European Commission

State of Health in the EU

Romania

Country Health Profile 2021

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European Observatory on Health Systems and Policies
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The Country Health Profile series

The *State of Health in the EU's* Country Health Profiles provide a concise and policy-relevant overview of health and health systems in the EU/European Economic Area. They emphasise the particular characteristics and challenges in each country against a backdrop of cross-country comparisons. The aim is to support policy makers and influencers with a means for mutual learning and voluntary exchange.

The profiles are the joint work of the OECD and the European Observatory on Health Systems and Policies, in co-operation with the European Commission. The team is grateful for the valuable comments and suggestions provided by the Health Systems and Policy Monitor network, the OECD Health Committee and the EU Expert Group on Health Systems Performance Assessment (HSPA).

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Data and information sources

The data and information in the Country Health Profiles are based mainly on national official statistics provided to Eurostat and the OECD, which were validated to ensure the highest standards of data comparability. The sources and methods underlying these data are available in the Eurostat Database and the OECD health database. Some additional data also come from the Institute for Health Metrics and Evaluation (IHME), the European Centre for Disease Prevention and Control (ECDC), the Health Behaviour in School-Aged Children (HBSC) surveys and the World Health Organization (WHO), as well as other national sources.

The calculated EU averages are weighted averages of the 27 Member States unless otherwise noted. These EU averages do not include Iceland and Norway.

This profile was completed in September 2021 based on data available at the end of August 2021.

Demographic and socioeconomic context in Romania, 2020

Demographic factors	Romania	EU
Population size (mid-year estimates)	19 328 838	447 319 916
Share of population over age 65 (%)	18.9	20.6
Fertility rate[1] (2019)	1.8	1.5
Socioeconomic factors		
GDP per capita (EUR PPP[2])	21 296	29 801
Relative poverty rate[3] (%, 2019)	23.8	16.5
Unemployment rate (%)	5.0	7.1

[1]Number of children born per woman aged 15–49. [2]Purchasing power parity (PPP) is defined as the rate of currency conversion that equalises the purchasing power of different currencies by eliminating the differences in price levels between countries. [3]Percentage of persons living with less than 60 % of median equivalised disposable income. Source: Eurostat Database.

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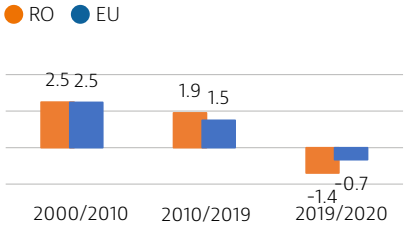
1 Highlights

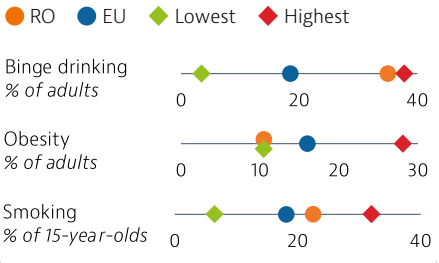
Life expectancy in Romania is among the lowest in Europe, and the COVID-19 pandemic reversed some of the gains made since 2000. The pandemic has highlighted the importance of strengthening primary care, preventive services and public health, in a health system currently heavily reliant on inpatient care. Health workforce shortages and high out-of-pocket spending are key barriers to access. The COVID-19 pandemic stimulated the creation of several electronic information systems to manage overstretched health resources better, and these may offer avenues to future health system strengthening.



Life expectancy gains, years

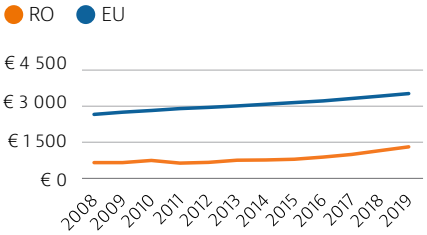
Health Status

Life expectancy in Romania increased by more than four years between 2000 and 2019, but declined temporarily by 1.4 years in 2020 due to the impact of COVID-19. There is a marked gender gap, with women living almost eight years longer than men. Cardiovascular diseases are the leading causes of mortality while lung cancer is the most frequent cause of cancer death.



Risk factors

Risky health behaviours contribute to nearly half of all deaths. Romanians report higher alcohol consumption and unhealthier diets than the EU averages, but adult obesity is the lowest in the EU. Smoking in adults is now marginally lower than the EU average. These risk factors are more prevalent among men than women. Overweight, obesity and smoking rates among adolescents are high, and have been growing steadily over the past two decades.



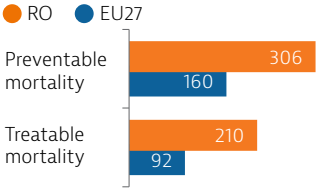
Per capita spending (EUR PPP)

Health system

Health spending in Romania increased in the last decade but remains the second lowest in the EU as a whole – both as a share of GDP and per capita. About 44 % of health spending was allocated to inpatient care in 2019, which is the highest proportion among EU countries. Although the public share of health spending is high and in line with the EU average, out-of-pocket payments are above the EU average and are dominated by outpatient pharmaceutical costs.

Effectiveness

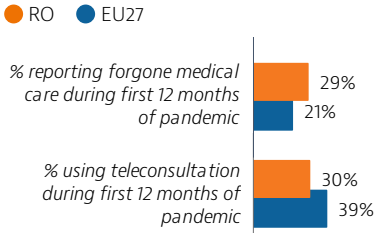
The preventable mortality rate is the third highest in the EU and can be attributed mainly to cardiovascular disease, lung cancer and alcohol-related deaths. Mortality from treatable causes is more than double the average for the EU and includes deaths from prostate and breast cancers that are amenable to treatment.



Age-standardised mortality rate per 100 000 population, 2018

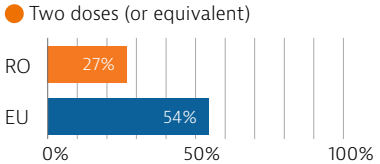
Accessibility

Although self-reported unmet needs for medical examinations had declined by more than half between 2011 and 2019, a high rate of forgone care was recorded in the first year of the COVID-19 pandemic. Teleconsultations were not used as widely as in other EU countries.



Resilience

Before the pandemic, Romania invested significantly in the health sector, albeit from a low base, but COVID-19 put great pressure on the system. Planning and communication for the COVID-19 vaccination campaign began early, but the rollout was delayed due to supply shortfalls. Vaccination coverage is low, largely due to vaccine hesitancy.



