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Foreword

The OECD Council decided to open accession discussions with Romania on 25 January 2022. On 10 June 2022, the Council adopted the Roadmap for the accession of Romania to the OECD Convention [C/MIN(2022)25/FINAL] (the Roadmap) setting out the terms, conditions and process for accession to the OECD. The Roadmap provides that in order to allow the Council to take an informed decision on the accession of Romania, Romania will undergo in-depth reviews by the OECD technical committees listed in the Roadmap, including the Health Committee.

The present report was prepared to support the accession review discussion of the Health Committee with Romania on 2 December 2024, during its 36th session. This report has benefited from the expertise and material received from many health officials, health professionals, civil society and other health experts that the OECD review team interviewed during a fact-finding mission in Bucharest on 25-28 June 2024. The report also reflects information provided in November 2023 to the Accession Survey on Health Data Capacity, the Accession Review Policy Questionnaire, as well as the regular OECD Health Data Questionnaires received in May 2024 and updates in 2025.

In accordance with paragraph 28 of the Roadmap and upon request of Romania, the Health Committee agreed to declassify this report on 4 April 2025 and publish it under the authority of the Secretary-General, in order to allow a wider audience to become acquainted with its content. Publication of this document and the analysis and recommendations contained therein do not prejudge in any way the outcome of evaluations conducted as part of Romania's accession process to the OECD.

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The OECD review team thanks officials at: the Ministry of Health; the National Authority for Quality Management in Healthcare; the National Health Insurance House; the Ministry of Finance; the Agency for Medicines and Medical Devices of Romania; the National Institute of Public Health; the National Institute of Health Services Management; representatives of professional organisations and patient's organisations, as well as the OECD Accession team from the Ministry of Foreign Affairs.

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Acronyms and abbreviations

AMI	Acute myocardial infarction
AMR	Antimicrobial resistance
ANMCS	National Authority for Quality Management in Healthcare
COPD	Chronic obstructive pulmonary disease
CNAS	National Health Insurance House
DDDs	Defined daily doses
DHIHs	District health insurance houses
DPHAs	District public health authorities
DTP	Diphtheria, tetanus and pertussis
ECDC	European Centre for Disease Prevention and Control
EHR	Electronic health records
EU	European Union
GDP	Gross Domestic Product
GDPR	EU General Data Protection Regulation
GP	General practitioner
HAI	Healthcare-associated infection
HIS	Health information system
HSPA	Health system performance assessment
HTA	Health technology assessment
ICT	Information and Communication Technology
INMSS	National Institute of Health Services Management
INSP	National Institute of Public Health
IPC	Infection prevention and control
IT	Information Technology
LTC	Long-term care
MoH	Ministry of Health
NAMMDR	National Agency for Medicines and Medical Devices of Romania
NCDs	Non-communicable chronic diseases
NHIF	National Health Insurance Fund
NGOs	Non-governmental organisations
NRRP	National Recovery and Resilience Plan
OOP	Out-of-pocket payments
P4P	Pay-for-performance
RSHMs	Regional Health Services Masterplans
SHI	Social health insurance
TB	Tuberculosis
VHI	Voluntary health insurance
WHO	World Health Organization

Executive summary

Over the past two decades, life expectancy in Romania has increased by more than 5 years, reaching 76.4 years in 2023, while infant and maternal mortality have decreased. Despite this progress, health outcomes and performance remain relatively low compared to OECD countries, as reflected in OECD indicators on health status, risk factors for health, access, quality of care, and healthcare capacity and resources. Avoidable mortality in Romania is one of the highest compared to OECD countries, signalling persistent challenges in public health policies and in the healthcare system.

Conscious of these challenges, Romania has recently adopted a strategic vision for a more efficient and resilient health system, particularly with the National Health Strategy 2023-2030. The country has led key reforms aiming to address issues of fiscal sustainability, shortages in health professionals, and deficiencies in quality and safety. First, to streamline public spending on healthcare, Romania performed a health spending review in 2023 that served to draft the 2024 budget proposal. To enhance financial sustainability, Romania is phasing out contribution exemptions for certain workers, and it is expected to expand the National Health Insurance Fund's contributor base. Second, to address the significant health workforce emigration, Romania has substantially increased the salaries of health professionals working in the public hospital sector. Third, Romania is fostering patient-centred care and safely through the National Authority for Quality Management in Healthcare and greater patient engagement, but further steps are needed to ensure continuous quality improvement and extend focus beyond hospitals.

Despite these recent policy developments, Romania faces important challenges that need to be addressed. This review identifies three main broad areas for improvement.

First, Romania should step up efforts to improve health system efficiency, including cutting wasteful spending and addressing corruption and bribery. Indicators point to inefficiencies in Romania's health system: avoidable hospital admissions are above the OECD average (569 vs. 473 per 100 000 population), antibiotic prescriptions are among the highest (26 defined daily doses per 1 000 inhabitants vs. 16 in the OECD average), and informal payments to doctors are estimated to be three times the EU average (9% vs. 3%). Romania needs to intensify efforts to reduce wasteful spending and improve efficiency, by limiting unnecessary hospital use, improving care quality and continuity, promoting value-based prescribing, and developing health technology assessments to update the public benefits package. To address corruption and bribery, Romania has taken recent measures, including raising doctors' salaries, improving awareness among medical staff and patients, implementing a patient feedback system in public hospitals, and providing integrity-related training. Yet, better co-ordination, strengthened institutional capacity and sustained political high-level commitment are needed to ensure the full adoption of the National Anti-Corruption Strategy measures in the health sector.

Second, Romania should further strengthen primary care and prevention and leverage health data use, to achieve its objective for a more efficient, people-centred and resilient health system. The healthcare system remains hospital-centred, with hospital bed rate above the OECD average (7.3 versus 4.2 hospital beds per 1 000 inhabitants), and hospital services accounting for 44% of health spending (vs. 39% in the OECD average), while primary care accounts for just 9% (vs. 14%) in 2023. A shift toward primary and community-based care is needed, including transferring hospital beds to day care and long-

term care in regions identified in the Regional Health Services Masterplans, strengthening gatekeeping, and collaborating with health professionals and patients to ensure appropriate service use. Primary and secondary prevention must be strengthened. Preventable mortality and behavioural risk factors – tobacco, alcohol, overweight and obesity – exceed OECD averages. While screening and preventive activities are incentivised (e.g. the "riskogramme"), broader strategies addressing the social determinants of health through education, regulation and fiscal measures, are needed. Secondary prevention, such as cancer screening, is limited by the lack of nationwide population-based programmes. Romania is working on pilot population-based screenings, developing a national cancer registry, and using mobile caravans and health mediators to reach underserved populations. But additional funding is necessary to procure more diagnostic and treatment equipment and to train specialised staff for diagnosis. To strengthen crisis preparedness and response, which was highly challenged during the COVID-19 pandemic, Romania is improving emergency co-ordination, upgrading laboratory infrastructure, and implementing a National Strategy for Disaster Risk Reduction 2023-2035 to improve resilience to health and natural shocks.

Mental health disorders, the second leading cause of years lived with disability in Romania, remain underdiagnosed due to stigma and limited access. The mental health system relies heavily on institutional care and pharmacotherapy, while unmet needs for mental healthcare are comparatively high. While a 2024-2029 action plan aims to improve psychiatric hospital conditions and ensure dignity in care, a broader national mental health strategy, supported by adequate resources and political commitment, is needed to address mental health through a whole-of-society approach.

Health data remain fragmented and underused for research and public interest purposes. Electronic health records exist but their usage is limited to administrative and accounting purposes. Romania is currently working on a National Digital Health Strategy to improve the potential for health data use. The strategy will aim to improve data integration, governance, and interoperability, establish a National Agency for Digital Health for data management, and expand telemedicine.

Third, Romania should improve access to healthcare. Unmet needs for healthcare in Romania are high compared to European countries, mainly due to low population coverage and high cost-sharing for certain services. Workforce shortages and uneven regional distribution further restrict access. While recent salary increases curbed doctor migration to some extent, further efforts are needed to improve working conditions. Expanding community nursing and adopting task-sharing models could help relieve pressure particularly in rural areas, especially if paired with local government support for housing and education incentives. Telemedicine, introduced during the pandemic, has the potential to widen access, but the absence of a secure national platform limits its reach. Greater digitalisation could also help attract physicians to underserved regions. As a significant step forward in the development of a strategic vision for workforce planning and retention, the government launched the Multi-Annual Health Workforce Development Strategy 2022-2030.

1 Assessment and recommendations

This chapter summarises the in-depth assessment conducted as part of Romania's accession review and presents key recommendations to enhance the performance of the health system across critical dimensions, including sustainability, efficiency, quality, access, and resilience. Romania's health system has made notable progress, but health status and performance remain low relative to OECD countries. To be adequately prepared to meet the 21st century health challenges, Romania would need to sustain its efforts and accelerate the transition towards a more sustainable and resilient health system, specifically by reducing inefficiencies, cutting wasteful spending, strengthening primary care and prevention, and improving access to care.

Romania's population has been ageing and declining – especially after its accession to the European Union (EU) in 2007, which facilitated emigration, including among health professionals. Although the pace of decline has recently slowed, demographic trends continue to place significant pressure on the health system. As many OECD countries, Romania needs to adapt the health system to the needs of its ageing population – including the burden of chronic diseases and long-term care needs, while ensuring fiscal sustainability.

Population decline also poses risks to the financial stability of the social health insurance system by reducing the contributor base. Romania's social health insurance system is financed through mandatory social insurance contributions from working residents, making it sensitive to workforce emigration. Founded on the principle of solidarity, the system provides a comprehensive basic benefits package to 89% of the population as well as a minimum package to uninsured individuals.

At the same time, the Romanian Government faces a high fiscal deficit and has limited capacity to increase the public budget of the health sector, while relying on significant EU fundings to restore and modernise its health infrastructure and digital environment. The Romania's health system has also faced additional pressure from the inflow of over 3 million refugees crossing the country since Russia's war of aggression against Ukraine began, requiring addressing their health and humanitarian needs.

Conscious of these challenges, Romania has initiated a series of measures to enhance the fiscal sustainability of the health system. The country has demonstrated a clear commitment to shifting towards primary care and community services, as outlined in the National Health Strategy 2023-2030 and the Operational Health Programme 2021-2027. In addition, efforts are made to strengthen prevention and screening within primary care settings, supported by investments of the National Recovery and Resilience Plan (NRRP). This transition aims to build a more resilient and efficient and sustainable health system capable of meeting the 21st century health challenges.

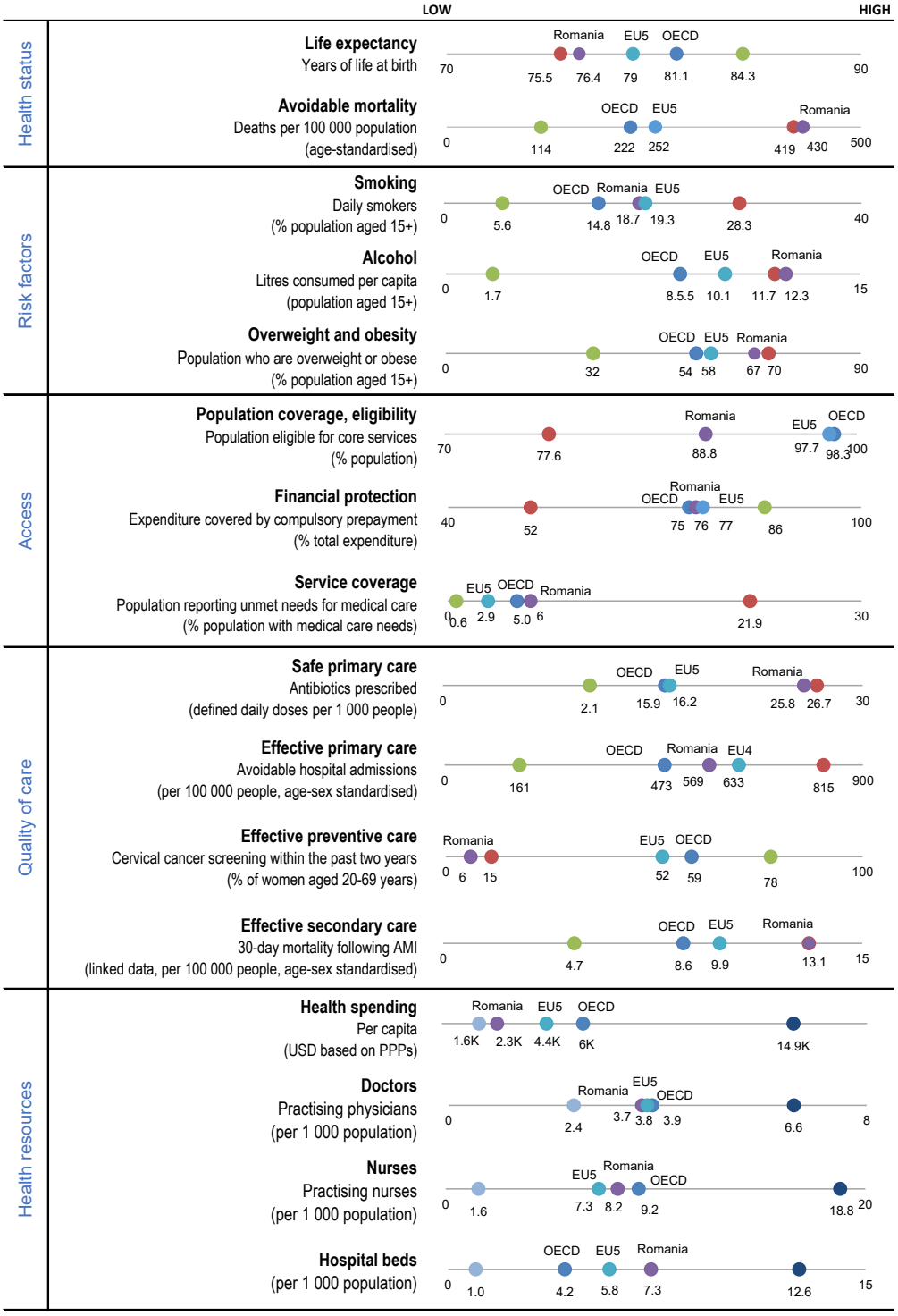
Romania became an OECD accession candidate in 2022. As part of the accession process, the OECD conducted a review of the Romania's health system, policies and practices. This chapter summarises the in-depth assessment and formulates recommendations to enhance the performance of the health system across critical dimensions, including sustainability, efficiency, resilience, quality and access. It focusses on three priority areas: increasing efficiency in the health system, strengthening primary care and prevention and leveraging health data use to enhance resilience, and improving access to healthcare.

1.1. Life expectancy in Romania has significantly improved, but health outcomes remain poor with high levels of behavioural risk factors

Life expectancy in Romania has increased by more than 5 years over the last two decades, reaching 76.4 years in 2023. Infant mortality was reduced by 68%, and maternal mortality by about 40% over the last two decades. Despite this progress, health outcomes and performance remain relatively low compared to OECD countries and five European OECD countries with comparable income level in the same region (Czechia, Hungary, Poland, the Slovak Republic and Slovenia, "EU5" here after), as reflected in OECD indicators on health status, risk factors for health, access, quality of care, and healthcare capacity and resources (Figure 1.1).

Avoidable mortality in Romania is one of the highest compared to OECD countries, signalling persistent challenges in public health policies and in the healthcare system. Almost a third of all mortality in Romania was attributable to behavioural risk factors which are preventable. Smoking, drinking, obesity and overweight rates are well above the OECD averages and the EU5 averages – except for the smoking rate which is close to the average of neighbouring EU5 countries (Figure 1.1). To address key behavioural risk factors for health, Romania has implemented some good practices but broader and more robust reforms in public health and disease prevention are still required.

Figure 1.1. Core set of indicators on health and health system, 2023 (or latest year available)



Note: A green dot stands for the best performing OECD country, whereas a red dot stands for the least performing OECD country. The exception of the colour-coded groups is for health resources, where indicators cannot be classified as showing better or worse performance. For this reason, lighter and darker shades of blue signal whether a country has less or more resources than the OECD average. The EU5 average is calculated across five EU neighbouring countries (Czechia, Hungary, Poland, the Slovak Republic, and Slovenia).

Source: OECD Health Statistics 2025, Eurostat (2025[1]), *Self-reported unmet needs for medical examination due to financial reasons, long waiting list or distance by sex, age and risk of poverty threshold - % of the persons having the same needs*, https://doi.org/10.2908/HLTH_SILC_08B.

1.2. Health budgeting and payment models are advancing, but tackling wasteful spending and improving efficiency and transparency require further effort

Romania has improved budgeting practices in the health sector with the aim of increasing the efficiency of health spending. In 2023, Romania's Ministry of Finance collaborated with the Ministry of Health and the National Health Insurance House (CNAS) to carry out a **health spending review**, to inform the 2024 budget proposal and streamline public healthcare expenditure. In addition, in 2023, Romania has introduced a **new framework contract** for healthcare services payment models between CNAS, district health insurance houses (DHIH) and health providers. This new framework contract aims to incorporate performance standards into the budgeting process, making CNAS and DHIH more active purchasers of healthcare services.

Despite these efforts, Romania needs to step up its actions to **ensure financial sustainability** to meet the growing demand of healthcare of an ageing population. Romania would need to prioritise spending in areas where improvements in health outcomes can be expected to be the highest. Key priority areas include, for example, reducing avoidable hospital admission, decreasing reliance on hospital care, addressing corruption and bribery, as further detailed below.

OECD indicators suggest persistent inefficiencies in the Romanian health system. For instance, Romania has a high rate of hospital admission for diabetes (228 per 100 000 population versus 111 in the OECD average), which is avoidable with effective prevention and treatment in primary care. The volume of prescribed antibiotics in Romania is very high, above the OECD average (26 versus 16 defined daily doses per 1 000 inhabitants) and the EU5 average (16 defined daily doses) (Figure 1.1).

Romania is making effort to increase efficiency. For example, masterplans have been developed – with support of Europeans funds – to assess regional healthcare needs and provider capacity, enabling a more rational allocation of resources. Measures to strengthen primary and community care include the establishment of integrated community centres across the territory. A recent noteworthy reform introduces the monitoring of antibiotic dispensing in emergency situations through the collection of patient and pharmacy data, aiming to limit misuse and prevent repeated unregulated dispensing. But further efforts are needed to **cut wasteful spending and make further efficiency gains**. This entails strategies such as increasing value for money in medicine prescribing, better targeting the use of resource-intensive hospital care by improving care co-ordination and shifting chronic disease management (e.g. diabetes) to lower levels of care, thereby reducing reliance on hospital services. Others can also include strengthening and expanding care quality measurement and policies, and making greater use of health technology assessment to more clearly define the goods and services covered by the public benefits package.

Corruption and bribery have been a long-standing issue in the Romanian health system. Romania has taken recent measures to address these issues, including increasing doctors' salaries to reduce incentives for informal payments, raising awareness among medical staff and patients, implementing a patient feedback system in public hospitals, and providing integrity-related training, with the support of NRRP. The country would need to further strengthen the transparency and integrity management in the health sector. In particular, the lack of co-ordination, low institutional capacity and political engagement has hindered the adoption and implementation of the National Anti-Corruption Strategy measures in the health sector, underscoring the need for further action.

To strengthen the fiscal sustainability of the health system, Romania is **raising the National Health Insurance Fund revenues** by increasing the number of people paying contributions through payroll taxes. Only one-third of insured individuals paid wage-based contributions in 2023, as many groups – including children, older adults, people with disabilities, certain patient groups, and workers in specific sectors – were exempt from them. Since 2023, Romania has begun phasing out some of these exemptions, starting with workers in agriculture, construction, and the food industry. Additional reforms introduced in 2025 further reduced exemptions for other groups, a move expected to broaden the contributor base in the coming years.

Romania is also envisaging **leveraging the potential of private voluntary health insurance** (VHI). Today, the contribution of VHI as a share of total health spending is marginal, yet about 700 000 inhabitants (3.6% of the population) are covered through company health insurance plan. While VHI creates opportunities for increasing patient choice and stimulating service capacity, it can also create inequities in access to healthcare based on insurance status and incentives for providers practising in both the public and the private sector to prioritise care for privately insured patients. It is thus essential to define a regulatory framework for the expansion of VHI to minimise the risks and maximise the benefits.

1.3. Romania aims for an efficient, people-centred, and resilient health system, but primary care, prevention and health data use need further strengthening

Romania has initiated the development of a strategic vision for a more efficient, people-centred and resilient health system, particularly with the adoption of the National Health Strategy 2023-2030. Continued efforts would need to focus on enhancing quality of services, strengthening primary care, improving prevention of non-communicable chronic diseases (NCDs), pandemic preparedness and response, building an integrated mental health system, and modernising the health information system – as further detailed below.

Romania is actively developing a strong culture of **care quality and patient safety**, with an initial focus on hospitals. The National Authority for Quality Management in Healthcare (ANMCS) was created in 2015, and patient engagement was increased, for instance through patients' participation in ethics committees in each hospital and in the National Patient Safety Council. While most effort has focussed on hospital's accreditation and the setting of hospital standards, further actions are needed to establish a system fostering continuous quality improvement and performance assessment that focusses on sectors outside the hospital.

Strengthening primary care is essential to build a more resilient health system and respond to epidemiological shifts that are occurring due to ageing population and the increased prevalence of diseases. Romania has taken some initiatives to boost primary and community care settings, but its healthcare system still heavily relies on hospital services. The hospital bed rate is above the OECD average (7.3 versus 4.2 hospital beds per 1 000 inhabitants in 2023) (Figure 1.1). Patients tend to directly go to hospitals bypassing lower levels of care, while up to 72% of emergency department visits could be managed within primary care settings according to researchers (Lăcătuș et al., 2024[2]). Hospital services account for 44% of the expenditure (vs. 39% in the OECD average, in 2023), while primary care accounts for just 9% (vs. 14% in the OECD average). Romania needs to reinforce its efforts to shift the system toward primary care and community settings, for instance by transforming acute hospital beds into day care and long-term care in regions identified in the Regional Health Services Masterplans, strengthening the gatekeeping system, and reinforcing incentives for health professionals and patients for appropriate use of hospital services.

Despite efforts made to improve infection prevention and control, **public health policy targeting NCDs** and associated risk factors is insufficient. Preventable mortality rate is above the OECD average (251 vs. 145 deaths per 100 000 population), which is also reflected in high levels of behavioural risk factors such as tobacco and alcohol consumption (Figure 1.1). The leading cause of death in Romania is cardiovascular diseases, followed by cancers. Romania has established a "riskogramme" screening questionnaire and other preventive activities in primary care settings, incentivised through performance-based payments. But more efforts are needed to implement a more comprehensive prevention strategy addressing the social determinants of health, including policy initiatives beyond the health sector, such as education, regulation and fiscal measures.

Secondary prevention also needs to be strengthened. Screening rates for cervical, breast and colorectal cancers are significantly lower than the OECD averages (Figure 1.1), mainly due to the lack of effective population-based programmes. Romania is actively participating in EU-funded pilot projects to develop population-based screening and is working on a national cancer registry (OECD, 2023[3]). To reach out to the disadvantaged populations in underserved areas, the country has also acquired ten mobile caravans through the NRRP funding to deliver cervical and breast cancer screenings. Further, it has initiated the use of health mediators to bridge communication between the health system and the Roma population, although this initiative has yet to be expanded. However, additional funding is necessary to procure more diagnostic and treatment equipment and to train staff for diagnosis.

Romania's capacity for **crisis preparedness and response** was highly challenged during the COVID-19 pandemic. Mortality rate from COVID-19 was about 12% higher than the EU average (OECD/European Observatory on Health Systems and Policies, 2021[4]). The response to the COVID-19 crisis was suboptimal, underscoring the necessity to better prepare for future public health emergencies. Romania has also recently experienced a measles epidemic, exacerbated by declining childhood vaccination coverage. In addition to health outbreaks, the country is exposed to several potential public health risks. Natural and climate-related disasters pose a considerable threat, with three in four inhabitants residing in areas vulnerable to earthquakes and nearly half exposed to heat waves. Russia's war of aggression against Ukraine and the inflow of people arriving from Ukraine are also placing considerable strain on the health system. Romania is enhancing its crisis preparedness and response capacities, focussing on strengthening emergency co-ordination and upgrading laboratory infrastructure. Romania has also adopted a multi-sectoral and comprehensive National Strategy for Disaster Risk Reduction 2023-2035 to improve the resilience to various disasters such as earthquakes, forest fires, and epidemics.

Mental health disorders are the second leading cause of years lived with disability in Romania, but the prevalence of mental health disorders was substantially lower than in OECD countries in 2021 due to stigma and limited access to diagnosis. Unmet needs for mental healthcare in Romania are higher than in European OECD countries, and suicide rates rose in adolescents and in the older population. The mental health system relies heavily on institutional care and pharmacotherapy, with allegations of ill-treatment in three psychiatric hospitals and a call for urgent actions made from the Council of Europe (Council of Europe, 2023[5]). In response, Romania set up an inter-institutional working group in 2023 and developed a 2024-2029 action plan to improve psychiatric hospital conditions and ensure that patients are treated with dignity. But beyond this action plan, a broader national mental health strategy, supported by adequate resources and strong political commitment, is essential to address mental health through a whole-of-society approach.

Strengthening health data system and governance is vital for a more efficient, people-centred and resilient health system. Romania's capacity to share internationally comparable data on health is of a high standard, also compared to OECD countries. However, despite the routine collection of health data, the national health information system remains highly fragmented, with significant duplication in data collection that undermines overall data quality. Romania has legally introduced electronic health records, but their usage is currently limited to administrative and accounting purposes, and not for supporting clinical optimisation and research. Different IT systems operate in several institutions, and the absence of an anonymised unique patient identifier limits data linkage and system interoperability. While Romania has established legislation and policies for health data governance, in practice, personal health data are not yet effectively accessible and used for research and public interest purposes. In addition, staff training on privacy protection and digital security responsibilities is lacking. Romania is currently working on a National Digital Health Strategy to improve the potential for health data use. This strategy will aim to establish the National Agency for Digital Health, which will oversee data pooling, analysis and dissemination, the setting of data standards and development of a telemedicine system, among others.

1.4. Despite remuneration reform to retain the health workforce, Romania faces challenges in meeting the healthcare needs of its population

Romania is facing **significant challenges in meeting the medical needs** of its population. Unmet needs for medical care in Romania are high compared to OECD and EU5 countries (Figure 1.1), mainly due to low population coverage and high cost-sharing for certain services. Specifically, 11% of the population is uninsured (compared to an OECD average of 2%), and the share of out-of-pocket payments is high and above the OECD average (23% vs. 19% of health expenditure), resulting in financial barriers to access to healthcare and putting less affluent families at risk of financial hardship (OECD/European Observatory on Health Systems and Policies, 2025[6]).

Shortages in health professionals and uneven distribution on the territory also hinder access to healthcare services. Many nurses and doctors have migrated to other European countries, a trend that has accelerated with Romania's accession to the EU in 2007. In response, Romania has introduced impressive salary increases which have reportedly curbed the emigration to some extent. The salaries of doctors and nurses working in public hospitals have increased by up to 160% in 2018 (European Observatory on Health Systems and Policies, 2018[7]). This was complemented by the increase and reconfiguration of remuneration in ambulatory care. Over the last decade, Romania's workforce capacity has also remarkably grown thanks to increased training capacity, with the physician number reaching the OECD average but the nursing capacity still below the OECD average in 2023 (Figure 1.1). Nevertheless, almost 60% of doctors under age 35 still had an intention to leave the country in 2023, posing a major challenge in meeting the growing healthcare demand. The most often cited reasons for emigration are poor working conditions, including inadequate health infrastructure, signalling the need to go beyond salary improvements and focus efforts on improving working conditions and other underlying factors.

Romania also faces important geographical imbalances in healthcare provision. In 2023, more than half of the Romanian population were living in rural areas, where access to healthcare and basic needs is reportedly more limited than in urban areas. Healthcare resources remain heavily concentrated in cities: more than 90% of the total number of hospitals and independent specialist clinics, and 60% of independent general practice offices were located in urban areas in 2024 (National Institute of Statistics, 2024[8]). This urban-rural divide is further compounded by the country's large size and the presence of remote, hard-to-reach regions – especially in the Carpathian Mountains and during winter snowfalls. The underserved population includes the Roma communities who represent about 9% of the total population and are primarily located in rural and underserved regions (OECD, 2022[9]).

To close the gap in rural territories, Romania aims to expand community nursing capacity by training 2 000 additional community nurses to work in community health centres. Considering new roles – or expanding existing roles – of health professionals, including nurses, to share some of the tasks would help addressing limited supply of doctors in these regions. Authorities could also develop collaborations with local governments to improve both working and living conditions, such as offering support for housing or education in return for public service. Telemedicine is another lever to improve access to care in underserved areas, which Romania has legislated and started to use during the pandemic, but a dedicated secure telemedicine platform has yet to be established. Digitalisation can additionally attract physicians to work in underserved areas by improving working conditions. For instance, the Prahova region has provided digitalised administrative processes and accounting assistance for opening practices, an exemplary initiative to improve doctors' working conditions. As a significant step forward in the development of a strategic vision for workforce planning and retention, the government launched the Multi-Annual Health Workforce Development Strategy 2022-2030.

Box 1.1 highlights policy areas where Romania could target its policy efforts to improve the health system performance, strengthen resilience, and bring it closer to OECD standards and best practices.

Box 1.1. Policy recommendations

Romania can consider the following recommendations as part of its strategy to improve the Romanian health system performance and strengthen its sustainability and resilience, to be further aligned with OECD standards and best practices.

Improve access and quality

- Work towards achieving effective universal health coverage, by extending coverage to uninsured groups such as people without identity documents or not registered in the social security system, informal and self-employed workers. Reassess cost-sharing mechanisms to improve access to care and reduce unmet needs for medical care.
- Improve access to care in rural and underserved areas, by increasing the provision and use of community centres and out-of-hours healthcare services. Scale up the development of "integrated community centres" backed up with sufficient laboratory and equipment capacity. Continue promoting teleconsultation and mobile health services to better reach remote populations.
- Attract health professionals to work in rural and underserved regions by developing collaborations with local authorities to improve both working and living conditions, such as offering support for housing or education, and/or offering digitalised administrative and accounting assistance for new opening practices. Consider advanced roles for community nurses, such as through task sharing, to alleviate rural doctor shortages. Retain community nurses by improving their pay and working conditions.
- Invest in and operationalise a national workforce planning based on population needs and on regional distribution of healthcare workers, as outlined in the Multi-Annual Health Workforce Development Strategy for 2022-2030.
- Foster continuous quality improvement at the system level. Consider quality management beyond the accreditation of hospital facilities by strengthening post-accreditation monitoring mechanisms and incorporating continuous quality assessment, while extending these efforts to ambulatory care. Consider introducing payment systems that reward care quality in both hospital and primary care, such as add-on payments and bundled payments to encourage care co-ordination and effective and efficient management of chronic diseases.
- Develop population-based screening programmes for cervical, breast and colorectal cancers. Train specialised staff for diagnosis and procure more diagnostic and treatment equipment for cancer care.

Strengthening efficiency, fiscal sustainability and transparency

- Strengthen the role of CNAS as an active purchaser of care, by introducing standards for performance as part of budgeting process. This will result in greater consideration to the creation of incentives for performance in healthcare provision, with the introduction of further performance-based payment schemes for providers.
- Strengthen primary healthcare, by improving the gatekeeping system and collaborating with health professionals and patients to ensure an appropriate use of services. Provide a greater role for family physicians in early detection, screening and management of NCDs. Encourage the development of home-based programmes and other delivery arrangements to reduce unnecessary hospitalisations. Strengthen patient pathways and co-ordination across different care levels by harnessing multidisciplinary teams or nurse co-ordinators for NCD management and improving the flows of health information across the care pathway.

