance billing) for all available services directly paid by the patient or reimbursed by the VHI (Government of Romania, 2021). This policy promoted informed patient choice and supported better financial protection though VHI uptake.

Financing – paying providers

Romania has introduced provider payment mechanisms as a measure to alleviate workforce shortages in the health system. In 2017 the

government introduced a threefold salary increase to retain the workforce. Law no. 153/2017 mandated a gradual rise in public-sector salaries until 2022, but an Emergency Ordinance in December 2017 accelerated the process, increasing the medical staff salary to the 2022 level until March 2018. This policy aligned with the Government Programme 2017–2022, envisioning "a motivating salary package for health professionals in order to stop the physicians' exodus" (Government of Romania, 2017). Data for 2018 show that the net monthly salary between 2017 and 2018 of a junior doctor increased by 162%, from about €344 to €902, while the net monthly salary of a senior physician increased by 131%, from €913 to €2112 (Government of Romania, 2018). To finance these salary increases, hospitals receive dedicated funds from the NHIH to cover the additional salary costs (see Section 3.2). Eurostat data show an increase in the number of health personnel (see Section 4.2.2), although no specific study has established a causal link between these increases and the salary increase.

In 2023 the family physician payment model was modified, changing the capitation from an FFS split from 50%:50% to 35%:65%, aiming to encourage the provision of services. Furthermore, a lump-sum payment was also introduced for performing specific health-risk assessments to promote the provision of preventive services. Performance payments commenced in 2025, based on activity in 2024 (see Section 3.7.1; Government of Romania, 2023c).

Financing – coverage and access

Since a large share of the population is not covered by SHI (see Section 3.3.1), several measures have been implemented to broaden both the breadth and scope of coverage. For example, since 2017 the list of population groups covered by SHI but exempt from paying SHI contributions (see Section 3.3.1) has gradually expanded. Furthermore, since 2023 the uninsured population has been entitled to the full benefits package for primary healthcare services. In July 2024 the benefits package for the uninsured population was further adjusted to include laboratory tests and specialist visits for early detection and treatment of certain diseases (Ministry of health & NHIH, 2023). Patients with confirmed diagnoses are subsequently treated under the relevant national health programmes.

Reforms related to service delivery in recent years have mainly aimed to improve access to basic services, especially in deprived and remote areas, as well as to alleviate the pressure on hospitals and emergency services, which are

overburdened by complicated cases resulting from late diagnosis and inadequate follow-up care. Between 2017 and 2023 several legislative measures were implemented to encourage and ensure better out-of-hours services provided by family physicians, such as increasing the hourly fees for family doctors and nurses, increasing the budget for continuity of care centres, and changing the organizational and operational conditions for these centres (see Section 5.3).

Reforms were also implemented to develop integrated community care services as a means to respond to the complex needs of the community, especially for vulnerable populations. The Law on Community Care, approved in February 2017, was followed by secondary legislation that approved an inter-institutional Collaboration Protocol for implementing integrated community care (2017) and approved methodological norms for the organization, functioning and financing of medical community care (2019).

Efficiency

Longstanding concerns in the Romanian health system have been inefficiency in spending and the lack of incentives to promote quality and performance in healthcare delivery. Some of the reforms included in the health component of the NRRP aim to increase the efficiency of public health spending by implementing a set of financial rewards to be granted to health providers that fulfil certain quality and performance indicators.

Health management and human resources

Another reform funded by the NRRP aims to increase the training capacity of the National Institute of Health Services Management and six medical universities in Romania. The focus is on health management and human resources in health, both considered essential for the effective operation of the health system, improved service delivery management and, ultimately, broader coverage of population healthcare needs. The reform is ongoing. At the time of writing (December 2025), capacity had already been strengthened through 1) a training-of-trainers programme, 2) a visiting-scholar programme, and 3) a comprehensive redesign of the training curricula. By 2026 the expected outcomes of the enhanced health management training capacity are: health management training for 1000 professionals at various managerial levels across the health system; human resource management training for 1000 professionals working in public health facilities; and integrity training for 3000 individuals working in health-related roles within the central administration.

TABLE 6.1 Major health reforms and legislative changes from 2016 to 2025

YEAR	NAME OF THE REFORM OR LEGISLATIVE CHANGE
2016	Ministry of Health Order no. 1376/2016 (*Ordinul nr. 1376/2016*), approval of regional health plans
2017	Emergency Ordinance no. 18/2017 (*OUG nr. 18/2017*), establishing community healthcare
2017	Emergency Ordinance no. 91/2017 to amend Framework Law no. 153/2017 (*OUG nr. 91/2017*), increased the salaries of health professionals
2017	Emergency Ordinance no. 79/2017 (*OUG nr. 79/2017*) to amend Law no. 227/2015 on the Fiscal Code, improve the collection of SHI contributions
2018	Several amendments to Law no. 95/2006 on healthcare reform, increased the number of population categories exempt from paying SHI contributions
2018	Emergency Ordinance no. 57/2018 (*OUG nr. 57/2018*), ensuring the operation and financing of primary healthcare through continuity care centres
2018	Ministry of Health Order no. 253/2018 (*Ordinul MS nr. 253/2018*), a new framework for organizing and operating palliative care
2019	Government Decision no. 324/2019 (*Hotărârea nr. 324/2019*), new regulation for organizing, operating and financing community healthcare
2020	Government Decision no. 252/2020 (*Hotărârea nr. 252/2020*), among other things, implementation of remote medical services during the COVID-19 pandemic
2021	Emergency Ordinance no. 54/2021 that amended Law no. 95/2006 on healthcare reform (*OUG nr. 54/2021*), new regulation of balance billing for publicly financed health services in private facilities
2021	ANNEX to the Proposal for a Council Implementing Decision on the approval of the assessment of the NRRP for Romania {SWD (2021) 276 final}, Brussels, 27.9.2021, COM (2021) 608 final. Reform 1. Increased capacity for the management of public health funds. In particular: increase the efficiency of public health spending by rewarding the most performant healthcare providers based on objective and measurable criteria
2022	Emergency Ordinance no. 76/2022 (*OUG nr. 76/2022*), for the establishment, organization, and operation of the National Agency for Health Infrastructure (ANDIS)
2022	Government Decision no. 1540/2022 (*Hotărârea nr. 1.540/2022*), expanded the statutory benefits package for the uninsured to include primary healthcare services
2023	Government Decision no. 521/2023 (*Hotărârea nr. 521/2023*), changed the payment model for family physicians and introduced a performance-based lump sum
2024	Order no. 1857/441/2023 (*Ordin nr. 1857/441/2023*), expanded the statutory benefits package for the uninsured to include diagnostic services such as lab tests and specialist consultations
2025	Law no. 141/2025 (*Lege nr. 141/2025*), on fiscal and budgetary measures

Source: Authors' own compilation

Some health reforms in Romania during this period were unsuccessful. One example is the proposed introduction of mandatory vaccination for children according to the national vaccination schedule and for the general population or specific groups during epidemics. Although a Vaccination Law was drafted in 2017 following a major measles outbreak in 2016, it has been stuck in Parliament owing to strong opposition. In 2023 the Romanian Government approved the National Vaccination Strategy 2023–2030, but it does not include mandatory vaccination.

6.2 Future developments

The 2023–2030 National Health Strategy "Together for Health" builds on the developments from the previous 2014–2020 Health Strategy, maintaining the same three core intervention areas: enhancing public health, improving access to safe and cost-effective health services, and ensuring an equitable health system. The strategy aligns with other European and national strategic frameworks. It is supported by the 2024–2030 WHO Country Cooperation Strategy (WHO Regional Office for Europe, 2024a) and the Romanian NRRP (European Commission, 2021b).

The strategy aims to support structural reforms that focus on the following priorities (Government of Romania, 2023c):

- development of modern and flexible public health services;
- empowering citizens and promoting active participation in health-related decisions;
- strengthening local capacity to implement effective and sustainable community health initiatives;
- improving access to high-quality primary care services;
- improved timely and integrated emergency services;
- increasing investment in preventive services to reduce the burden of preventable diseases;
- investing in infrastructure, human resources and health services quality assurance tools;
- expanding the range of services delivered in ambulatory settings, and improving the efficiency and quality of secondary and tertiary care;

- strengthening institutional capacity for health policy development and implementation, service planning and organization;
- adapting financing and contracting mechanisms to meet health system needs;
- increasing the diversity, flexibility, performance and resilience of the health workforce;
- promoting coordinated and integrated care through regional networks;
- modernizing the health information system, mainly by increased interoperability and digitalization; and
- supporting translational research to foster innovation and develop new tools and solutions.

While the results of the national elections in May 2025 may shift political priorities and impact the health policy agenda, some of the priorities and reforms outlined in the current strategy will remain unchanged, particularly those financed by the European Commission or mandated by EU regulations.