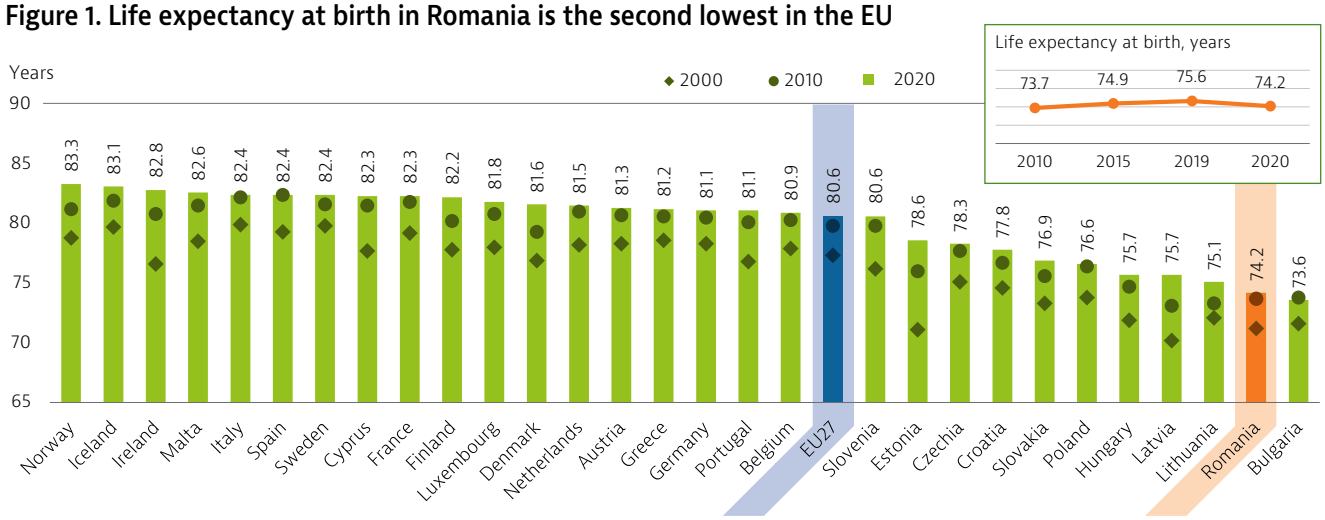
Share of total population vaccinated against COVID-19 up to the end of August 2021

2 Health in Romania

Life expectancy declined significantly due to COVID-19, and is far below average for the EU

Life expectancy at birth in Romania increased by more than four years between 2000 and 2019 (from 71.2 to 75.6 years), but remained among the lowest in the EU, at almost six years below the EU average (Figure 1). The COVID-19 pandemic resulted in a substantial temporary decline in life expectancy in many countries, including Romania, where it fell by 1.4 years to 74.2 years. In contrast, the average reduction across the EU in 2020 was 0.7 years. In 2020, the gender gap in life expectancy was marked: women live almost eight years longer than men (78.4 years compared to 70.5), which is among the largest gaps in the EU.

Figure 1. Life expectancy at birth in Romania is the second lowest in the EU



Note: The EU average is weighted. Data for Ireland refer to 2019.
Source: Eurostat Database.

More than a third of deaths in Romania in 2018 were from cardiovascular diseases

Ischaemic heart disease was the leading cause of mortality in Romania in 2018, accounting for over 19 % of all deaths (Figure 2). The death rate from ischaemic heart disease was more than double the EU average. Mortality from stroke – the second leading cause of death – accounted for 16 % of all deaths, despite steep improvements since 2000. Lung cancer was the most frequent cause of cancer death, with a mortality rate that has increased by nearly 11 % since 2000, due mainly to high smoking rates. Mortality rates of other cancer types have also increased in recent years – particularly colorectal cancer.

Figure 2. Cardiovascular diseases are the main cause of death, but COVID-19 led to many deaths in 2020

Note: The number and share of COVID-19 deaths refer to 2020, while the number and share of other causes refer to 2018. The size of the COVID-19 box is proportional to the size of the other main causes of death in 2018.
Sources: Eurostat (for causes of death in 2018); ECDC (for COVID-19 deaths in 2020, up to week 53).

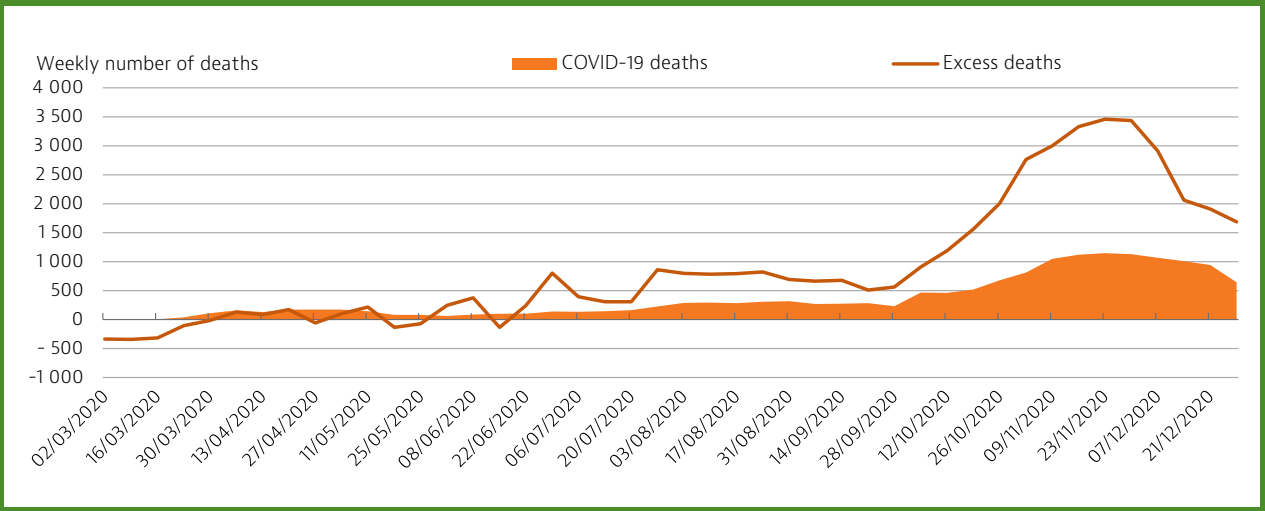
In 2020, COVID-19 accounted for about 16 000 deaths in Romania (5 % of all deaths). Around 18 500 more deaths were registered by the end of August 2021. The mortality rate from COVID-19 up to the end of August 2021 was about 12 % higher in Romania than the average across EU countries, at approximately 1 790 per million population compared with an EU average of about 1 590. However, the broader indicator of excess mortality suggests that the direct and indirect death toll related to COVID-19 in 2020 could be substantially higher (Box 1).

Box 1. The official number of COVID-19 deaths underestimates the full impact of the pandemic in 2020

In Romania, as in many other countries, the actual number of deaths from COVID-19 is likely to be higher than the number of reported deaths because of limited testing, as well as issues related to the attribution of cause of death early in the pandemic. The number of COVID-19 deaths also does not include possible indirect deaths – for example, those arising from reduced access to health services for non-COVID-19 patients and fewer people seeking treatment due to fear of catching the virus. The indicator of excess mortality (defined as the number of deaths from all causes exceeding the number expected based on the baseline from previous years) can provide a broader measure of the direct and indirect deaths due to COVID-19 that is less affected by issues related to testing and cause of death registration.

Overall, excess mortality between early March and the end of December 2020 (39 000 deaths) was more than double reported COVID-19 deaths (16 000 deaths) (Figure 3). A possible explanation for this gap is the limited testing capacity in Romania, which might have left positive cases unidentified (see Section 5.3). In addition, access to non-COVID-19 hospital care may have been hampered by pressure on the system from treating COVID-19 cases, leading to high rates of excess non-COVID-19 deaths.