- Operationalise measures to implement the Regional Health Services Masterplans, such as transferring hospital beds to day care and long-term care -or reducing them- in the regions identified with low bed occupancy.
- Utilise health technology assessment (HTA) to better identify benefits to be covered. Expand the use of HTA to high-cost medical technologies, diagnostics, and surgical procedures.
- Increase value for money in medicine prescribing and use. Increase biosimilars and generics prescribing by applying a series of measures, such as patient and doctor awareness and education, guidance to doctors, monitoring prescriptions, and reaching out doctors with non-compliant prescribing behaviours, that have shown to be successful.
- Improving integrity in the health system by expanding the scope of the national anti-corruption strategy based on an analysis of risks in the health sector. Such an analysis could support further reforms, such as developing a comprehensive anti-corruption policy for the health sector, incorporating integrity as a component of institutional performance, and implementing monitoring mechanisms for key processes such as allocation funds, appointments and medical input procurement.

Improving resilience and preparedness

- Increase children's vaccination coverage. Address vaccine hesitancy by boosting health literacy. Address misinformation by introducing effective national communication campaigns through traditional and social media. Roll out vaccination programmes to reach those living in rural areas and the uninsured populations. These strategies must be implemented at national, regional and local levels to address public health concerns and vaccine hesitancy effectively.
- Strengthen actions against antimicrobial resistance (AMR) by incorporating the financial provisions for the implementation of the AMR action plan into the national action plans and budgets. Ensure that national guidelines are implemented and that data on antimicrobial use is systematically fed back to prescribers.
- Reinforce primary prevention of NCDs by addressing behavioural risk factors for health, such as smoking and harmful alcohol use. Implementing policy measures beyond the health sector, such as education, regulation and fiscal measures. Consider raising tax share of tobacco products to reach the WHO recommended level, implementing tobacco plain packaging, introducing alcohol minimum unit pricing, limiting alcohol availability, and strengthening marketing to children.
- Speed up the implementation of measures to better prepare for and respond to future public health emergencies, by upgrading laboratory and testing infrastructures, and strengthening emergency co-ordinating structures at national and county levels.

Improving mental health and integrated policies

- Develop a national roadmap for mental health by engaging in with patient organisations and non-governmental organisations with a particular focus on stigma, protection of vulnerable groups including the Roma population, mental health literacy, suicide in young and older age populations, and hospital conditions.
- Expand the provision of mental health services at primary care level, particularly for early detection and intervention of mild- to moderate- mental health conditions.
- Improve the capacity to implement education and employment policies to achieve a whole-of-society approach for a better integration of people with mental health conditions without discrimination.

Strengthening health data infrastructure and governance

- Adopt and implement the national digital health strategy to encourage the availability and use of personal health data for public interest purposes. Accelerate the creation of the National Agency for Digital Health.
- Accelerate the functioning of disease registry datasets at the national level (e.g. cancer and diabetes) to improve care quality and benchmark performance against national guidelines. Establish standardised data collection mechanisms on formal long-term care and patient experiences.
- Introduce data de-identification policies with an agreed unique patient identifier nationwide, to facilitate secondary data usage. Build capacity and training for healthcare workers, policymakers and the public in using personal health data.
- Develop an integrated secure digital health and telemedicine platform.
- Encourage the effective use of electronic health records and telemedicine. This is important to improve care co-ordination and quality.

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2 Overview of Romania's health system

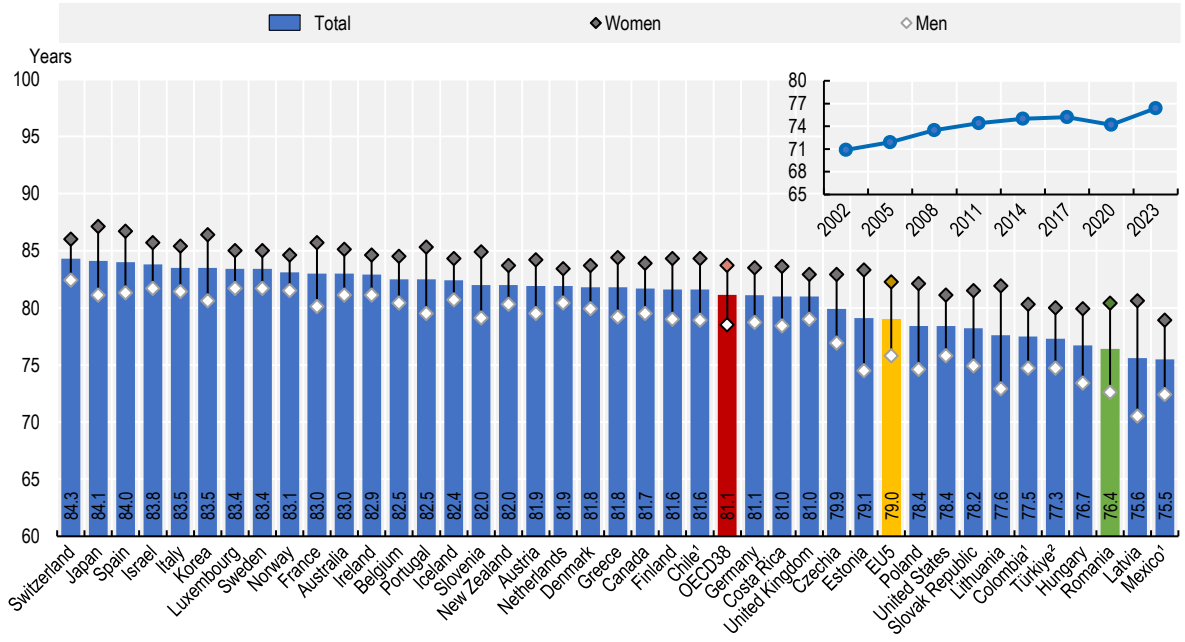
This chapter provides an overview of Romania's health system, examining its performance, recent policy reforms, and opportunities to enhance efficiency, transparency and data-driven policymaking. The first section analyses the health status and healthcare needs of the Romanian population, addressing both physical and mental health conditions. The second section explores the structure and governance of the health system, outlining key challenges and policy efforts aimed at strengthening primary and community healthcare and addressing corruption and bribery in the health sector. The third section examines the health data infrastructure and governance supporting healthcare delivery, highlighting challenges such as data fragmentation, limited interoperability and underuse of health data for research and public interest purposes.

2.1. Health status and healthcare needs

2.1.1. Life expectancy in Romania has progressed over the past two decades, but it is still relatively low compared to OECD countries

Over the last two decades, life expectancy in Romania has increased remarkably by 5.4 years from 71.0 in 2003 to 76.4 years in 2023, reaching 80.4 years for women and 72.6 years for men. During the COVID-19 pandemic, life expectancy fell more than the OECD average (reduction by 2.8 years versus 0.7 years between 2019 and 2021), which partly wiped out the gains in life expectancy from the previous decades. But life expectancy started to bounce back in 2022 and improved further in the following years. Despite the post-pandemic improvement, life expectancy in Romania remains relatively low compared to the OECD average (81.1), but close to the average (79.0) of five European OECD countries with comparable income level in the same region[1] (Czechia, Hungary, Poland, the Slovak Republic and Slovenia, "neighbouring EU5" hereafter) (Figure 2.1). The difference was greater than seven years compared to top performing countries, Switzerland and Japan.

Figure 2.1. Life expectancy at birth is low compared to OECD countries, despite the remarkable progress made in the last two decades



Note: Data refer to 2023 or the nearest year available. 1. 2024 data. 2. 2022 data. The top-right graph shows the trend of life expectancy in Romania over time.
Source: OECD Health Statistics 2025.

2.1.2. Romania's population has declined considerably in the past decades, compounded with the ageing population

Romania's population has been declining for more than a decade, though recent trends show signs of stabilisation. Since Romania's accession to the European Union (EU) in 2007, the population decreased by 10%, from 21.1 million to just above 19 million in 2024. However, this decline has slowed since 2022 due to lower emigration, increased immigration following Russia's war of aggression against Ukraine, and relatively high fertility rates. Romania's fertility rate, which had declined consistently through the 2000s,

rebounded to 1.8 in 2017 and remained stable until 2022, before dropping to 1.5 in 2023 – still the fifth highest in the EU (Eurostat, 2025[1]). Yet even these relatively high fertility rates have been insufficient to offset overall population loss.

The elderly population has been on the rise, with the share of people aged 65 and over increasing from 16.3% in 2013 to 19.7% in 2023. This is projected to increase further to 30.6% by 2050 (Eurostat, 2023[2]). As more people live longer, the burden of chronic diseases and the demand for long-term care (LTC) will rise. The population size is also expected to decline in the next ten years, although at a slower rate, reaching around 18.1 million by 2030. Like many OECD countries, Romania needs to adapt the health system to the needs of its ageing population, while ensuring the fiscal sustainability of the health system. The declining population poses a risk to the financial stability, as the pool of tax revenues may potentially shrink.

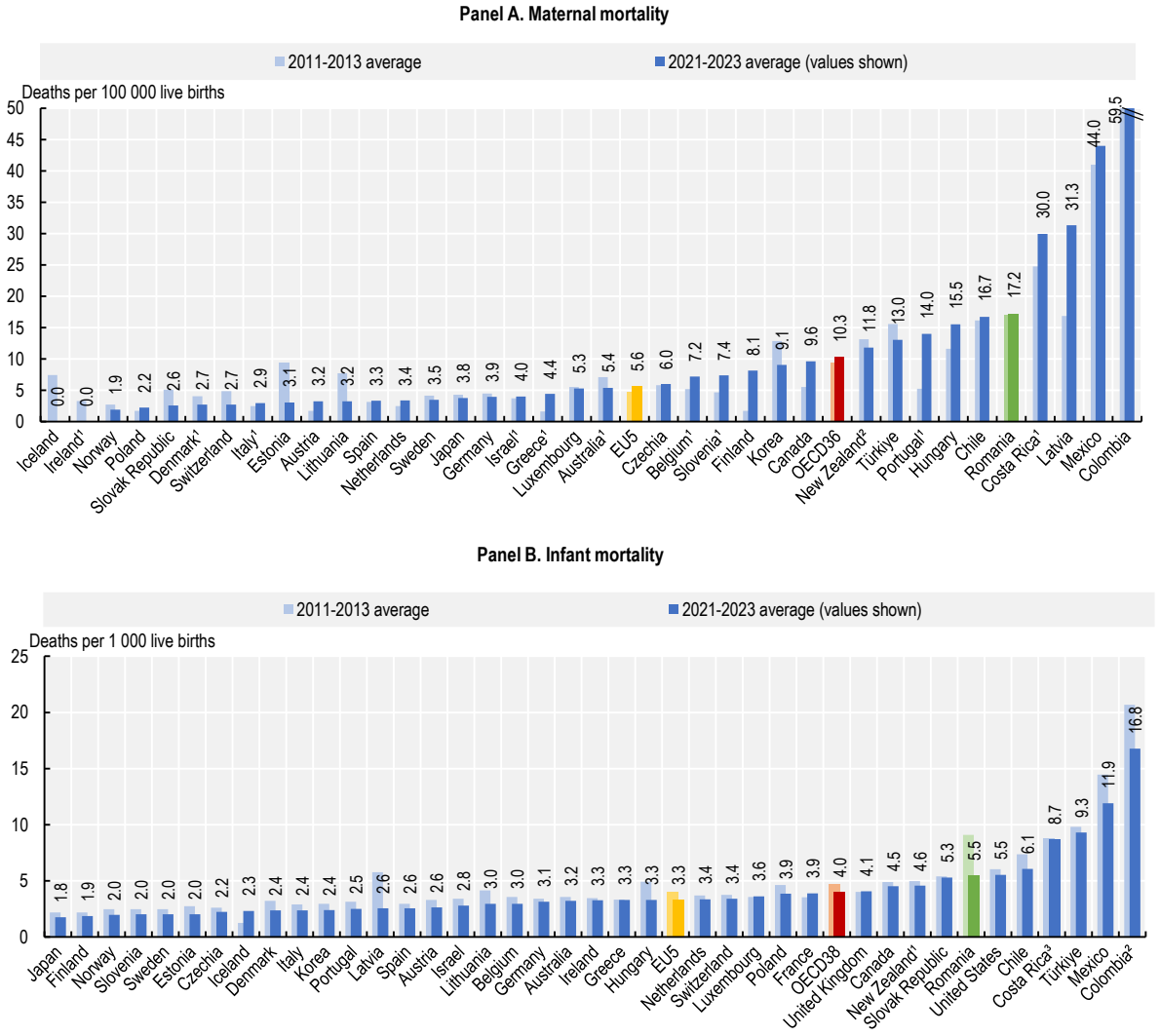
In 2023, more than half (54%) of the Romanian population were living in rural areas, where access to healthcare and basic needs is reportedly more limited than in urban areas (OECD, 2025[3]). The country is large with hard-to-reach areas where geographical and meteorological constraints in winter hamper timely and effective interventions. This underserved population includes the Roma communities – the largest minority group in Europe – that represent about 9% of the total population, and they are primarily located in rural and underserved regions (OECD, 2022[4]). Limited access to care in rural regions and by vulnerable populations are one of the longstanding issues encountered in the Romanian healthcare, which the country aims to address mainly through improving logistic and workforce capacity (see Section 4.2 in Chapter 4).

2.1.3. Romania has made progress in maternal and infant mortality over the past two decades, but there is still room for improvement

Maternal deaths during pregnancy or childbirth in Romania have seen an improvement in the past decades. Maternal mortality rate fell (by about 40%) from 29.0 deaths per 100 000 live births in 2001-2003 to 17.1 deaths in 2011-2013, and then stabilising at 17.2 in 2021-2023. Yet, it remains above the OECD average and more than three times higher than the neighbouring EU5 average (Figure 2.2 Panel A). Likewise, infant mortality has seen a substantial decline (by 68%) over the last decades but remains significantly above the OECD average. Infant mortality rate dropped from 17.5 deaths per 1 000 live births in 2001-2003 to 9.1 deaths in 2011-2013, down to 5.5 deaths in 2021-2023 (Figure 2.2 Panel B).

High infant and maternal mortality rates partly reflect issues with access to effective primary care and emergency care, particularly in hard-to-reach areas that suffer from geographical and meteorological constraints. In some regions, adverse weather conditions in winter cause delays in response time, as access to emergency care is only possible by emergency helicopter, ultimately leading to high infant mortality rates (AHEAD, 2022[5]). Romania is currently investing in new neonatal intensive care units and modernising existing ones to curb high infant mortality rates. With the National Recovery and Resilience Plan (NRRP) funding, the country will purchase equipment for 12 mobile neonatal intensive care units, 200 current and additional beds, and establish eight regional training centres for critical neonatal patients. However, the country needs to complement these strategies by improving access to emergency care, particularly with ambulance services in regions where geographical and meteorological constraints hamper effective and timely intervention. In addition, reproductive health programmes and services, prenatal education, pregnancy monitoring and early child development must be improved.

Figure 2.2. Maternal and infant mortality remain above OECD and EU5 averages



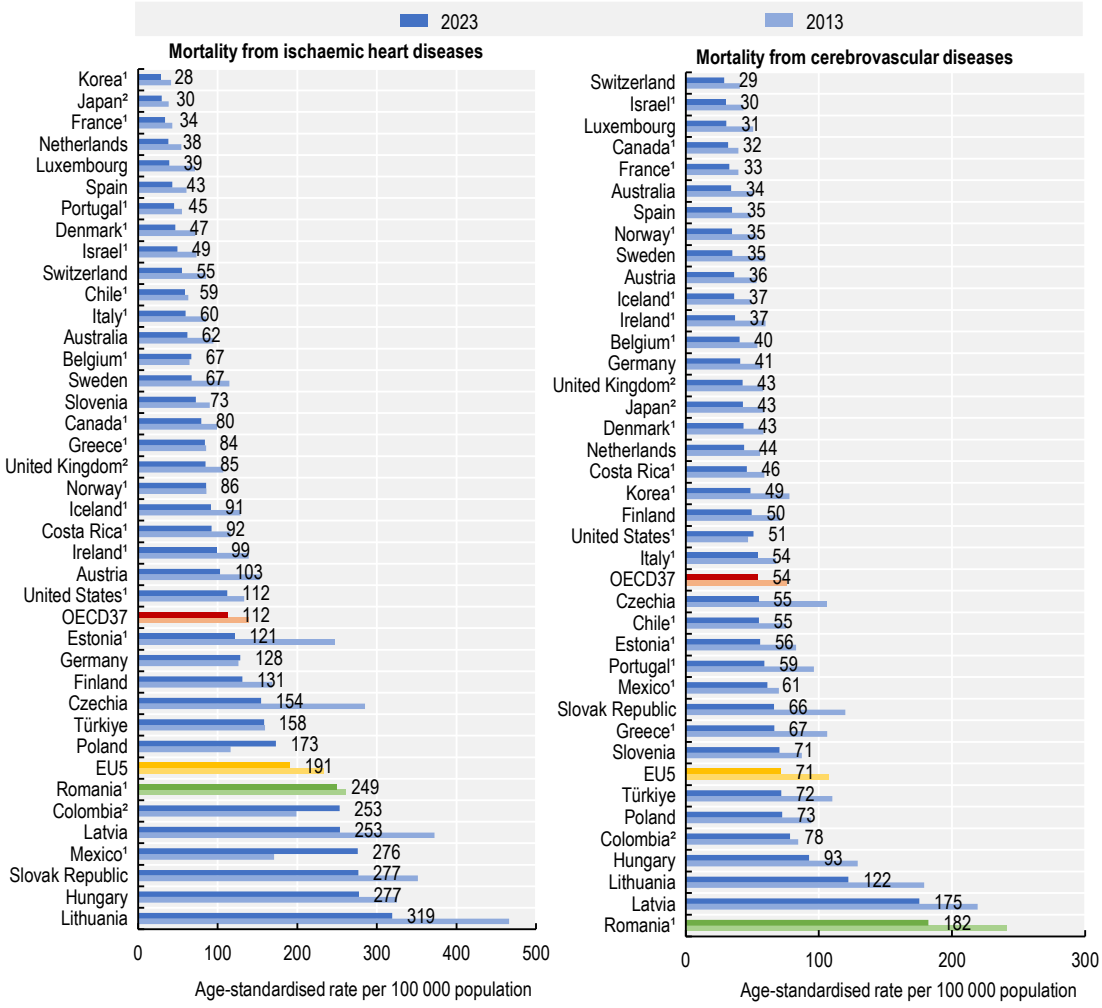
Notes: For Panel A: 1. Latest data from 2020-2022. 2. Latest data from 2018-2020. For Panel B: 1. Latest data for 2018-2022 2. Latest data for 2019-2021. 3. Latest data for 2020-2022.

Source: OECD (2025[6]), *Health at a Glance 2025: OECD Indicators*, https://doi.org/10.1787/8f9e3f98-en.

2.1.4. The leading causes of death are cardiovascular diseases and cancer

Ischaemic heart diseases were the leading cause of mortality in 2022 and represented about 19% of all mortality cases (OECD/European Observatory on Health Systems and Policies, 2025[7]). This was followed by cancer (17%) and stroke (13%). Lung cancer was the most frequent cause of mortality among cancer sites (see Section 3.2 in Chapter 3). Mortality due to ischaemic and cerebrovascular diseases was comparably higher than in most OECD countries, signalling issues in acute care provision and intervention (Figure 2.3).

Figure 2.3. Mortality due to ischaemic and cerebrovascular diseases was comparably higher in Romania than most OECD countries



1. 2022 data. 2. 2021 data.
Source: OECD (2025[6]), *Health at a Glance 2025: OECD Indicators*, https://doi.org/10.1787/8f9e3f98-en.

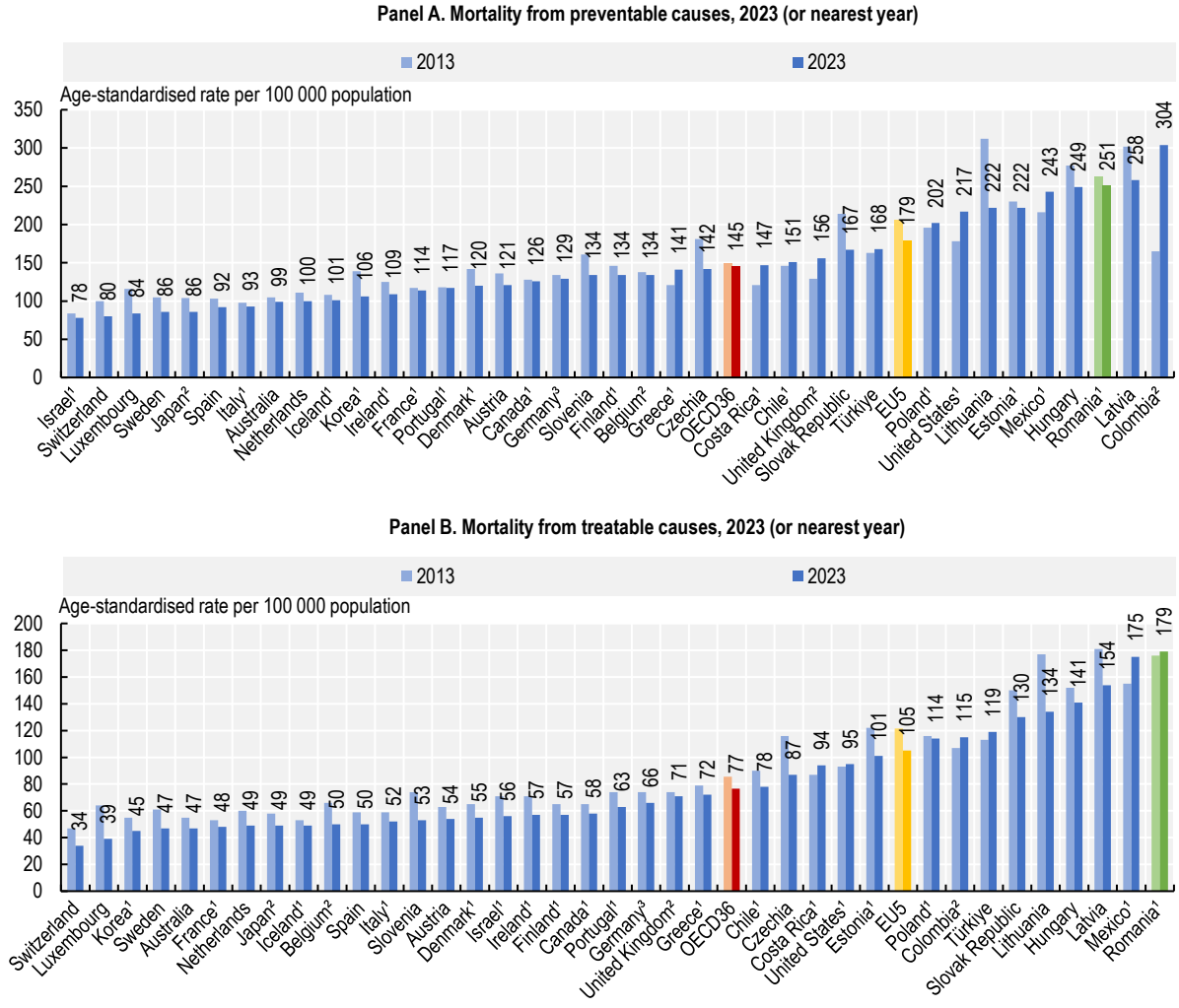
To address the persistent gaps in cardiovascular outcomes, the government adopted the 2024-2030 National Strategy to Fight Cardiovascular and Cerebrovascular Diseases, which prioritises prevention, early detection, and improved care pathways. Recent policy steps, such as the adoption of the Stroke Action Plan for Europe and expansion of the national acute stroke programme (including a new interventional registry), aim to streamline emergency pathways and improve referral to rehabilitation services, but their impact remains to be seen.

2.1.5. High avoidable mortality and associated risk factors call for better health infrastructure and public health policies

Romania has one of the highest rates of avoidable mortality compared to OECD countries, signalling persistent challenges in public health and the healthcare system. Mortality from preventable causes – which can be avoided through effective public health and primary prevention strategies – was equal to

251 deaths per 100 000 population, above the OECD average of 145 deaths and the neighbouring EU5 average of 179 deaths (Figure 2.4 Panel A). Similarly, mortality from treatable causes – which can be avoided through healthcare interventions, including screening and treatment – was the highest among OECD countries, with 179 deaths per 100 000 population (Figure 2.4 Panel B). This clearly highlights that there is room for improving the effectiveness and timeliness of healthcare delivery. Romania aims to address these deficiencies by modernising the outdated healthcare infrastructure and by investing in medical equipment and upgrading healthcare facilities through NRRP (see Section 2.2).

Figure 2.4. Romania had higher avoidable mortality rates than most OECD countries



Note: For Panel A: 1. 2020 data. 2. 2021 data. 3. 2020 data. For Panel B: 1. 2022 data. 2. 2021 data. 3. 2020 data.
Source: OECD (2025[6]), *Health at a Glance 2025: OECD Indicators*, https://doi.org/10.1787/8f9e3f98-en, based on WHO Mortality Database.

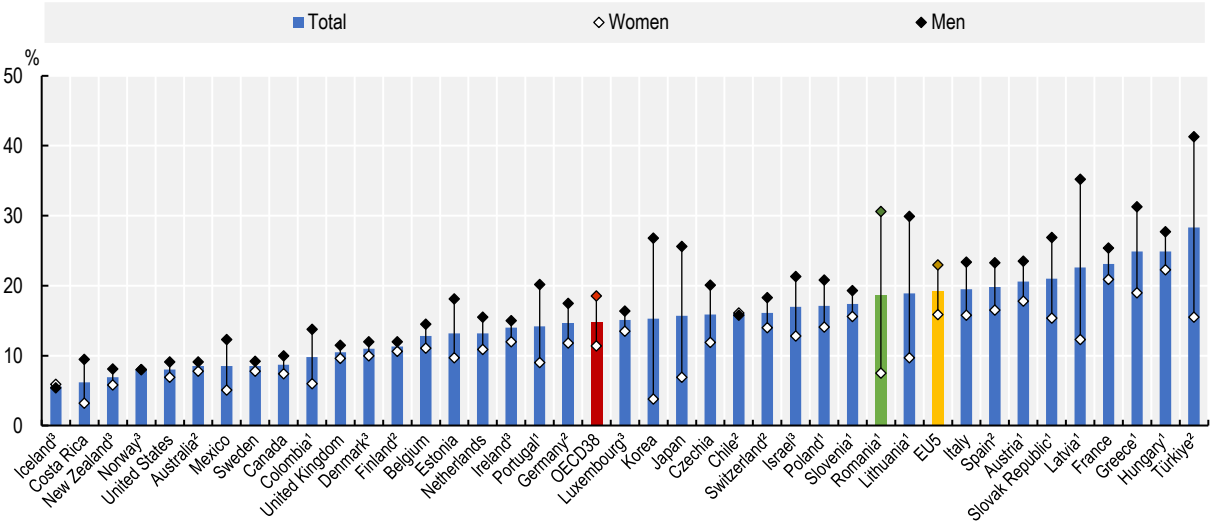
In 2021, 29% all mortality in Romania was attributable to behavioural risk factors such as dietary risks, physical inactivity, smoking and alcohol consumption. Dietary risks accounted for 16% of all deaths and exceeded the OECD average (10%), reflecting poor diet habits in the country (OECD/European Observatory on Health Systems and Policies, 2025[7]). The share of adult Romanians consuming at least five portions of fruit and vegetables per day is among the lowest compared to OECD countries, with only

around 40%. Similarly, only one in five Romanians engaged in physical activity more than three times per week, among the lowest in EU countries.

In 2019 (latest year with available data), more than two-thirds (67%) of Romanian adults were considered overweight or obese, compared to the OECD average of 54%. Adolescent overweight rates were also higher than in OECD countries, with one in four 15-year-olds reporting being overweight or obesity in 2022. To address poor diet habits in both general and young populations, the government has recently taken measures such as implementing taxation on sugar drinks and banning the sale of food products high in fat, salt and sugar in schools and nearby premises. In addition, family physicians are encouraged to provide individuals, both insured and uninsured, with annual preventive consultations, but uptake has been under the desired level (see discussion on riskogramme at the end of this section).

Tobacco smoking was responsible for 9% of all deaths in 2021, which was on par with the OECD average (10%) (Institute for Health Metrics and Evaluation, 2024[8]). Adult smoking rates in Romania (18.7% in 2019 – latest data available) were slightly lower than the average of neighbouring EU5 countries (19.3%), but well above the OECD average (14.8%) (Figure 2.5). The differences in smoking between men and women are significant, with men smoking around four times more than women. To control and reduce the use of tobacco products, Romania has taken important steps against smoking in the last ten years, including a total smoking ban in closed places, prohibition of advertising of tobacco and electronic cigarettes, and adding health warnings on smoking packs. However, the country does not require plain packaging for tobacco products, and the tax share of tobacco in 2022 was below the level recommended by the Word Health Organization (WHO) (Tobacconomics, 2022[9]). As a fiscal measure, the government has also implemented a three-year gradual tax increase on tobacco products, over the period 2024-2026. Adolescent smoking has not changed between 2014 and 2022, with almost 23% of the 15-year-olds reporting having smoked at least once in the last 30 days. Yet, one in four 15-year-olds used e-cigarettes or vapes in 2022, one of the highest shares among European OECD countries (OECD/European Observatory on Health Systems and Policies, 2025[7]). In 2024, the government extended existing tobacco control measures by banning the sale of e-cigarettes, nicotine pouches, and heated tobacco products to individuals under the age of 18.

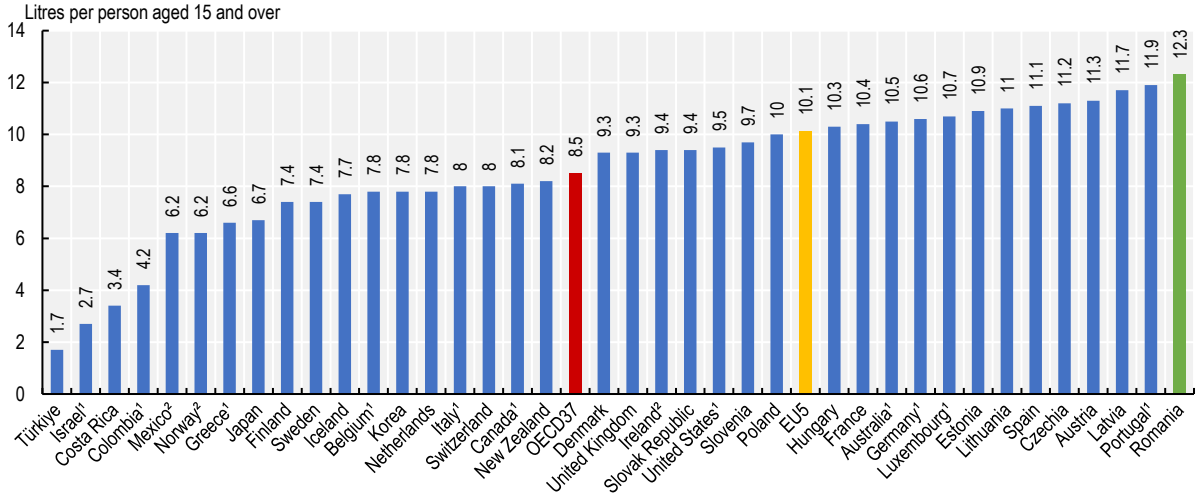
Figure 2.5. Daily smoking rates are higher than the OECD average, with more pronounced difference between men and women



Note: Data refer to 2023 or nearest year. 1. Latest data from 2019. 2. Latest data from 2020-2022. 3. Latest data from 2024.
Source: OECD (2025[6]), *Health at a Glance 2025: OECD Indicators*, https://doi.org/10.1787/8f9e3f98-en.