7

Assessment of the health system

Chapter summary

- The overall governance of the Romanian health system has improved over the last decade, and there are plans for further improvements to be supported by the 2022–2026 NRRP, which focuses on improving management knowledge and skills across all health system levels, strengthening human resource capacity, and increasing integrity while reducing vulnerabilities and risks of corruption in the health system.
- A significant share of the Romanian population (11% as of 2023) is not covered by SHI. However, since 2023 the uninsured population has also been entitled to primary care services (including preventive, diagnostic and treatment services) and home care, and since 2024 to specialized services for early detection and treatment of diseases such as cancer, hepatitis B and C, and HIV/AIDS in pregnant women.
- Romania has a high share of households facing catastrophic health spending (12.5% in 2015). The largest driver of catastrophic health spending for households in the poorest income quintiles is outpatient medicines, while for wealthier households it is dental care.
- Healthcare quality has become a high priority in Romania over the past decade, but Romania did not collect data on quality of care regularly until 2022 when the country started the process of

OECD accession. Quality improvement was included as one of the reforms under the NRRP to address this gap.

- Mortality from preventable causes in Romania was 304 per 100 000 population in 2022, the fourth highest in the EU and significantly higher than the EU average of 168 per 100 000 population, highlighting the limited effectiveness of public health interventions. Mortality from treatable causes was 215 per 100 000 population in 2022, the highest among EU countries and more than double the EU average of 90 deaths per 100 000 population.
- Funding allocations remain driven largely by political decisions rather than evidence or cost-effectiveness, contributing to persistent regional inequalities and inefficiencies in service provision.

7.1 Health system governance

Health system governance in Romania remains primarily a function of the national government. Recent health policy development has been driven by the European Commission's ex-ante conditionalities for funding, which required a national health strategy and action plans. These requirements resulted in two National Health Strategies (2014–2020 and 2023–2030), eight regional master plans, and several sectoral strategies (see Section 2.4). However, political instability and insufficient administrative and managerial capacity often hinder policy implementation.

Strengthening the capacity for policy development and implementation was among the main objectives of the 2014–2020 National Health Strategy (Ministry of Health, 2014). However, limited progress prompted further emphasis in the 2023–2030 National Health Strategy, which includes specific objectives to enhance health governance (Government of Romania, 2023c). Both strategies also highlighted the need to improve health system transparency. Furthermore, the 2022–2026 NRRP includes an objective on good governance in the public sector. The NRRP incorporates a reform which focuses on improving management knowledge and skills across all health system levels, strengthening human resource capacity and increasing integrity while reducing vulnerabilities and risks of corruption in the health system.

Patient information is partially available (see Section 2.8.1), but only reaches some population groups (for example, a great deal of information

can be obtained on the internet but there are some patient categories – such as older people, those living in rural areas, and those with no skills or without internet access – which are not able to reach it) and is often insufficient for fully informed decision-making. Although legislative procedures require the public administration to submit all decisions for public debate or consultation before implementation, patients are less involved in health policy decision-making than in other countries. Insufficient information on entitlements to health services contributes to OOP payments, such as when physicians deliberately refer patients from public facilities to their private practices, recommend costlier drugs or medical devices outside the benefits package or charge high extra billing payments. To overcome these issues, a 2021 regulation mandated private providers to display estimated costs on their website (see Section 6.1), and in April 2024 the Minister of Health announced plans to reduce referrals from public facilities to providers' private practices (Euronews.ro, 2024).

Patients have the right to be informed about alternative treatment options and to seek second opinions, but there is no evidence on whether they exercise these rights. Patient involvement in reform initiatives primarily occurs through participation in public debates or as members of administrative boards (see Section 2.8), though their influence on decision-making is not well documented. For expensive treatments not covered by health insurance, patients, many through patient organizations, have gone to court. Over the past decade, approximately 500 lawsuits have been filed for the right to free medication, with patients winning 95% of these cases, according to patient representatives (Jurnalul.ro, 2024).

Despite progress in combating corruption, challenges remain. A recent OECD report showed a decrease in the bribery rate in the health system from 33% in 2016 to 22% in 2021, following the implementation of the 2016–2020 National Anti-corruption Strategy (OECD, 2023b). However, the Romanian population still perceives health as the most corrupt sector, which differs from the EU average, placing political parties at the top (European Commission, 2024). In 2023 Romania was ranked in 63rd place on the Corruption Perception Index, with a score of 46, behind all EU Member States except Bulgaria (ranked 67th with a score of 45) and Hungary (ranked 76th with a score of 42) (Transparency International, 2023). Furthermore, a Eurobarometer survey showed that in 2023, 9% of Romanians visiting a healthcare provider had to give an extra payment or

valuable gift, the second highest rate in the EU after Greece (14%). In comparison, reported extra payment rates in other countries range from 7% in Croatia, 6% in Austria and Bulgaria, to none in the Netherlands, Spain and Sweden. Notably, Romania saw the largest decrease from 2022, dropping 9 percentage points, followed by Slovakia (7 percentage points) and Malta (4 percentage points) (European Commission, 2023). Anti-corruption initiatives continue, such as the 2021–2025 National Anti-corruption Strategy, the 2023–2030 National Health Strategy, and the NRRP. While these strategies and government programmes set priorities, there is no publicly available process for priority-setting. Proposed interventions are not always evidence-based or aligned with best practice, and performance is not systematically assessed.

Efforts to address insufficient capacity for health policy development, implementation and evaluation were lately addressed by several EC-financed projects. Examples include the 2016 project "Improving Ministry of Health capacity for strategic planning and management of the national health programmes" and the 2019 project "Developing the strategic and operational framework for planning and reorganization of health services at national and local levels" (see Section 6.1).

7.2 Accessibility

A significant share of the Romanian population (11% as of 2023) is not covered by SHI, although insurance is statutory (see Section 3.3.1). There are no statistics on the characteristics of the uninsured population. However, according to local social services, the uninsured include members of large low-income families, single parents, Roma citizens and unemployed people not registered for social benefits (Economica.net, 2023).

Historically, uninsured individuals were entitled to a limited benefits package, which primarily covered life-threatening emergencies, epidemic-prone infectious diseases, care during pregnancy and childbirth, family planning, and community care. Since 2023 the uninsured population has also been entitled to primary healthcare services, including preventive, diagnostic and treatment services, as well as home care (Government of Romania, 2022c). Furthermore, since 1 July 2024 the uninsured population is also entitled to early detection and treatment of several serious diseases such as

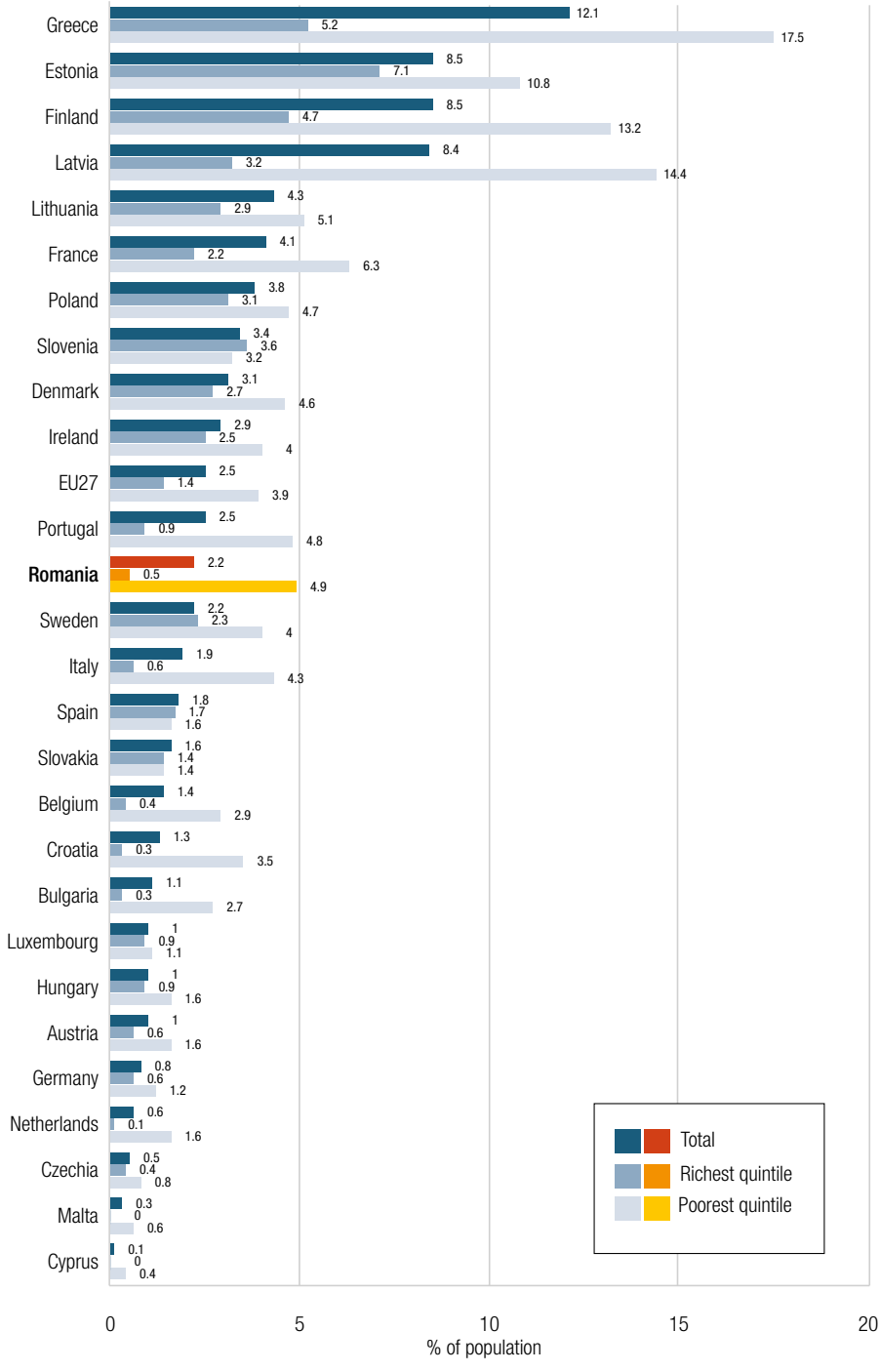
cancers, hepatitis B and C, and HIV/AIDS in pregnant women. Despite these improvements, uninsured patients still must pay OOP for laboratory tests, imaging investigations and outpatient medicines prescribed by a family doctor for other diseases (Government of Romania, 2024). Insured people are entitled to a relatively comprehensive statutory benefits package that includes a wide range of health services, pharmaceuticals and medical devices (see Section 3.3.1). Still, many do not make use of their rights for different reasons (for example, some do not know that they are entitled to those services, while others cannot afford other indirect costs such as co-payments, travel to the service provider, etc.).