Figure 3. COVID-19 and excess deaths peaked in autumn 2020

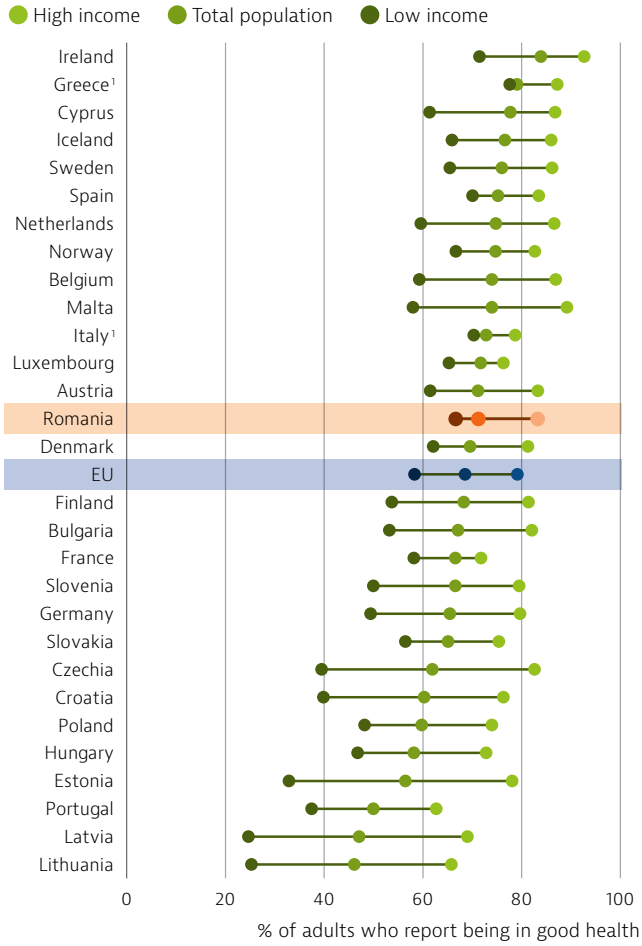


Note: Data on excess mortality extracted on 17 June 2021.
Sources: Eurostat Database for excess mortality and ECDC for COVID-19 deaths.

Most people report being in good health, but disparities exist by income group

Nearly three quarters of Romanians reported being in good health in 2019 (71 %) – slightly more than average across the EU (69 %). More than four in five people in the highest income quintile considered themselves to be in good health, compared with about two thirds of those in the lowest (Figure 4). However, these disparities in self-perceived health are smaller than in most EU countries.

Figure 4. Most Romanians rate their own health as good or very good

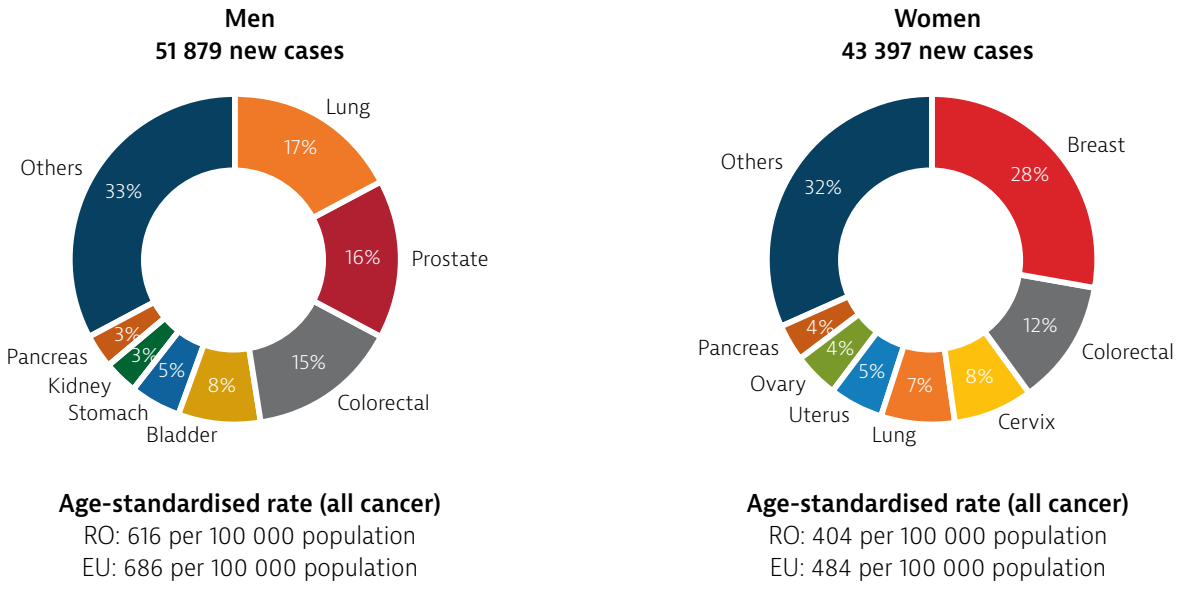


Note: 1. The shares for the total population and the population on low incomes are roughly the same.
Source: Eurostat Database, based on EU-SILC (data refer to 2019).

The burden of cancer mortality is considerable

According to estimates from the Joint Research Centre based on incidence trends from previous years, around 95 000 new cancer cases and about 54 000 deaths from cancer were projected to occur in Romania in 2020[1]. While cancer incidence was expected to be lower than the EU average, overall mortality from cancer in Romania was estimated to be slightly higher, at 283 deaths per 100 000 population; the average across the EU was 264. This indicates that there are weaknesses in cancer diagnosis and treatment outcomes (see Section 5.1). Figure 5 shows that estimates of the main types of cancer expected in men are lung (17 %), prostate (16 %) and colorectal (15 %), while among women breast cancer is the leading cancer type (28 %), followed by colorectal (12 %) and cervical cancer (8 %).

Figure 5. An estimated 95 000 people in Romania were diagnosed with cancer in 2020



Note: Non-melanoma skin cancer is excluded; uterus cancer does not include cancer of the cervix.
Source: ECIS – European Cancer Information System

1. It should be noted that these estimates were made before the COVID-19 pandemic; this may have an effect on both the incidence and mortality rates of cancer during 2020.

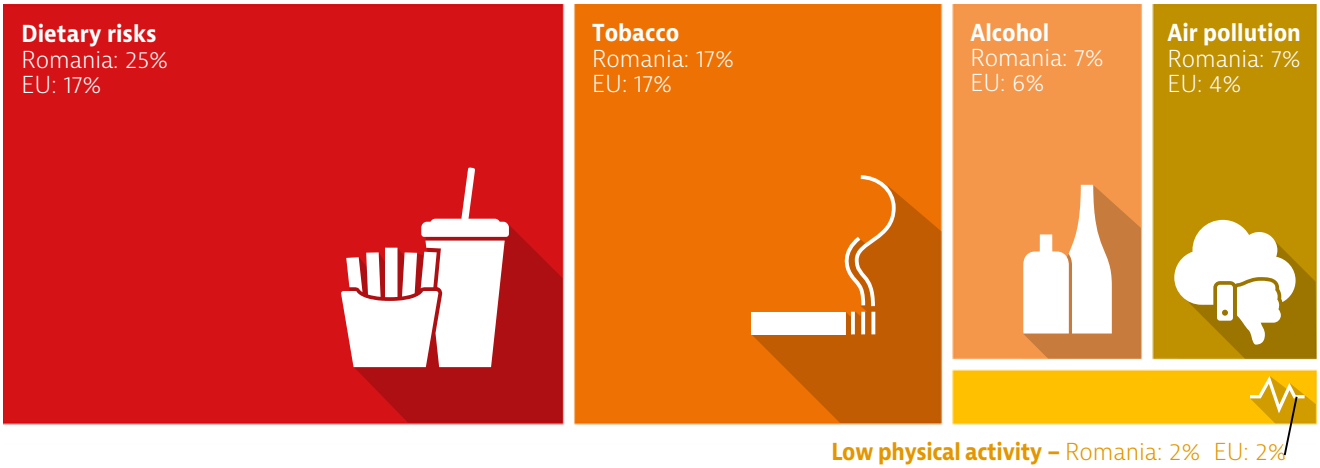
3 Risk factors

Behavioural and environmental risk factors account for more than half of all deaths