Alcohol use was responsible for 5% of all deaths in Romania in 2021, higher than the OECD average (3%) (Institute for Health Metrics and Evaluation, 2024[8]). In 2023, Romanian adults consumed 12.3 litres (equivalent of pure alcohol) per capita on average, which was higher than the countries in the same region, such as Czechia (11.2), Hungary (10.3) and Poland (10.0), and substantially higher than the OECD average (8.5 litres) (Figure 2.6). Alcohol consumption has been on the rise over the last decade, increasing by 30% between 2013 and 2023. The increase was particularly pronounced after the pandemic, with consumption increasing by 2 litres between 2020 and 2023. Romania also displayed high level of harmful patterns of drinking such as heavy episodic drinking (defined as drinking more than six standard drinks within a session). In 2019, 11% of the Romanian population reported heavy episodic drinking at least once a week, the highest proportion across OECD countries. Heavy episodic drinking was almost eight-fold more common among men than women (20% vs. 3%) (Eurostat, 2024[10]).

Figure 2.6. Romania has the highest alcohol consumption levels compared to OECD countries



Note: Data refer to 2023 or nearest year. 1. Latest data from 2022. 2. Latest data from 2024.
Source: OECD Health Statistics 2025.

Romania lacks a strong alcohol policy. The country has no national strategy in place to reduce harmful alcohol use and has so far only implemented a limited set of measures, such as alcohol excise taxes, regulations on alcohol advertising and sponsorship, and – more recently in 2024 – a ban on alcohol sales to those under 18. While brief interventions by family doctors and zero-tolerance rules for drink-driving are also in place, there are important gaps in the policy landscape given the alcohol-related burden in the country. For instance, alcohol can be purchased in petrol stations. To strengthen its alcohol policy and improve population health, Romania should envisage to undertake further actions recognised as effective and cost-effective (OECD, 2021[11]). Potential areas include applying fiscal measures (e.g. minimum unit pricing), strengthening penalties against drink-driving to reduce car crashes and injuries, regulating alcohol availability (e.g. petrol stations), strengthening marketing targeting children (for instance on social media), and improving the implementation of screening and counselling within primary care services for people who drink heavily.

2.1.6. Romania has been increasingly embarking on public health and prevention, but actions fall short of the ambitions

Romania has been placing more focus on public health and prevention strategies through national plans and projects in the recent years. The national public health programmes established and funded by the

Ministry of Health organise a range of activities concerning the prevention of common non-communicable diseases (NCDs) such as cardiovascular diseases and diabetes. The National Institute of Public Health plays a central role in co-ordinating population-level prevention activities and supporting national health strategy implementation. It regularly conducts health promotion campaigns to raise awareness and improve health literacy on key behavioural risk factors such as obesity, alcohol and tobacco use, and physical inactivity. However, these efforts often fail to reach rural and remote communities. In 2020, the Institute launched a cardiovascular risk screening programme – financed by the European Social Fund – to introduce complex CVD risk assessments at the primary care level, including for vulnerable groups. The same year, the Institute also initiated the "PDP1" project in collaboration with the WHO and Norway, which focussed on strengthening preventive care at the community level. The project's outcomes included regional health needs assessments, the development of community care guidelines, and the creation of training tools for doctors, community nurses, and health mediators (The National Institute of Public Health, 2023[12]).

As part of Romania's NRRP commitments, a new contractual framework has been developed to introduce a pay-for-performance (P4P) scheme and reform primary care remuneration. Negotiated between the National Health Insurance House, the Ministry of Health, and key stakeholders, the framework prioritises preventive services by offering higher reimbursement rates compared to curative care. A central feature is the "riskogramme" – a screening questionnaire for adults that was rolled out more prominently in 2024. The riskogramme enables primary care physicians to assess patients aged 40 and over for a range of diseases and risk factors, including cardiovascular disease, cancer, diabetes, kidney disease, high cholesterol, alcohol and tobacco use. Primary care doctors performing an annual riskogramme to patients aged 40 and over started receiving P4P payments as of 2025. However, uptake has so far fallen short of expectations. Low health literacy among the target population and the programme's opportunistic design cause limited participation, and the initiative has yet to demonstrate its full potential in improving preventive care coverage.

The National Health Strategy 2023-2030 outlines plans to modernise public health services and make substantial investments in primary prevention, with a focus on reducing disease burden linked to key behavioural risk factors. The strategy aims to strengthen co-ordination and integration of services through functional territorial networks for major chronic diseases, thus helping to reduce avoidable mortality. However, these ambitions are not yet matched by concrete actions or a sufficiently multisectoral approach to addressing the determinants of health. Significant gaps remain in tackling the country's high levels of dietary risk, smoking, and alcohol use. Greater emphasis on sustained health literacy initiatives and long-term preventive measures is needed to support meaningful progress on NCDs.

Romania mainly leverages the funds coming from EU and other international projects to accomplish progress in public health and prevention, as the share of prevention in the health budget remains low. The country allocates a lower share of its health spending on prevention compared to OECD average (1% vs. 3% in 2023), which hinders the implementation of sustainable public health policies to address NCDs and their risk factors (see Section 4.1 in Chapter 4). The budget allocated to national public health programmes has stagnated over the last decade (RON 0.86 billion – EUR 0.17 billion in 2024), while the budget for curative health programmes has increased by 230% (to 12.20 billion – EUR 2.45 billion in 2024), according to the Ministry of Health. This raises concerns about the sustainability of public health policies. Reorienting the focus towards prevention will therefore require shifting a greater share of health budget and resources to public health activities, improving population health literacy, creating initiatives to nudge behaviours towards heathier choices (such as public campaigns, regulation on advertising and point of sales of tobacco and alcohol, and fiscal measures), and working closely with primary healthcare providers to further increase their role in health promotion and disease prevention.

2.1.7. Mental health disorders are a substantial cause of burden, but masked by low prevalence due to stigma and limited access to care

Mental health disorders are the second leading cause of years lived with disability in Romania, but the prevalence of mental health disorders was still substantially lower than in the OECD average in 2021 (16 099 cases vs. 13 254 per 100 000 population) (Institute for Health Metrics and Evaluation, 2024[8]). This comparatively low prevalence was also reflected in low self-reported depressive symptoms: only 4.1% of Romanians reported currently having depressive symptoms in 2019, compared to the OECD average of 6.6% (Eurostat, 2024[13]). Symptoms were more common in women, reporting three times more symptoms than men. Disparities are also striking in the Roma communities: Roma people are twice as likely to suffer from depression or anxiety as the general population (Robinson et al., 2022[14]).

The relative low prevalence of mental health disorders and self-reported depression can be linked to the limited access to diagnosis and first-line interventions at primary care level and stigma associated with mental illness. Mental health problems accounted for 12% of total unmet needs in the population (OECD/European Observatory on Health Systems and Policies, 2023[15]), and more than half (52%) were not able to seek care because it was too expensive. A further 36% reported avoiding care due to fear of doctors or treatment – nearly double the OECD average of 20%. Stigma remains a powerful deterrent: over 80% of people agreed that mental health patients are judged differently by society, and 53% felt that medical professionals also stigmatise these patients – the highest rate across OECD countries (Eurobarometer, 2023[16]).

The mental health system remains highly reliant on institutional care and pharmacotherapy, with scarce services available in community and primary care settings, especially in rural areas (see Section 3.3 in Chapter 3). While family physicians do screen for depression during preventive consultations, this alone is not enough. Further steps are needed to build an effective primary care-led mental health system, expand access to early diagnosis and psychosocial interventions, and reduce the significant social and structural barriers that currently prevent people from seeking care.

2.1.8. Increasing suicide rates calls for greater attention

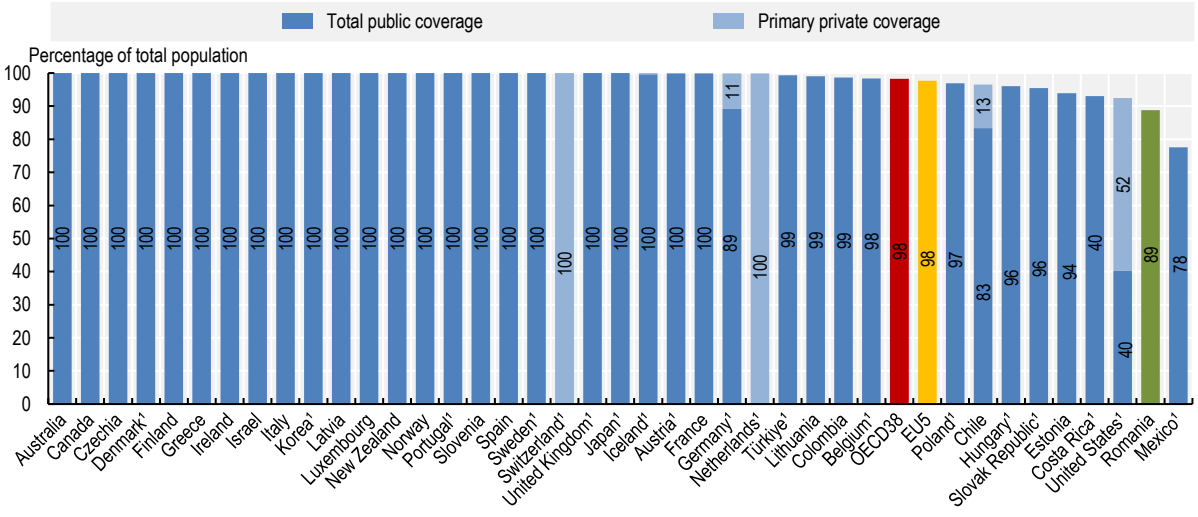
Between 2012 and 2022, suicide rates decreased considerably by 45% to 8.4 deaths per 100 000 population but remained below the OECD average (10.7). With the pandemic, mortality rates due to intentional self-harm were particularly on the rise in adolescents and elderly: between 2020 and 2021, suicide rates increased by 26% among young aged between 15-19 (Eurostat, 2025[17]). In 2020, almost half of Romanian young people reported having suicidal thoughts at least once in the last six months (UNICEF, 2022[18]). Similarly, the suicide rates increased among those aged 85 and above, with a 25% increase between 2020 and 2021 (Eurostat, 2025[17]). These rates may be underestimated because of underreporting, as some cases were reportedly entered as accidents in Romania (Civic Labs, 2023[19]). There are no current standalone policies to address suicide in general and vulnerable populations (see Section 3.3 in Chapter 3).

2.2. The health system and its governance

2.2.1. Romania's social health insurance system offers a comprehensive benefits basket to almost 90% of the population, but only one-third of the population finances it

Romania has a social health insurance (SHI) system with compulsory health insurance based on the principle of solidarity. The SHI system provides a comprehensive basic benefits package to 89% of the population, which is the second lowest rate of population coverage for a core set of services in OECD countries (Figure 2.7). The basic benefits basket covered by the SHI includes a large variety of services, but they may not be covered in full, and patients may be entitled to co-payments for certain services. It includes preventive healthcare services, ambulatory care, hospital care, medical emergency services, dental care, medical rehabilitative services, perinatal medical services, home care nursing, pharmaceuticals and medical devices (Vladescu et al., 2016[20]).

Figure 2.7. 89% of the Romanian population is covered by the social health insurance, one of the lowest compared to OECD countries



Note: Data refer to 2024 or nearest year. 1. 2021-2023 data.
Source: OECD (2025[6]), *Health at a Glance 2025: OECD Indicators*, https://doi.org/10.1787/8f9e3f98-en.

In 2024, 11% of the population was not covered by the SHI, consisting of people living abroad, people without identity documents or not registered in the social security system (mainly the Roma communities living in rural areas), and informal or self-employed workers. Those not registered in the social security system or not holding an identity document are mainly from the Roma communities, and only 54% of Roma reported being covered by the SHI (ERGO Network, 2022[21]). The uninsured have access to a minimum package of benefits (OECD/European Observatory on Health Systems and Policies, 2023[15]), which includes life-threatening emergencies, treatment for infectious diseases, care during pregnancy, primary care services, screening recommended by family practitioners as well as consultations, examination, day hospitalisation for cancer detection in case of suspicion. In particular, the primary care services provided to uninsured individuals have been aligned with the basic level of coverage offered to insured persons since January 2023. Furthermore, since July 2024, the paraclinical services recommended by family physicians are covered for uninsured individuals, as well as the services related to the detection of cancer in case of suspicion, treatment, monitoring and evaluation of oncological conditions. The costs of treating uninsured people are covered from the state budget. Although the minimum benefits package has been

expanded for the uninsured in recent years, Romania needs to step up efforts to expand population coverage and thereby improve access to equitable care – including end-of-life and mental healthcare – for all population groups to build a more resilient health system.

The SHI system is funded by mandatory social insurance contributions made by working residents. There are historically a number of exemptions from SHI contributions. First, vulnerable population groups (including unemployed people, retired people and people on social benefits) are exempted. Second, specific population groups – such as pregnant women, people with disabilities or chronic diseases, as well as children and students aged under 26 – are financed from the SHI contributions of the working population. Last, employees from some sectors are exempted from wage-based contributions. Hence, contributions to the National Health Insurance Fund (NHIF) were paid by only one-third of the insured people (specifically, 36%) in 2020. This raises the question of sustainability of financing of the national health insurance system in an ageing society, especially during periods of economic downturns. To address under-funding and to improve the fiscal sustainability of the SHI, Romania has started to eliminate the tax exemptions for certain categories of workers (e.g. agriculture, construction, and food industry) since 2023. Additional reforms introduced in 2025 further reduced these exemptions for other groups, a step expected to expand the contributor base in the coming years (CNAS, 2025[22]).

2.2.2. The Romanian health system operates at national and country levels, but its governance remains highly centralised

The key authorities in the Romanian health system are the Ministry of Health (MoH), the National Health Insurance House (CNAS), the National Authority for Quality Management in Healthcare (ANMCS), and the National Agency for Medicines and Medical Devices of Romania (NAMMDR). Professional organisations are represented at the national level by five organisations, namely 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. The MoH is responsible for stewardship, policy development, regulatory framework development, and management of the health system, overseeing the activities of the National Institute of Public Health (INSP), the National Institute of Health Services Management (INMSS) and NAMMDR. The MoH is demonstrating strong leadership in policy and practice to align with the National Health Strategy. It receives a public budget allocation from the Ministry of Finance and distributes it to other authorities. CNAS is the public payer which contracts with health providers (e.g. hospital, family doctor, ambulatory specialists); it administers and regulates NHIF. ANMCS is a key body created in 2015 under the authority of the government and the co-ordination of the Prime Minister. It asserts regulatory functions regarding the accreditation and monitoring of health establishments, with the primary aim of improving patient safety and quality of care. INSP, INMSS and NAMMDR are subordinated to the MoH, with their own roles. INSP is in charge of health promotion, health status evaluation, surveillance and control of communicable and non-communicable diseases, including the management of disease registries and the implementation of public health programmes. It provides technical and methodological guidance of the public health network, develops the methodology, tools and indicators for monitoring and evaluating public health services and programmes, such as health promotion and health education, and ensures an integrated information system for public health management. INMSS deals with training, continuing medical education, management and administration of health services, including the management of the diagnosis-related group system. NAMMDR is the competent national authority in the field of human medicines and medical devices.

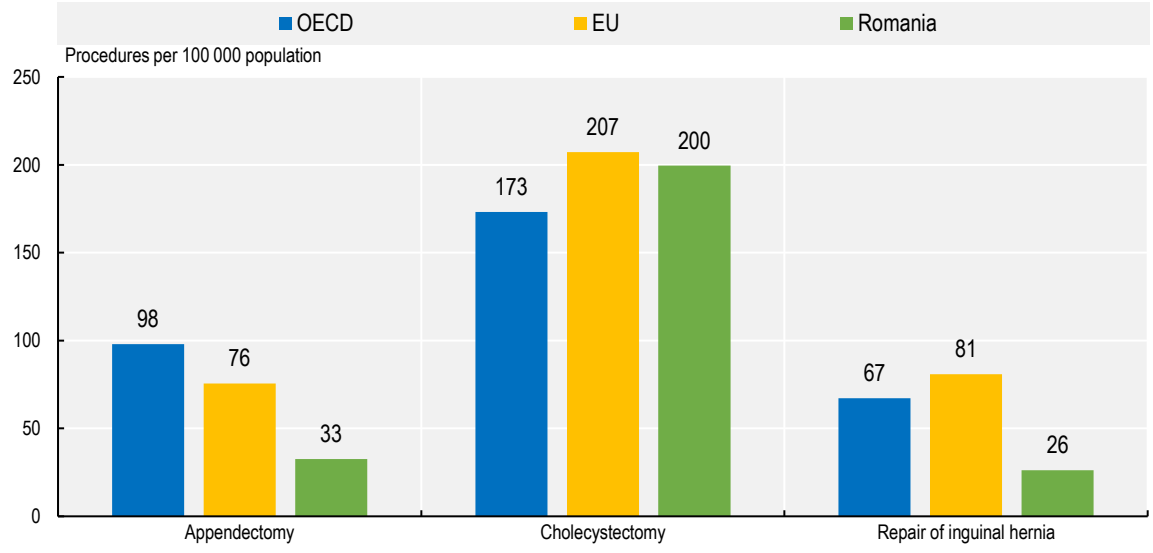
The Romanian health system is organised at two levels: national and county[2] (judet). The national level is responsible for setting and achieving general objectives in line with the principles of the government's health policy. The county level is responsible for ensuring public health services provision according to the rules set by the central level, mainly through two main bodies. The district public health authorities (DPHAs) -representing the MoH at the county levels- are in charge of implementing national policies, developing local programmes, organising health structures, and reporting health statistics, among others. The district

health insurance houses (DHIHs) operate for CNAS at the county level. Their activities consist, among others, in contracting with health providers and managing national curative health programmes.

2.2.3. Romania is investing in the modernisation of its healthcare infrastructure

The hospital infrastructure is outdated and struggles to respond to today's care standards and needs. Some hospital buildings do not meet the required safety standards in the event of a fire or earthquake. Old buildings and equipment hinder the introduction and use of new technologies to perform modern surgeries due to suboptimal integration of intra-hospital circuits and logistical limitations, which is reflected in the low numbers of laparoscopic procedures compared to the OECD averages, except for laparoscopic cholecystectomy. In 2023, Romania performed 33 laparoscopic appendectomies and 26 laparoscopic inguinal hernia repairs per 100 000 population, rates substantially lower than the OECD and neighbouring EU5 averages (Figure 2.8).

Figure 2.8. Laparoscopic procedures performed in Romania are lower than in OECD countries, with the exception of laparoscopic cholecystectomy



Note: Data refer to 2023 or nearest year.
Source: OECD Health Statistics 2025.

Romania is taking measures to address the outdated hospital infrastructure. Through the NRRP investments, the country plans to renovate 3 000 family doctor cabinets and 160 hospital infrastructures (Box 2.1). Some of the main goals include implementing measures that safeguard against fires, structural damage, and seismic events, and upgrading microbiology laboratory equipment to reduce healthcare-associated infections and enhance patient safety in healthcare facilities. In 2022, the government created the National Agency for Development of Health Infrastructure which oversees major public health infrastructure projects and facilitates access to health infrastructure investments. The agency is also responsible for the efficient allocation of hospital resources by transferring hospital beds to other services such as day care and long-term care beds in accordance with the needs identified by the Regional Health Services Masterplans (RHSMs) (Box 2.1). In addition to renovation, Romania is currently investing in the construction of three new regional hospitals with the support of the European Investment Bank.

Box 2.1. Major healthcare strategies and plans in Romania

The National Health Strategy 2023-2030

The national healthcare reform strategy targets all levels of healthcare with a specific focus on diversification, co-ordination, and modernisation of healthcare services. The reform is projected to take place until 2030. The objectives include strengthening and modernising public health and primary healthcare, involvement of the citizens, co-ordination between primary care and hospital care, investment in health workforce, improving quality of care, achieving financial sustainability, and encouraging research for innovative sustainable care.

The National Plan for Resilience and Recovery 2022 – 2026

As part of the EU's recovery strategy following the pandemic, Romania launched the National Resilience and Recovery Plan. The healthcare components of this plan consist of three reforms and two investments:

Reforms:

- Increasing the capacity for the management of public health funds through a pilot programme to improve the quality and cost-effectiveness of health services, and the development of a new model of framework,
- Increasing the capacity to undertake investments in health infrastructures,
- Increasing the capacity for health management and human resources in health by improving human resources management skills, strengthening the workforce capacity to retain and motivate workers, and reducing vulnerabilities and risks of corruption in the health system.

Investments:

- Development of pre-hospital medical infrastructure to improve healthcare access for people in disadvantaged areas by investing in primary care practices including family physicians, mobile medical units, outpatient care units, integrated community centres and family planning offices,
- Development of public hospital infrastructure with new infrastructure, medical equipment and devices, intensive care facilities for newborn and investment in equipment to reduce the risk of nosocomial infections.

The Operational Health Programme financed by the European Commission (2021-2027)

The priorities of the operational health programme are to (1) increase the quality of primary care and preventive services, (2) adapt the rehabilitation, palliation, and hospitalisation services to the ageing population, (3) increase the effectiveness and resilience of the medical system, (4) invest in new hospital infrastructures, (5) encourage innovative approaches in medical research, (6) support digitalisation of the medical system, and (7) support research in the field of oncology and transplantation.

The government programme for 2023-2024

The priorities of the government programme focus on:

- Resilience of the health system, safe access to good healthcare services quality for every citizen,
- Strengthening the co-ordination of the public health system,
- Financing the health system by implementing budgeting to ensure a high degree of absorption of European funds dedicated to the field of health in the period 2021-2027.

The National Health Programmes

The national health programmes aim to prevent and treat diseases with serious consequences on the health of the population and with increased epidemiological risks (e.g. AIDS, tuberculosis). They are implemented and co-ordinated by MoH, funded by state budget and NHIF. Four health programmes include:

- Community public health programme,
- Programme of the prevention and control of non-communicable diseases,
- Child and family health programme,
- Health administration programme and health policies.

Regional Health Services Masterplans

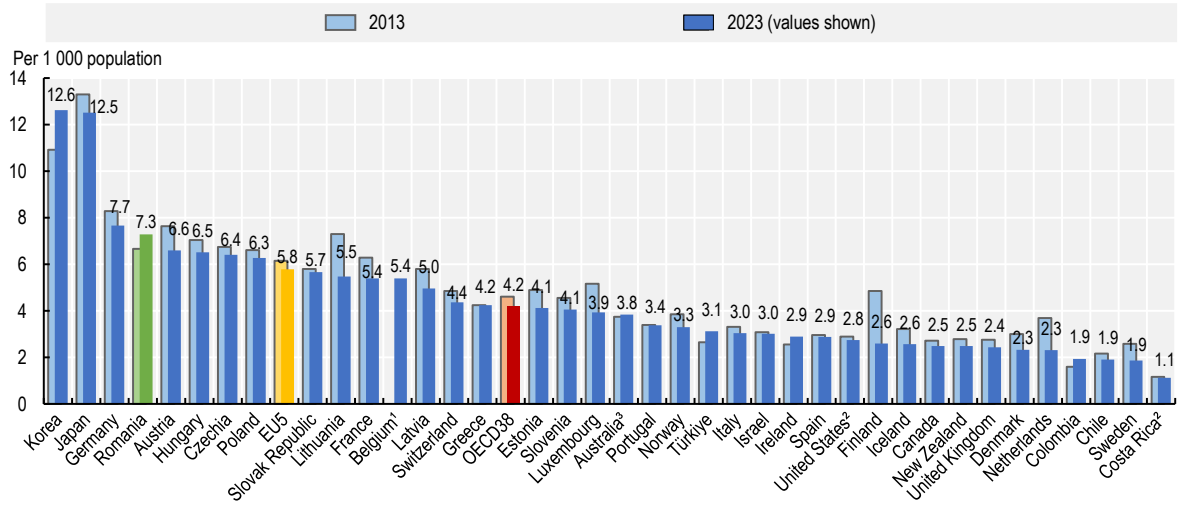
Financed by the European funds, the Masterplans identify regional needs and have analysed the capacity of service providers, human resources, equipment, as well as funding opportunities. They ultimately aim to ensure efficient use and allocation of healthcare resources by restructuring the health system based on regional needs and by shifting the care paradigm to primary care. The Masterplans have been recently published, but relevant actions have not yet taken place.

2.2.4. Romania's health system still heavily relies on hospital services, despite the reforms to shift the focus to primary care and community settings

Romania's health system is hospital-centric, with high numbers of hospital beds, high discharge rates, and high spending on hospital services. Specifically, Romania has 7.3 hospital beds per 1 000 population, compared to the OECD average of 4.2 and the neighbouring EU5 average of 5.8 in 2023 (Figure 2.9). This figure has increased over the last decade, with the hospital bed rates being markedly higher than most OECD countries, reflecting the over-reliance on the hospital sector for acute care provision. Meanwhile hospital discharge rate was 169 per 1 000 population in 2023, relatively high compared to OECD countries. Nearly half of the total health spending is dedicated to hospital activities (44% compared to 39% in the OECD average) (Chapter 4). Closely linked, the inappropriate use of emergency room services is high in Romania (Chapter 3).

Romania is committed to the transition from hospital-based services to primary care and community services, as stated in the National Health Strategy 2023-2030 and the Operational Health Programme 2021-2027. The country has also taken measures to strengthen prevention and screening within primary care settings, with the financial support ensured by the NRRP investments. This entails providing a "riskogramme" screening test (see Section 2.1), providing an annual preventive checkup for adults aged 18 and over (which was granted once every three years for people aged 18-39, before 2023), and restructuring provider payment method to encourage family physicians to detect and follow-up patients with chronic diseases starting from 2024. The country has recently introduced a P4P scheme that rewards preventive activities at a higher rate and has increased the weight of fee-for-service payments from 50% to 65% by reducing the share of capitation in remuneration in order to encourage disease management and prevention in primary care. Romania is also making effort to enhance the provision of primary and community care services by developing a network of about one hundred integrated community centres across the territory, along with the modernisation of diagnostic and testing facilities within these centres (see Section 3.1 in Chapter 3). But these actions should be underpinned by strong political commitment and reallocation of resources to primary care and prevention to build stronger, more resilient health system capable of meeting the needs of ageing population and future health challenges (further discussion in Chapters 3 and 4).

Figure 2.9. Romania had one of the highest number of hospitals beds in 2023



1. Data include only acute care and psychiatric hospitals. 2. Latest data from 2021-2022. 3. Latest data from 2016.
Source: OECD (2025[6]), *Health at a Glance 2025: OECD Indicators*, https://doi.org/10.1787/8f9e3f98-en.

2.2.5. Stakeholder accountability is improving, with increased patient engagement

The role of patient associations is gaining importance in the Romanian health system. Patient associations are being formally involved with health system stakeholders. They take part in various activities such as healthcare quality, health prevention, and supporting patients in legal suits. For instance, a representative of patient associations is nominated in the board of directors of ANMCS. Patient associations are also represented in the National Patient Safety Council, an entity created in 2021 with the objective to embrace patient safety culture among health professionals and patients, and to encourage research around quality of care and patient safety. At hospital level, patient organisations are represented in the ethics councils in each hospital. Patients have the possibility to fill in online patient discharge questionnaires to provide feedback about their experiences with public hospitals. The data collected by the MoH is then made publicly available. Another example of the patient empowerment is the participation of associations of chronically-ill patients (e.g. the Coalition of Organizations of patients with Chronic Diseases in Romania) in a project to develop a screening programme for cardiovascular risk factors, co-funded by the European Social Fund, as part of the Human Capital Operational Program 2014-2020.

Patients' rights to information are governed by law, however the capacity of patients to navigate the health system is uncertain. Patients have the rights to information about their health and available treatments, to informed consent, to information about the range of available services and certain information about the providers (Vladescu et al., 2016[20]). To this end, starting from 2021, CNAS published the Insured's Guide providing information about the health insurance system, benefits packages, rights and obligations of the insured. In particular, the guide describes how health services can be accessed and what services the patients are entitled to from each provider, including services available to the uninsured patients. Yet, patients report a lack of information about how to get diagnosed to enter in existing treatment pathways. Further, there is no evidence on how well-informed patients are about their rights and if the available information is seen to be useful. The country does not collect data about the level of health literacy.

2.2.6. Romania is taking steps to address corruption in the health system

Romania has historically had problems of informal payments in the health system, either linked to high level appointment, procurement of medical supplies, such as bribery of health facility managers to get

lucrative contracts, or informal payments at the point of care delivery (OECD, 2024[23]; OECD, 2023[24]). In 2023, 9% of Romanians reported having to give an extra payment or a valuable gift to a nurse or a doctor or having to donate to the hospital (not including official fees) when visiting a healthcare setting, which is three times higher than the EU average (Eurobarometer, 2023[25]). Yet, recent data show that "under the table" payments in public hospitals are reportedly on the decline. Patient feedback mechanisms put in place since 2016 report a reduction in "under the table" payments in public hospitals from 4.3% in January 2017 to 1.7% in January 2024 (Graphs.ro, 2024[26]).

While Romania has taken cross-cutting measures to address corruption and promote integrity in the health system, there is room for improvement in strengthening integrity management in the Romanian health sector. Corrupt acts are increasingly getting prosecuted by the Romanian National Anticorruption Directorate. To tackle fraud and bribery in public procurement, a special IT monitoring system is in place for budget execution, monitoring contracts, suppliers, and payments from the public budget. Other measures have contributed to the reduction of informal payments, including doctor's salary increases, increased education and awareness actions of both medical staff and patients. NRRP invests in the training of 3 000 health workers, including those working in the central administration, in de-centralised institutions, in the management of healthcare units, and those providing direct care to patients. The trainings cover a range of integrity-related topics, albeit they have yet to be implemented. The training courses address the prevention of corruption and the resolution of conflicts of interest within the healthcare system, the protection of whistleblowers, and the transparency of public procurement in the healthcare sector. The reform also aims to increase transparency by sharing information on activities and results achieved, and through awareness campaigns. One notable initiative is the online publication of the monitoring and reporting of the progress in NRRP (https://monitorpnrr.eu/). These efforts are promising, yet further efforts are needed to strengthen integrity management in the Romanian health sector. The lack of co-ordination, institutional capacity, and political engagement at high-level has hindered the adoption and implementation of the National Anti-Corruption Strategy measures in the health sector (OECD, 2023[24]). Expanding the scope of the National Anti-corruption Strategy based on an analysis of risks in the health sector is essential to improve integrity in the health sector. Such an analysis could support further reforms, such as developing a comprehensive anti-corruption policy for the health sector, incorporating integrity as a component of institutional performance, and implementing monitoring mechanisms for key processes such as allocation funds, appointments and medical input procurement. Increasing public awareness about the legal consequences of corruption, including informal payments, is also key to changing mindset and building integrity in the health system.