In 2024, 2.2% of Romanians reported unmet needs for a medical examination due to cost, waiting time or travel distance, slightly below the EU average of 2.5% (Eurostat, 2025). As in other EU countries, a significant disparity exists between income groups: 0.5% of those in the highest income quintile reported unmet needs, compared to 4.9% in the lowest quintile (see Fig. 7.1). The gap between the two income groups has reduced, from 5.7 percentage points in 2018 to 4.4 in 2024. The main driver of unmet needs for a medical examination is costs (1.1% in 2024), likely related to travel expenses and co-payments for outpatient medications. Again, a significant disparity exists between the lowest (3.3%) and the highest income quintiles (0.3%).

Unmet needs for a dental examination increased from 5.2% in 2022 to 6.3% in 2023, with the highest increase for the lowest income quintile, from 8.8% to 10.5% (Eurostat, 2024). In 2024 unmet needs for a dental examination decreased to 3.8% and to 6.7% for the lowest income quintile (Eurostat, 2025). As with unmet medical needs, the main driver of unmet needs for a dental examination is costs (3.7% in 2024). Again, there is a considerable income gap, with 6.6% in the lowest income quintile indicating unmet needs compared to 2.2% in the highest. The higher rate of unmet needs for a dental examination due to cost compared to a medical examination stem from the limited coverage of dental services under statutory health insurance or other funding sources.

A Eurofound survey conducted during the COVID-19 pandemic (2021–2022) revealed that unmet needs for healthcare in Romania were higher than the EU average (22% in Romania compared to 18% for the EU). However, unmet needs for mental healthcare were lower in Romania, accounting for 12% of total unmet healthcare needs compared to 22% in the EU.

FIGURE 7.1 Unmet needs for a medical examination (due to cost, waiting time or travel distance), by income quintile, EU/EEA countries, 2024



Source: Eurostat, 2025

This may not reflect an actual lower demand but rather underreported or unexpressed needs, possibly due to stigma (OECD & European Observatory on Health Systems and Policies, 2023).

The availability of services also influences access to health services, which can result in inequities. One aspect is the disparity between rural and urban areas, driven by the unequal distribution of health workers and facilities. For example, in 2024 only 36.2% of family physicians were located in rural areas, despite the rural population accounting for 44.6% of the total population. On the other hand, 63.8% of family physicians practised in urban areas, where 55.4% of the population reside (NHIH, 2025a; INS, 2025c). Long distances, lack of infrastructure and unaffordable travel costs widen this gap. Apart from specialized care being concentrated in urban areas, many rural areas lack access to basic primary healthcare due to shortages of health personnel (see Section 4.1, Section 4.2 and Section 5.3). Various national and local measures have been implemented to enhance coverage and address access inequalities, such as mobile healthcare units and telemedicine services to reach rural areas (see Section 6.1). However, the outcomes of these measures are not specifically measured yet, but the last reported data to Eurostat show a sharp decrease in unmet needs for medical services to 2.2% in 2024, under the EU 27 (from 2020) average of 2.5%, with 0.6% of those in the highest income group and 3.6% of those in the lowest income group (Eurostat, 2025).

7.3 Financial protection

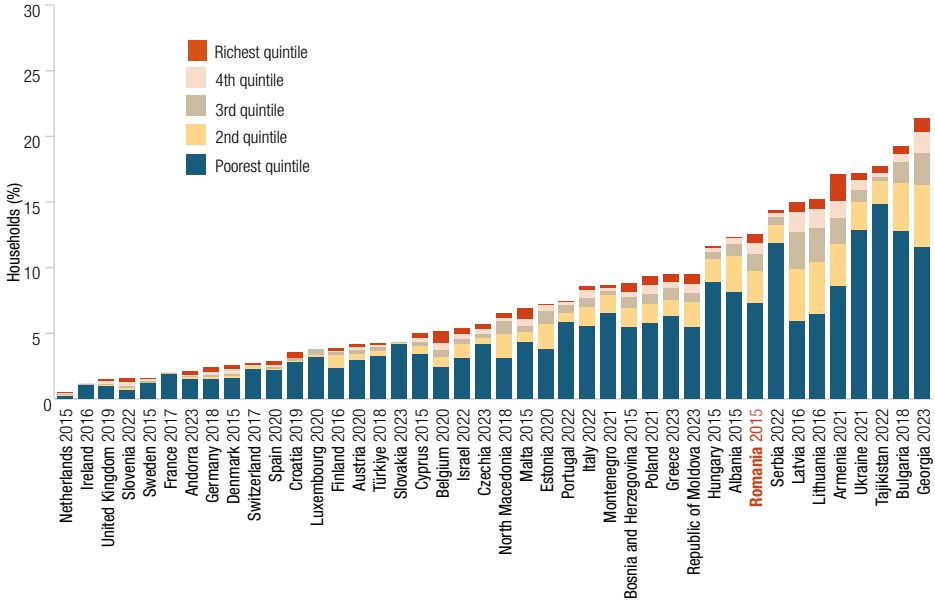
Over the last decade OOP spending on health has averaged 20% of CHE (WHO Regional Office for Europe, 2024b; see also Section 3.4). In 2015 OOP spending represented 4.9% of total household consumption, with 62% of households reporting OOP payments (Scîntee, Mosca & Vlădescu, 2022). Outpatient medicines account for the largest share of OOP payments (70% in 2015), followed by dental care (14%). OOP payments vary among income quintiles: OOP payments for outpatient medicines ranged from 90% in the poorest quintile to 54% in the richest quintile, while OOP payments for dental care range from 4% in the poorest quintile to 23% in the richest quintile (2015 data) (Scîntee, Mosca & Vlădescu, 2022).

OOP payments are the second largest source of revenue for healthcare, and in 2022 reached 21.4% of CHE, while OOP payments lead to financial

hardship for richer households accessing dental services and for poorer households buying outpatient medicines, and also lead to unmet healthcare needs (see Section 3.3).

Several factors contribute to financial hardship in Romania, placing it among the countries with a high share of households facing catastrophic health spending: in 2015 (the latest year for which internationally comparable data are available), 12.5% of Romanian households experienced catastrophic health spending, an increase from 10.4% in 2010 (Fig. 7.2). These factors include a high proportion of uninsured people, access barriers for the insured population due to resource shortages, lack of information regarding entitlement to benefits, high user charges (for example, for outpatient medicines), or lack of coverage for certain health services (that is, dental services) (Scîntee, Mosca & Vlădescu, 2022).

FIGURE 7.2 Share of households that experienced catastrophic health expenditure, latest year for all countries with data available



Source: UHC Watch, 2025

The burden of catastrophic spending is disproportionately borne by poorer and older households (those with at least one member over 60 years) and by people living in the poorest regions (North-East and South-West

Oltenia). Among the poorest income quintiles, the incidence rate increased from 28% in 2010 to 36% in 2015, with almost 90% of catastrophic spending directed towards outpatient medicines. Dental care was the largest driver of catastrophic health spending for wealthier households, which increased from 28% in 2010 to 38% in 2015 (Scîntee, Mosca & Vlădescu, 2022).