Almost half of all deaths in Romania in 2019 can be attributed to behavioural risk factors, including tobacco smoking, unhealthy diet, alcohol consumption and low physical activity. Environmental factors such as air pollution also contribute to a considerable number of deaths (Figure 6). Unhealthy diets, including low fruit and vegetable intake, and high sugar and salt consumption, were implicated in a quarter of all deaths in 2019. Tobacco consumption (including second-hand smoking) contributed to an estimated 17 % of all deaths, while around 7 % were attributable to alcohol consumption, and 2 % to low levels of physical activity.

Air pollution, in the form of fine particulate matter ($PM_{2.5}$) and ozone exposure alone contributed an estimated 7 % of all deaths in 2019 (over 17 000 deaths) – a much higher proportion than on average across EU countries (4 %). In most cases, air pollution contributes to deaths from cardiovascular and respiratory diseases, and some types of cancer.

Figure 6. Poor diet, tobacco and air pollution are major contributors to mortality in Romania



Note: The overall number of deaths related to these risk factors is lower than the sum of each one taken individually, because the same death can be attributed to more than one risk factor. Dietary risks include 14 components such as low fruit and vegetable intake, and high sugar-sweetened beverages consumption. Air pollution refers to exposure to $PM_{2.5}$ and ozone.
Sources: IHME (2020), Global Health Data Exchange (estimates refer to 2019).

Overweight and obesity rates in adolescents are a growing public health issue

Over three quarters of Romanian adults reported in 2019 that they did not eat at least one piece of fruit daily, and a similar proportion did not consume vegetables. These figures are much higher than in most other EU countries. Fewer than two fifths of Romanian adults (38 %) reported engaging in at least moderate physical activity every week – the lowest proportion in the EU. Despite the low levels of fruit and vegetable consumption and low levels of physical activity, the self-reported adult obesity rate in Romania is the lowest in the EU: only 11 % of adults were obese in 2019, while the EU average was 16 %. However, overweight and obesity rates in adolescents have grown steadily over the last two decades, with one in five 15-year-olds falling into these categories in 2018, which is slightly above the EU average.

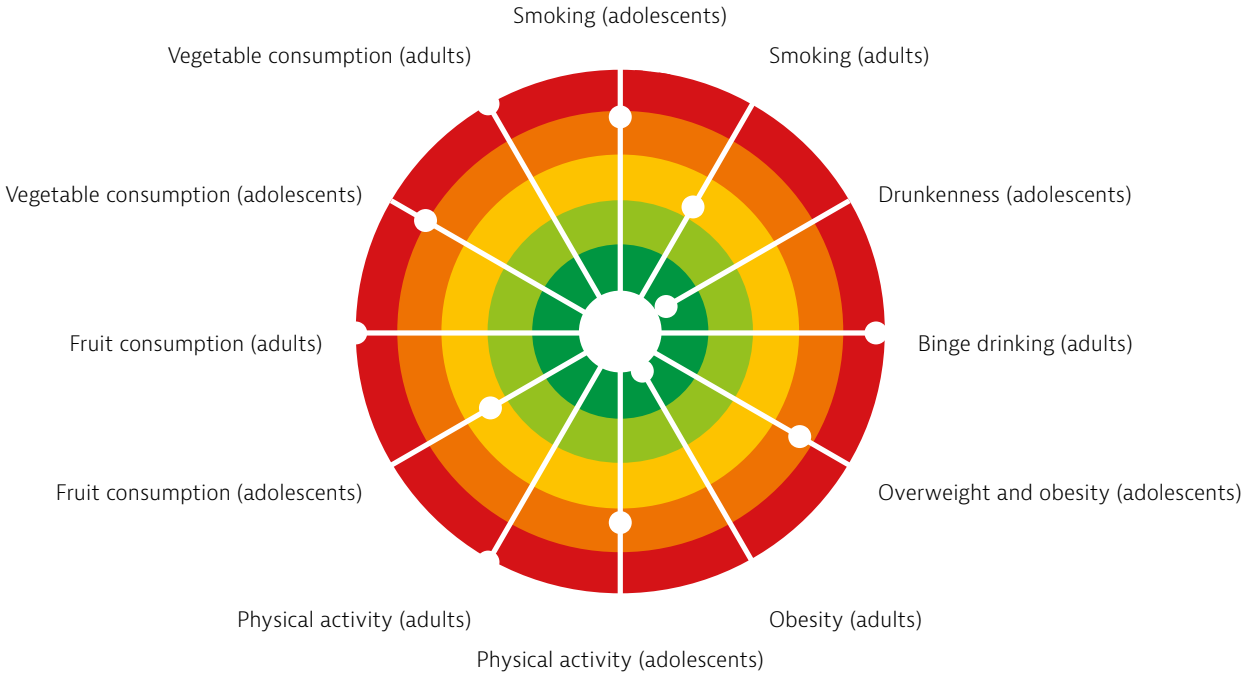
Around one in five Romanian adults smoke on a daily basis

Despite a slight reduction in smoking rates since 2008, just under one in five adults still smoked daily in 2019, which is slightly below the EU average (Figure 7). There is a large gender gap in smoking, with smoking rates among men (31 %) nearly four times higher than those among women (8 %). Tobacco consumption among adolescents is also a matter of concern, with nearly one third of 15-16-year-olds reporting that they had smoked during the past month in 2019 (31 %) – a proportion much higher the EU average (21 %). Adolescent smoking rates have remained unchanged since 2014 but, unlike adults, there is little difference between rates for boys and girls. When e-cigarettes are included in addition to conventional cigarettes, 40 % of 15-16-year-olds in Romania had smoked in the last month in 2019 – this is the highest across all EU countries (the EU average was 28 %).

Excessive alcohol consumption is a major problem, particularly among Romanian men

On average, more than one third of adults in Romania reported engaging in episodic, heavy alcohol consumption (binge drinking[2]) at least once a month – one of the highest rates in the EU (35 % compared with an EU average of 19 %). However, there is a strong gender gap in heavy drinking, with more than half of men (53 %) reporting such behaviour but fewer than one in five women (18 %) reporting the same. Nearly two fifths of 15- and 16-year-olds in Romania reported at least one episode of heavy drinking during the preceding month in 2019, which is similar to the EU average.

Figure 7. Romania fares worse than most EU countries on many risk factors



Note: The closer the dot is to the centre, the better the country performs compared to other EU countries. No country is in the white "target area" as there is room for progress in all countries in all areas.
Sources: OECD calculations based on HBSC survey 2017-18 for adolescents indicators; and EU-SILC 2017, EHIS 2014 and 2019 for adults indicators.