2.3. Health data infrastructure and its governance

2.3.1. Routine data collection, standardisation and linkage present challenges, but Romania is making effort to reach international standards for data collection

Although health data is routinely collected in Romania, there are a number of inefficiencies in data collection, such as high degree of data fragmentation and duplication in data collection, which impair the quality and effective use of data. Romania has multiple co-existing information systems and parallel information flows due to inconsistent legislative reforms not envisioning overarching health information system (HIS) objectives. The HIS lacks a coherent and integrated data processing, suffering from a sharp division of the collection, reporting, and decision making processes. Three main entities operate data collection and processes. INSP is responsible for collecting, analysing, and disseminating data on the state of health of the population, used for statistical reporting, such as the Yearbook of Health Statistics and health-specific bulletins sent to policymakers and DPHAs directors. CNAS organises and administers the Health Insurance Information Technology (IT) platform, including the single integrated information system, the national health insurance card system, the national electronic prescription system, and the patient's

electronic health record system. ANMCS collects data from health service providers and organisation in the view of their accreditation. Due to various data flows, data collection processes are burdensome and inefficient, leading to low quality data (e.g. providers must report the same information to different institutions and in different formats; the data collected can be irrelevant for the decision making process). The Romanian HIS is lacking effective data validation mechanisms to ensure data quality, and qualified personnel in the field of medical statistics, to process raw data and use it for analytic purposes, resulting in the underuse of the collected data for public health decision making.

Romania collects administrative health data from hospitals and health practitioners, as well as census and population health data. Chronic disease registries are not yet operational, albeit the country is planning to implement registries for cancer and diabetes, among others, under the NRRP projects. The proportion of health data which is digitised and available at the national level for further processing is unclear. In 2023, around EUR 175 million was invested in information and communication technology (ICT) for health and social care – equivalent to EUR 0.9 million per 100 000 people, less than half the EU average – largely financed through the RRP and EU Cohesion policy funds (OECD/European Observatory on Health Systems and Policies, 2025[7]).

Romania has enhanced data standardisation, although interoperability remains constrained by the presence of disparate data systems and limited capacity. Regarding CNAS's Health Insurance IT platform, Romania has adopted international coding standards for hospital service reporting (with the International Classification of Diseases ICD-10 and ICD-10-AM and intends to move to ICD-11). ANMCS's datasets are structured on references, standards, and requirements. The National Health Strategy aims for modernisation of the HIS, with emphasis on information interoperability and digitisation, with initial efforts started within the framework of NRRP. Regarding health data interoperability, there is some evidence of data linkage, for instance between laboratories, DPHAs, family physicians and patients accelerated during the COVID-19 crisis, but these remain limited (OECD/European Observatory on Health Systems and Policies, 2021[27]).

Romania is making efforts to reach international standards for data collection. The country contributes to international data collection, specifically to the OECD Health Data Questionnaire, the OECD/Eurostat/WHO-Europe Joint Questionnaire on Non-Monetary Healthcare Statistics, the OECD/Eurostat/WHO-Europe Joint Health Accounts Questionnaires, and the OECD Healthcare Quality Indicators and Outcomes questionnaire. To improve data collection and reporting around quality of care, a National Commission for Supervision of the Health Information system and Reporting to the OECD was created in 2019, functioning under ANMCS. This inter-institutional body, involving MoH, ANMCS, CNAS and the National Institute for Statistics, aims to unify the reporting process to international organisations.

2.3.2. Romania is enhancing its health information infrastructure, with the introduction of electronic health records and teleconsultation

In 2014, Romania introduced the electronic health record (EHR) system (*Dosarul Electronic de Sanatate* – DES) managed by CNAS. In 2021, 16 million EHRs (about 85% of the population) have been created with the co-operation of healthcare providers and institutions, but only 12 000 were actually used and accessed by patients in 2023 (Adevarul, 2022[28]). Low level of actual use of EHRs is likely to be related to the low level of digital literacy in the country. In 2023, only 28% of the Romanians had basic or above basic digital skills, less than half of the OECD average (61%) (Eurostat, 2024[29]). On provider's side, about 45% of doctors (mostly family physicians) have submitted EHR data. EHR data are available in reports and statistics in an anonymised form, and their usage is currently limited to administrative and accounting purposes, calling for better exploitation of EHRs for clinical reasons.

The use of telemedicine has quickly progressed due to the impact of the COVID-19 pandemic and the movement restrictions. According to the 2022 Eurofound survey data, the proportion of Romanians who had teleconsultations with doctors during the first year of the pandemic increased from 22% to 30%

between June 2020 to February 2021. On average across EU countries, this proportion raised from 30% to 39% (OECD/European Union, 2022[30]). However, Romania has not yet a secure dedicated platform for telemedicine. For instance, during COVID-19, doctors used individual communication platforms such as WhatsApp, to provide medical consultations and send documents to the patients (e.g. prescription for medication). Since, telemedicine has been legislated (Chapter 3) and the elaboration of the specific quality management standards are in process of drafting. Romania does not yet regularly report data on the number of teleconsultations.

2.3.3. Romania is working on a national digital health strategy to leverage the potential of health data

To date, Romania has legislations and policies related to health data governance, but the country has not yet adopted an overarching national health data governance strategy. Romania's health data governance consists of laws which include provisions on patients' data privacy and security safeguards, as well as cross-border co-operation in the processing of personal data for health-related purposes that serve the public interest. As a member state of the EU, Romania applies the EU General Data Protection Regulation (GDPR), regarding personal data processing requirements and protections. There are opportunities to clarify how, when, and with what controls data access should be provided for care, public health, innovation, and health system operations. In practice, personal health-related data are not yet effectively accessible or used for research and public interest purposes, and there is a lack of training for staff on their responsibilities regarding privacy and digital security. Romania has not yet adopted a national health data governance strategy, albeit this is in process. A new digital health strategy was submitted for a public consultation by the end of 2024, and a working group is being established to develop a masterplan for implementing the strategy. This new strategy will include creating a National Agency for Digital Health to oversee data pooling, analysis, dissemination, standard setting, and telemedicine development, as well as establishing a National Observatory for Health Data to support digitalisation and collection of data. It also seeks to expand and consolidate the social health insurance information platform to enhance data management, streamline expenses, and improve insured individuals' access to healthcare services.

Strengthening health data governance will require providing guidelines on training and skills development (e.g. in privacy and security measures) to improve the capacity and training of health and IT workforce, conducting tests for potential security breaches, and enabling data access for research and public interest purposes, for instance by developing standard data sharing agreement for disclosing data. Further progress is also needed to enable and facilitate cross-border data sharing and participate to the European Health Data Space, promote the use of common data formats, quality assurance and data interoperability standards in line with the European Health Data Space. Encouraging the co-operation between organisations processing personal health data, including in the public and private sector is also essential. The process of developing such co-ordination started with NRRP which allocates EUR 442 million for the development of an integrated eHealth and telemedicine system.

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Notes

[1] Refer to neighbouring EU5 countries in the rest of this document.

[2] There are 41 counties + Bucharest the capital.

3 Access and quality of care in Romania's healthcare system

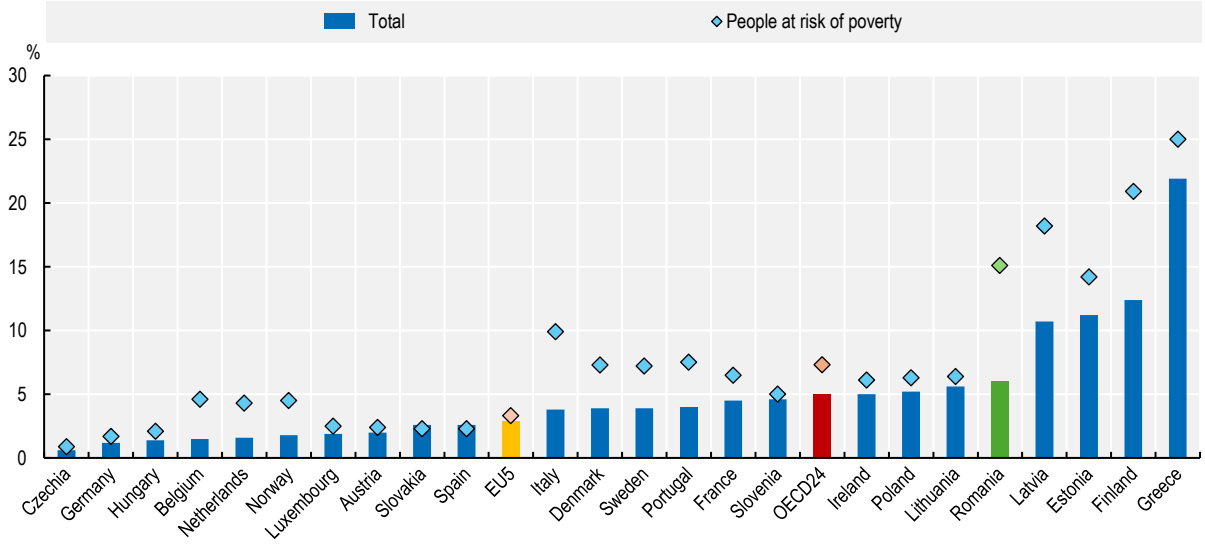
This chapter provides an overview of access to and quality of care in Romania's health system, assessing its performance, recent policy reforms and opportunities aimed at improving equity, efficiency and resilience. The first section analyses unmet healthcare needs and services utilisation, highlighting the suboptimal use of primary healthcare and persistent geographical disparities in access. The second section explores the quality of care, outlining key challenges and policy initiatives to reduce avoidable hospitalisation and improve cancer care. The third section focusses on mental health needs and service provision, identifying gaps and policy efforts to strengthen community-based care. The last section examines long-term and palliative care, underscoring limited resources and capacity constraints.

3.1. Making healthcare accessible

3.1.1. Unmet needs for medical care are high, especially among people at risk of poverty and those living in rural areas

In 2023, 6% of Romanians with medical care needs reported that their needs were unmet due to costs, geographical distance or waiting times, a figure higher than the OECD average (5%) (Figure 3.1). Socio-economic disparities are marked: people at risk of poverty reported three times higher unmet needs than the total population, a gap considerably wider compared to the OECD average. Similarly, people living in rural areas reported almost 1.5 times higher unmet needs compared to those located in cities (Eurostat, 2025[1]). In 2024, 6% of adults also reported unmet needs specifically for primary care – twice the EU average – highlighting significant access challenges in this foundational layer of the health system (Eurofound, 2025[2]).

Figure 3.1. Romania had one of the highest levels of unmet needs compared to OECD countries in 2024



Note: The EU average is weighted. Data refer only to individuals who reported having medical care needs. People at risk of poverty are defined as those with an equivalised disposable income below 60% of the national median disposable income.
Source: Eurostat Database 2025, based on EU-SILC data.

3.1.2. Routine care remains costly due to low population coverage and high cost-sharing

In Romania, financial costs are the main reason people forgo necessary healthcare – in contrast to most OECD countries, where waiting times are more commonly cited. In 2023, over half of those reporting unmet needs said they did not seek care because it was too expensive (Eurostat, 2024[3]). This is closely linked to the relatively low insurance coverage in the population (see Section 2.2 in Chapter 2) and the significant cost-sharing requirements for services such as outpatient-prescribed medicines and rehabilitation. While the Social Health Insurance (SHI) scheme offers a comprehensive benefits package for insured individuals, uninsured people have access only to a limited set of services, leading many to resort to emergency care to avoid high upfront costs. Even among the insured, high out-of-pocket payments – especially for outpatient medicines – expose households to financial hardship and deepen existing health and socio-economic inequalities (OECD/European Observatory on Health Systems and Policies, 2025[4]).

High healthcare costs can put people at risk of financial hardship, particularly those who are the most vulnerable, potentially exacerbating health and socio-economic inequalities. To mitigate these barriers and improve equitable access to care, Romania should prioritise expanding the depth and breadth of coverage and clarifying the scope of the benefits package, particularly for vulnerable groups. Clearer benefits and lower cost-sharing would help reduce financial burden, unnecessary emergency care use, and unmet health needs.

3.1.3. The primary care system is weak, leading to over-use of specialist and emergency care services

Family physicians who work mainly in independent practices are the first point of contact for patients in Romania, and they act as gatekeepers by providing referrals to specialist consultation as needed. However, in practice, they are often used to obtain referral for higher levels of care rather than providing direct care. This stems from two key issues: the limited scope of practice for family physicians and the absence of co-payments to discourage unnecessary specialist visits. Additionally, broad exemption rules allow certain groups – including people with mental health conditions or those enrolled in national curative programmes – to bypass the referral system altogether, even for conditions that could be managed effectively at the primary care level.

Consequently, this leads to inefficient use of primary care resources for chronic condition management, long waiting times for certain specialties (particularly in rural areas), and encourage patients to use emergency departments as a shortcut to access specialist care. The problem is compounded by chronically low investment: in 2023, only 9% of total health spending went to primary care – the lowest share in the OECD – resulting in insufficient capacity and weakened ability to serve as a true first point of contact.

3.1.4. Emergency care is overburdened and becomes inaccessible during winter in some rural areas

Emergency care is primarily available at regional emergency hospitals, which are equipped with specialised emergency units and are managed by regional authorities. These hospitals serve for their designated regions with each county having one regional emergency hospital (except Bucharest having several). The distribution of emergency services remains uneven between rural and urban areas, with ambulance services facing challenges particularly during adverse weather conditions in winters (AHEAD, 2022[5]). To modernise its emergency care infrastructure, Romania purchased IT and medical equipment to connect 131 emergency units to the regional telemedicine emergency centres, which would in turn facilitate immediate transfer and ensure timely care for patients (European Observatory on Health Systems and Policies, 2024[6]).

Emergency care in Romania is often overburdened due to bottlenecks in primary and specialist care. Many patients with non-emergency complaints visit emergency care services for faster access to care: in 2018, less than 18% of patients visiting emergency rooms had urgent conditions, according to a national report (Department for Emergency Situations Romania, 2018[7]). A more recent analysis also showed that around 80% of patients in emergency care services were assigned green codes, signifying non-immediate conditions, while 72% of the total cases had diagnoses that could have been managed at the primary care level (Lăcătuș et al., 2024[8]).

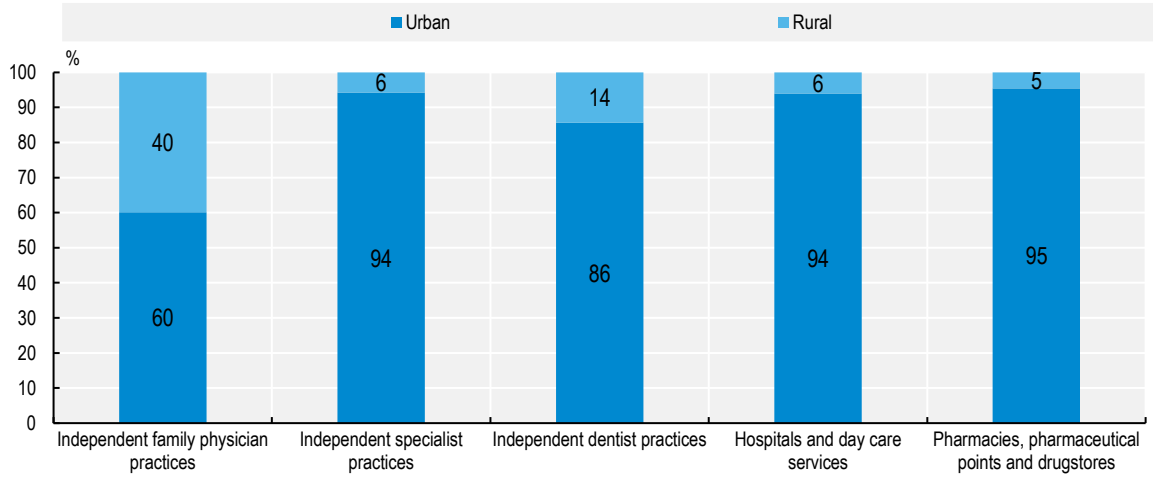
As an alternative to emergency care services, out-of-hours primary care centres offer basic emergency and primary care services regardless of a patient's insurance status. These centres are staffed by family physicians who provide 24/7 on-call service but remain limited in number and distribution. In an effort to expand these services, the government increased tariff rates for providers in 2018, but this has not fully addressed the capacity and availability issues related to family physicians (European Observatory on

Health Systems and Policies, 2018[9]). Out-of-hours centres have the potential to reduce the burden on emergency care, and Romania should consider enhancing the workforce and logistic capacity of these services. Intensifying efforts to increase their public awareness is also crucial to maximise their use for non-urgent conditions, as only about 5% of emergency care patients reported being aware of these centres (Lăcătuș et al., 2024[8]).

3.1.5. Rural areas have limited access to healthcare facilities, but community health centres and mobile medicine can improve access

More than half of the Romanian population (54%) was living in rural areas in 2023, where significant challenges in access to healthcare persist. There is a concerning disparity in allocated resources between urban and rural places, with urban areas holding more than 90% of the total number of hospitals and independent specialist clinics, and 60% of independent family physician offices in 2024 (National Institute of Statistics, 2024[10]) (Figure 3.2). The distribution of health workers also shows a similar pattern, with workers overwhelmingly concentrated in urban areas (see Section 4.2 in Chapter 4).

Figure 3.2. Healthcare services are overwhelmingly concentrated in urban areas in Romania



Note: Data refer to 2024.
Source: National Institute of Statistics (2024[10]), Activitatea retelei sanitare 2024, https://insse.ro/cms/sites/default/files/field/publicatii/activitatea_retelei_sanitare_in_anul_2024_0.pdf.

Community health centres bring additional capacity to care for vulnerable populations living in underserved areas, including the Roma communities. These centres focus on preventive care and basic health needs. Managed by local authorities, they operate through collaborative efforts among general practitioners, social services, and other health professionals, including community nurses and health mediators. While community nurses play a central role in these centres, their numbers remain insufficient to expand these services throughout the country, and their training often relies on international funding (see Section 4.2 in Chapter 4). Health mediators, introduced in 2002, also play a key role in improving healthcare access for the Roma population. They mainly take role in facilitating communication between patients and the healthcare system, with an aim to ensure care delivery without discrimination.

The NRRP aims to expand the role and coverage of community health centres in Romania. Funding is allocated to upgrade these facilities into “integrated community centres” by enhancing their logistical and

equipment capacity. This includes establishing laboratories for basic diagnostic tests, creating dental offices, and acquiring medical equipment for certain specialties. These centres will therefore be able to employ family physicians, specialists and dentists to work in a collaborative manner. Further, collaboration with the Ministry of Labour will also allow these centres to have better access to social services when needed. The initial plan is to establish 200 integrated community centres, either renovated or newly built, with half of them located in marginalised areas. However, the full functioning of these services hinges on overcoming crucial challenges, particularly in training and attracting community nurses and doctors to work in these centres.

Mobile services are also a means to deal with accessibility issues in rural areas, particularly for disadvantaged populations. For the past decade, several non-governmental organisations (NGOs) have voluntarily provided free medical care through medical caravans and units. The government has recently passed a legislation to establish and co-ordinate these services based on the needs identified in the rural communities (Mobile Healthcare Act). This legislation allows doctors and other health workers to treat patients in mobile medical units, even if employed elsewhere. Services will include, but not limited to, medical check-ups, preventive screenings, and medical treatments covered by the national health programmes. In addition to doctors, nurses or other health professionals such as therapists, health mediators, social workers or paramedics can also work in these medical units. As a first step towards improving access in rural areas, the country has purchased ten mobile caravans to perform cervical and breast cancer screening in underserved areas (see Section 3.2 in Chapter 3).

3.1.6. Financial incentives and telemedicine have partially addressed the critical health workforce shortages in rural areas, but efforts need to continue

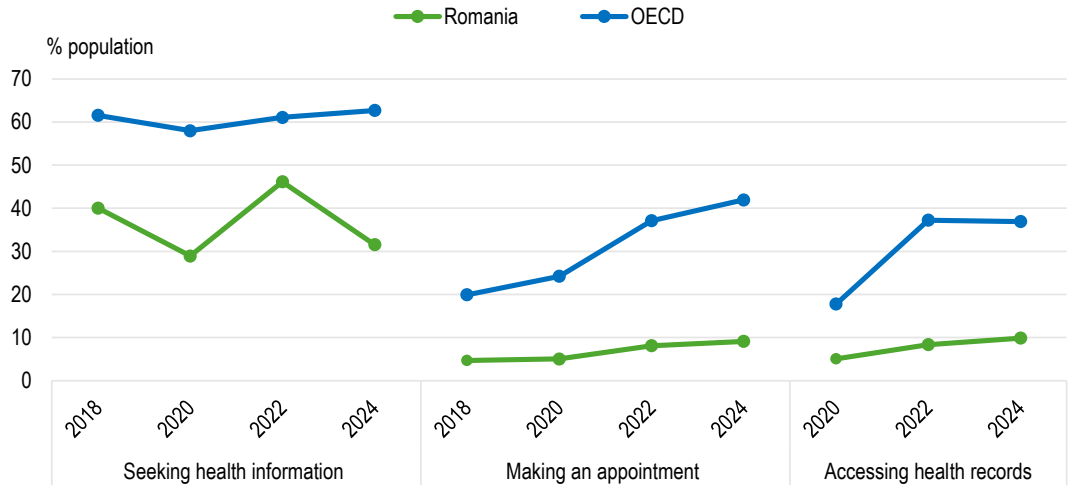
Healthcare workforce shortages in rural areas remain one of the most critical challenges to equitable access in Romania, as 90% of physicians and nurses are located in urban healthcare settings. Although doctors are permitted to open a practice anywhere as long as they meet minimum patient registration requirements, many choose to work in more developed areas with better professional and personal prospects. This results in stark regional disparities, with some rural hospitals unable to recruit essential specialists such as cardiologists or paediatricians, while urban areas remain saturated with medical professionals. To address these imbalances, Romania has primarily relied on financial incentives and relaxed regulations to encourage doctors to establish practices in underserved areas. However, these measures alone have proven insufficient. A more comprehensive strategy – including supportive infrastructure, professional development opportunities, and stronger integration of rural healthcare into broader workforce planning – is needed to ensure equitable distribution of health professionals across the country (see Section 4.2 in Chapter 4).

The increased availability of teleconsultations during the pandemic helped improving access to care to some extent. The share of the population who had received a remote medical consultation increased from 22% to 30% between June/July 2020 and February/March 2021 thanks to the legislation enabling the widespread use of telemedicine (OECD/European Observatory on Health Systems and Policies, 2023[11]). In 2020, the government promulgated an emergency ordinance to boost the use of telemedicine, which subsequently helped to offset access problems in rural areas in particular. The ordinance simplified the administrative procedure for video consultations and GP prescriptions for patients with chronic conditions (OECD/European Observatory on Health Systems and Policies, 2023[11]). Following the regulation, the healthcare act was modified in 2022 to enable telemedicine further by setting the legal framework, which subsequently led to the identification and adoption of medical services and requirements for telemedicine (European Observatory on Health Systems and Policies, 2022[12]). However, teleconsultation uptake has been hindered by misaligned financial incentives. Under the previous payment system, remote consultations were covered under capitation, whereas in-person consultations generated fee-for-service payments – discouraging doctors from offering remote care. To address this, the new contractual

framework now specifies teleconsultation services, with dedicated reimbursement rates to make them financially attractive for providers. Once the associated authorisation requirements are finalised, these services will be formally included in the CNAS service package, paving the way for broader telehealth expansion.

Digital engagement in health remains low in Romania compared to OECD countries, reflecting broader challenges in telemedicine implementation and system digitalisation. In 2024, only about 30% of Romanians used the internet to search for health information – roughly half the OECD average of 60%. Even fewer (around 10%) booked medical appointments online or accessed their health records, despite modest gains since 2018. The gap with OECD countries has widened most notably in these transactional services, underscoring the slow uptake of digital tools in routine care (Figure 3.3) (Section 2.3 in Chapter 2). As a next step to translate legislative action to tangible improvement, Romania would greatly benefit from an integrated telemedicine platform that would allow doctors to remotely consult with patients and access their data at the same time. During the pandemic, doctors mainly provided teleconsultations through communication apps, which posed significant risks to data privacy and security. Establishing such platform will be the first and most important step in ensuring secure digital access to care and facilitating information sharing and exchange between providers.

Figure 3.3. The use of digital solutions for health are below the OECD average in Romania



Source: Eurostat (2025[13]), Individuals - internet activities, https://doi.org/10.2908/ISOC_CI_AC_I. Adapted from OECD/European Observatory on Health Systems and Policies (2025[4]), Country Health Profile 2025: Romania.

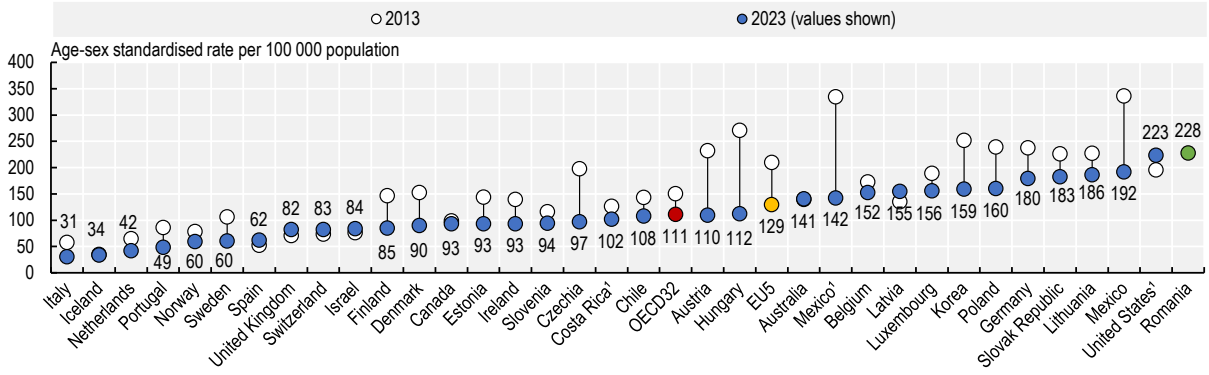
3.2. Improving quality of care

3.2.1. Avoidable admissions are high for diabetes, asthma and COPD, but remain low for congestive heart failure

Diabetes mellitus is one of the NCDs with increasing prevalence in Romania, and avoidable hospital admission rates due to diabetes are among the highest compared to OECD countries. In 2023, there were 228 admissions per 100 000 population after the pandemic-induced decline in visits to hospitals (Figure 3.4). This is mainly due to weak NCD management at primary care level, as well as late diagnosis and intervention of diabetes: 70% of diabetes cases are diagnosed at an advanced stage, when

complications are already present and require more intensive interventions (The Romanian Diabetes Forum, 2022[14]).

Figure 3.4. Avoidable hospital admissions due to diabetes in Romania were higher than in most OECD countries



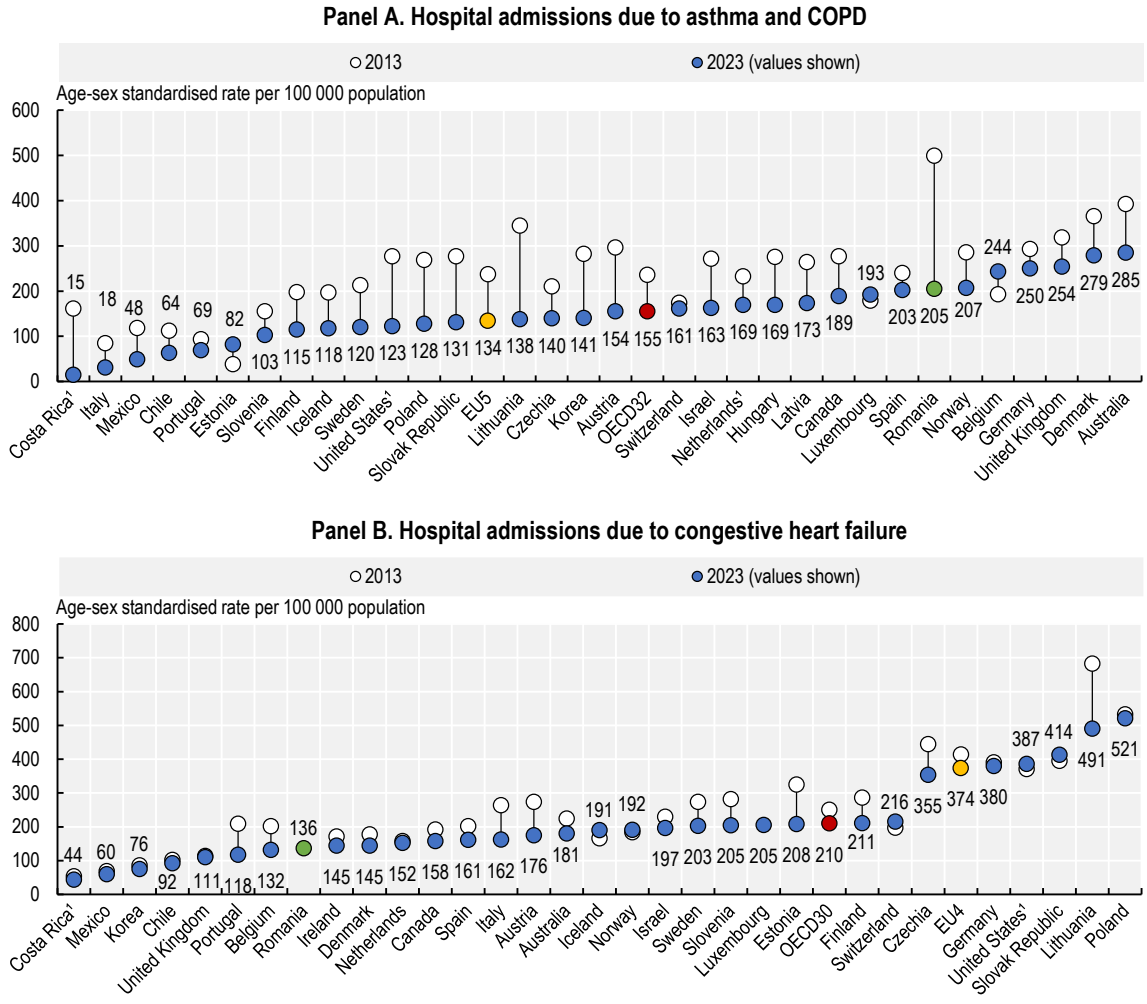
Note: Data refer to 2023 or nearest year available. 1. Latest data from 2021-2022.
Source: OECD (2025[15]), *Health at a Glance 2025: OECD Indicators*, https://doi.org/10.1787/8f9e3f98-en.

In 2020, Romania adopted its first National Diabetes Prevention Programme, financed by the Ministry of Health, to strengthen early detection and prevention: this enabled family physicians to screen high-risk individuals and run health education initiatives. However, they still play a limited role in ongoing diabetes management, as specialist care remains the dominant treatment pathway. This contributes to delays in intervention due to long waiting times at secondary care level – a growing challenge, given that the national curative health programme for diabetes served 1.3 million patients in 2024 (CNAS, 2025[16]). In an effort to relieve pressure on specialists, the government has recently allowed family physicians to prescribe certain antidiabetic medications for non-complex cases, signalling an important but modest shift toward primary care-based management.

To meaningfully improve chronic disease outcomes and reduce avoidable hospital admissions, Romania needs clearer action to strengthen care co-ordination and leverage the full potential of primary care. While the National Health Strategy 2023-2030 outlines goals such as multidisciplinary team-based care and nurse-led co-ordination, no concrete steps have yet been taken to operationalise these efforts. A crucial missing component is a national diabetes registry: the current National Diabetes Programme collects only basic statistics on service use and patient numbers, without tracking clinical outcomes or adherence to treatment guidelines. With NRRP support, Romania plans to establish such a registry, which would play a vital role in benchmarking care quality, tracking patient outcomes, and ensuring guideline-based diabetes management nationwide.

Avoidable hospital admissions for congestive heart failure, asthma and chronic obstructive pulmonary disease (COPD) have declined between 2019 and 2021 in Romania, as in many OECD countries. The steep reductions in hospital admissions for these chronic conditions were largely due to disruptions in hospital services and hesitancy among patients to seek hospital care during the COVID-19 pandemic. The most recent data show that avoidable admissions for asthma and COPD remain very high compared to OECD and EU5 averages, but admissions for congestive heart failure is in the lower range (Figure 3.5).