7.4 Healthcare quality

Healthcare quality has become a high priority in Romania over the past decade. In 2015 the NAQMH was established (see Section 2.2) and the Law on Quality Assurance (Law no. 185/2017) was passed. However, this Law primarily focused on the organization and operations of the NAQMH, particularly its role in accrediting health providers (see Section 2.7.2).

Romania did not collect data on quality of care regularly until 2022, when the country started the process of OECD accession. Through the NAQMH, Romania became an observer in several OECD working groups, including the Health Committee, the Working Group on Healthcare Quality Indicators, the Working Group on Patient Safety and the Working Group on PaRIS instrument.

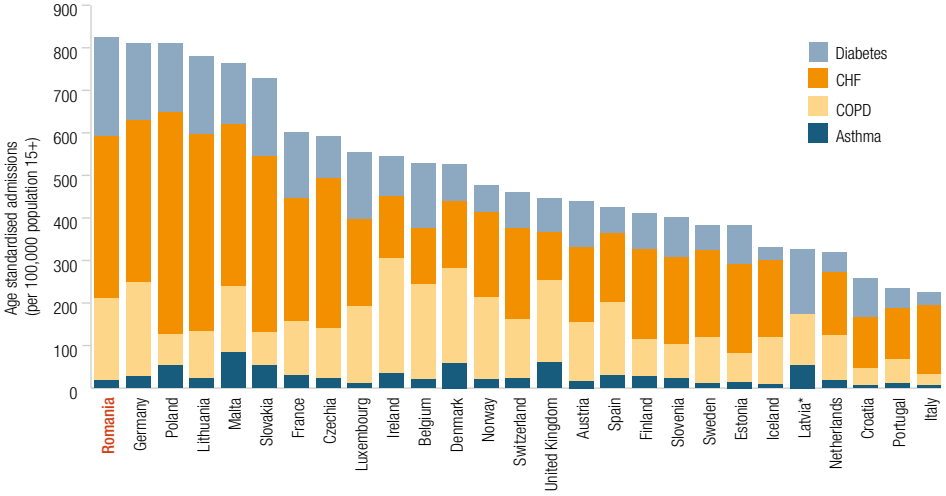
7.4.1 *Primary (ambulatory) care*

The quality of primary care for chronic conditions in Romania seems to have improved over the last decade as avoidable hospital admissions for asthma, COPD, congestive heart failure (CHF), hypertension and diabetes have all decreased between 2014 and 2021 (OECD, 2024). In 2024 Romania had the highest overall avoidable hospital admission rates for asthma, COPD, CHF and diabetes-related complications, compared to other EU countries (Fig. 7.3). In 2024 Romania was the country in the EU with the highest number of avoidable hospital admissions for diabetes, reporting 231.5 cases per 100 000 population (OECD, 2024).

Antibiotic prescribing, another indicator of primary care quality, is a concern in Romania, and the control of AMR is one objective in the 2023–2030 National Health Strategy. As an immediate measure, the Ministry of Health has issued an order (Order no. 63/2024) approving an outpatient

prescription guideline to control antibiotics prescriptions (HSPM, 2024). According to a 2023 ECDC report, Romania has the highest rates for quinolones at 3.3 DDD per 1000 inhabitants per day, significantly exceeding the EU/EEA average of 1.3 DDD (ECDC, 2023).

FIGURE 7.3 Avoidable hospital admission rates for asthma, COPD, CHF and diabetes-related complications, Romania and selected countries, 2024

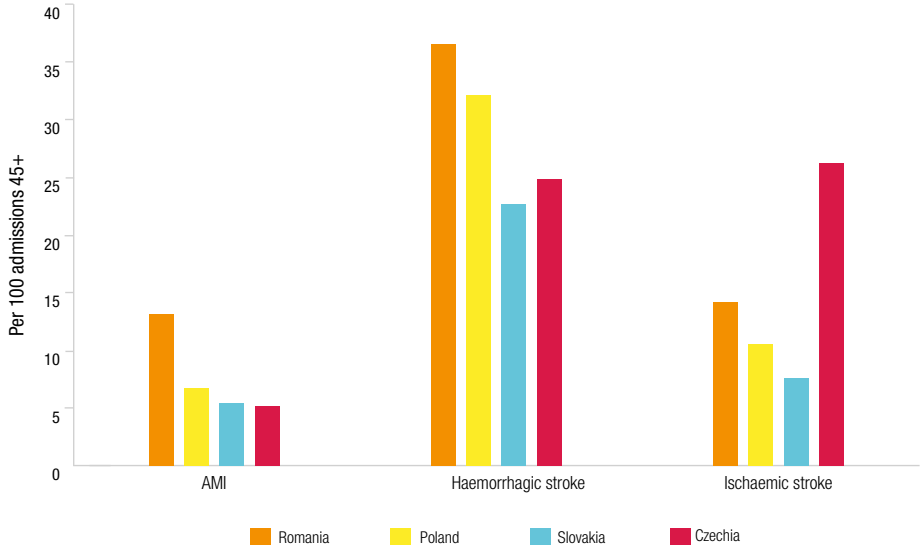


Source: OECD, 2025

7.4.2 *Hospital (inpatient) care*

The quality of hospital care, as reflected by in-hospital mortality rates within 30 days of admission for acute myocardial infarction (AMI), haemorrhagic stroke and ischaemic stroke, has declined overall since 2014. Although all three indicators showed promising reductions in mortality rates between 2014 and 2017, this trend reversed in subsequent years (OECD, 2024). By 2024 the rates for all three conditions had risen markedly, exceeding the levels observed in 2014. That year, the 30-day mortality rate for AMI stood at 13.1 per 100 patients, significantly higher than in neighbouring countries. In contrast, the rate for haemorrhagic stroke was lower than in neighbouring countries at 36.5, while ischaemic stroke mortality, at 14.2, was roughly comparable to regional averages (Fig. 7.4).

FIGURE 7.4 In-hospital mortality rates (deaths within 30 days of admission) for admissions following AMI, haemorrhagic stroke and ischaemic stroke, Romania and selected countries, 2024



Source: OECD, 2025
Note: Data for Czechia, Poland and Slovakia refer to 2023.

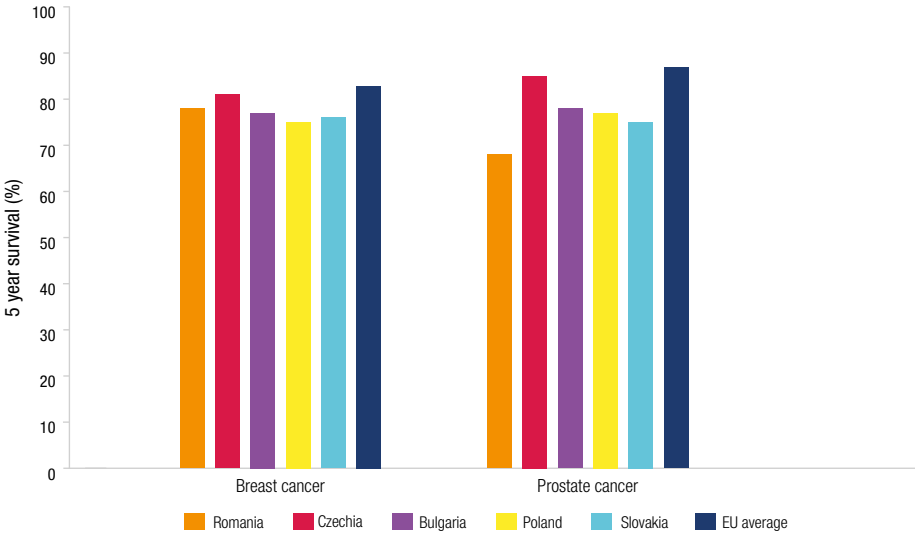
7.4.3 *Cancer care*

Cancer survival rates for breast and prostate cancer in Romania are below the EU averages, but comparable to those in other Central and Eastern European countries (Fig. 7.5). For breast cancer, the five-year survival rate during 2010–2014 was 75%, slightly higher than 74% in Lithuania but well below the EU average of 83%. Similarly, Romania ranks among the countries with the lowest five-year survival rates for prostate cancer, 77% compared to the EU average of 87%.

The comparatively low cancer survival rates in Romania are linked not only to the limited availability of innovative treatments but also to the lack of systematic screening programmes, which are crucial for detecting cancers at early, more treatable, stages. For example, in 2019 only 7.9% of Romanian women over 15 years had a mammography screening compared to 35.4% across the EU. Similarly, only 2.9% of people over 15 years had a colorectal cancer screening, compared to the EU average of 18.9%, and just

30% of women over 15 years had a cervical cancer screening, far below the EU average of 59.5% (Ministry of Health, 2023d).