4 The health system

Romania operates a compulsory social health insurance system with strong state stewardship

The Ministry of Health is responsible for overall governance of the social health insurance (SHI) system, while the National Health Insurance House administers and regulates the National Health Insurance Fund (NHIF). Both the Ministry and the National Health Insurance House are locally represented through district public health authorities and district health insurance funds. Health care services are provided by 41 districts and the capital (Bucharest), in line with centrally determined rules. In the SHI system, district health insurance funds buy services from health care providers (general practitioners (GPs), specialist practices, laboratories, hospitals and so on) at the local level. Health care providers are also paid by the Ministry of Health under national health programmes. These programmes cover priority areas such as maternal and child health, infectious disease control, mental health and screening. All levels of the system were involved in the COVID-19 response (Box 2).

2. *Binge drinking is defined as consuming six or more alcoholic drinks on a single occasion for adults, and five or more alcoholic drinks for children.*

Box 2. Pandemic crisis management was initially centralised, but later devolved to local authorities

In March 2020 Romania opted for centralised management of the COVID-19 pandemic, in which the central government oversaw the pandemic and district-level decision makers had the power to enforce local measures. The Prime Minister headed the national emergency response and established special crisis management structures. As early as January 2020, the National Committee for Special Emergency Situations set up a technical and scientific support group for pandemic response and initiated an emergency action plan to fight the COVID-19 pandemic. The Committee comprised representatives of the Ministry of Internal Affairs, Department for Emergency Situations, the General Inspectorate for Emergency Situations, the Ministry of Health, the National Institute for Public Health, the National Centre for the Surveillance and Control of Communicable Diseases and the Ministry of Defence.

After the first three months, active management of the pandemic was decentralised, and responsibility for implementation of measures passed to regional and district authorities.

Source: COVID-19 Health Systems Response Monitor.

Social health insurance contributions for vulnerable populations are paid from the state budget

Before 2017, the payment of SHI contributions to the NHIF was split between employees and employers, yet the latter consistently failed to pay their shares. Following new legislation, since 2017, employees have been responsible for covering the full amount of SHI contributions, and receive corresponding salary increases equal to the employer's share. Some vulnerable population groups are exempt from making direct contributions (including unemployed people, retired people and people on social benefits). Their contributions are paid by the state budget to the NHIF, which guarantees their coverage. Specific population groups – such as pregnant women, people with disabilities and chronically ill patients, as well as children and students aged under 26 – are financed from the SHI contributions of the working population.

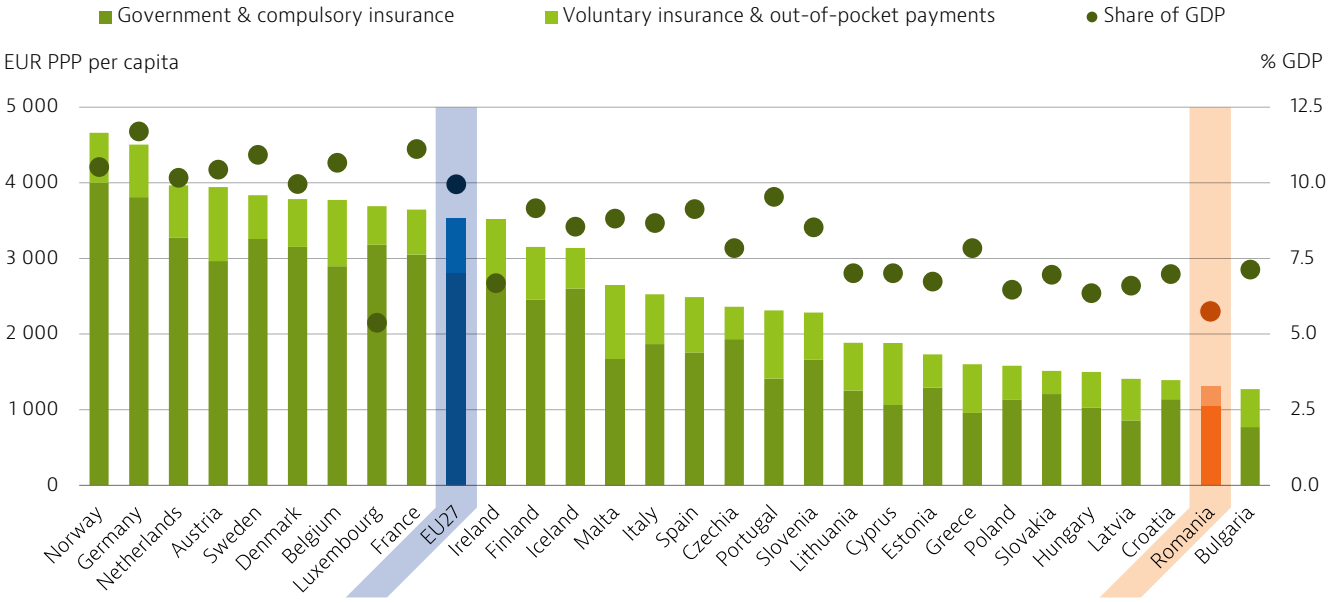
Despite the compulsory SHI system, approximately 11 % of the population remains uninsured, particularly in rural areas (see Section 5.2). Those who are uninsured are entitled to a minimum benefits package that covers life-threatening emergencies, infectious diseases (including COVID-19 – see Section 5.2) and care during pregnancy. Overall, the reliance on employee contributions and the relatively small working population results in chronic underfunding of the health system (see Section 5.3).

Health spending has increased since 2015 but remains very low

Romania has significantly increased its health spending in recent years, but remains one of the EU countries with the lowest health expenditure, both on a per capita basis, and as a proportion of GDP (Figure 8). Several financial injections were made to cover extra demands on the system throughout the COVID-19 pandemic (Box 3).

Between 2015 and 2019, health spending increased on average by 10.3 % per year, which is the largest increase among EU countries. In 2019, however, Romania still spent less than half the average per capita across EU countries (EUR 1 310 compared to EUR 3 523, adjusted for differences in purchasing power). As a share of GDP, Romania spent 5.7 % on health – the second lowest among EU countries. Although the public share of health spending is high (80 % in 2019) and in line with the EU average, at 18.9 %, out-of-pocket (OOP) payments are above the average of 15.4 % across the EU (see Section 5.2). Informal payments are believed to be substantial, although their full extent is unknown.

Figure 8. Health spending per capita in Romania is among the lowest among EU countries



Note: The EU average is weighted.
Source: OECD Health Statistics 2021 (data refer to 2019, except for Malta 2018).

Box 3. Several financial injections and reallocations supported the COVID-19 pandemic response

During 2020, the Romanian Ministry of Health paid for some of the COVID-19-related costs not covered by the NHIF, such as medicines, equipment and consumables. It also covered the cost of isolating COVID-19 patients in specially designated facilities.

The government introduced a legislative budget adjustment to ensure availability of funds needed to pay for COVID-19 services, including bonuses for health workers treating COVID-19 cases and salary increases for those dealing with prevention and control measures. Alongside reallocations from the national budget, additional funds came from the European Commission, consisting of unspent allocations from the European Structural and Investment Funds from 2019 (around EUR 483 million) and 2020 (around EUR 637 million). These funds were used for the procurement of personal protective equipment (PPE), tests and medical equipment, home medical and social services for older people, hygiene products for vulnerable groups, and bonuses for health workers. Additional funds and in-kind contributions came from donations and charity.