Figure 3.5. Avoidable hospital admissions for asthma and COPD in Romania is among the highest compared to OECD, but lower for congestive heart failure

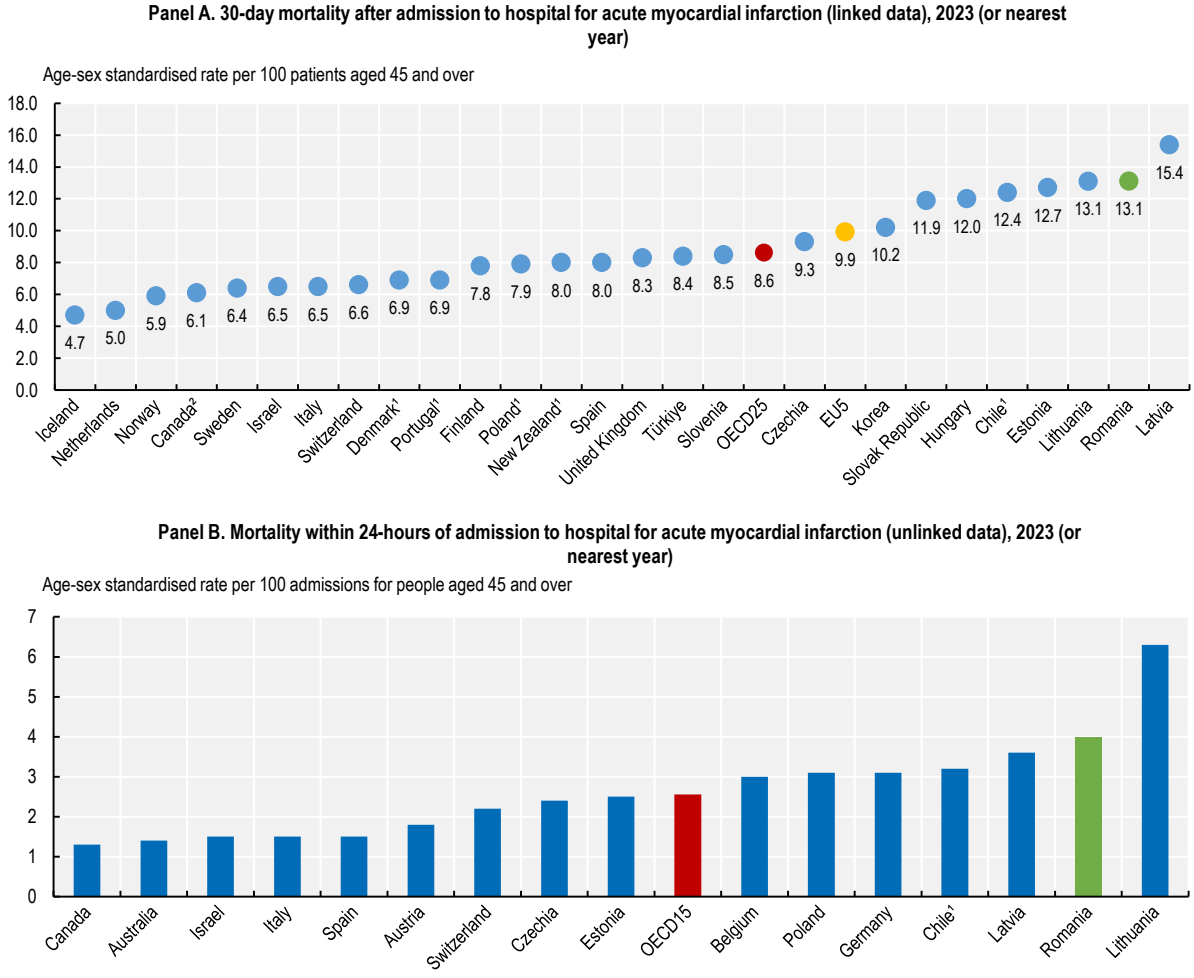


Note: For Panel A: 1. Latest data from 2021-2022. For Panel B: 1. Latest data from 2021-2022.
Source: OECD (2025[15]), *Health at a Glance 2025: OECD Indicators*, https://doi.org/10.1787/8f9e3f98-en.

3.2.2. 30-day mortality rate for acute myocardial infarction is high

In Romania, 30-day mortality rate for acute myocardial infarction (AMI) was 13.1 deaths per 100 patients aged 45 and over in 2023 (linked data), much higher than the EU5 average of 9.9 deaths and the OECD average of 8.6 deaths (Figure 3.6 Panel A). While Romania has an established acute intervention programme for AMI in emergency hospitals, there is considerable room for improvement for acute intervention of AMI: in 2023, 24-hour mortality rate for AMI was 4 per 100 patients aged 45 and over, almost double the OECD average (Figure 3.6 Panel B). This suggests that bottlenecks in early diagnosis and rapid treatment initiation continue to undermine the effectiveness of acute cardiac care.

Figure 3.6. The 24-hour and 30-day AMI mortality rates in Romania are well above the OECD average



Note: For Panel A: 1. Latest data from 2020-2022. 2. Data do not include deaths outside acute care hospitals. For Panel B: 1. Latest data from 2020-2021.
Source: OECD (2025[15]), *Health at a Glance 2025: OECD Indicators*, https://doi.org/10.1787/8f9e3f98-en.

3.2.3. Cancer mortality is high, suggesting room for improvement in early detection and treatment

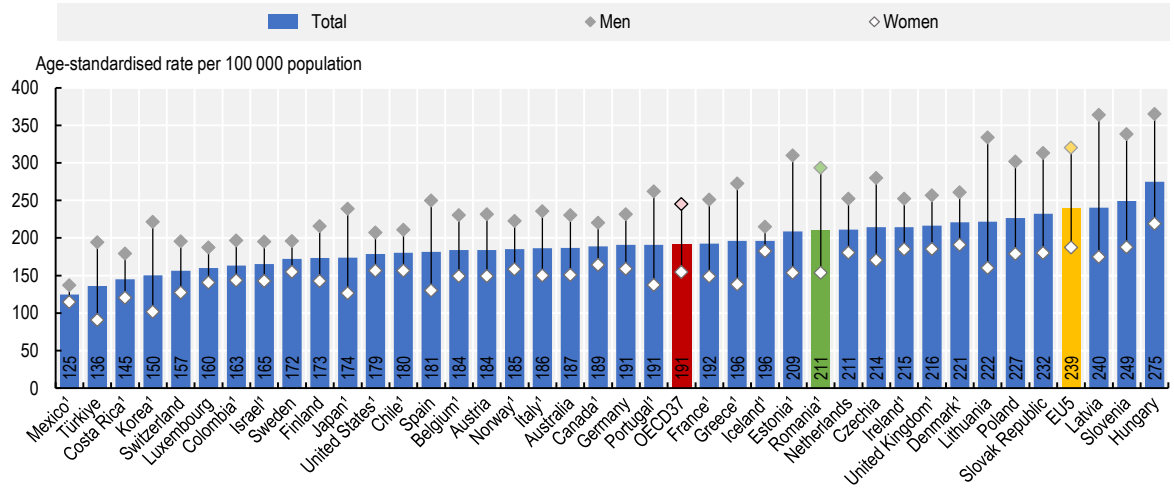
Cancer mortality is among the highest, but major prevention gains are possible through addressing behavioural risk factors

Cancer mortality rate was among the highest compared to OECD countries (211 compared to 191 deaths per 100 000 population in 2022) but remained below the neighbouring EU5 average (239) (Figure 3.7). The gap between men and women is wide: 294 deaths per 100 000 population from cancer in men, compared to 154 deaths for women. This is mainly due to large differences in risk factors between men and women, as excessive alcohol consumption and smoking are mainly problems among men (OECD/European Observatory on Health Systems and Policies, 2023[11]).

Reducing behavioural risk factors would have significant health benefits. According to OECD Strategic Public Health Planning (SPHeP) modelling, meeting tobacco reduction targets alone could prevent more

than 65 000 cancer cases in Romania between 2023 and 2050. In addition, achieving national goals on alcohol consumption and obesity could avert a further about 25 000 cancer cases respectively over the same period (OECD, 2024[17]).

Figure 3.7. Romania ranks above the OECD average in cancer mortality



Note: Data refer to 2023 or nearest year. 1. 2021-2022 data.
Source: OECD (2025[15]), *Health at a Glance 2025: OECD Indicators*, https://doi.org/10.1787/8f9e3f98-en.

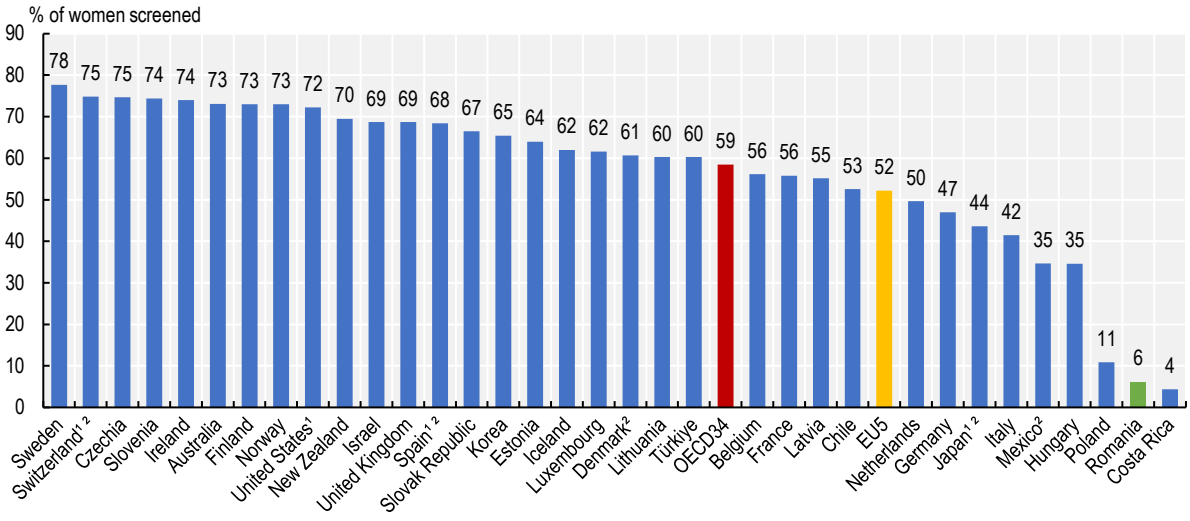
Cancer care is free of charge through the national curative health programme in Romania, both for insured and uninsured people. However, this has not led to better cancer outcomes yet. Cancer mortality has decreased only modestly between over the past decade and remained the second leading cause of mortality in Romania in 2022, partly reflecting slow progress made in the quality and performance of cancer care.

While lung, colorectal, and prostate cancers were the most common causes of cancer deaths in men in 2021; breast, colorectal, and lung cancers were the top causes in women (OECD/European Commission, 2025[18]). With more than 100 000 estimated new cancer cases in 2022, overall cancer incidence rate in Romania was lower than the EU average – partly due to underdiagnosis (OECD/European Observatory on Health Systems and Policies, 2025[4]).

Population-based cancer screening is not effectively in place for common cancers, but the country is making progress

Poor cancer outcomes in Romania are closely linked to the absence of effective, population-based screening programmes that enable early detection. According to programme data, only 6% of Romanian women aged between 20 and 69 years had a cervical screening in 2023, a figure well below the OECD average (59%) and neighbouring EU5 average (52%) (Figure 3.8). The programme data are not available for other common cancers such as colorectal and breast cancer. However, survey data showed that about 3% of Romanians aged between 50 and 74 years reported having had colorectal cancer screening in 2019, around 15 times lower than the OECD average of 45%. Around one in ten women aged between 50 and 69 years had reportedly mammography for breast cancer screening, almost seven times lower than the OECD average. As in many OECD countries, there is a clear socio-economic disparity in the uptake of screening. This is primarily due to the absence of population-based programmes: reliance on opportunistic screening has entrenched stark socio-economic inequalities, with wealthier individuals significantly more likely to be screened than those on lower incomes (OECD, 2023[19]).

Figure 3.8. Uptake for cervical cancer screening is very low in Romania



Note: Data refer to 2023 or nearest year. Programme data unless otherwise stated. 1. Survey data. 2. Latest data from 2020-2022.
Source: OECD (2025[15]), *Health at a Glance 2025: OECD Indicators*, https://doi.org/10.1787/8f9e3f98-en.

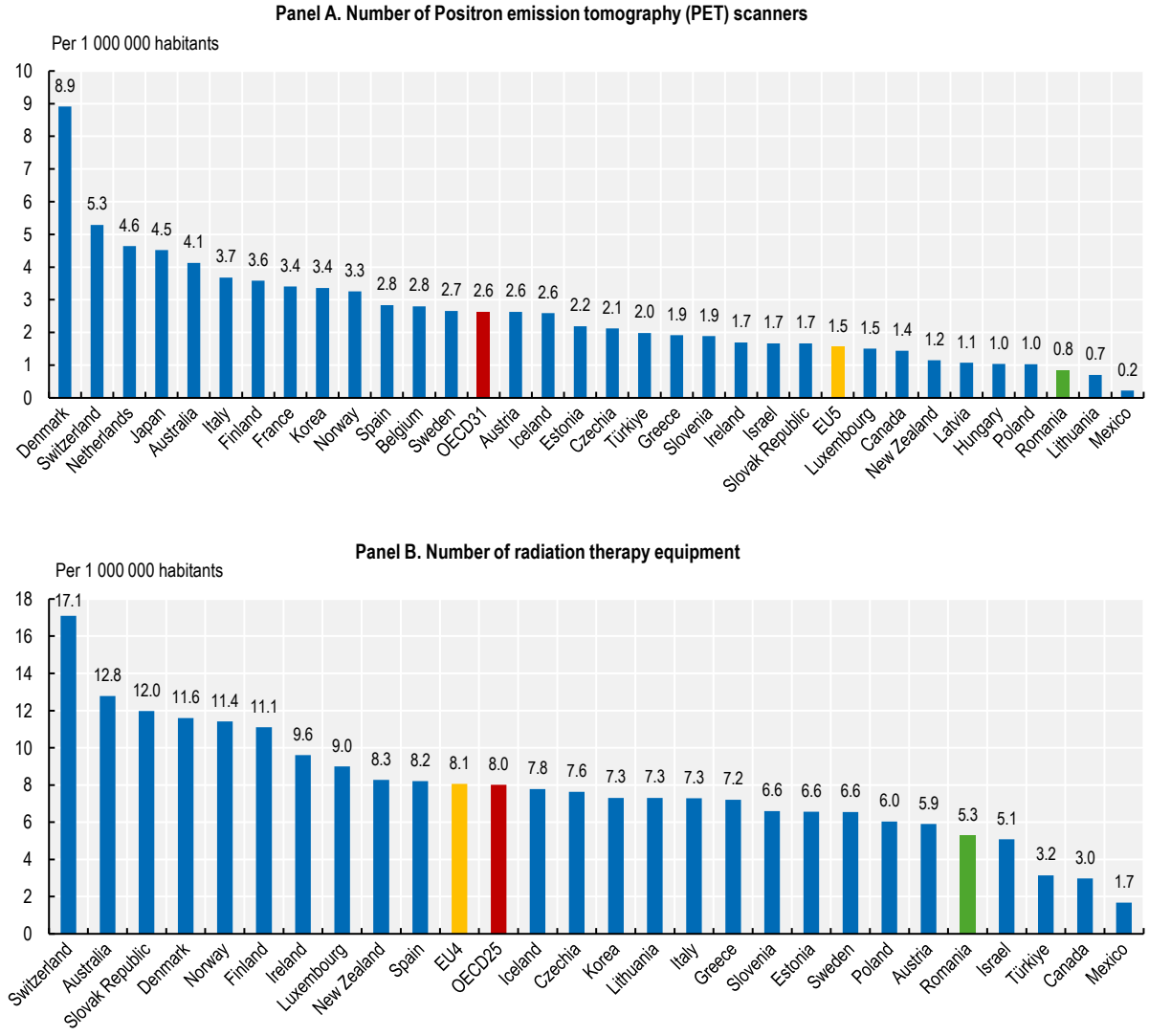
Romania launched a cervical cancer screening programme in 2012 for women aged 25 to 64 years, regardless of insurance status. As of now, it is the only active nationwide screening initiative, but its effectiveness has been hampered by several deficiencies. In the first five years, only 12% of eligible women received programmatic smear tests, while up to 30% underwent opportunistic testing (OECD, 2023[19]). The programme fell short of its goals due to the absence of a clearly defined pathway for managing positive results, causing confusion, particularly among uninsured individuals. A shortage of skilled personnel to interpret diagnostic materials further impeded its success. In response, Romania developed new methodology and guidelines for cervical cancer screening in 2019, and family physicians took on new responsibilities to facilitate test material collection in cervical screening in 2024. Quality and safety indicators for cervical cancer screening were also adopted in 2024 (OECD/European Commission, 2025[18]). As a next step, the country aims to establish a national screening registry to ensure proper follow-up for women with positive smear tests.

The country has also intensified its efforts to improve population-based screening programmes for breast and colorectal cancers by carrying out EU-funded pilot projects. In 2022, the country announced the National Cancer Plan 2022-2027 that dedicates approximately EUR 400 million to cancer prevention, early detection and screening, diagnostics and treatment, research infrastructure, professional training, and the development of standards and practice protocols (OECD, 2023[19]). In 2024, national plans were put in place to scale up pilot screening projects to fully fledged population-based programmes. These plans include new training programmes for primary healthcare physicians and other health workers, increased involvement of community nurses and health mediators, and specific provisions to use national and structural funds for testing, diagnostics, and treatment of precancerous lesions among vulnerable population groups (OECD/European Commission, 2025[18]). Supported by the EU funds, and the country has recently acquired ten mobile caravans to deliver cervical and breast cancer screenings in underserved areas. While these initiatives are a step in the right direction, it is clear that more robust action is needed to enhance the efficacy of screening. To expand these initiatives beyond the regional level, additional funding is also necessary to procure more diagnostic and treatment equipment and to train specialised staff.

Cancer care is hampered by inadequate medical equipment and a lack of national registries

Medical equipment capacity in the country is insufficient to meet demand in cancer care. Positron emission tomography scanner numbers were markedly lower than both the OECD and neighbouring EU5 averages in 2023 (Figure 3.9, Panel A). Similarly, Romania had around 5 radiation therapy units per 1 000 000 inhabitants in 2023, a figure significantly lower than the EU4 average and the OECD average (Figure 3.9, Panel B). The shortage in equipment, combined with inadequate human resources and insufficient investment in technology, leads to territorial disparities in cancer care.

Figure 3.9. Romania had markedly lower equipment capacity in cancer compared to OECD countries



Note: Data refer to 2023 or nearest year.
Source: OECD Health Statistics 2025.

The suboptimal functioning of national cancer registries poses a challenge for cancer care management and quality. Data fragmentation and a lack of systematic collection makes it difficult to monitor patient

progress, follow-up, and outcomes after positive cancer screenings. Following the announcement of the National Cancer Plan 2022-2027, the MoH has begun designing a national cancer registry to consolidate data on cancer cases and treatment from eight regional centres. Funded by NRRP, the digitalisation of this registry will enable better evaluation of cancer care quality and effectiveness, ultimately improving cancer surveillance.

Effective implementation of the National Cancer Plan 2022-2027 and more funding will be key to progress

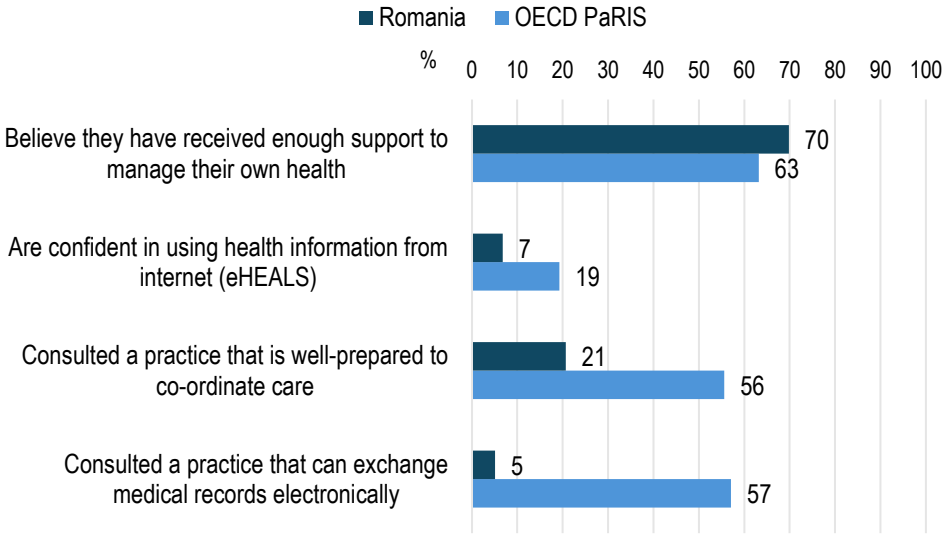
Romania has a National Cancer Plan 2022-2027 and benefits from the Europe's Beating Cancer plan addressing cancer control. Approximately EUR 400 million from the National Health Insurance Fund has been allocated for its implementation, covering prevention, early detection and screening, diagnostics, treatment, research infrastructure, professional training, and the development of clinical standards and practice protocols. Additional investment from the European Regional Development Fund under the Operational Health Programme 2021-2027 is helping to modernise oncology wards and institutes, including upgrades to radiotherapy and chemotherapy units. Romania is also preparing to open its first proton therapy centre, funded through the Health Operational Programme, marking a significant step forward in advanced cancer treatment capacity.

3.2.4. Despite feeling supported, patients with chronic conditions in Romania report poor health outcomes and experience major gaps in digital and co-ordinated care

People with chronic conditions in Romania reported notably poorer health outcomes and experiences compared to the average of countries participating in the OECD Patient-Reported Indicator Survey (PaRIS). In 2024, only 43% of patients rated their general or physical health as good (OECD PaRIS average: 66%), and just two in five felt confident managing their own health (OECD PaRIS average: 59%) (OECD, 2025[20]). Although a majority reported receiving adequate support to self-manage (70%), primary care capacity remains limited in key areas (Figure 3.10). About one in five patients consulted a practice that was well-prepared to co-ordinate care, and only 5% were seen in practices capable of EHR exchange – a stark contrast to the OECD average. Patients with multiple chronic conditions were also less likely to receive sufficiently long consultations or regular follow-up, highlighting broader system-level capacity constraints in managing complex care needs.

Figure 3.10. Most patients with chronic conditions in Romania felt supported in managing their health, but few benefited from digitally connected or well-co-ordinated care

Percentage of people with chronic conditions



Note: Results for people with one or more chronic conditions who are registered with a practice. Co-production: Patient receiving enough support and feeling confident in using health information from the internet (eHEALS), as reported by patients. Co-ordination: Patients managed in practices that are well prepared to co-ordinate care and that can exchange medical records electronically, as reported by patients and participating primary care practices. OECD PaRIS average does not include the United States for practice-level indicators.
Source: Does Healthcare Deliver? Results From the Patient-Reported Indicator Surveys: Romania (2025).

3.2.5. Romania needs to take concrete action to improve care continuity and co-ordination for patients with complex needs

Patients often face a lack of co-ordination among different care providers in Romania, leading to fragmented care and patient pathways, particularly for patients with complex needs. Oncology patients need services that extend beyond cancer treatment, such as palliative care, pain management or psychosocial support. Meeting patients' needs in a seamless manner is an objective pursued by the National Cancer Plan, but actions so far have been limited. The recent changes in the framework contract aims expand access to cancer care and psycho-oncology services, but palliative care services remain suboptimal (OECD/European Commission, 2025[18]).

To improve care quality for patients with chronic conditions, Romania's RSHMs sets out plans for better care co-ordination and continuity. This entails defining referral systems across care levels, establishing patient pathways for key patient groups, and developing metrics to evaluate hospital activity and referral mechanisms. These plans have been recently released but putting them into practice will first and foremost require stewardship, commitment, and collaboration across authorities.

3.2.6. Romania is committed to address nosocomial infections and should continue efforts to improve reporting

Healthcare associated infection (HAI), also known as nosocomial infections, are infections acquired while receiving healthcare that were absent upon admission. HAIs are often caused by antibiotic-resistant

bacteria (see Section 4.3 in Chapter 4). According to the European Centre for Disease Prevention and Control (ECDC), the average prevalence of HAI was 6.8% in EU countries in 2022, while the prevalence was 3.1% in Romania, one of the lowest in the EU (ECDC, 2024[21]). In contrast, the country shows unfavourable levels of infection, prevention and control (IPC) capacity (e.g. IPC nurses, beds with alcohol based handrub dispenser) compared to EU countries, suggesting that the low HAI prevalence could be related to under-reporting of cases rather than better performance (Iancu et al., 2023[22]) (Table 3.1). Despite significant improvements in HAI reporting in Romania, with reported incidence nearly tripling in the last decade, HAIs still appear to be underreported (European Observatory on Health Systems and Policies, 2023[23]). The country requires hospitals to report nosocomial infection rates to inform the surveillance system for communicable diseases and to report to the ECDC. However, evidence show data on nosocomial infections are not systematically collected and reported, calling for further improvement. Gaps in HAI reporting were identified in an activity report from 2019 underlining that 25% of the clinics analysed did not comply with the annual nosocomial infection surveillance and control plan, 8% did not have a register, and 8% did not collect data on the incidence and prevalence of HAI (Szabó et al., 2022[24]).

Table 3.1. Romania has lower nosocomial infection prevalence compared to EU countries despite the limited infection, prevention and control capacity, signalling under-reporting of cases

		Minimum among EU/EEA	EU/EEA (mean or median)	Maximum among EU/EEA	Romania
HAI indicator	HAI prevalence (% of patients with HAI)	3.0	6.8 (mean) 7 (median)	13.8	3.1
Infection prevention and control indicators	IPC nurses (full-time equivalents per 250 beds)	0.28	1.25 (median)	3.28	1.11
	Beds with alcohol-based handrub dispenser at point of care (% beds)	18.5	49.2 (median)	100	18.5
	Beds in single rooms (% beds)	3.2	15.8 (median)	56.5	4.5
	Blood culture sets (number per 1 000 patient-days)	12.4	44.7 (median)	167.1	14.6

Note: Data refer to 2022. Refers to EU and European Economic Area (EEA) countries. Green colour indicates better performance than EU/EEA mean/median, and orange colour indicates worse performance than EU/EEA mean/median.
Source: Adapted from the country factsheet of Romania published with the Point Prevalence Survey of Healthcare-Associated Infection and Antimicrobial Use In Acute Care Hospitals 2022-2023 report (ECDC, 2024), https://www.ecdc.europa.eu/en/publications-data/country-factsheet-romania.

In 2023, the government adopted the National Strategy for Preventing and Limiting Healthcare-Associated Infections and Combatting Antimicrobial Resistance (2023-2030) to improve patient safety and quality of care in hospital settings. The strategy's objectives include (1) improving awareness and understanding of antimicrobial resistance (AMR) through communication, education and training, (2) improving surveillance and research on resistant bacteria, (3) implementing infection prevention and control measures, and (4) optimising the use of antibiotics. The plan is being translated into action following its introduction, especially with the establishment of a special training for HAI dedicated to nurses. Further, NRRP also

invests in equipping at least 25 public hospitals with HAI prevention and control equipment and tools. Romania should strengthen efforts to operationalise measures set out in the strategy and continue to improve reporting and monitoring of HAIs.

3.2.7. The commendable progress made in care quality management in hospitals should now extend to measuring and assuring quality outside hospital settings

Romania is committed to fostering a robust culture of care quality and patient safety, a goal underscored by the establishment of ANMCS in 2015. ANMCS plays a key role in the development of quality management and the accreditation of healthcare providers through an objective, systematic process. It assesses quality standards and grants hospital accreditation based on indicators such as sentinel events, 30-day readmission rates, and the number of recorded patient complaints. Currently, clinical (technical) audits and performance indicators are not included in the accreditation process. Additionally, the reporting of nosocomial infections is not required in the accreditation process. This is to prevent hospitals from perceiving it as a potential form of penalisation for high infection rates, which may ultimately result in under-reporting of such cases.

Hospitals must obtain accreditation and establish quality management units to secure contracts with CNAS. The responsibility for monitoring the quality of care in contracted hospitals lies with CNAS and DHIHs. Due to a shortage of specialised staff, these bodies primarily focus on performance indicators rather than a comprehensive assessment of care quality. In response, ANMCS is currently in collaboration with INMSS to train “quality experts” to evaluate quality standards in hospitals and engage in international projects to learn from other countries’ training and evaluation systems.

While most effort has traditionally focussed on hospital’s accreditation and setting standards, quality measurement and monitoring in ambulatory services outside the hospital sector lags behind. However, ensuring continuous quality improvement and enhance quality infrastructure requires going beyond hospital settings and strengthening post-accreditation monitoring mechanisms. ANMCS has recently published the specific quality management standards for ambulatory settings, but the quality assessment process is on a voluntary basis in these settings.

Romania faces several obstacles to effectively implementing healthcare quality standards and measurement systems. A key issue is the absence of a structured, system-wide framework for quality monitoring, compounded by fragmented and poorly digitalised health information systems (see Section 2.3 in Chapter 2). Currently, the CNAS and ANMCS collect data independently for separate purposes – resource allocation and hospital accreditation – with little integration or standardisation. In primary care, the continued reliance on paper-based documentation further hinders reliable assessment of care quality and safety. These structural shortcomings are exacerbated by limited financial resources and low awareness among medical staff regarding quality and patient safety practices. To drive improvement, Romania needs to establish a cohesive system for measuring, reporting, and analysing healthcare quality and safety metrics, underpinned by accelerated digitalisation. Better use of EHRs and telemedicine could enhance communication across care settings, reduce medical errors, and strengthen co-ordination – all essential for embedding a culture of quality and safety in healthcare delivery.

Although progress has been made in defining care quality standards, Romania still lacks a mature system for measuring performance and incentivising high-quality care. A promising development is a pilot programme funded through the NRRP and co-developed by the Ministry of Health, CNAS, and ANMCS. The initiative aims to introduce quality metrics tied to performance-based payments through the new Health Service Quality Fund. The first phase focussed on developing and testing quality indicators in hospitals, with plans to expand the programme to ambulatory care providers by the end of its implementation period.

Romania has consistently engaged in the OECD PaRIS project and the work of the OECD Working Party on Healthcare Quality and Outcome to improve quality and safety of healthcare with the involvement of

ANMCS. To further improve care quality measurement and performance assessment, the country could also consider developing a health system performance assessment (HSPA) framework drawing from international best practices. Developing such framework would ultimately benefit from the digitalisation of the health system which allows systematic data collection for performance assessment and reduces reliance on paper-based reporting. A key initiative in this effort is the establishment of the National Observatory for Health Data through the Operational Health Programme. The Observatory could facilitate real-time data collection and analysis, which would contribute to build a robust and dynamic HSPA. By leveraging digital technologies, Romania can create a data-driven healthcare system that continuously improves based on timely and accurate performance metrics.