FIGURE 7.5 Cancer survival rates for breast cancer (among women) and prostate (among men), Romania and selected countries, 2010–2014



Source: Allemani et al., 2018

7.4.4 *Overall quality of care*

The overall quality of care in Romania is affected by weak integration between different providers and across levels of care. Despite being on the policy agenda since 2014, there has been limited visible progress in improving integration and coordination of services. Primary and community care services remain underutilized, leading to overuse of emergency and inpatient care. Furthermore, patients are not guided through the right care pathways, lacking integration and continuity of care. The 2016 European Quality of Life Survey also showed that patient-reported satisfaction with the quality of health services in Romania was below the EU average (see Box 5.4). Patient feedback on hospital care is collected through questionnaires at discharge and, since 2016, via SMS or web-based surveys distributed by the Ministry of Health. Unfortunately, no aggregated results on all hospitals and time series reports on patient opinions exist.

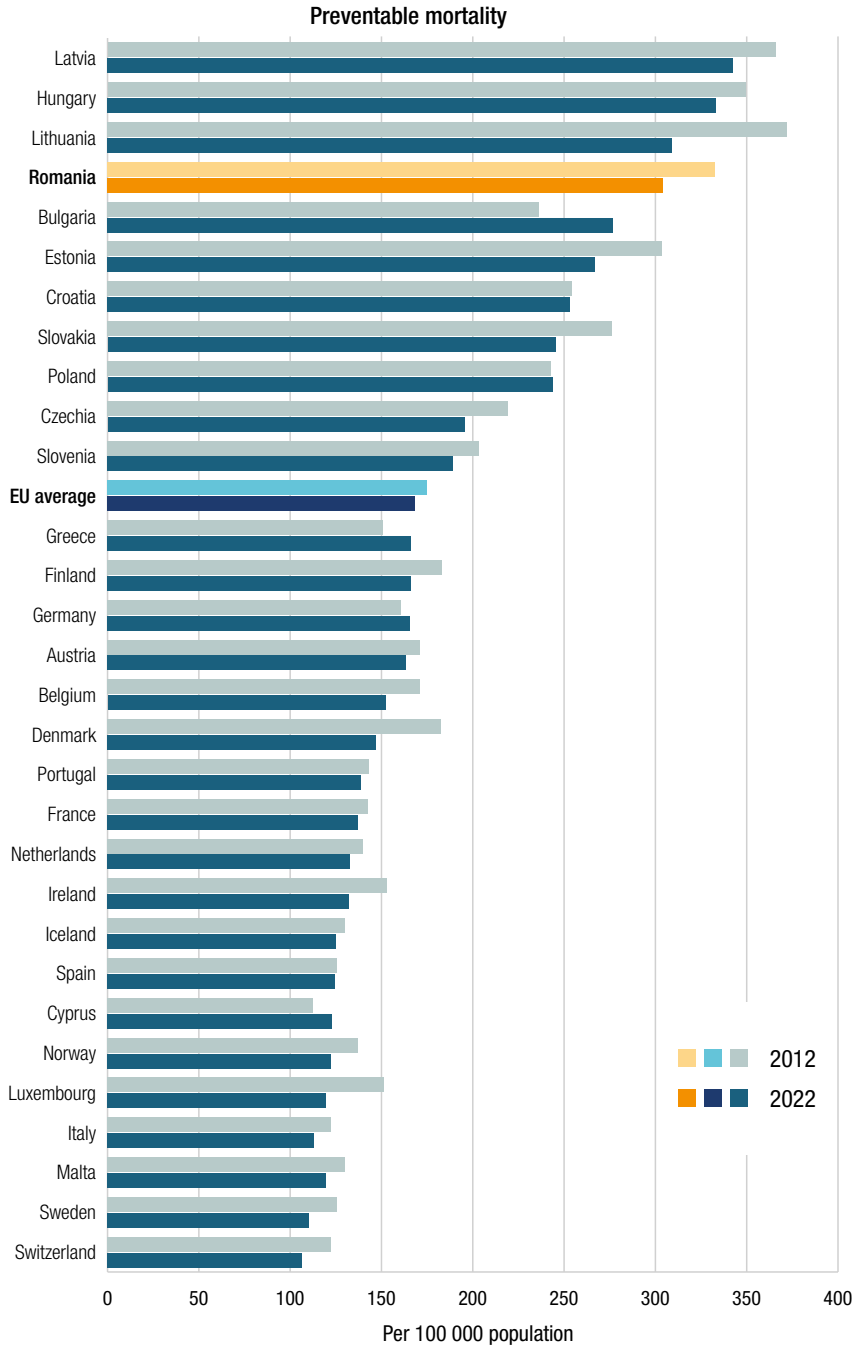
The current National Health Strategy has outlined quality-related objectives and measures, including restructuring the hospital sector (see Box 5.3). However, neither the 2014–2020 National Health Strategy nor the current strategy includes proper outcome indicators to measure the impact of these initiatives to improve the quality of healthcare.

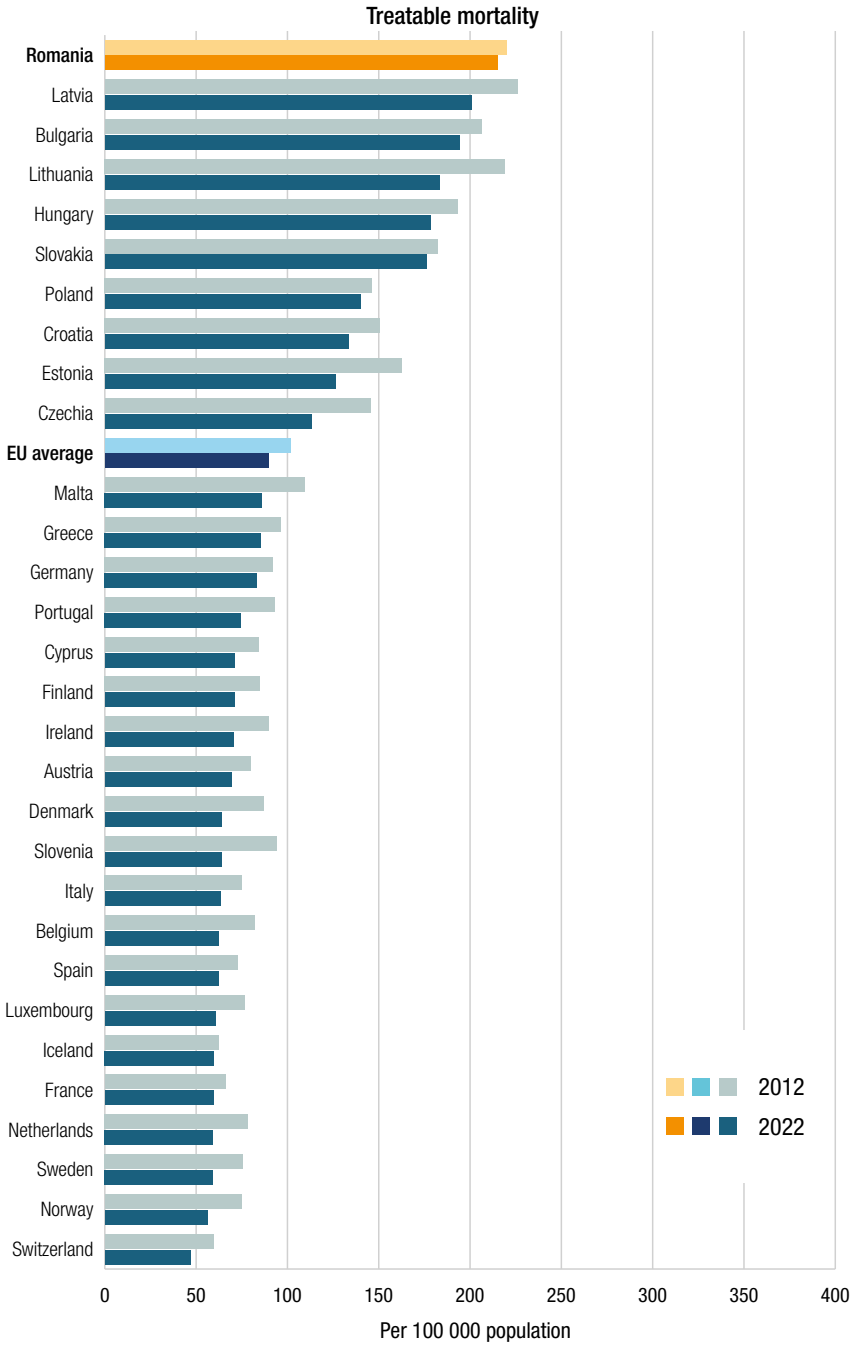
In general, information on quality of care in Romania has been scarce. There is no routine data collection on service quality and patient safety. The Romanian Ministry of Health launched a Quality Improvement reform in 2022 under the NRRP to address this gap. The reform includes the implementation of a pay-for-performance model for hospitals based on quality indicators. Between 2022 and 2023, with support from WHO, a set of 25 quality indicators were developed and piloted in six public hospitals. The results of this project led to the issuance of a Ministerial Order approving the methodology for selecting hospitals to be monetarily rewarded for improving and achieving higher quality of care (Ministry of Health, 2023e). A technical guidebook was also created to support public hospitals in adopting the Health Quality Fund methodology (WHO Regional Office for Europe, 2024b). The project identified several critical factors for successful and sustainable quality improvement in Romanian hospitals, including political support, developing a data-driven culture focused on quality improvement, and ensuring continuous monitoring, analysis and refinement of quality indicators (Ivanković et al., 2024).