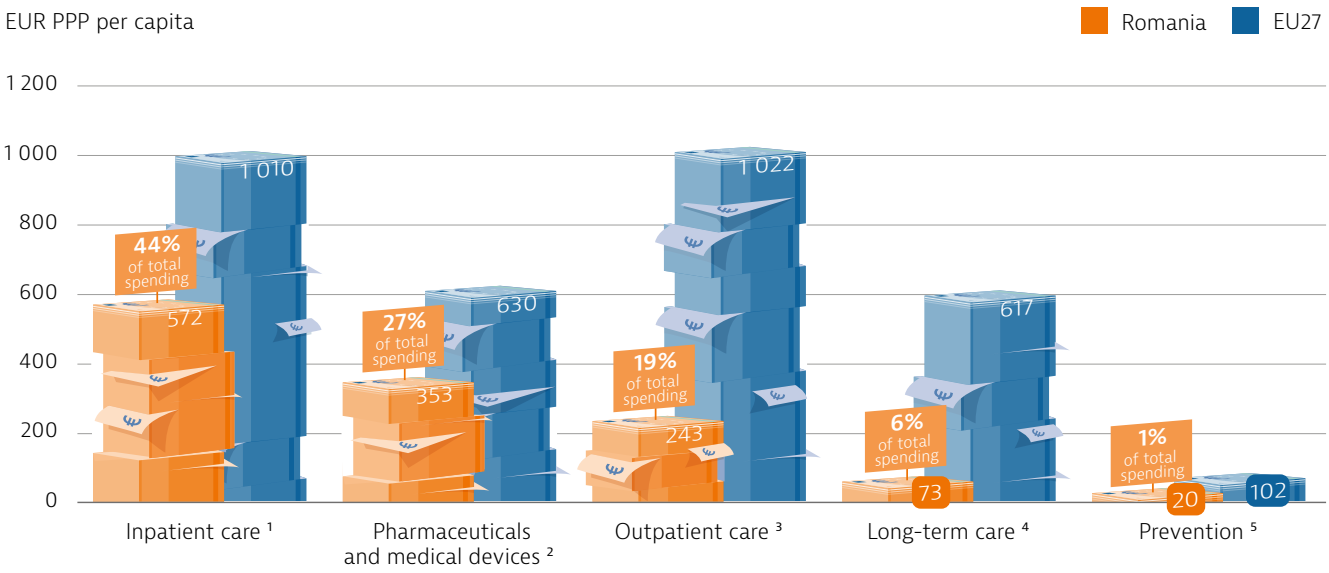
Source: COVID-19 Health Systems Response Monitor.

The proportion of spending on hospital care in Romania continues to increase

About 44 % of health spending in Romania was allocated to inpatient care in 2019 (an increase of 3 percentage points since 2010). This is the highest proportion among EU countries, for which the average stands at 29 %. However, the overall amount per capita remains low in absolute terms (Figure 9). Another 27 % is spent on outpatient pharmaceuticals and medical goods – a proportion that has been falling since 2013 but is still higher than the EU average. In absolute terms, per capita spending on outpatient pharmaceuticals and medical devices (EUR 353) is among the lowest in the EU. Inpatient care and pharmaceuticals are relatively expensive activities in the health care system and so absorb a higher proportion of the limited funds available than they would if the health budget were larger.

Despite efforts to strengthen primary care, the proportion of health spending devoted to primary and ambulatory care (18.6 %) remains the second lowest in the EU (after Bulgaria), and is also the second lowest in absolute terms. In 2018-19, Romania introduced new screening programmes, yet per capita spending on prevention has continued to decline, and is the second lowest in the EU (see Section 5.1).

Figure 9. Romania spends far less than the EU-wide average in all care areas



Note: Note: The costs of health system administration are not included. 1. Includes curative-rehabilitative care in hospital and other settings; 2. Includes only the outpatient market; 3. Includes home care and ancillary services (e.g. patient transportation); 4. Includes only the health component; 5. Includes only spending for organised prevention programmes. The EU average is weighted.
Sources: OECD Health Statistics 2021, Eurostat Database (data refer to 2019).

Ambulatory care is free, but outpatient pharmaceutical cost-sharing can be significant

The SHI scheme covers a comprehensive benefits package including primary care and most medicines, including medicines for children and pregnant women, for certain severe diseases, and for conditions covered by national health programmes. However, patients need to pay a proportion of the cost of outpatient pharmaceuticals: 10 % for lower-priced generics, 50 % for expensive generics and patented medicines, and 80 % for prescription drugs with low cost–effectiveness (see Section 5.2). Cost-sharing also applies for rehabilitation and inpatient care, amounting to about 35 % per episode of care, but more than 60 % of the population are exempted from user charges for inpatient care. Exempt groups include children under 18, and young people aged up to 26 if they are enrolled in any form of education; patients covered by national health programmes; pregnant women without income; and pensioners.

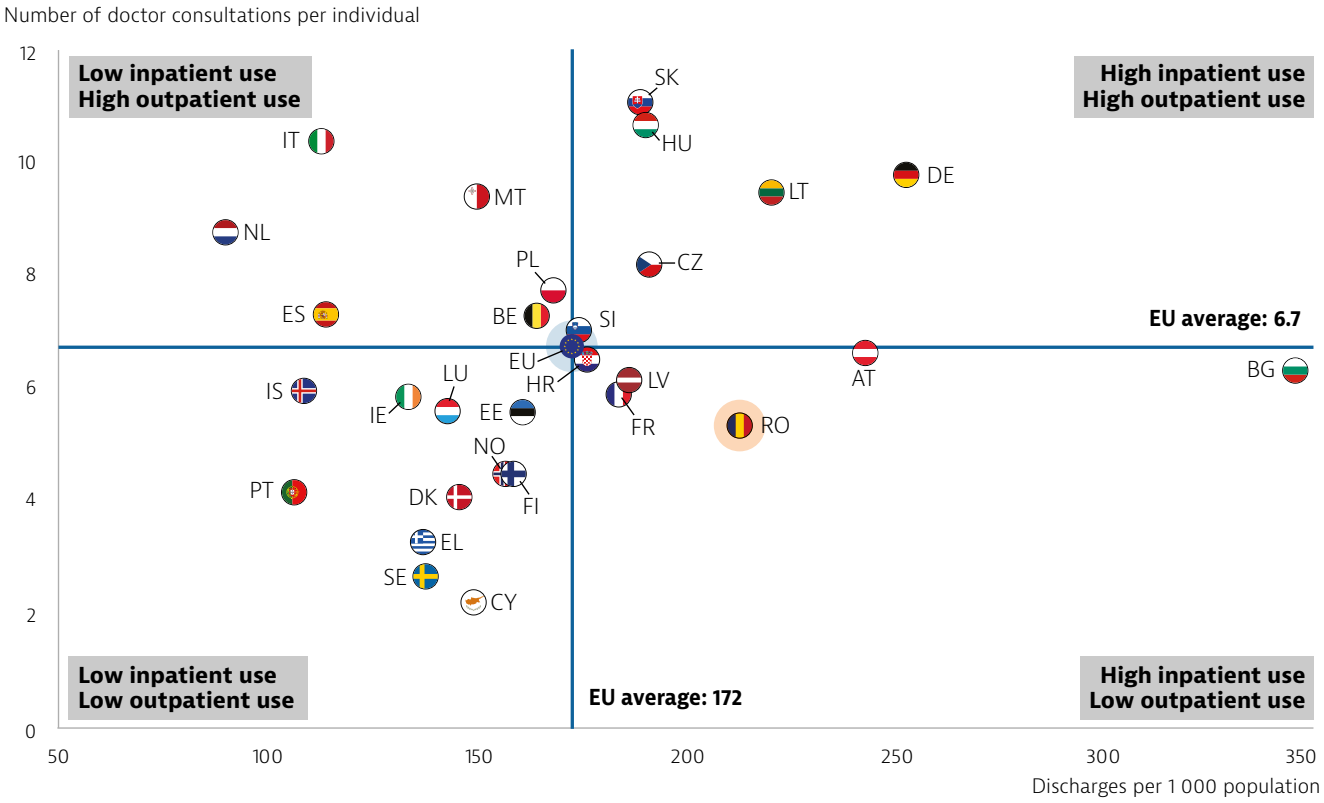
Romania trains sufficient medical professionals, but many migrate to other countries