3.3. Mental healthcare

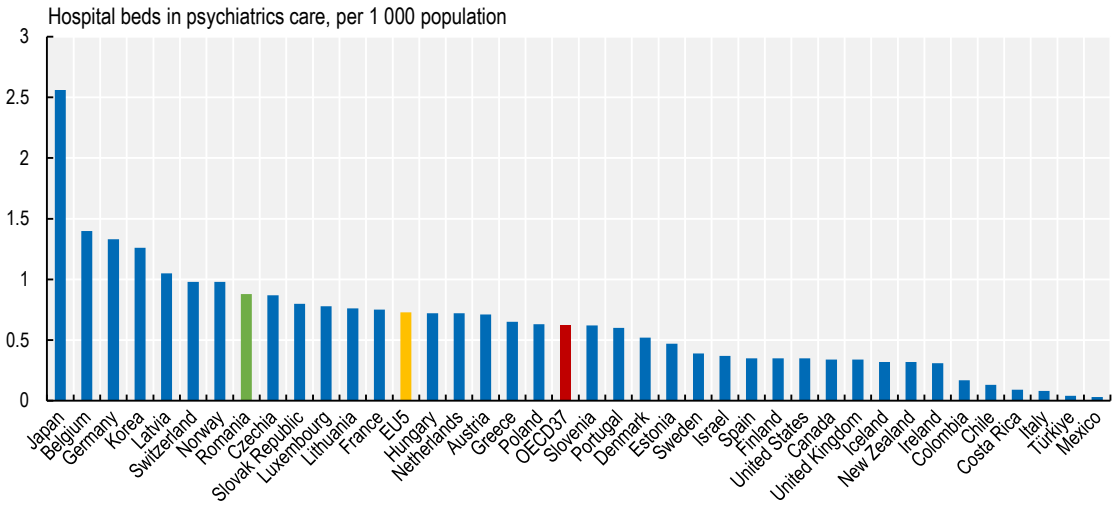
3.3.1. Mental health disorders have substantial costs to the health and other sectors, despite the relatively low prevalence of mental health disorders

Mental health disorders costed almost EUR 3.5 billion to Romania in 2018, equivalent to 2.1% of gross domestic product (GDP). While direct costs on the health system and social benefits accounted for 1.4% of GDP, indirect costs on the labour market were equal to 0.7% (OECD/European Union, 2018[25]). A more recent analysis revealed that the total cost estimation increased to around EUR 10 billion in 2022, representing 3.8% of GDP (Economic and Social Council of Romania, 2023[26]). Mental health disorders are the second leading cause of years lived with disability in Romania, with mental health problems accounting for 12% of total unmet needs in the population (see Section 2.1 in Chapter 2).

3.3.2. The mental health system remains hospital-centric

Romania has markedly higher number of psychiatric beds, with 0.9 beds per 1 000 population in 2023 and exceeded the large majority of OECD countries (Figure 3.11). Bed capacity increased by 4% compared to a decade ago, despite the initiatives to reorganise the system towards community-based care. Mental health disorders were one of the most common hospital diagnoses and accounted for 6.2% of hospital admissions in 2020 even during the pandemic, reflecting the persistent reliance on institutional care (National Institute of Public Health, 2020[27]).

Figure 3.11. Romania has markedly higher psychiatric beds compared to the OECD and EU averages



Note: Data refer to 2023 or nearest year.
Source: OECD Health Statistics 2025.

The mental health system remains hospital-centric with high reliance on institutional care and pharmacotherapy in Romania. Stigma, coupled with shortages of physical and human resources, hinders patient re-integration and limits access to psychosocial support. As a result, many individuals with long-term mental health needs experience a "revolving door" pattern of repeated hospitalisation due to the lack of adequate follow-up care at the primary level. Post-discharge support, including for patients who have attempted suicide, is often fragmented and insufficiently focussed on rehabilitation and social reintegration. Staff shortages also contribute to concerning conditions in some psychiatric facilities, including hygiene and sanitation issues. While many hospitalised patients report good interactions with healthcare staff, there have been documented allegations of ill-treatment in certain mental health hospitals (Economic and Social Council of Romania, 2023[26]; Euractiv, 2023[28]).

3.3.3. Mental health services are available at both public and private settings

Mental healthcare is free of charge for insured people, and most people often visit psychiatrists for their needs. Specialist care is accessible at both public and private settings through mental health centres, mental health hospitals, general hospitals, private clinics or individual practices. People with chronic mental health conditions are also entitled to medication for free, if prescribed in line with the treatment guidelines by a CNAS-contracted psychiatrist.

There are 52 community mental health centres and 34 mental health hospitals, located mainly in urban and densely populated areas. Community mental health centres provide care for people with mental health conditions including early detection, psychosocial rehabilitation, consultation and treatment. The services are managed by multidisciplinary teams consisting of psychiatrists, nurses, other mental health professionals. The availability of these services, particularly in rural areas, is reportedly hampered by lack of specialised mental health professionals. Community assistance programmes and health mediators also take part in outreach activities and the management of mental healthcare provision for vulnerable groups, such as the Roma population or those living in rural areas. However, there is a lack of integration between community mental health services and other sectors. For instance, community centres do not offer social care, counselling for education or employment, or crisis management for individuals at risk of suicidal or homicidal activities.

Psychotherapy and counselling are available in both public and private settings for the insured population. However, the availability of psychotherapy and counselling in public services is nearly absent due to the lack of staff, leading to people seeking care in private settings with high out-of-pocket payments.

3.3.4. INSP and NGOs take role in prevention and promotion activities, but a standalone national mental health strategy plan is missing

Romania does not have a standalone national strategy plan for mental health, but relevant actions and strategies are defined and set under the National Mental Health Programme and the National Health Strategy 2023-2030. The National Mental Health Programme is one of the national curative health programmes run by CNAS and consists of three distinct subprograms targeting substance misuse, autism spectrum disorders, and major depressive disorder. The National Health Strategy 2023-2030 defines goals for the promotion, prevention, and intervention of mental health disorders. The objectives include identifying relevant mental health actors in society, improving community-based services through multidisciplinary teams, developing preventive mental health interventions, and monitoring epidemiological trends. However, the implementation of these strategies suffers from lack of funding and poor digitalisation in the health system.

Romania's efforts to prevent mental ill-health have mainly focussed on raising awareness through national campaigns. INSP carries out national campaigns periodically to raise awareness among citizens and to promote early detection of mental health disorders. In 2024, the national "Don't let depression control your life!" campaign targeted youth mental health, while the previous ones focussed on mental health issues among elderly and maternal mental health (National Institute of Public Health, 2023[29]; National Institute of Public Health, 2024[30]). On a smaller scale, INSP also runs campaigns to raise awareness among health staff and education professionals and to combat stigma.

Romania lacks dedicated strategies or plans targeting key mental health issues such as stigma, dementia, child mental health, suicide or alcohol use. The National Health Strategy 2023-2030 has one objective addressing the monitoring of alcohol consumption to devise evidence-based interventions but does not mention stigma and suicide. Despite the worrying trend in suicide rates among adolescents, the National Strategy for Child and Adolescent Mental Health 2016-2020 only addresses suicide prevention once, without specifying the actions to be taken. To enhance the effectiveness of suicide prevention, a multifaceted programme could be implemented. For instance, the programme *Suicide Prevention in Austria* incorporates several components such as providing support to individuals at risk, restricting access to means of suicide, and safe-guarding of hotspots for suicide attempts (OECD, 2025[31]).

NGOs and civil society also play a role in promotion, prevention and intervention. Mainly funded by the European Union, the Estuar Foundation has been involved in a variety of activities such as establishing psychosocial support programmes for Ukrainian immigrants, introducing first call centre for the Romanian health workers during the pandemic, providing housing and shelter for those in need, and offering counselling and psychiatric consultations for people with mental health conditions. Similarly, another non-profit organisation set up the only hotline in Romania for people with suicidal thoughts with the aim of providing emergency counselling in crisis situations (Civic Labs, 2023[32]). However, as of now, there are no mental health-related patient organisations to further support these activities and promote patient rights.

3.3.5. The National Health Strategy 2023-2030 sets out the objectives to strengthen community-based care

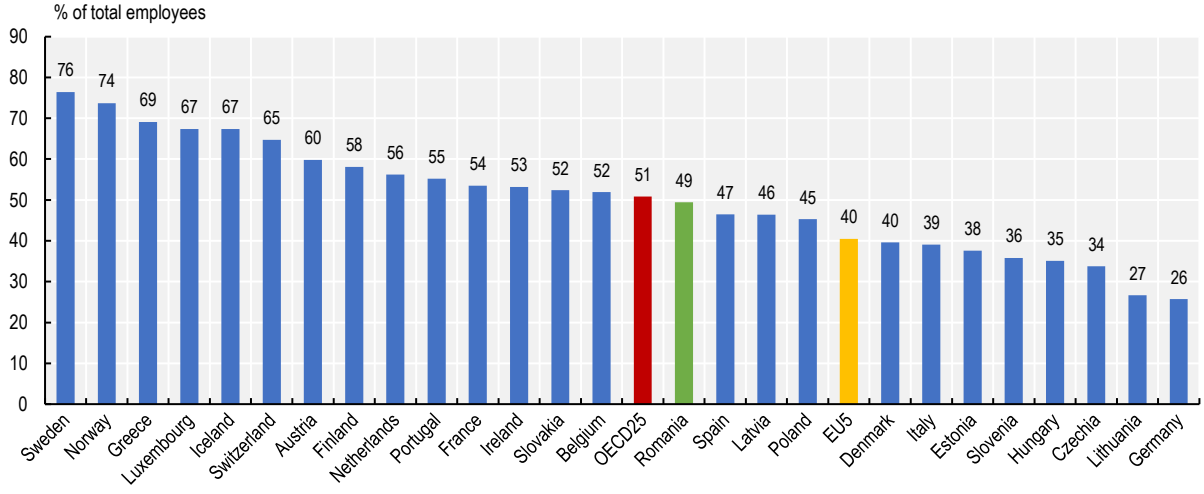
Shifting the care paradigm from institutional care to community-based care is a slow but ongoing process in Romania. The very first efforts started around in the early 2000s, yet the country still hasn't made substantial progress except for the establishment of community mental health centres. More recently, the National Health Strategy Plan 2023-2030 sets out the objectives to strengthen community-based services

and increase the capacity to respond to the mental health needs of Romanians. The Plan places particular emphasis on the integration of mental health interventions at community level to improve the re-integration of patients into society. To achieve this, the Plan foresees an increase in the workforce and logistical capacity of community-based outpatient mental health services to establish multidisciplinary teams with a focus on prevention and early intervention. To ensure the accessibility for disadvantaged communities, community health nurses and health mediators will play a pivotal role in these multidisciplinary teams to facilitate the communication between patients and care providers. Additionally, family physicians are expected to play a greater role in the identification and timely management of mental health conditions through the introduction of appropriate diagnostic and referral tools. Overall, the plan aims to reduce the number of hospital admissions due to mental health conditions by enhancing community-based care, thereby alleviating the burden on hospitals (Ministry of Health, 2022[33]).

3.3.6. Mental health is touched upon in education and employment policies, but more effort is needed for the full implementation of strategies

The protection of mental well-being at workplace is ensured by legislations in Romania. According to the law, the employers are obliged to periodically assess and take action against the risks of occupational injury and diseases, including psychosocial risks. Post-traumatic stress syndrome is recognised as an occupational disease, and burnout syndrome have also been recently recognised under the scope of moral harassment at workplace. In 2022, a new legislation mandated a better protection of employees against discrimination and unfavourable treatment, particularly by prohibiting firing of employees who filed a complaint due to violation of their legal rights or discrimination. However, half of the workers in Romania reported being exposed to risk factors that can adversely affect their mental well-being in 2020 (Eurostat, 2023[34]) (Figure 3.12). Further, according to the European Survey of Enterprises on New and Emerging Risks 2019 survey, over two-third of people (64%) working in the establishments with 20 employees or more reported that their workplace did not have a procedure in place to address bullying or harassment in their workplace, compared to the EU average of 54% (European Agency for Safety and Health at Work, 2022[35]). There is a need for better co-ordination and inspection mechanisms to ensure the full implementation of these legislations, particularly in co-operation with health and social care services.

Figure 3.12. Around half of employees in Romania reported exposure to risk factors that can adversely affect their mental well-being



Note: Data refer to 2020.
Source: Eurostat (2024).

The re-integration of people with mental health conditions into the labour market is addressed to some extent, mainly through legislation. Employers receive subsidies for hiring people who have graduated from special education schools or who come from marginalised groups. People with disabilities additionally benefit from vocational training courses and job counselling both before and during employment. Return-to-work plans are available to facilitate the transition to full-time employment after long sick leave. However, they are reportedly not feasible in all sectors, as some employers are reluctant to accept these plans due to financial and logistical constraints. If possible, some employers offer other options such as flexible working hours, job reassignment or partial teleworking (Civic Labs, 2023[32]). Employees with psychiatric diagnoses reportedly stay in the system for short-term after a long sick leave, usually followed by an exit from the labour market due to disability.

Persons with chronic mental health conditions are eligible to get a disability degree that allows them to receive a monthly allowance and social assistance. In 2023, more than half (52%) of people with disability followed in social assistance institutions[1] had a psychiatric diagnosis in Romania (National Institute of Statistics, 2025[36]). Social services are provided by counties, in a co-ordinated manner with the health authorities.

In the education sector, Romania provides free medical, psychological and speech therapy assistance in schools or in medical centres, primarily to meet the needs of children with special needs. A legislation is available to tackle psychological violence and bullying in the pre-university education system, and psychopedagogical services can be accessed through dedicated school offices and county centres. School counsellors are available in schools, but there are reportedly insufficient number of counsellors to cope with the high number of students (Civic Labs, 2023[32]). County centres also organise a range of other services for both students and schools, such as speech therapy, professional guidance or advice on inclusive education in schools. Students in higher education can also seek psychological support and therapy in university psychosocial units. However, it is not clear how many of these services are accessible in school settings given that the country struggles with insufficient number of mental health professionals.

3.3.7. Increasing resources and introducing a national mental health strategy will be key to achieve a whole-of-society approach to mental health

National plans and policies set the ambitious goals for improving mental health in Romania, but not enough action has been taken yet. The country does not have a separate budget for the mental health system to improve community-based care and the conditions in mental health hospitals. Following the Council of Europe's report on ill-treatment and poor living conditions in Romanian mental health hospitals (Council of Europe, 2023[37]), an interinstitutional working group was established in 2023. The group announced a 2024-2029 action plan to improve human rights in hospitals and to ensure patients to be treated with dignity.

Poor multisectoral collaboration, and insufficient financial and human resources undermine the implementation of actions set out in policies and plans. The absence of a national strategic plan for mental health further obstructs the way to achieve a whole-of-society approach. Romania would benefit from adopting a comprehensive policy package, backed by a national mental health strategy across all relevant sectors, to strengthen mental health support. This approach should be developed with the involvement of patient associations and NGOs and be backed by adequate resources for its implementation.

3.4. Long-term care

3.4.1. Long-term care in Romania is underdeveloped with limited resources and capacity

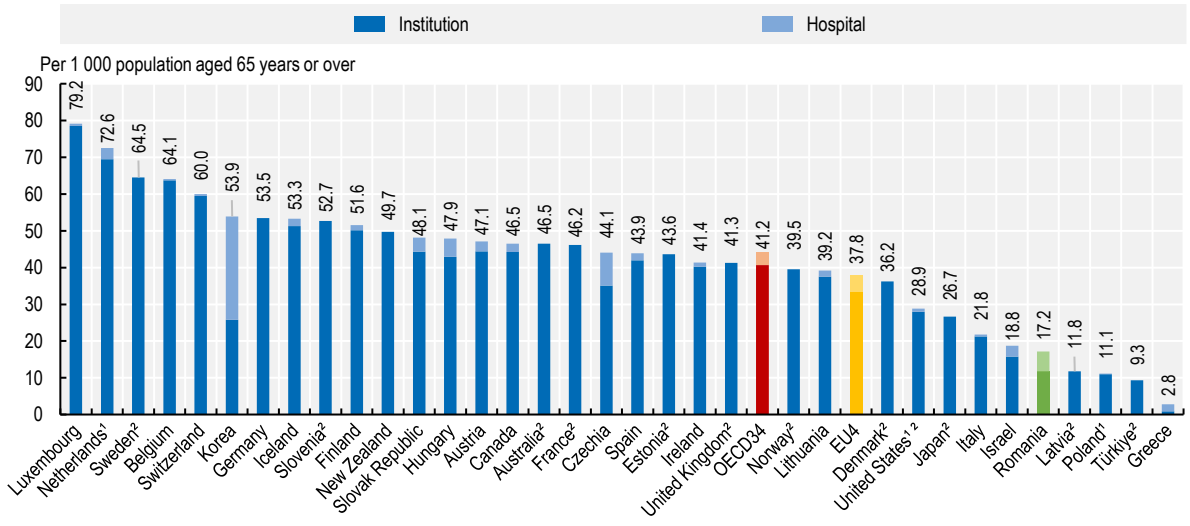
Long-term care (LTC) organisation is currently dispersed across various systems, including health, social assistance (for frail elderly people), social protection (for disabled people and children), and pension (for those benefiting from disability pension). The Ministry of Labour organises care for elderly people, while the National Authority for Disabled People, subordinated to the Ministry of Labour, is responsible for people with disabilities.

LTC can be provided at home, in residential or day care centres or by personal workers, although the vast majority of LTC is provided at home. Romania reported to the OECD that about 400 000 people receiving at-home services in 2023, and about 36 900 people received LTC in institutions in 2022. Out of the 400 000 LTC at-home recipients, nearly half (about 192 000 recipients) were aged 65 and over.

Romania's LTC system is under-funded, and most LTC expenditure is spent on hospital-based services. The tight budget allocated to LTC spending in Romania reflects the limited volume in LTC. The latest available data shows that the country spent 0.3% of its GDP on LTC in 2023, a remarkably low share compared to the OECD average of 1.7% and the neighbouring EU5 average of 1.0. Contrary to most OECD countries, hospital-based LTC accounted for nearly half of total LTC spending in Romania, substantially higher than in OECD countries (43% in Romania compared to the OECD average of 9% and a neighbouring EU5 average of 10%). Conversely, expenditure on nursing homes in Romania was significantly lower than in OECD countries (30% compared to the OECD average of 52% and a neighbouring EU5 average of 46%) in 2023.

Romania has a relatively low residential LTC capacity and relies more on hospital beds than on institutional beds. The country has a relatively low rate of LTC beds in both institutions and hospitals, with 17 LTC beds per 1000 population aged 65 and over, more than twice lower than the OECD average (41 beds per 1000 population) and the neighbouring EU5 average (38) (Figure 3.13). Rural areas are particularly affected by the insufficient capacity of LTC beds and suffer from geographical constraints in accessing LTC (WHO Regional Office for Europe, 2020[38]). Hospital beds represent 31% of residential LTC beds in Romania, compared to 8% in the OECD average and 12% in the neighbouring EU5 countries, suggesting scope for improving LTC provision and reducing intensive hospital resources.

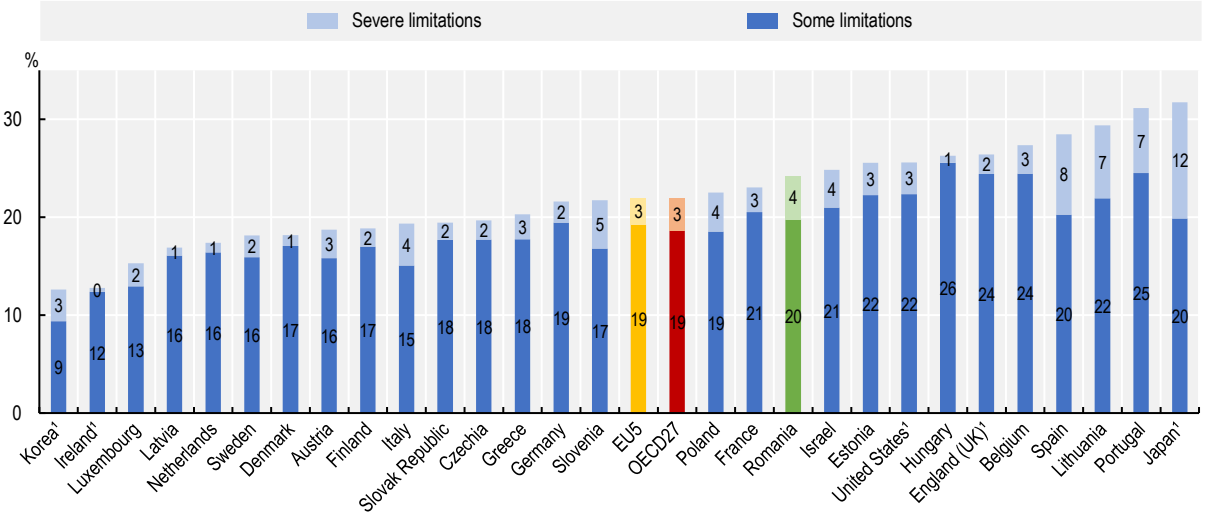
Figure 3.13. Long-term care beds in institutions and hospitals are below the OECD average



Note: Data refer to 2023 or nearest year. 1. Latest data from 2021-2022. 2. Data only includes beds in institutions.
Source: OECD Health Statistics 2025.

The demand for LTC in Romania, as in many OECD countries, is likely to raise as the population ages, calling for improvements in LTC provision and capacity. The share of people aged 65 and over was equal to 20% in 2023, and this is projected to increase further to 31% by 2050 (Eurostat, 2023[39]). Almost one-quarter of people aged 65 and over reported having severe or some limitations in daily activity in 2021-2022, compared to an average of 22% in OECD countries and the neighbouring EU5 countries (Figure 3.14).

Figure 3.14. The proportion of adults aged 65 and over who report limitations in daily activities is relatively high in Romania compared to the OECD average



Note: Data refer to 2021-2022 (or nearest year). 1. 2017-2019 data.
Source: OECD Health at a Glance 2025, based on SHARE wave 9 (2021 22); ELSA, wave 9 (2019), for the UK; HRS (2018) for the United States; KLoSA (2018) for Korea; SSJDA (2017) for Japan, TILDA wave 5 (2018) for Ireland.

The costs of LTC in Romania are often unaffordable for many people aged 65 and over, putting them at a high risk of poverty. Public social protection mainly supports people with severe needs, while those with low and moderate needs receive little or no assistance. As a result, out-of-pocket expenses for care are substantial. Consequently, poverty risks linked to home care remain well above the EU average across all levels of need, even after receiving public social protection (OECD, forthcoming[40]).

3.4.2. While the formal care capacity is limited, informal carers and family members are the backbone of long-term care

The capacity of formal LTC workers is insufficient to meet the demand for formal care for older people in Romania. Romania has a very low number of formal LTC workers, with one LTC worker per 100 older persons in 2021-2022, lower than the OECD average of 5 LTC workers and the EU5 average of 2 (OECD, 2025[15]). Difficulties to recruit LTC workers include low salaries and working conditions. The shortage of LTC staff has negative impacts on the quality of both care and life of beneficiaries, including situations of violence and abuse (World Bank, 2023[41]), which ultimately results in high reliance and burden on informal care workers.

Family members are the main carers of dependent older people, although this tends to be more common in rural areas. In Romania, around 6% of people aged 50 and over reported they provided informal care on a daily or weekly basis, compared to 13% in OECD countries in 2021-2022 (OECD, 2025[15]). Most family caregivers are women, usually wives or daughters. In Romania, 60% of informal daily carers were women in 2021-2022, on par with the OECD average of 61. Further, only 10% of informal daily carers in Romania reported they worked in addition to caring, which contributes to increase the burden of informal care (OECD, 2025[15]). Yet, the country has no policy in place seeking to address and support informal carers.

3.4.3. Palliative care is insufficient to meet the needs, calling for increased capacity

Palliative care in Romania remains insufficient to meet the growing needs of the population. An estimated 170 000 people need palliative care each year (Ministry of Health, 2017[42]). Yet only around 5% of palliative care needs are met. Most patients – nearly 30 000 out of 33 000 patients requiring palliative care – were hospitalised because inpatient services are largely the only available option. Home-based palliative care, which would offer more accessible and patient-centred support, covered just 5% of patients, and is predominantly offered by private providers (OECD/European Commission, 2025[18]). While developments in medical and nursing education and training have helped to improve the provision of palliative care, the shortage of specialist palliative care services and staff continues to limit the reach and effectiveness of palliative care.

Recent initiatives have begun to expand palliative care capacity, though gaps remain. Funding through the European Regional Development Fund of Health Programme 2021-2027 aims to enhance the infrastructure of palliative care, particularly in regions with significant shortages (OECD, 2023[19]). Legislative measures introduced in 2024 have led to a significant increase in the number of beds contracted with health insurance houses. However, there is still a lack of providers offering such services in specialised outpatient clinics and for home-based palliative care.

3.4.4. The National Strategy on long-term care guides Romania on transition from institutional care to community-based care

Romania has introduced a strategy on *Long-Term Care and Active Ageing* for the period 2023-2030, which aligns with NRRP. The strategy's objectives include strengthening LTC service management for the elderly, ensuring a continuum of services, securing sustainable financing, and improving service quality.

Additionally, it aims to improve the workforce dedicated to elderly care and promote active social participation among older individuals.

The strategy emphasises the need for moving away from institutional care to community-based services, which would ultimately yield more efficient social assistance spending over time and a positive impact on the quality of care for the elderly. NRRP earmarks an investment of EUR 87 million to create a network of day care centres for assistance and recovery of elderly people. As for residential care centres, the government is in the process of closing large institutions and transferring beneficiaries to local centres to ensure better LTC care delivery. Further, a legislative reform has been introduced in 2024 to regulate the minimum package of social assistance and the financing of social assistance funds to beneficiaries, as well as giving more responsibility to local and regional authorities for the provision of LTC services.

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Notes

[1] Social assistance institutions include care and assistance centres, occupational therapy and integration centres, recovery and rehabilitation centres.

4 The resilience and sustainability of Romania's healthcare system

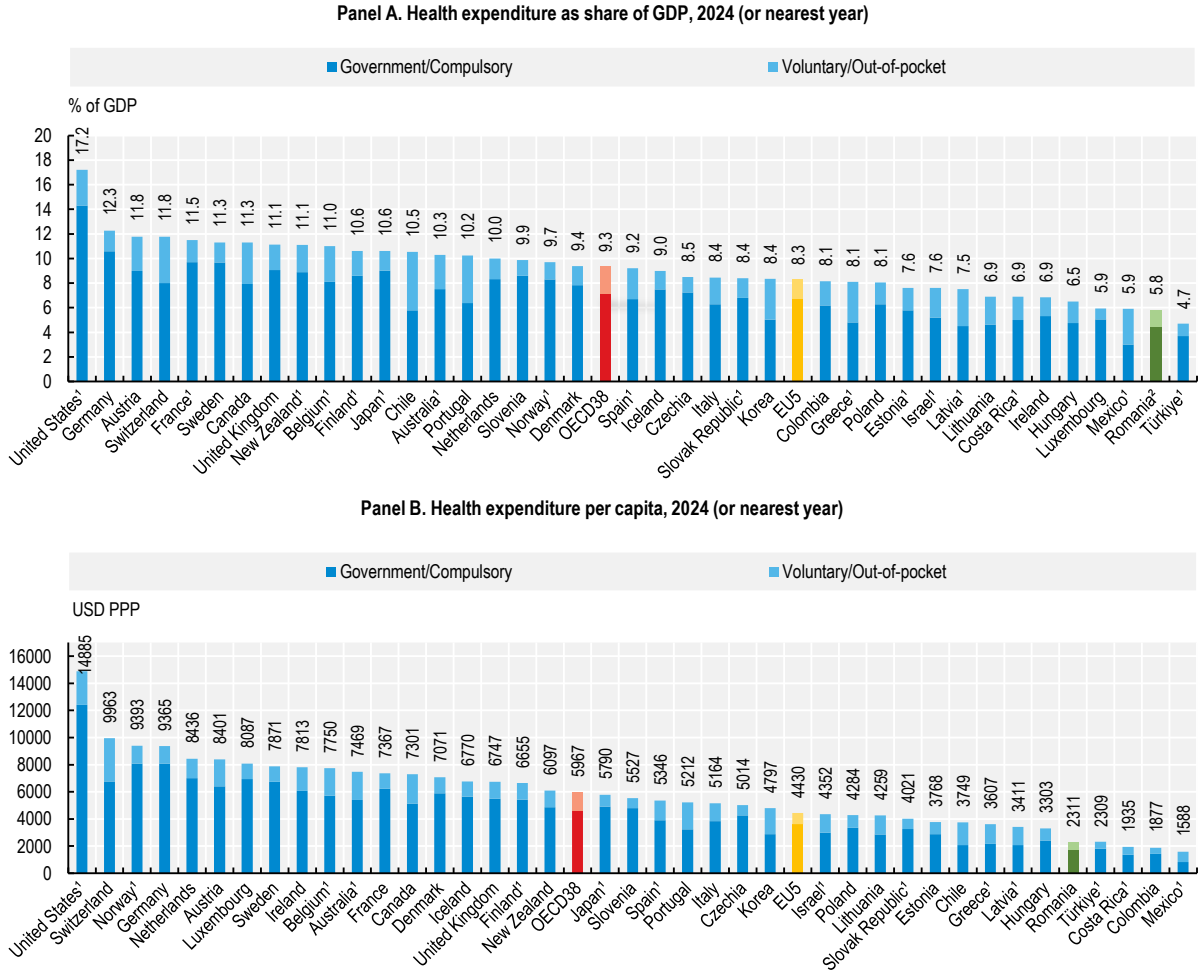
This chapter examines the key characteristics of Romania's health system and the policies supporting its sustainability and resilience. The first section focusses on system financing and financial sustainability, outlining challenges and recent efforts to enhance sustainability. The second section assesses the health workforce, addressing shortages and uneven distribution while outlining recent reforms aimed at improving retention. The third section reviews recent developments to address communicable diseases, tackle antimicrobial resistance, and enhance the system's preparedness for effective crisis response.

4.1. Strengthening health system financing and sustainability

4.1.1. Spending on health is relatively low, but with high out-of-pocket payments

Health expenditure in Romania increased over the past decade, but remains within the lowest spending compared to OECD countries and neighbouring EU5 countries. Health expenditure has been increasing steadily in the period 2012-2022, which supported the objectives of the national health strategy, including the workforce retention, national health programmes, and better access to medicines, as well as the response to the COVID-19 pandemic. There was a notable slowdown in health spending growth in 2022, as the country exited the acute phase of the pandemic. The latest data available show that Romania spent 5.8% of GDP on health, on par with Luxembourg and Mexico, but lower than the neighbouring EU5 average (8.3%) and the OECD average (9.3%) (Figure 4.1, panel A). In per capita terms, Romania's health spending is close to that of Hungary, but represents less than half the average per capita across OECD countries. In 2024 (or the latest year available), Romania spent USD 2 311 per capita on health, compared to the neighbouring EU5 average of USD 4 430 and the OECD average of USD 5 967, adjusted for differences in purchasing power (Figure 4.1, panel B).