7.5 Health system outcomes

In Romania the preventable mortality rate decreased from 332.47 deaths per 100 000 population in 2012 to 304.31 in 2022 (Fig. 7.6). Mortality from preventable causes in Romania is the fourth highest in the EU and much higher than the EU average of 168.14 per 100 000 population in 2022 (Eurostat, 2024). Mortality from treatable causes has also decreased from 219.8 deaths per 100 000 population in 2012 to 215 in 2022, although it remains the country with the highest rate of treatable mortality in the EU (Fig. 7.6). Similarly to preventable deaths, the treatable mortality rate in Romania is more than double the EU average of 89.7 deaths per 100 000 population (Eurostat, 2024).

FIGURE 7.6 Preventable and treatable mortality in Romania and selected countries, 2012–2022





Source: Eurostat, 2025

In 2022, with 47.83 deaths per 100 000 population, ischaemic heart disease was the main cause of treatable mortality, followed by malignant neoplasm of trachea-bronchus-lung (35.5 deaths per 100 000 population), cerebrovascular diseases (29.34 per 100 000 population) and hypertensive diseases (23.89 per 100 000 population) (Eurostat, 2025). The main driver of preventable mortality was COVID-19, with 124.8 deaths per 100 000 population in 2021, followed by ischaemic heart disease (56.7 per 100 000 population) and alcohol-related diseases (36.0 per 100 000 population) (Eurostat, 2024). Besides the weakness of primary care, limited spending on prevention, the high OOP costs of outpatient pharmaceuticals and the low uptake of COVID-19 vaccinations have resulted in major challenges (OECD & European Observatory on Health Systems and Policies, 2023).

Behavioural risk factors continue to have a major impact on health outcomes, with very little improvement or in some cases even a deterioration. As in 2014, in 2019 one in five adults reported smoking daily. Alcohol consumption increased from 9.6 litres per capita in 2014 to 11 litres per capita in 2022 and to 12.3 litres in 2023 (OECD & European Observatory on Health Systems and Policies, 2025). The proportion of adults consuming the recommended five servings of fruit and vegetables daily decreased from 3.5% in 2014 to 2.4% in 2019 (OECD & European Observatory on Health Systems and Policies, 2017, 2023). Among the common factors with a major impact on deaths, high blood pressure, diet, high body-mass index and high cholesterol are responsible for a larger share of deaths in Romania compared to the EU.

The high rate of preventable mortality highlights the limited effectiveness of public health interventions (see Section 5.1 and Box 5.1) aimed at addressing behavioural risk factors such as high rates of daily smoking, excessive alcohol consumption and low intake of fruit and vegetables (see Section 1.4). Public health interventions in Romania are generally constrained by limited financial and human resources, resulting in inconsistent and narrow areas of action. Despite increasing initiatives over the past decade to strengthen disease prevention and health promotion, the health system remains predominantly oriented towards curative care. The 2023–2030 National Health Strategy recognizes these shortcomings as critical areas for improvement and outlines specific measures to enhance health promotion and education (Government of Romania, 2023c).

7.5.1 *Equity of outcomes*

Health outcomes in Romania vary significantly across geographical regions and population groups. In 2023 men lived on average 7.8 years less than women, a larger gender gap than the EU average of 5.3 years (OECD & European Observatory on Health Systems and Policies, 2025). This disparity is largely associated with differences in exposure to risk factors such as smoking and alcohol consumption (OECD & European Observatory on Health Systems and Policies, 2023). Life expectancy also differs based on education level and place of residence. In 2017 there was a gap of 6.4 years in life expectancy at age 30 between men with higher education and those with lower education (Eurostat, 2025). Similarly, in 2020 individuals living in urban areas lived 3.8 years longer than those in rural areas (INSP, 2021) (see Section 1.4).

Self-perceived health status among the Romanian population aged 16 to 64 years also reveals inequalities. In 2024 the percentage of individuals reporting "good and very good" health differed by 8.1 percentage points between the highest (93.1%) and lowest income (85%) groups, more than double since 2017, when the difference was 4 percentage points (85.5% and 81.5%, respectively) (Eurostat, 2025). Despite these disparities, Romanians generally report better self-perceived health than the EU average (see Section 1.4); in particular, those from the lowest income group report better self-perceived health than the EU average (69.1%). However, this might reflect a higher unperceived and undiagnosed need for healthcare in Romania. High unmet needs, particularly among low-income groups (see Section 7.2), are also a reason for inequity in health outcomes.

The lack of systematic data collection and analysis prevents the development of a comprehensive and up-to-date profile of health inequalities in Romania. This gap hinders the formulation of proper and targeted policies to ensure equity in health outcomes and, ultimately, improved health.

7.6 Health system efficiency

7.6.1 *Allocative efficiency*

Despite policy intentions to shift focus from inpatient to outpatient care, funding for the outpatient sector has stagnated at 11–14% of CHE over the

past decade (INS, 2020b, 2025a). Contrarily, instead of reducing the number of hospital beds as envisioned, the number of beds increased from 688.24 per 100 000 population in 2014 to 728.43 in 2023. During the same period the EU average decreased from 548.78 to 510.81 beds per 100 000 population (Eurostat, 2025). Bed distribution also varies across the country, with the highest concentration in Bucharest-Ilfov with 1056 beds per 100 000 population in 2023 and significantly fewer beds in the South-East region (602) and the South-Muntenia region (536) (INS, 2024e) (see also Box 4.1).

Health workers are also unevenly distributed. For example, in 2023 Bucharest-Ilfov had 109 family physicians per 100 000 population, while the North-East region had only 48 family physicians per 100 000 population and the South-Muntenia region had 47 (INS, 2024e). A 2020 report identified 1414 localities with a shortage of family physicians and 271 localities with an oversupply (FNPMF, 2020) (see also Box 4.2).

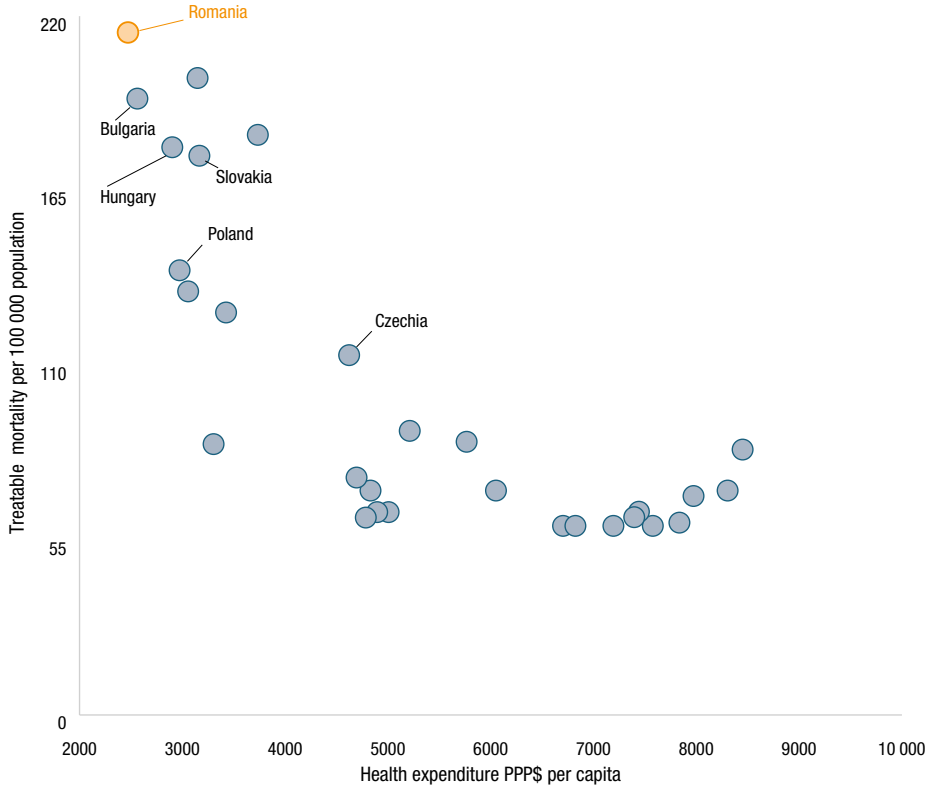
The allocation of funds among different sectors of care (ambulatory, impatient care, laboratory, dental care, home care, treatment under the national health programmes, etc.) is a political decision. The health insurance fund budget allocated to each sector is voted by Parliament annually in the Budget Law. The allocation of funds among the same types of providers is adjusted according to specific criteria (see Chapter 3), i.e. there are adjustments for primary healthcare providers according to numbers of patients or their location in deserted, remote areas, and adjustments of the DRG payment formula for different categories of hospitals, depending on their competency/specialization level, etc. Except for pharmaceuticals, where HTA is in use, evidence about effectiveness, including cost-effectiveness, is not used in allocation decisions (see Box 3.3).