Despite increases in workforce numbers over the last decade, the densities of doctors and nurses remain well below EU averages. In 2019, there were 3.2 practising doctors per 1 000 population, which is among the lowest ratios in the EU (the EU average is 3.9), and 7.5 nurses per 1 000 population (the EU average is 8.4). Romania trains a large medical workforce; in 2019, its education system generated the fifth highest number of medical graduates (4 967) and third highest number of nursing graduates (17 549) in absolute terms in the EU. Nevertheless, migration of medical staff has contributed to the low numbers of health professionals working in Romania, and this adversely affects access to care (see Section 5.2).

Weak gatekeeping leads to high hospital care use

GPs provide primary care mainly in (private) solo practices contracted by the district health insurance funds. They have a gatekeeping role, although patients with certain conditions can access specialists directly. GPs made up 24.5 % of the doctor workforce in 2019, which is below the EU average of 26.5 %. However, patients often rely on hospital emergency departments if they need medical assistance – including non-urgent care – and choose to bypass primary care altogether. Moreover, the system remains very hospital-centric, with relatively high spending on hospitals and comparatively large numbers of beds (7 per 1 000 population compared with an average of 5.3 across the EU in 2019). All these factors contribute to a situation in which primary care continues to be underutilised, while there is overutilisation of hospital services (Figure 10; see Section 5.3).

Figure 10. Outpatient care remains underutilised in Romania



Note: The EU average is unweighted.
Sources: OECD Health Statistics and Eurostat Database (data refer to 2019 or nearest year).

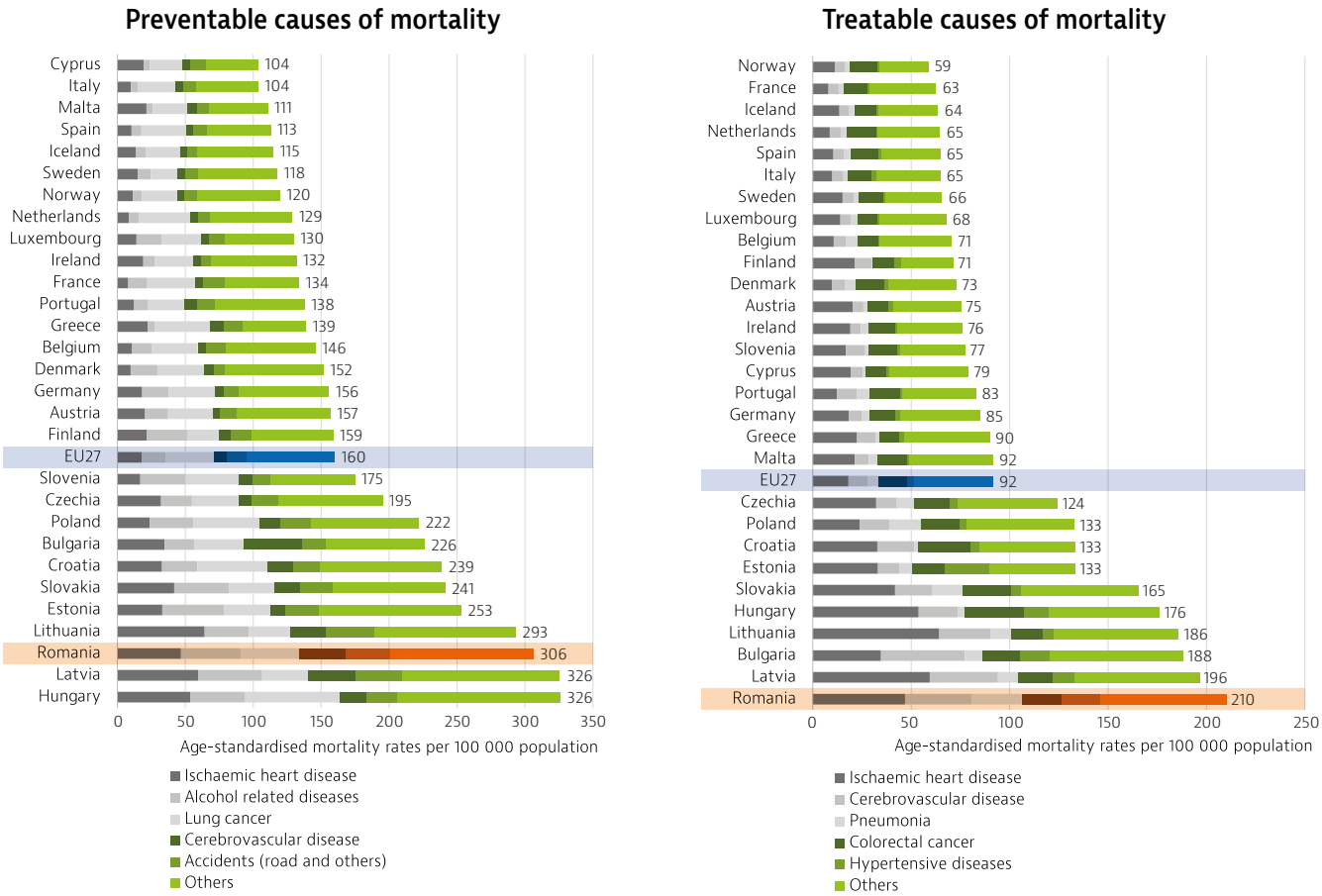
5 Performance of the health system

5.1 Effectiveness

Major improvements in prevention and treatment are needed to reduce mortality

In Romania, mortality from both preventable and treatable causes is very high. The rate of preventable mortality was the third highest in the EU in 2018, pointing to the need to improve health promotion and disease prevention (see Section 3). The main causes of preventable mortality are ischaemic heart disease, lung cancer and alcohol-related diseases. Mortality from treatable causes is the highest in the EU and more than double the average across EU countries (Figure 11). Major deficiencies in the health system's ability to provide appropriate and timely treatment to the population are shown by the high rates of treatable mortality due to ischaemic heart disease (which is considered both preventable and treatable), stroke, pneumonia and colorectal cancer.