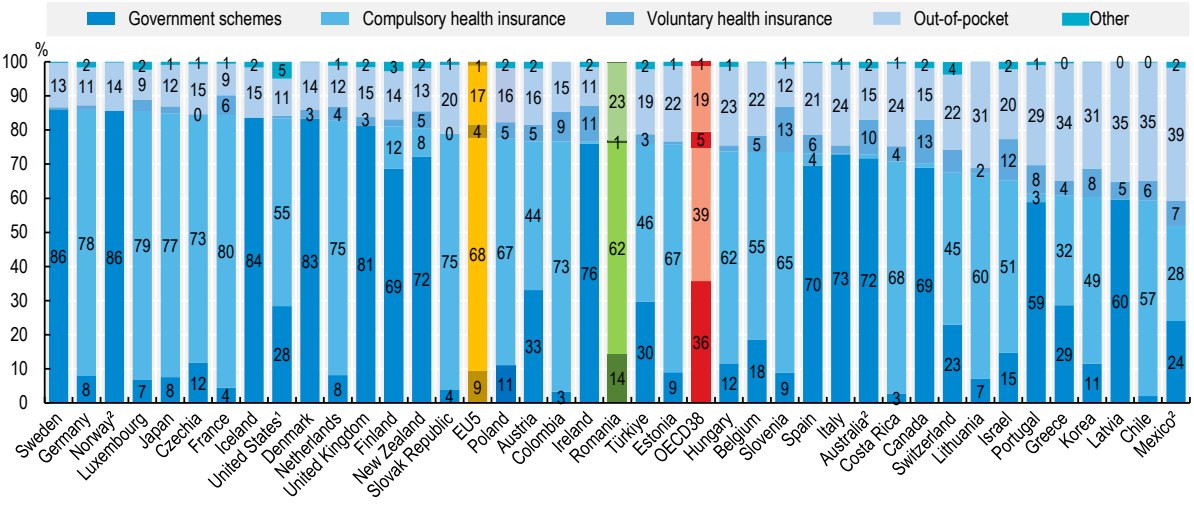
Figure 4.1. Health spending in Romania holds markedly low share of GDP compared to OECD countries



Note: For Panel A: 1. OECD estimate for 2024. 2. 2022-2023 data. For Panel B: 1. OECD estimates.
Source: OECD (2025[1]), *Health at a Glance 2025: OECD Indicators*, https://doi.org/10.1787/8f9e3f98-en, based on OECD Health Statistics and WHO Global Health Expenditure Database.

The public share of health spending in Romania (76%) is in line with the average in OECD countries (75%). NHIF finances most of healthcare (62% of health spending) while the state budget, through the MoH, finances capital investments (e.g. material and infrastructure), national health programmes, and contributions to NHIF for vulnerable groups such as unemployed and retired people, and people on social benefits (14%) (Figure 4.2). Private financing is made primarily from household's out-of-pocket (OOP) payments. OOP spending is mainly driven by pharmaceutical expenditure and represents 23% of health spending, higher compared to the OECD and EU5 averages. OOP payments usually include both payments made on a fully discretionary basis and those as part of some co-payment arrangements. High OOP creates financial barrier to access to healthcare and puts less affluent families at risk of financial hardship and catastrophic expenditures.[1] In addition, informal payments are reported to be higher in Romania than in other EU countries (see Section 2.2 in Chapter 2).

Figure 4.2. Government schemes and compulsory insurance finance for over three-quarter of health spending in Romania



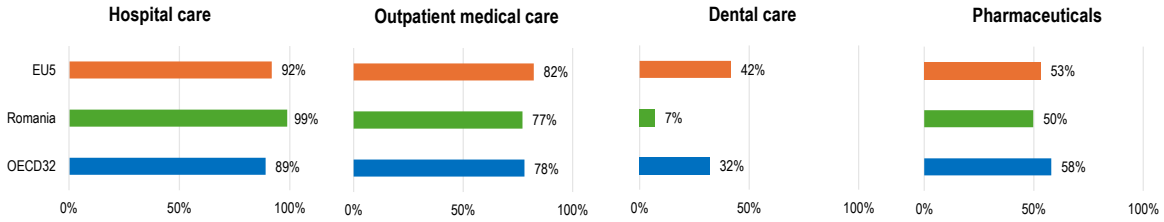
Note: Data refer to 2023 or nearest year, Category "Other" refers to financing by NGOs, employers, non-resident schemes and unknown schemes. 1. All spending by private health insurance companies reported under compulsory health insurance. 2. Latest available data from 2022.

Source: OECD (2025[1]), *Health at a Glance 2025: OECD Indicators*, https://doi.org/10.1787/8f9e3f98-en.

4.1.2. Inpatient and outpatient medical care are largely publicly financed, while dental care is virtually fully privately financed

Romania had a higher public share of spending of inpatient services compared to OECD averages, while dental care is nearly fully financed privately. Public financing covered 99% of inpatient care expenditure in Romania in 2023, compared to 89% on average in OECD countries. The share of public expenditure on outpatient medical care in Romania was close to the OECD average. For dental care, pharmaceuticals and therapeutic appliances, the share of public financing was much lower than the OECD averages. Only half of pharmaceutical spending is from public sources, lower than both OECD and EU5 averages. Dental care is nearly fully privately financed, with only 7% covered by public financing – almost five times lower than the OECD average (Figure 4.3).

Figure 4.3. The level of public financing for inpatient care is high in Romania, while it is lower for other key areas of healthcare services



Note: Data refer to 2023 or nearest year. Outpatient medical services mainly refer to services provided by generalists and specialists in the outpatient sector. Pharmaceuticals include prescribed and over-the-counter medicines as well as medical non-durables.
Source: OECD Health Statistics 2025.

4.1.3. The private health insurance market is small, but there is interest in expanding it

The contribution of voluntary health insurance (VHI) as a share of total health spending is marginal: Romania's VHI represents 1% of total health expenditure versus 5% in OECD countries in 2023. However, the interest for private health insurance has been recently growing. The share of VHI increased by 60% total health spending over the past decade. Today, private health insurance covers 700 000 people through company insurance plan, equivalent to 3.6% of the population. VHI in Romania has a supplementary role (i.e. offering quicker access to healthcare services that are already covered publicly, such as outpatient services and dental care, with greater choice of healthcare providers or enhanced amenities).

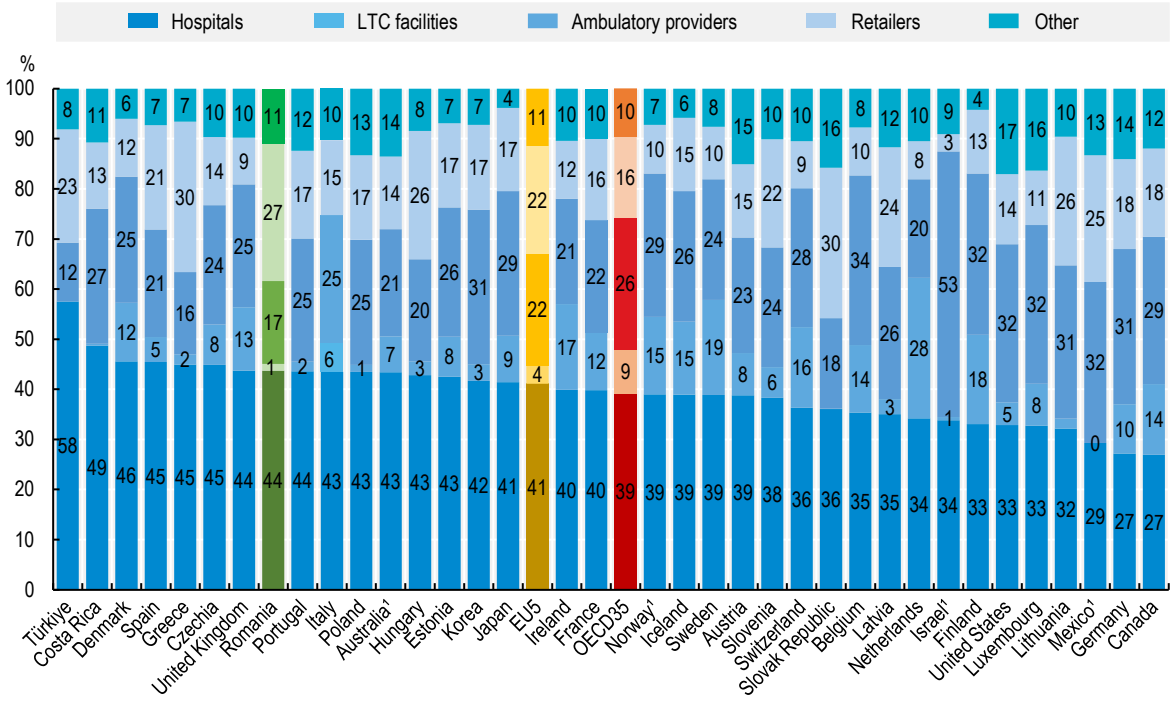
Private health insurance companies have established contractual agreements with private clinics, through which they have negotiated pricing and agreed upon key performance indicators (KPIs), including quality indicators. They provide coverage for outpatient services and dental care, while coverage for emergency care and outpatient prescriptions are excluded. VHI is seen as a way to get faster access to services and greater choice of healthcare providers or enhanced amenities (e.g. superior accommodation, meals). However, there are challenges associated with VHI. VHI may raise concerns about inequities in access to healthcare services based on insurance status and create incentives for providers practising in both the public and the private sector to prioritise care for privately insured patients. In particular, private health insurance is associated with the risk of creating a two-tier system. Higher-income people who can afford VHI may have faster and greater access to higher quality services, leaving those with lower income facing access problems, potentially exacerbating social and regional inequalities in health. To address these challenges, it is essential to set a regulatory framework for VHI, define equal quality standards across both the public and the private sectors and define the standards for practice for providers that practice both in the public and private sectors. Learning from the experience of other countries with important VHI markets, such as Australia, Ireland and Israel, would also be helpful.

4.1.4. Hospital services account for nearly half of the expenditure, while primary care accounts for just under one tenth

Hospital spending remains high in Romania. Compared with OECD countries, the country has a relatively high level of hospital-related expenditure, on par with Czechia and Poland, and below countries such as Türkiye and Costa Rica. In 2023, hospital activities received 44% of the health financing in Romania, substantially exceeding the OECD and neighbouring EU5 averages (39% and 41%) (Figure 4.4). The proportion spent on hospital services has increased over the last decade by about 5 percentage points (p.p.) in Romania, while it remained mostly unchanged for the OECD and neighbouring EU5 averages. In

contrast, the shares of the expenditure attributed to ambulatory care and LTC providers (respectively, 17% and 1%) are considerably lower compared to the OECD and neighbouring EU5 averages.

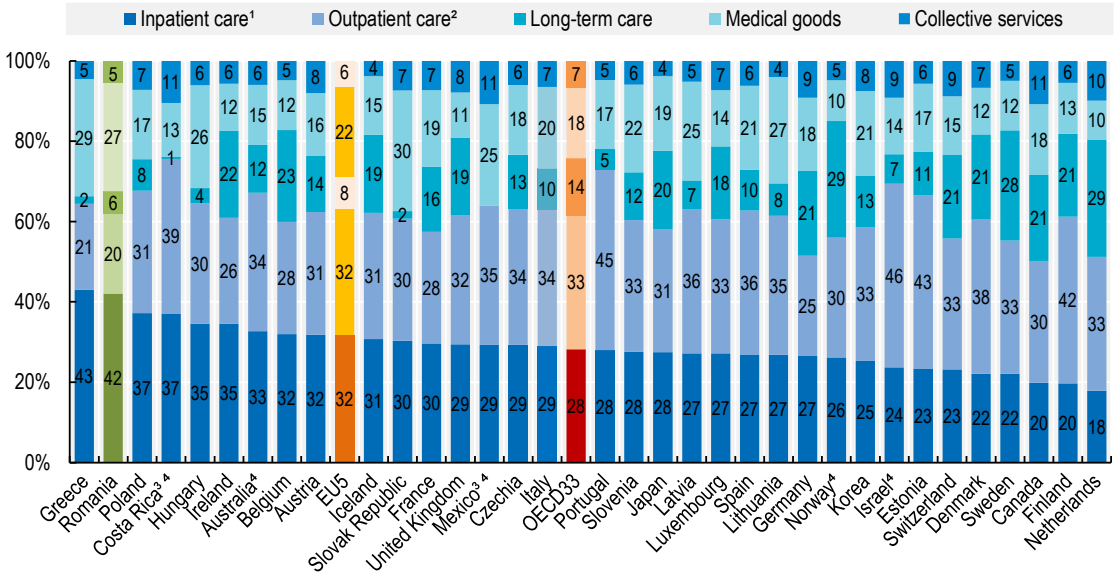
Figure 4.4. Hospital-related health expenditure is notably high in Romania, and spending on ambulatory and long-term care remain markedly low



Note: Data refer to 2023 or nearest year. "Other" includes ancillary service providers (e.g. patient transport and laboratories); health system administration, public health and prevention agencies; households in cases where they provide paid long-term care (LTC); and atypical providers, where healthcare is a secondary economic activity. 1. 2022 data.
Source: OECD (2025[1]), *Health at a Glance 2025: OECD Indicators*, https://doi.org/10.1787/8f9e3f98-en.

Most of the health spending is dedicated to inpatient care services (42%), while outpatient care and LTC represent about one-quarter of health expenditure in Romania (Figure 4.5). The share of inpatient care spending is the second highest when compared with OECD countries. Looking at hospital expenditure, Romania has one of the highest proportions of spending on day care with 21% of total hospital expenditure. This is almost four times higher than the OECD average, but the data must be taken with caution as they might not be comparable across countries due to methodological deviation.

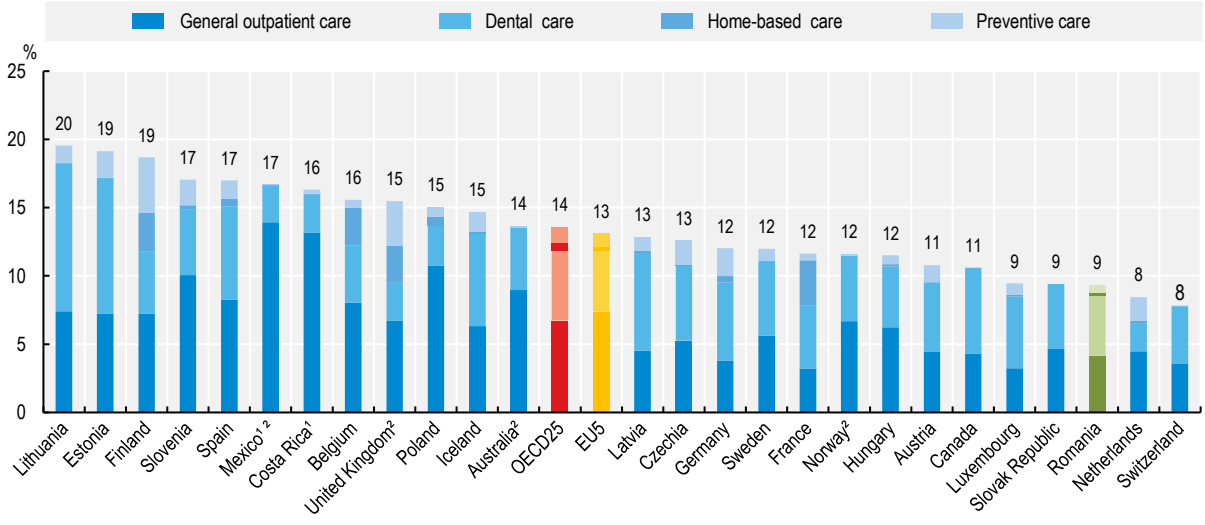
Figure 4.5. Inpatient care accounts for 42% of health spending in Romania



Note: Data refer to 2023 or nearest year. Countries are ranked by curative-rehabilitative care as a share of current expenditure on health. 1. Refers to curative-rehabilitative care in inpatient and day care settings. 2. Includes home care and ancillary services. 3. Medical goods financed by government and compulsory schemes are included either under inpatient our outpatient care. 4. Latest available data from 2022.
Source: OECD (2025[1]), *Health at a Glance 2025: OECD Indicators*, https://doi.org/10.1787/8f9e3f98-en.

Strengthening primary care is essential to improve care co-ordination and health outcomes, while also reducing the number of unnecessary hospitalisations and the costs associated with them. Romania's spending on primary care and prevention is relatively low, suggesting limited financial resources to strengthen primary care. Spending on primary healthcare services represented 9% of current health expenditure in 2023, lower compared to OECD and EU5 averages (Figure 4.6), and spending on prevention was only 1% (versus 3% in the OECD average).

Figure 4.6. Spending on primary healthcare services is substantially low compared to OECD countries



Note: Data refer to 2023 or nearest year. 1. Spending on general outpatient care can include pharmaceuticals. 2. Latest available data from 2022.
Source: OECD (2025[1]), *Health at a Glance 2025: OECD Indicators*, https://doi.org/10.1787/8f9e3f98-en.

4.1.5. More efforts are needed to reduce the pressure on the healthcare system

Romania's health system requires a continued transformation towards primary healthcare and community settings in order to respond to the rapidly shifting health needs towards chronic conditions due to an ageing population. This would not only better reflect the needs of the populations, but also help reduce pressure on spending by helping patients being treated in less resource-intense and more adequate care settings. The National Health Strategy 2023-2030 and the Operational Health Programme 2021-2027 set clear objectives to operationalise this transformation, while NRRP allocates funds for the modernisation of the primary healthcare facilities (EUR 250 million are allocated for renovating and equipping family physician's practices and outpatient care units, representing one fifth of the budget allocated to hospital's modernisation). In addition, it is essential to reduce unnecessary hospitalisations and associated costs, by giving greater responsibilities to health professionals in primary care regarding early detection, screening and management of NCDs, improving care co-ordination for the management of NCDs, and improving the flows of health information across the care pathway.

4.1.6. While Romania has recently carried out a health sector spending review to inform budget decisions, further actions are required to increase efficiency and cut wasteful spending

Romania, like many OECD countries, is facing a dual challenge of health spending pressure and resource constraint. Healthcare demand is likely to increase with rising income and ageing population, while new technologies will drive up expenditure. Romania has a high public deficit, and its health spending represented 11% of the public spending in 2023 (versus 15% in OECD), suggesting the country has limited fiscal capacity to spend a greater share of national budgets on health. Romania has taken important steps towards good budgeting practices in order to increase the efficiency of health spending. To streamline public spending on healthcare, Romania's Ministry of Finance, in collaboration with the MoH and CNAS, have newly carried out a health spending review in 2023, that served to draft the 2024 budget proposal. The review defined five medium and long-term efficiency measures, including (1) increasing the number of preventive consultations, (2) optimising the monitoring of patients with chronic diseases, (3) rationalising expenses associated with sick leaves, (4) abolishing SHI contribution exemptions for some worker categories, and (5) optimising medicines prescribing and spending (e.g. prioritizing the prescribing and issuing of biosimilar and generic medicines). In 2023, Romania has also implemented a new framework contract for healthcare services contracted between CNAS/DHIH and providers. This new framework contract aims to incorporate standards for performance as part of budgeting process, making CNAS/DHIH more active purchasers of healthcare services. Recent initiatives include a reconfiguration of provider remuneration and a P4P scheme to incentivise GP's preventive activities (see Section 2.2 in Chapter 2), although this could be extended to a broader set of providers and activities. In addition, Romania has taken a series of measures in 2023 to increase budget revenues (adopted by Law no. 296/2023). These include measures related to the health sector, such as increasing excise values for tobacco and alcoholic products, and introducing an excise on non-alcoholic beverages containing added sugar for which the total sugar level is higher than 5 g per 100 ml (Fiscal Council of Romania, 2024[2]).

Conducting and using a health spending review marks an important step. It is vital to pursue the objectives set in the spending review, with clear and regular monitoring of progress both in terms of rising revenues and in terms of efficiency improvements. Efforts to further reduce corruption in public procurement (see Section 2.2 in Chapter 2) will also contribute to tackling inefficiencies and wasteful spending. Romania should consider further options that will increase efficiency and ensure the fiscal sustainability of the health system. These options include cutting ineffective and wasteful spending (e.g. pharmaceuticals), shifting services from hospitals to new settings for the delivery of primary healthcare to rationalise hospital spending and improve care continuity, relying on new provider payment schemes to incentivise care quality

and continuity, and expanding the use of health technology assessment (HTA) to define and update the benefit basket provided by SHI. These options are further described thereafter.

Continue efforts to improve value for money in medicine prescribing and utilisation

Romania has taken significant measures to address ineffective pharmaceutical spending, such as increasing biosimilars prescribing and limiting the use of antibiotics. The country has notably increased the share of biosimilars prescribing, especially for erythropoietins and tumour necrosis factor inhibitors, resulting in a reduction in list prices for the total market of these medicines. To achieve this goal, the country took a series of measures such as improving guidance for doctors, monitoring prescriptions every six months, and reaching out to doctors with non-compliant prescribing behaviours. Stepping up efforts by extending the measures to further biosimilars and generics is required to achieve higher gains. Increasing patient and doctor awareness and education to combat misperceptions about the lack of safety of generics and biosimilars is also a key lever for the update of generics and biosimilars. Regarding antibiotics which are dispensed only with a doctor's prescription except for emergency cases, Romania passed a law to enable monitoring of antibiotic dispensing in emergency situations –- through the collection of patient and pharmacy data, aiming to limit misuse and prevent repeated unregulated dispensing. This measure is expected to reduce the very high volumes of antibiotics prescribing (about 50% higher than the OECD average, see Section 4.3), and ultimately reduce wasteful spending and limit the progress of antimicrobial resistance.

Consider new ways to rationalise hospital spending and improve care continuity

Romania aims to shift the care paradigm towards primary care, but spending on hospital services remains significantly higher than in most OECD countries. The country should consider ways to rationalise hospital spending by improving efficiency, thus creating more fiscal capacity to allocate budget for primary care. For instance, low rates of bed occupancy in some hospitals identified by RHSMs indicate that hospital beds could be transferred to day care and LTC beds or reduced. This would ultimately address the inefficient use of acute care beds. Early discharge home-based programmes reduce length of hospital stays, lower the risk of readmission, and show good clinical outcomes (OECD, 2020[3]). Romania should thus consider further developing community care facilities and home-based programmes that are effective to improve care continuity and reduce the use of resource-intensive hospital beds. For instance, Canada and the United Kingdom have introduced virtual wards to provide short-term transitional care at home for high-risk patients with complex needs recently discharged from hospitals (OECD, 2020[3]). In a step forward to facilitate the provision of home-based care, Romania has recently revised regulations and tariffs.

Consider further provider payment schemes based on performance

While Romania is newly introducing P4P remuneration scheme to incentivise family physicians to provide prevention services, further payment modalities also exist to increase efficiency gains. Romania can envisage new provider payment schemes that reward performance, improve care quality and continuation and reduce costs, such as add-on payments and bundled payments. About half of OECD countries have introduced add-on payments that remunerate specific activities, such as early discharge from hospital and care co-ordination (OECD, 2020[3]). These can help improve care processes and co-ordination, and cost-efficiency efforts, but their impact on health outcomes is limited. Bundled payments, used for instance in Australia and Belgium, -consisting of one payment per patient, per chronic illness, covering the cost of all healthcare services provided by different providers during a specific defined time period- show some promising results in containing cost and improving patient outcomes and satisfaction (OECD, 2020[3]). These payment models are however difficult to implement and require advanced information systems to monitor and follow-up process and outcome indicators.

Develop Health Technology Assessment to define and update the goods and services included in the publicly defined benefits package

HTA in Romania is used to define medicines that are included in the reimbursement list. The HTA process, led by NAMMD since 2014, involves a scoring system that relies largely on HTA reports and decision making from other selected jurisdictions, including France, Germany and the United Kingdom. Romania's HTA system faces many challenges, including a short institutional history, a lack of comprehensive evaluation capacity, inconsistencies due to siloed operations with no formal links to national health programmes or clinical guidelines, limited collaboration, a fragmented data system and insufficient capacity building (Lopert, Ruth; Ruiz, Francis; Gheorghe, Adrian; Chanturidze, Tata, 2017[4]). However, Romania is willing to learn from other countries and participate in joint international work, such as the European Network for Health Technology Assessment (EUnetHTA).

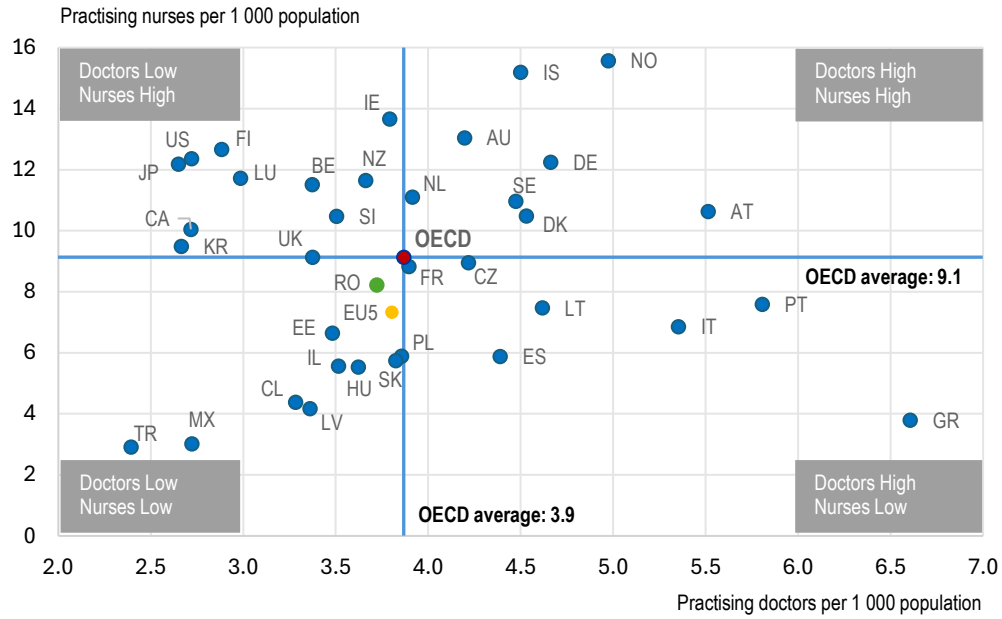
To leverage the potential of HTA in Romania, it is important to improve methodological and human capacity, upgrade the information system, and develop collaborations. Expanding the use of HTA and integrating economic evaluation into routine HTA practices could help further inform reimbursement decision and better define and update the goods and services included in the publicly defined benefits package, thereby improving efficiency of public spending and improving care quality. HTA could be extended to high-cost medical technologies, diagnostics, and surgical procedures. For instance, in France, the *Haute autorité de santé* uses HTA to evaluate medical devices or medical interventions (in addition to drugs and vaccines). It also makes recommendations on reimbursement levels and evaluates the actual benefit and the improvement in actual benefit which are essential for price negotiations and the formulation of clinical guidelines.

4.2. Ensuring adequate and efficient workforce

4.2.1. Workforce capacity has remarkably improved to levels comparable to OECD countries, but emigration to other EU countries remains significant

Romania's workforce capacity has seen a remarkable increase, with physician numbers increasing by 40% over the past decade and reaching the OECD average (3.7 versus 3.9 practising physicians per 1 000 population) and close to the average of the neighbouring EU5 countries (3.8) (Figure 4.7). On the other hand, despite a steady increase of 41% over the same period, practising nursing capacity in the Romanian health system is still below the OECD average (9.2), with 8.2 nurses per 1 000 inhabitants in 2023 (Figure 4.7). This was nevertheless above the EU5 average of 7.3.

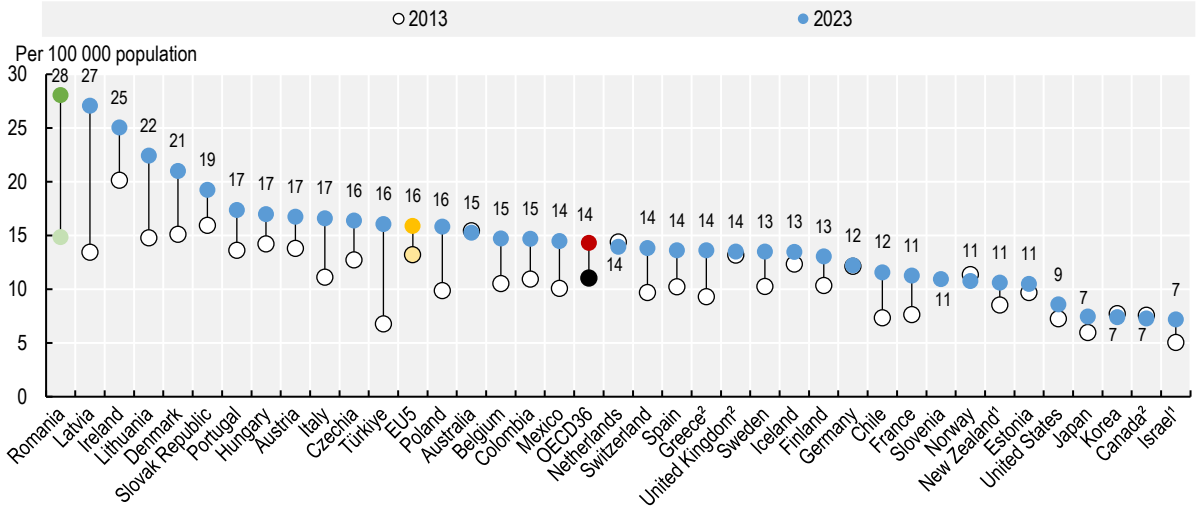
Figure 4.7. The number of practising doctors has come close to the OECD average, but the nurse capacity remains below



Note: Data refer to 2023 or nearest year. The OECD average is unweighted. For physicians: 1. The data include physicians-in-training (interns and residents) in most countries (including for countries such as France and Italy which were not including them previously). 1. In Chile, Greece and Portugal, data refer to all doctors licensed to practice, resulting in a large over-estimation of the number of practising doctors. 2. In Colombia, the Slovak Republic and Türkiye, data include not only doctors providing direct care to patients but also those working in the health sector as managers, educators, researchers, etc. (adding another 5-10% of doctors). 3. In Sweden and the United States, latest data from 2021-2022. 4. In Luxembourg, latest physician data from 2017. For nurses: 1. Associate professional nurses with a lower level of qualifications make up more than 50% of nurses in Slovenia and Romania; between 33% and 50% in Greece, Iceland, Korea, Mexico and Switzerland; and between 15% and 30% in Australia, Canada, Hungary, Japan, the United Kingdom and the United States. 2. In Colombia, Portugal, the Slovak Republic, Türkiye and the United States, nurse data include nurses working in the health sector as managers, educators, researchers and similar. 3. In Chile, nurse data include all nurses licensed to practise. 4. In Greece, data only refer to nurses employed in hospitals. 5. In Belgium, France, Japan and Sweden latest data from 2021-2022. 6. in Luxembourg, latest data from 2017.
Source: OECD Health Statistics 2025.

Medical training capacity has increased by about 80% in the last decade, boosting medical graduate numbers to 28 graduates per 100 000 population in 2023 (Figure 4.8). The significant increase in the number of medical graduates is also the result of the internationalisation of medical education, which Romania has undertaken following its accession to the EU in order to attract foreign students. In the 2018/19 academic year, almost all medical schools offered education in English and/or French, in addition to the Romanian programme. The latest data available show that the capacity in foreign language medical programmes increased by 75% between 2011/12 and 2018/19, while there was almost no growth in the programmes provided in the Romanian language (OECD, 2019[5]). However, as is the case for domestic medical graduates, the health system remains unattractive for international students to stay in the country after graduation, despite some recent effort to improve remuneration.

Figure 4.8. Romania had markedly high number of medical graduates in 2023, mainly due to the large number of international students coming to study medicine



Note: A large number of medical graduates are international students in some countries (e.g. Romania, Latvia, Ireland, the Slovak Republic, Hungary and Czechia). 1. Data excludes international students, resulting in an under-estimation. 2. Latest data from 2022.
Source: OECD (2025[1]), *Health at a Glance 2025: OECD Indicators*, https://doi.org/10.1787/8f9e3f98-en.

Romania also produces a high number of nursing graduates, with 100 per 100 000 population in 2023 – more than double the OECD average of 43. However, much of the current nursing workforce still consists of professionals with legacy diplomas that do not meet EU standards for automatic recognition (82%). In 2024, a targeted amendment (Directive (EU) 2024/505) brought Romania's 2014 "special revalorisation" programme into EU legislation (OECD/European Observatory on Health Systems and Policies, 2025[6]), which should reduce the share of non-compliant nurses over time, though skill gaps may persist. At the same time, nursing is becoming less attractive to young people: only 1.4% of 15-year-olds expressed an interest in pursuing the profession in 2022 according to the OECD PISA survey – a 20% decline since 2018 and below the OECD average of 2.1%, threatening the future supply of nursing students (OECD, 2025[7]).