7.6.2 *Technical efficiency*

Assessing a health system's performance regarding inputs, costs and outcomes is often challenging. One way to provide a basic illustration is by plotting CHE against treatable mortality rates. While it is not possible to completely separate the influence of health behaviours from the impact of the healthcare system on treatable mortality levels, this indicator serves as a valuable starting point for discussion. Compared to countries with similar levels of health spending per capita, such as Bulgaria, Czechia, Poland,

Slovakia and Hungary, Romania had the highest treatable mortality rate per 100 000 population in 2022 (Fig. 7.7). This suggests that the health system is less efficient in translating spending into improved health outcomes.

FIGURE 7.7 Treatable mortality per 100 000 population vs. health expenditure per capita, in Romania and selected countries, 2022



Sources: WHO, 2025; Eurostat, 2025

The issue of low technical efficiency in the health system has been widely debated in Romania, with the general perception being that the scarce resources are not being used most cost-effectively.

Data shows that the average length of inpatient stays has continuously decreased in Romania, reaching levels comparable to the EU average (that is, 7.3 days and 7.5 days in 2018, respectively, for all causes of hospitalization). On the other hand, for certain services the length of stay in Romanian hospitals exceeds the EU average. For example, the average length of stay for an uncomplicated delivery in 2018 was 4.5 days, compared to the EU average of

3.4 days (OECD & European Union, 2020). Additionally, the proportion of hospital admissions for day care services has increased significantly, from 41.6% in 2014 to 66.4% in 2023, with the list of day care services and procedures continuously expanding (see Section 5.4.2).

Besides budgetary constraints, the health workforce shortage and improper skill-mix of the health workforce contribute to poor health outcomes among the population. Furthermore, another possible reason for inefficiency could be the preferences of physicians for performing certain procedures. For example, in 2017 Romania had the second-highest rate of caesarean sections in the EU, at 44.1%, after Cyprus at 54.8% (Simionescu et al., 2021). Inadequate policies have also led to the withdrawal of cheap generics from the market or inadequate drug planning capacity in hospitals (see Box 5.5). Another reason for inefficiencies in the Romanian health system is the overuse of investigation as defensive medicine, especially in emergency rooms, where even non-urgent cases are attended due to the legislation not allowing them to refuse a patient before investigation (see Section 5.2 and Section 5.5). Moreover, over-prescription of antibiotics causes AMR leading to further costs (OECD & European Observatory on Health Systems and Policies, 2023). Additionally, the inappropriate use of hospital services for some conditions that could be treated in outpatient settings, such as diabetes (see Section 7.4), as well as incoherent policies, outdated regulatory frameworks and cumbersome administrative procedures, obstruct efficiency gains in hospitals (Duran et al., 2019). Addressing these challenges is essential for improving healthcare outcomes and system efficiency.

8

Conclusions

Since the early 1990s Romania's health system has undergone significant reform, transitioning from the Semashko model to an SHI system. However, elements of the previous centralized structure and service delivery approach remain evident to this day. In particular, the Romanian health system is hospital-centric, with high bed capacity; patients seeking timely care often bypass primary care facilities and go directly to hospitals. As a result, nearly half of all health financing in Romania goes towards inpatient care. Bypassing primary care is partly the result of patient preference, but is also due to the limited availability of GPs, particularly in rural areas. The weakness of primary care has serious implications for reducing avoidable mortality rates, which are the highest in the EU. Healthcare financing increased during the COVID-19 pandemic in Romania, but health spending per capita in Romania remains the lowest among EU countries. A significant portion of the funding provided through the EU's Recovery and Resilience Plan and Cohesion Policy is being directed towards prioritizing health digitalization and to developing an integrated digital health system and improving telemedicine systems.

The need to achieve financial stability has so far dominated the reform agenda (see Chapter 6) and this goal is yet to be achieved. Expenditure on the Romanian health system, both in terms of percentage of GDP and per capita, remains the lowest across EU countries (2022 data). This underfunding of the health system results in poor infrastructure and outdated equipment, low salaries for some categories (though measures have been in place to increase

them in recent years) and a shortage of medical professionals. The shortage of medical professionals is evident mainly in rural and remote areas, though in big cities with Medical Schools the density of medical personnel is significantly higher than the EU average. The large majority of the population (89% in 2023) is covered through SHI and is entitled to a broad range of benefits, but OOP payments remain high (21.4% in 2022). Health outcomes have also improved in many areas (see Section 1.4), albeit with differences between different population groups and between rural and urban areas.

A related challenge is a shortage of health workers in rural and remote areas; even if the number of physicians and nurses per population has increased almost to the EU average, there remain huge disparities between the urban and rural populations. Thus, while there was a rise in workforce numbers due to significant salary increases in 2017 and mass hiring during the COVID-19 pandemic, shortages remain, particularly for family physicians, with nearly 200 localities having no family physician in 2024. In March 2023 the Minister of Health approved sectoral action plans for human resources for health development over 2023–2030, which aim to attract health professionals to underserved areas, and improve the education, recruitment, retention and motivation of the workforce. However, a dedicated budget for their implementation has not been detailed.

Healthcare quality has become a high priority in Romania over the past decade. In 2015 the NAQMH was established and the 2017 Law on Quality Assurance was passed. However, Romania did not collect data on quality of care regularly until 2022 when the country started the process of OECD accession. Other areas that require systematic attention include the integration of healthcare services and sectors, the development of community care, the introduction of incentives to strengthen and develop prevention and promotion services, and increasing the use of evidence in decision-making at all levels of care. In addition, the widespread use of informal payments further reduces the accessibility, efficiency and quality of the health system.

While healthcare reforms have been stepped up, recent and ongoing healthcare reforms have been perceived by both patients and healthcare professionals as being fragmented and poorly coordinated, with a focus on achieving financial balance at the expense of long-term goals, and demonstrating a lack of continuity. A major challenge remains ensuring stability in governance – since 1989 there have been 33 Ministers of Health and since 1999, 31 Presidents of the NHIH. There is also a need for concerted effort

in addressing corruption in the healthcare (and other) sectors (see Section 1.3). It is expected that in the coming years the new National Strategy for Health will be implemented in a better way and with better outcomes compared to former strategies, and that the use of funds available from the EU and their impact on the performance of the health system will be increased.

9

Appendices

9.1 References[3]

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9.2 Useful web sites

Coalition of Patients with Chronic Diseases Organizations from Romania (*Coaliția Organizațiilor Pacienților cu Afecțiuni Cronice din România*)
http://www.copac.ro

European Health Insurance Card
http://www.ceass.ro/index.php?lang=en

International Organization for Migration Office in Romania
https://romania.iom.int/

Institute of Pneumology "Marius Nasta"
(*Institutul de Pneumoftiziologie "Marius Nasta"*)
http://www.marius-nasta.ro

Ministry of Health (*Ministerul Sănătății*)
https://www.ms.ro/ro/

Minister of Labour, Family, Youth, and Equal Opportunities
(*Ministerul Muncii, Familiei, Tineretului și Solidarității Sociale*)
https://mmuncii.ro/j33/index.php/ro/

Mobile Emergency Service for Resuscitation and Extrication
(*Serviciul Mobil de Urgență, Reanimare și Descarcerare*)
http://www.smurd.ro

National Authority for Quality Management in Health Care
(*Autoritatea Națională de Management al Calității în Sănătate*)
https://anmcs.gov.ro/web/

National Agency for Medicines and Medical Devices
http://www.anm.ro/anmdm/en

National Health Insurance House
http://www.cnas.ro/default/index/index/lang/EN

National Institute for Infectious Diseases "Prof. Dr. Matei Balș"
(*Institutul Național de Boli Infecțioase "Prof. Dr. Matei Balș"*)
https://mateibals.ro/

National Institute of Public Health
(*Institutul Național de Sănătate Publică*)
http://www.insp.gov.ro

National Medical-Military Institute for Research and Development "Cantacuzino" (*Institutul Național de Cercetare-Dezvoltare Medico-Militară "Cantacuzino"*)
https://cantacuzino.mapn.ro/

National Institute of Statistics
(*Institutul National de Statistica*)
http://www.insse.ro/cms/en

National Institute of Health Services Management
(*Institutul Național de Management al Serviciilor de Sănătate*)
http://www.inmss.ro

Order of Biochemists, Biologists and Chemists in the Romanian Health System (*Ordinul Biochimiștilor, Biologilor și Chimiștilor in Sistemul Sanitar din România*)
http://obbcssr.ro

Order of Nurses, Midwives and Medical Assistants in Romania (*Ordinul Asistenților Medicali Generaliști, Moașelor și Asistenților Medicali din România*)
https://www.oamr.ro/

Romanian Association of International Producers of Generic Drugs (*Asociația Română a Producătorilor Internaționali de Medicamente Generice*)
http://arpim.ro

Romanian College of Dentists
(*Colegiul Medicilor Dentiști din România*)
http://www.cmdr.ro

Romanian College of Pharmacists
(*Colegiul Farmaciștilor din România*)
http://www.colegfarm.ro

Romanian College of Physicians
(*Colegiul Medicilor din România*)
http://www.cmr.ro

Romanian National Society of Family Medicine
(*Societatea Națională de Medicina Familiei*)
https://snmf.ro/

9.3 HiT methodology and production process

HiTs are produced by country experts in collaboration with the Observatory's research directors and staff. They are based on a template that, revised periodically, provides detailed guidelines and specific questions, definitions, suggestions for data sources and examples needed to compile reviews. While the template offers a comprehensive set of questions, it is intended to be used in a flexible way to allow authors and editors to adapt it to their particular national context. The most recent template is available online at: http://www.euro.who.int/en/home/projects/observatory/publications/health-system-profiles-hits/hit-template-2010.

Authors draw on multiple data sources for the compilation of HiTs, ranging from national statistics, national and regional policy documents, to published literature. Furthermore, international data sources may be incorporated, such as those of the OECD and the World Bank. The OECD Health Data contain over 1200 indicators for the 34 OECD countries. Data are drawn from information collected by national statistical bureaux and health ministries. The World Bank provides World Development Indicators, which also rely on official sources.

In addition to the information and data provided by the country experts, the Observatory supplies quantitative data in the form of a set of standard comparative figures for each country, drawing on the European Health for All database. The Health for All database contains more than 600 indicators defined by the WHO Regional Office for Europe for the purpose of monitoring Health in All Policies in Europe. It is updated for distribution twice a year from various sources, relying largely upon official figures provided by governments, as well as on health statistics collected by the technical units of the WHO Regional Office for Europe. The standard Health for All data have been officially approved by national governments. With its summer 2007 edition, the Health for All database started to take account of the enlarged EU of 27 Member States.

HiT authors are encouraged to discuss the data in the text in detail, including the standard figures prepared by the Observatory staff, especially if there are concerns about discrepancies between the data available from different sources.

A typical HiT consists of nine chapters.

1. Introduction: outlines the broader context of the health system, including geography and sociodemography, economic and political context, and population health.
2. Organization and governance: provides an overview of how the health system in the country is organized, governed, planned and regulated, as well as the historical background of the system; outlines the main actors and their decision-making powers; and describes the level of patient empowerment in the areas of information, choice, rights, complaints procedures, public participation and cross-border healthcare.
3. Financing: provides information on the level of expenditure and the distribution of health spending across different service areas,

sources of revenue, how resources are pooled and allocated, who is covered, what benefits are covered, the extent of user charges and other out-of-pocket payments, voluntary health insurance and how providers are paid.

4. Physical and human resources: deals with the planning and distribution of capital stock and investments, infrastructure and medical equipment; the context in which IT systems operate; and human resource input into the health system, including information on workforce trends, professional mobility, training and career paths.
5. Provision of services: concentrates on the organization and delivery of services and patient flows, addressing public health, primary care, secondary and tertiary care, day care, emergency care, pharmaceutical care, rehabilitation, long-term care, services for informal carers, palliative care, mental health care, dental care, complementary and alternative medicine, and health services for specific populations.
6. Principal health reforms: reviews reforms, policies and organizational changes; and provides an overview of future developments.
7. Assessment of the health system: provides an assessment based on the stated objectives of the health system, financial protection and equity in financing; user experience and equity of access to healthcare; health outcomes, health service outcomes and quality of care; health system efficiency; and transparency and accountability.
8. Conclusions: identifies key findings, highlights the lessons learned from health system changes; and summarizes remaining challenges and future prospects.
9. Appendices: includes references, useful web sites and legislation.

The quality of HiTs is of real importance since they inform policy-making and meta-analysis. HiTs are the subject of wide consultation throughout the writing and editing process, which involves multiple iterations. They are then subject to the following:

A rigorous review process (see the following section).

There are further efforts to ensure quality while the report is finalized that focus on copy-editing and proofreading.

HiTs are disseminated (hard copies, electronic publication, translations and launches). The editor supports the authors throughout the production

process and in close consultation with the authors ensures that all stages of the process are taken forward as effectively as possible.

Three of the authors are also members of the Observatory staff team and they are responsible for supporting the other authors throughout the writing and production process. They consult closely with one another to ensure that all stages of the process are as effective as possible, and that HiTs meet the series standard and can support both national decision-making and comparisons across countries.

9.4 About the authors

Cristian Vlădescu is Professor of Public Health and Management at the "Titu Maiorescu" University, Faculty of Medicine, in Bucharest. Professor Vlădescu graduated from the Faculty of Medicine and specialized in Public Health and Management at the University of Pharmacy and Medicine Carol Davila, Bucharest, has postgraduate degrees in politics and administration (Bucharest University) and comparative analysis of health systems (New York University), and he obtained a master's degree in health services management at Nuffield Institute for Health, Leeds University. He also has a PhD in Sociology and a PhD in Public Health. His main areas of expertise are health policy and planning, health management and comparative analysis of health systems. He was President of the National Health Insurance Fund, Secretary of State and Director General in the Ministry of Public Health, President of The Romanian Hospital Accreditation Commission (CoNAS) and Chairman of the Presidential Commission for Health.

Silvia Gabriela Scîntee is Deputy General Director at the National Institute of Health Services Management. She has a master's degree in health services management from the London School of Hygiene & Tropical Medicine and a PhD in Public Health from the University of Medicine and Pharmacy "Carol Davila" Bucharest. Dr Scîntee has extensive knowledge of the Romanian health system as she worked as a Public Health Consultant at the Institute of Public Health Bucharest (1992–2005) and was Deputy General Director of the Romanian National Health Insurance House (2005–2007). She also has working experience at international level, having been engaged in different assignments for WHO and the European Commission, and having worked

as an international expert for several consultancy firms and international organizations.

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Florian Tille is a Technical Officer at the European Observatory on Health Systems and Policies, based at the Berlin University of Technology. He works across different analytical pillars at the European Observatory and contributes to knowledge-brokering through a range of activities including presentations, policy briefs and webinars.

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The Health Systems in Transition Series

A series of the European Observatory on Health Systems and Policies

The Health Systems in Transition (HiT) country reports provide an analytical description of each health system and of reform initiatives in progress or under development. They aim to provide relevant comparative information to support policy-makers and analysts in the development of health systems and reforms in the countries of the WHO European Region and beyond.

The HiTs are building blocks that can be used:

- to learn in detail about different approaches to the financing, organization and delivery of health services;
- to describe accurately the process, content and implementation of health reform programmes;
- to highlight common challenges and areas that require more in-depth analysis; and
- to provide a tool for the dissemination of information on health systems and the exchange of experiences of reform strategies between policymakers and analysts in countries of the WHO European Region.

How to obtain a HiT

All HiTs are available as PDF files at www.healthobservatory.eu where you can also join our list for monthly updates of the activities of the European Observatory on Health Systems and Policies, including new HiTs, books in our co-published series with Cambridge University Press, Policy briefs, Policy Summaries, and the Eurohealth journal.

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Albania
(1999, 2002[a g])

Andorra
(2004)

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Australia
(2002, 2006)

Austria
(2001[e], 2006[e], 2013[e], 2018)

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(2004[g], 2010[g])

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(2000, 2007, 2010, 2020)

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(1999, 2005[k], 2011, 2019)

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Republic of Korea
(2009*)

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(2001, 2005, 2012, 2023)

Switzerland
(2000, 2015)

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(2002[g i], 2011[i])

Turkmenistan
(2000)

Ukraine
(2004[g], 2010[g], 2015)

United Kingdom of Great Britain and Northern Ireland
(1999[g], 2015, 2022)

United Kingdom (England)
(2011)

United Kingdom (Northern Ireland)
(2012)

United Kingdom (Scotland)
(2012)

United Kingdom (Wales)
(2012)

United States of America
(2013, 2020)

Uzbekistan
(2001[g], 2007[g], 2014[g])

Veneto Region, Italy
(2012)

All HiTs are available in English. When noted, they are also available in other languages:

- [a] Albanian
- [b] Bulgarian
- [j] Estonian
- [c] French
- [d] Georgian
- [e] German
- [k] Polish
- [f] Romanian
- [g] Russian
- [h] Spanish
- [i] Turkish

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HiTs are in-depth profiles of health systems and policies, produced using a standardized approach that allows comparison across countries. They provide facts, figures and analysis and highlight reform initiatives in progress.

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