4.2.2. Intention to emigrate among doctors remains high, posing a challenge for meeting rising demand for healthcare

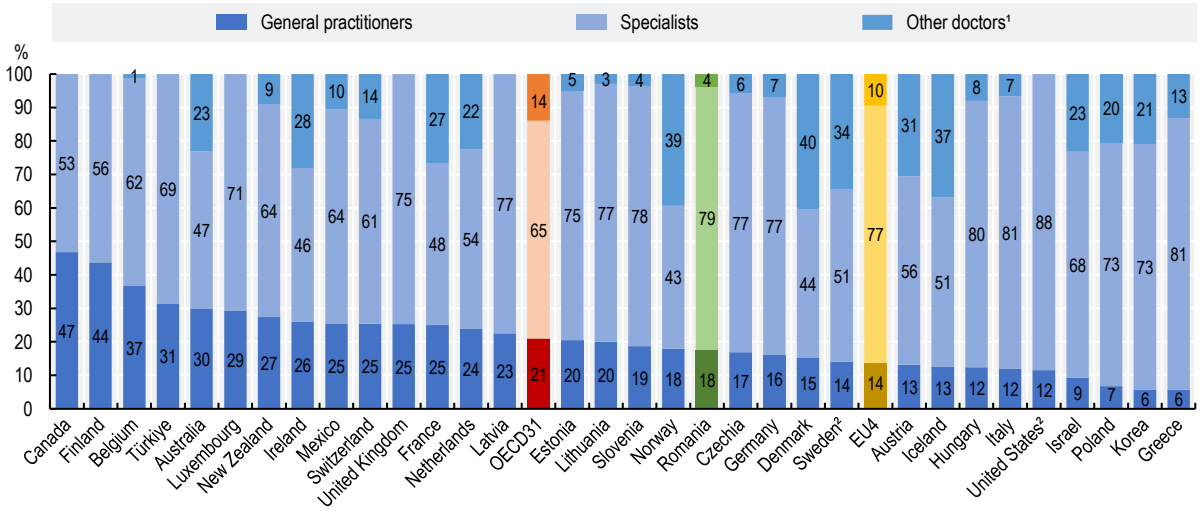
Emigration of health workers remains an impediment to overcome. Both nurses and doctors tend to move to other European countries, particularly to Germany, Italy and France, a trend that has accelerated with Romania's accession to the EU in 2007. Dissatisfactions with working conditions, including outdated health infrastructure and equipment, bureaucracy and inefficient management, explain the high level of outmigration. As in other OECD countries, Romanian doctors struggle with high workloads and unsatisfactory working conditions particularly exacerbated after the COVID-19 crisis, such as high numbers of night shifts, paper-based documentation and outdated equipment. The outflow of health workers seems to have stabilised in the recent years, thanks to the significant increase in health professionals' salaries (detailed below). However, according to a survey of the Romanian College of Physicians, almost two-third of doctors under age 35 still intended to leave the country in 2023 following the pandemic (Romanian College of Physicians, 2023[8]). Although intention to leave does not necessarily reflect actual migration numbers, the high proportion of doctors intending to leave poses a future risk for meeting rising demand for healthcare and calls for further measure to address both push and pull factors in the country. A health

professionals register is currently under progress, which will provide more understanding about the migration trends of health workers.

4.2.3. An ageing doctor workforce and decreasing attractiveness of family medicine are likely to put primary care under dual pressure in the coming years

General practitioners (GPs), which mainly correspond to family physicians in Romania, represent 18% of the Romanian doctors, a proportion lower than the OECD average (21%), but still higher than the neighbouring EU4 average of 14% (Figure 4.9). The numbers of GPs had generally shown a downward trend until 2019 and then remained mostly stable. However, this still represents a 9% decline between 2010 and 2023. The decline was also reflected in national sources, as the number of primary care practices contracted with CNAS fell from 10 157 in 2018 to 9 125 in 2024 (CNAS, 2025[9]). This is potentially due to reduced interest in family medicine and emigration among young physicians, signalling the need for tailored interventions to encourage physicians to choose family medicine as a career.

Figure 4.9. 18% of physicians are general practitioners, well below the OECD average



Note: Data refer to 2023 or nearest year. EU4 refers to Czechia, Hungary, Poland and Slovenia. 1. Includes non-specialist doctors working in hospitals and recent medical graduates who have not yet started postgraduate specialty training. 2. In Portugal, only about 30% of doctors employed by the public sector work as GPs in primary care – the other 70% work in hospitals. 3. Latest data from 2022.
Source: OECD (2025[1]), *Health at a Glance 2025: OECD Indicators*, https://doi.org/10.1787/8f9e3f98-en.

An important outflow factor affecting the future labour market is the age distribution of the current workforce. Romania has a considerably lower share of older medical workforce compared to OECD countries, with only one in five doctors aged 55 years and older in 2023 (OECD average: 32%). However, looking at primary care providers, GPs under the age of 35 account for 15% of the total number of GPs, while those aged 61 and over comprise 41% (National Institute of Statistics, 2025[10]). This indicates that Romania's primary healthcare is likely to face a dual pressure of an ageing workforce and decreasing attractiveness among young physicians over the coming years.

4.2.4. An overwhelming majority of health professionals are located in urban settings, leaving rural areas underserved

In Romania, hospitals and other healthcare facilities in urban areas are overstaffed, while rural areas struggle to fill posts. In 2024, more than 90% doctors were employed in urban settings, reflecting the

striking uneven distribution of physicians (National Institute of Statistics, 2025[10]). Similar disparities exist among GPs: in 2023, the Vest region had the highest GP density at 4.7 per 10 000 population, while Nord-Est and Sud-Est lagged significantly behind at just 2.2 (OECD/European Observatory on Health Systems and Policies, 2025[6]). This is partly because most young graduates choose to stay in urban areas upon their graduation due to better career prospects and working and living conditions. Likewise, the number of community nurses is low, representing less than 1% the country's nursing capacity.

4.2.5. Romania has significantly increased doctors' salaries to retain them, but retention also requires measures going beyond salary improvements

The main lever to mitigate the emigration of the health workforce and improve the shortage in rural areas has been the increase in remuneration in recent years. In 2018, the government introduced impressive salary increases for doctors working in public hospitals, with 130% increase for senior doctors and 160% for junior doctors (European Observatory on Health Systems and Policies, 2018[11]), which helped to improve retention (OECD/European Observatory on Health Systems and Policies, 2019[12]). Regarding private practices, the capitation payment (which is capped at 2 200 patients per doctor under the current system) was relaxed for family physicians working in rural areas by allowing them to register more than 2 200 patients. In 2019, the government revised the regulations, in order to permit family physicians to open two practices in different locations or even in the same location if they are in specified rural areas (European Observatory on Health Systems and Policies, 2022[13]). To further incentivise family physicians to practice in rural areas, the 2023 new framework contract reduced the minimum registration requirement (from 1 000 to 800 patients) (European Observatory on Health Systems and Policies, 2022[13]), and provided financial incentives. Further, since 2023, new family physicians working in rural settings benefit from a 50% increase in payment for six months compared to their urban counterparts. This increase can be up to 100% if they choose to work in an area where there are no family medicine physicians. These issues and approach are not unique to Romania, and evidence suggest that those incentives are helpful but not sufficient to entirely address the challenge (WHO, 2020[14]).

The most often cited reasons for intention to leave among doctors are the limited health infrastructure and working conditions (Romanian College of Physicians, 2023[8]), signalling the need to go beyond salary improvements and take actions on working conditions and other underlying factors. As in other OECD countries, Romanian doctors struggle with high workloads and unsatisfactory working conditions, which were exacerbated after the COVID-19 crisis, such as a high number of night shifts, paper-based documentation, and outdated equipment. Fragmented care delivery and the lack of an adequate HIS, which currently relies on paper documentation, result in unnecessary doctor visits, administrative burdens, and extra workload. The MoH has recently taken steps to reduce paper documentation to alleviate the administrative burden on doctors, but these strategies have not yet resulted in a significant improvement. Some regions are taking independent actions to improve working conditions: an exemplary initiative is from the Prahova region which has managed to attract physicians only by digitalising administrative process and offering accounting assistance for opening practices. Such efforts should be extended at the national level to avoid the competition between regions to attract doctors, which would only deepen regional disparities. The authorities should also develop collaborations with local governments to improve both working and living conditions, such as offering support for housing or education in return for public service. Further, encouraging students from rural backgrounds to pursue careers in healthcare and promoting rural clinical placements in primary care settings for medical students could also improve rural workforce recruitment and retention (Russell et al., 2021[15]).

A greater capacity of community nurses would be vital for the implementation of preventive programmes in underserved areas struggling with doctor shortages. Romania plans to train 2 000 additional community nurses using European funds to bolster primary care, especially in rural areas. To further address workforce gaps, the country could introduce advanced practice nursing roles, enabling nurses to take on

expanded responsibilities through task sharing – a strategy that could alleviate pressure on doctors and improve service delivery. Strengthening pay and working conditions, particularly for community nurses, will be key to retaining this essential workforce, as post-training retention is currently low, with many nurses leaving after just one or two years due to inadequate remuneration.

4.2.6. Romania's Multi-Annual Health Workforce Development Strategy is an important step towards better workforce planning and retention

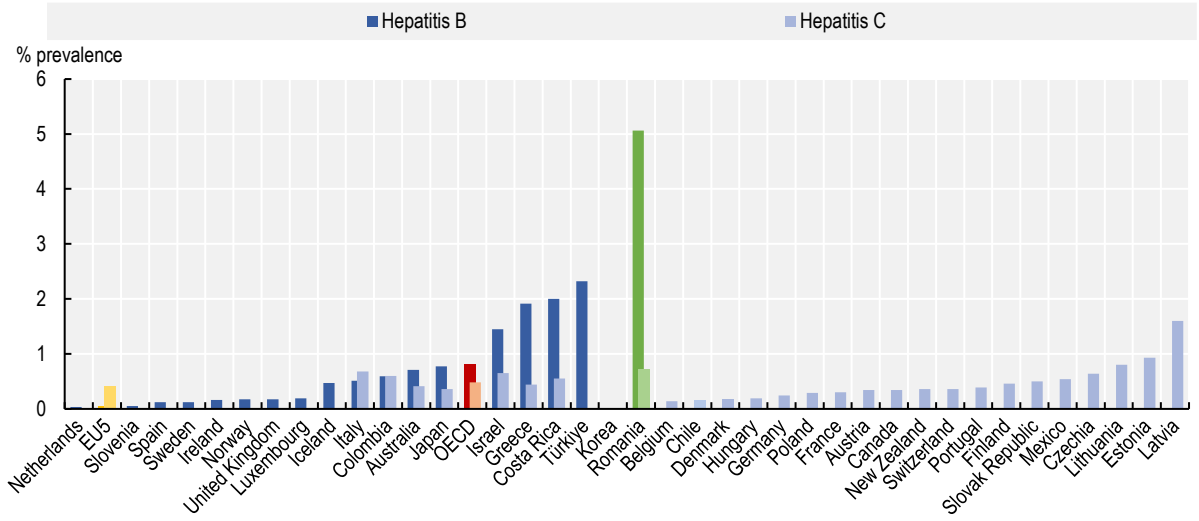
To address the lack of a strategic plan for workforce planning and retention, Romania took an exemplary step by announcing the Multi-Annual Health Workforce Development Strategy for 2022-2030. The plan was developed in collaboration with WHO following the National Health Strategy 2030 and NRRP, and identified five strategic areas to work on: building workforce capacity, leadership and governance, identifying and responding to issues related to working conditions, and improving retention. The plan seeks to identify successful initiatives to attract and retain doctors in underserved areas, such as different payment models, improve medical education and training programmes, particularly through the use of digital tools, and revise medical practice regulations to meet European standards. The programme also aims to improve the collection and analysis of health workforce data to forecast current and future needs, monitor health workforce, and manage and govern it with a more tailored approach. However, the government has not yet set a dedicated budget for the actions needed to implement these strategies.

4.3. Prevention and preparedness

4.3.1. While hepatitis B and C and tuberculosis remain significant concerns, Romania is implementing programmes to prevent and control the spread of diseases

Romania had one of the highest prevalence rates of hepatitis B and C in the EU (ECDC, 2022[16]) and across OECD countries in 2022 (Figure 4.10). A series of screening pilot programmes implemented during 2021-2023, led to improvements in disease diagnosis, and partly explained the higher prevalence. To control the spread of the diseases, the country has set up a National Framework Plan for the control of viral hepatitis 2019-2030. Co-ordinated by MoH, this plan aims to strengthen the surveillance system, reinforce primary prevention, and extend access to treatment to all. As a step forward to the pilot projects, hepatitis B and C testing has been made available to the uninsured population as of July 2024, as newly regulated in the framework contract. Furthermore, Romania successfully increased the vaccination coverage for hepatitis B (reaching 94% of the new-borns in 2024) (WHO, 2025[17]). However, in order to control the prevalence rates of viral hepatitis, further long-term actions are required to curb the figures.

Figure 4.10. The prevalence of hepatitis B and C in Romania remains high despite the ambitious efforts



Note: Data refer to 2022. Countries are ranked by rising prevalence rate of hepatitis B.
Source: WHO, 2022. Hepatitis - prevalence of chronic hepatitis among the general population, https://www.who.int/data/gho/data/indicators/indicator-details/GHO/hepatitis---prevalence-of-chronic-hepatitis-among-the-general-population.

Tuberculosis (TB) is another cause for concern in the country. In 2022, TB caused 3.6 deaths per 100 000 population in Romania, a number that exceeded all OECD countries and four times higher than the OECD average (0.8 deaths). Until 2017, the mortality rate had been falling steadily as a result of community public health programmes and an established network of TB treatment and surveillance services, but it stabilised in the following years. More worryingly, TB incidence, which had been declining before the pandemic, increased by 22% between 2020 and 2022, almost reaching pre-pandemic levels (ECDC, 2022[18]). As a response to the increasing incidence and the unfavourable trend in mortality, the government approved the National Strategy for Tuberculosis Control for 2022-2030 and launched its implementation. The plan aims to eradicate TB by 2035 and sets out objectives to achieve TB eradication such as shifting care delivery from hospital to ambulatory care, adapting the financial model to encourage prevention and early detection, increasing the use of innovative diagnostic tests and vaccines, and improving access to treatments (Ministry of Health, 2022[19]). While TB screening programmes for Ukrainian refugees and rural population have been rolled out in 2021 and 2023, the country also plans to reinstate a TB screening programme for vulnerable populations.

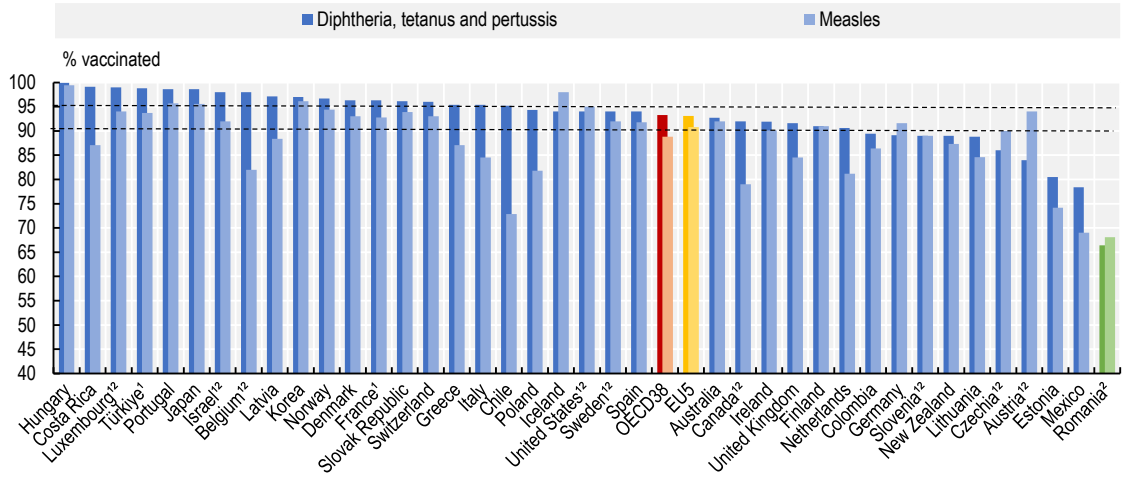
Romania is committed to prevent and control infectious diseases. The National Health Strategy 2023-2030 plans to reduce the burden associated with priority communicable disease, such as TB, viral hepatitis, and HIV/AIDS, by improving prevention, increasing the capacity for diagnosis and for rapid and adequate treatment, as well as monitoring of patients, mainly in ambulatory, and favouring their social reinsertion. The country has national action plans against TB, HIV/AIDS and others sexually transmitted diseases underway.

4.3.2. Declining childhood vaccination coverage and the increasing measles cases call for new strategies to improve the vaccination coverage

In 2024, only 68% of children in Romania are estimated to be immunised against measles, which is one of the lowest rates after Poland and Estonia, and below the OECD average (89%) (Figure 4.11). For

diphtheria, tetanus and pertussis (DTP), vaccination coverage among children aged one year old was only 66% in 2024, below the OECD average (93%) (Figure 4.11). Like half OECD countries, Romania falls short of the WHO-recommended minimum immunisation level for measles (95%) and DTP (90%). The country has experienced a decline in children's vaccination coverage (especially for measles) over the past decade, a trend observed in OECD countries, especially during the COVID-19 pandemic. As a consequence, measles cases surged, and the country has declared a national measles epidemic in December 2023. In 2024, 30 692 measles cases were reported in Romania, representing 87% of all cases in EU/EEA countries (ECDC, 2025[20]).

Figure 4.11. Vaccination rates for measles and DTP among 1-year-old children are very low compared to OECD countries

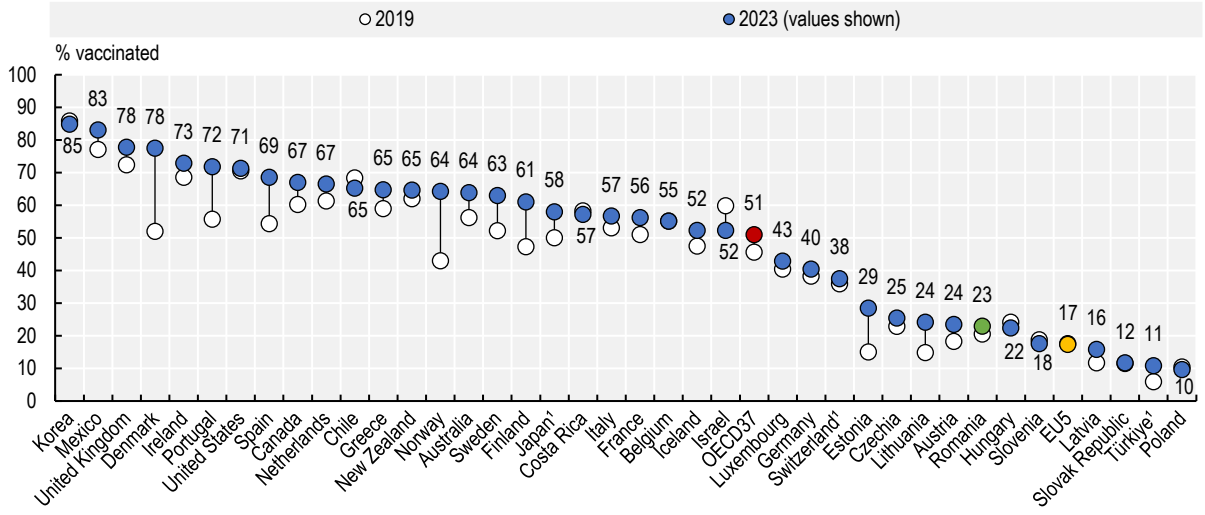


Note: Data refer to 2024. 1. Latest data from 2023. 2. Data refer to estimates. Lines indicate WHO minimum targets of 95% for measles and 90% for DTP.
Source: OECD (2025[1]), *Health at a Glance 2025: OECD Indicators*, https://doi.org/10.1787/8f9e3f98-en.

About 23% of those aged 65 and over were immunised against influenza in Romania in 2023, below the OECD average (51%) but higher than the average of the neighbouring EU5 countries (17%) (Figure 4.12). Influenza vaccination uptake has increased by 12% since the pandemic.

Vaccinations are advised but not mandatory, and vaccines included in the national immunisation programme are free-of-charge for children and at-risk population. For children, the national vaccination schedule covers hepatitis B, tuberculosis, diphtheria, pertussis, tetanus, poliomyelitis, streptococcus pneumoniae, haemophilus influenzae B, measles, mumps and rubella. In 2017, a proposed vaccination law aimed to mandate children's vaccinations by reviewing children's vaccination records at school entry, but the proposal was vetoed by the parliament. All vaccines included in the national immunisation programme are available for free at delivery point, funded by the state budget. In order to facilitate greater access to vaccination, the MoH issued since 2023 a legislative framework that enables the provision of additional vaccines (e.g. human papillomavirus (HPV) and pneumococcal) at no cost or with partial reimbursement to at-risk populations. Specifically, HPV vaccine is provided free of charge to all girls and boys aged 11-26 (OECD/European Observatory on Health Systems and Policies, 2025[6]). These vaccines are funded from the health insurance fund.

Figure 4.12. Vaccination coverage for influenza among 65-year-old people is still below the OECD average, but higher than the neighbouring EU5 average



Note: Belgium's data excludes people in nursing homes. Iceland's data covers people aged 60+. and the Slovak Republic's data covers people aged 59+. 1. Latest data from 2022.
Source: OECD (2025[1]), *Health at a Glance 2025: OECD Indicators*, https://doi.org/10.1787/8f9e3f98-en.

Low vaccination coverage and the downward trend must be explained by factors other than cost, given that children vaccinations and the influenza vaccine for at-risk populations are available for free at delivery point under the national immunisation programme. Potential reasons include low level of health literacy, family doctors' concerns about administering vaccines, delays in vaccine procurement, and an increase in cross-border migrants (Rechel, Richardson and McKee, 2018[21]). For instance, following the 2016 measles outbreak in Romania, although 92% of the population was aware of the measles outbreak, only 43% identified the lack of vaccination as the main cause (Rechel, Richardson and McKee, 2018[21]). This suggests there is room for enhancing health literacy and assisting people in making informed decisions regarding vaccination and public health.

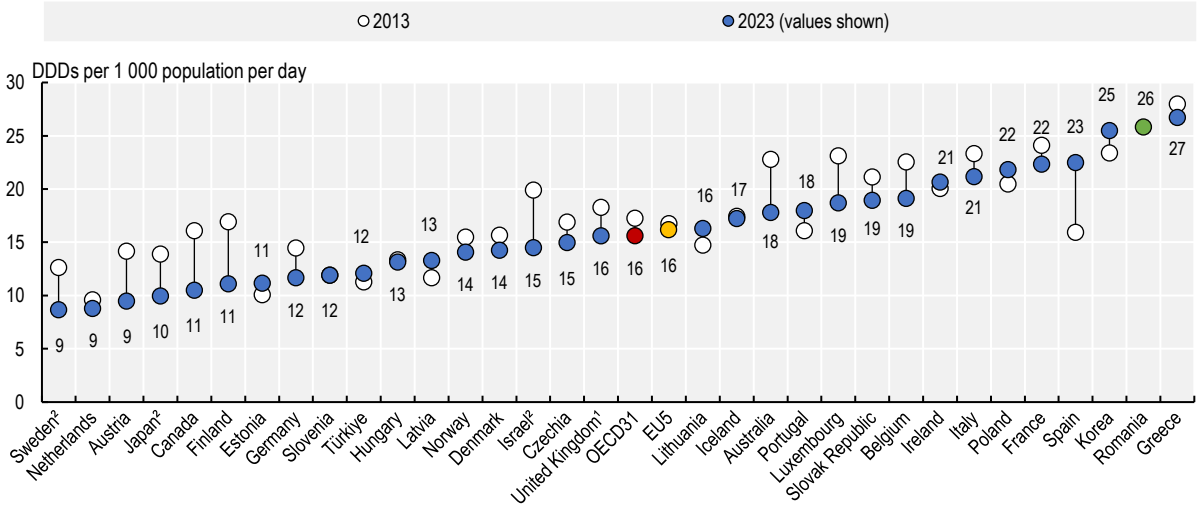
Another challenge to address is vaccine hesitancy among some medical practitioners, while others require guidance on how to persuade patients to get vaccinated. In response, in 2024, Romania developed a specialised curriculum for physicians dedicated to vaccination, to enhance their competencies. Vaccination in pharmacies was also introduced as a new initiative with pharmacists trained for influenza vaccination. However, further action is needed to achieve greater coverage in children's vaccination and reduce infant mortality. It is crucial to introduce effective national communication campaigns through traditional and social media to address misinformation, thereby improving health literacy to overcome vaccine hesitancy. Outreach vaccination programmes are also required to reach those living in rural areas and uninsured populations. These strategies must be implemented at national, regional and local levels to address public health concerns and vaccine hesitancy effectively.

4.3.3. Romania is actively tackling the rise in antimicrobial resistance

Antimicrobial resistance (AMR) is of serious concern. Romania recorded the highest AMR composite index in the EU, with nearly 70% of bacterial isolates resistant to key antibiotics in 2022-23 (ECDC, 2024[22]). Without further policy actions, AMR is expected to further grow in the coming years. A significant driver of AMR is the overuse and misuse of antibiotics. The volume of antibiotic consumption in Romania is very high, well above the OECD average in 2023 (26 defined daily doses (DDDs) per 1 000 inhabitants compared to 16 DDDs in OECD), which has not changed over the last decade (Figure 4.13). Regarding

the safe use of antibiotics, Romania falls short of the WHO target for the use of Access-group antibiotics – which are first and second-line pharmacotherapies with lower potential for AMR. With just above 50% in 2023, Romania remained below the WHO minimum target of 65% (OECD/European Observatory on Health Systems and Policies, 2025[6]).

Figure 4.13. The volume of prescribed antibiotics in Romania is above the OECD average and has not changed over the last decade



Note: 1. Latest data from 2019. 2. Latest data from 2021. Data refer to antibiotics prescribed in community setting only.
Source: OECD (2025[1]), *Health at a Glance 2025: OECD Indicators*, https://doi.org/10.1787/8f9e3f98-en., based on ECDC (for EU countries and United Kingdom); OECD Health Statistics.

Romania has been actively taking actions aligned with the National Health Strategy preventing HAI and combating AMR 2023-2030. To effectively reduce antibiotic consumption, the country passed a law to enable monitoring of antibiotic dispensing in emergency situations – through the collection of patient and pharmacy data, aiming to limit misuse and prevent repeated unregulated dispensing. Other concrete measures recently implemented include providing training and education to healthcare staff on AMR and supporting awareness campaigns at local and/or sub-national level about risks of AMR and actions to address it. To strengthen its actions against AMR, Romania should consider incorporating the financial provisions for the implementation of the AMR action plan into the national action plans and budgets. To optimise antimicrobial use in human health, it is essential to ensure that national guidelines are implemented and that data on antimicrobial use is systematically fed back to prescribers. To improve infection prevention and control, it is recommended that good practices are systematically implemented at national and health facility levels, compliance and effectiveness are assessed, and that guidance is regularly updated. The OECD estimates that investing just USD 1 per person annually in policies that respect the One Health[2] approach would result in saving in healthcare costs of USD 8 million for the Romanian economy (OECD, 2023[23]).

4.3.4. The COVID-19 crisis highlighted important shortcomings in Romania's preparedness and response to health outbreaks and other emergencies

In response to the COVID-19 pandemic, the Romanian Government enacted a series of measures in alignment with the WHO recommendations and the International Health Regulations. Despite these measures, the rates of testing and vaccination remained low, resulting in a mortality rate from COVID-19 that was about 12% higher than the EU average. Specifically, Romania recorded approximately

1 790 deaths per million population due to COVID-19, compared with an EU average of about 1 590 between 2020 and 2021 (OECD/European Observatory on Health Systems and Policies, 2021[24]). This suboptimal response underscores the need to reinforce crisis preparedness and response, including in updating preparedness plans, better intersectoral preparation, more effective communication, and improved co-ordination at the national and sub-national levels.

Beyond pandemics, Romania is exposed to several potential public health risks including natural and climate-related disasters. Romania's earthquake risk is among the highest in the EU. In each of the last five centuries, the country has on average experienced two earthquakes of magnitude 7 or above (World Bank, 2019[25]). And, three in four inhabitants lives in areas that are susceptible to earthquakes (World Bank/Romanian Government, 2023[26]). Climate change is expected to lead to more frequent and persistent heat waves and more severe droughts. Romania is particularly exposed to hot weather, increasing people's health problems and mortality risk. For instance, nearly half (48%) of the Romanian population is exposed to hot summer days (days where the temperature exceeds 35°C), compared to 29% on average in OECD countries (OECD, 2023[27]). In addition, following the Russia's war of aggression against Ukraine, the inflow of people arriving from Ukraine are also placing considerable strain on the health system. Since the war began, over 3 million refugees have crossed into Romania, with around 77 000 Ukrainians residing in the country as of March 2024 (WHO, 2024[28]). The Romanian healthcare system has responded to the refugee's health needs, by granting free of charge medical care to displaced people arriving from Ukraine.

Romania's self-assessed capacity for public health emergencies, as measured by the WHO e-SPAR tool, was 62% in 2024, well below the EU average of 75% (OECD/European Observatory on Health Systems and Policies, 2025[6]), particularly reflecting gaps in infection prevention and control, human resources, risk communication, and health services provision (WHO, 2024[28]). The authorities recognise the importance of strengthening their capacity for preparedness and responses to health crisis. Concrete measures include upgrading the laboratory infrastructure and establishing a national reference laboratory to enhance testing and surveillance capabilities during health emergencies. Together with WHO, the country has initiated a project dealing specifically with strengthening emergency co-ordinating structures at national and county level and with developing standard operating procedures for the co-ordination of joint operations for emergency response (WHO, 2024[28]). To improve resilience to various types of disasters, Romania has adopted the National Strategy for Disaster Risk Reduction 2023-2035. This strategy aims to improve preparedness and responses for a range of potential hazards, such as forest fires, earthquakes and epidemics, through a multi-sectoral and comprehensive approach that engage all relevant stakeholders. Strategy implementation efforts are co-ordinated by the Ministry of Internal Affairs, through the General Inspectorate for Emergency Situations and the Department of Emergency situations. To effectively address future health challenges, it is important to strengthen efforts and speed up the implementation of measures to prepare for and respond to any future crises.

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Notes

[1] Catastrophic expenditure is defined as household OOP spending exceeding 40% of total household spending net of subsistence needs (i.e. food, housing and utilities).

[2] One Health is an integrated strategic approach aiming to establish multisectoral collaboration between public health, veterinary, and environmental actors to address cross-cutting health challenges such as antimicrobial resistance or food safety (World Health Organization).

OECD Reviews of Health Systems: Romania 2025

Over the past two decades, Romania's health system has made notable progress, reflected in increased life expectancy and significant reductions in infant and maternal mortality. Despite this progress, performance remains low relative to OECD countries in several areas, including health risk factors, access to healthcare, quality of services, healthcare capacity and financing. In response, Romania has implemented reforms to strengthen system efficiency and resilience, from enhancing health budgeting, to increasing remuneration for healthcare professionals, and the introduction of performance-based payment models. Persistent challenges remain to be addressed, notably in addressing wasteful health spending, workforce shortages, corruption, inefficiencies in primary and community healthcare, inadequate access to services, and fragmented health data systems. This review highlights Romania's ongoing efforts to improve sustainability, efficiency, quality, access, and resilience, providing policymakers and stakeholders with evidence-based insights to guide future reforms.

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