Figure 11. Romania has high rates of avoidable deaths from both preventable and treatable causes



Note: Preventable mortality is defined as death that can be mainly avoided through public health and primary prevention interventions. Treatable mortality is defined as death that can be mainly avoided through health care interventions, including screening and treatment. Half of all deaths for some diseases (e.g. ischaemic heart disease and cerebrovascular disease) are attributed to preventable mortality; the other half are attributed to treatable causes. Both indicators refer to premature mortality (under age 75). The data are based on the revised OECD/Eurostat lists.
Source: Eurostat Database (data refer to 2018, except for France 2016).

Cancer survival rates are low, but new programmes should improve screening, diagnosis and treatment

Five-year survival rates from treatable cancers are well below the EU average, including for prostate cancer (77 % compared to 87 % for the EU) and breast cancer (75 % compared to 82 % for the EU). Despite lung cancer survival increasing from 8 % in 2009 to 11 % in 2014, it is still well below EU average of 15 % (Figure 12). The outlook for childhood leukaemia is also particularly poor – the five-year survival rate is only 54 %; this is 21 percentage points lower than in any other EU country (the next lowest is in Lithuania, where 75 % of children with leukaemia survive at least five years from diagnosis). These poor outcomes suggest a need to increase the timeliness and effectiveness of treatment. Cervical cancer survival in Romania is 2 percentage points above the EU average, but prevalence is much higher and screening rates are much lower, so it may be underdiagnosed.

Figure 12. Although cancer survival rates are improving, they remain well below the EU average

Prostate cancer
Romania: 77 %
EU23: 87 %

Childhood leukaemia
Romania: 54 %
EU23: 85 %

Breast cancer
Romania: 75 %
EU23: 82 %

Cervical cancer
Romania: 65 %
EU23: 63 %

Lung cancer
Romania: 11 %
EU23: 15 %

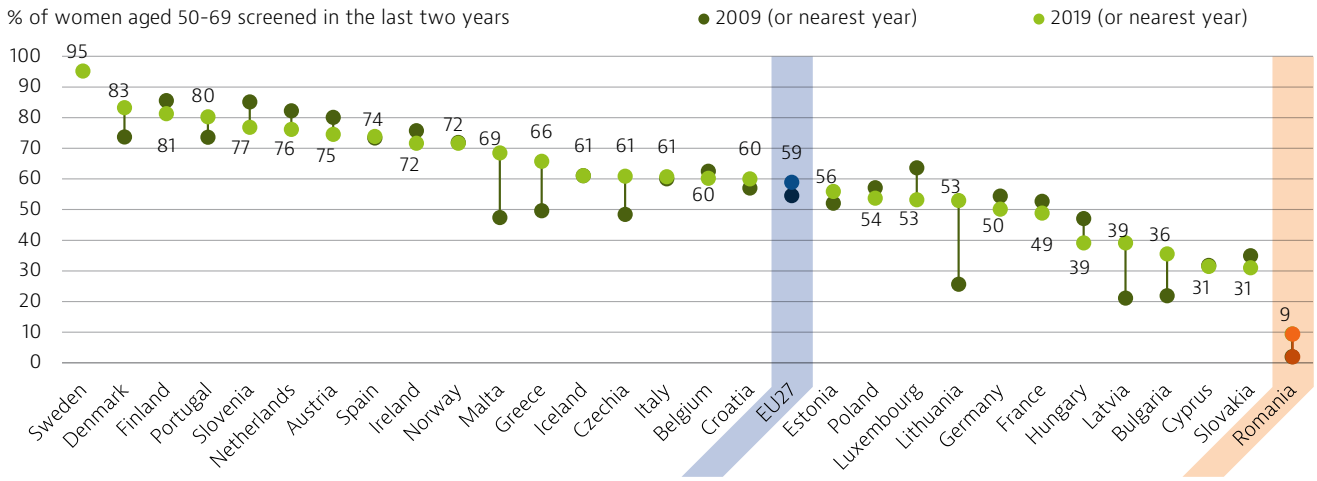
Note: Data refer to people diagnosed between 2010 and 2014. Childhood leukaemia refers to acute lymphoblastic cancer.
Source: CONCORD Programme, London School of Hygiene and Tropical Medicine.

New cancer screening programmes aim to strengthen prevention

In 2018-19, Romania invested in efforts to strengthen prevention, but spending remains low (see Section 4). There is a lack of systematic screening, participation is low, and the quality of screening practices is suboptimal. In 2014, only a quarter of women aged 20-69 reported having been screened for cervical cancer over the preceding two years (compared to the average of 62 % for EU countries with data available). Only 9 % of Romanian women aged 50-69 reported accessing breast cancer screening over the same period (the EU average is 57 % in 2019), and only 5 % of those aged 50-74 had been screened for colorectal cancer at least once in their life (the EU average is 47 %).

In 2018, new screening programmes were introduced for cancer, cardiovascular diseases and tuberculosis. Underserved areas received more mobile health units to promote prevention, particularly for cervical cancer screening. These measures could help to improve the uptake of breast cancer screening among women in the target group, which is extremely low (Figure 13).

Figure 13. Survey data show very low rates of breast cancer screening



Note: The EU average is unweighted. For most countries, the data are based on screening programmes, not surveys.
Sources: OECD Health Statistics 2020 and Eurostat Database.

New breast, cervical and colorectal cancer screening programmes were introduced as pilots in four regions, to run from 2018 to 2023. As part of this pilot scheme, cervical cancer screening changed the testing strategy to human papillomavirus primary testing, and the plan is to roll this out nationwide. These programmes were funded by EU Structural Funds and the World Bank, with a percentage of costs covered from national sources. Two key challenges are ensuring adequate staffing levels, as well as adequate quality assurance and quality control procedures for their full implementation. The planned revision of the National Integrated Multiannual Plan for Cancer Control in 2020 was delayed by the COVID-19 pandemic. The European Commission's Europe's Beating Cancer Plan was introduced in 2021 and provides a framework for the development of new cancer proposals (Box 4).

Box 4. The Europe's Beating Cancer Plan should inspire new proposals in Romania

The European Commission's Europe's Beating Cancer Plan is dedicated to enhancing the prevention, detection, treatment and management of cancer, while also reducing inequalities between and within Member States. It takes a patient-centred approach and makes the case for cancer to be addressed in a holistic manner.

There is an expectation that, considering the current state of cancer care in Romania, the Cancer Plan will spur a series of new proposals. The European funds allocated for the Plan are to be used at the national level, following the pay-for-value principle.

Sources: Centre for Innovation in Medicine (2021); European Commission (2021a).

Other public health programmes have also been implemented

Screening for cardiovascular disease risk factors is implemented by cardiologists in collaboration with 900 GPs, who receive additional pay for this new task. As with cancer screening, funding is from EU Structural Funds, with a percentage of costs covered from national sources. This funding will be in place until 2023.

There is scope for the introduction of public health programmes tackling key risk factors such as smoking and alcohol consumption. Currently, the population does not have equitable access to health promotion and education resources, with the most vulnerable groups – such as the Roma population and homeless people – experiencing significant access barriers.

The influenza vaccination rate has increased but remains low

Among the target older age group, the seasonal influenza vaccination rate remains low. After declining considerably from 54 % in 2007 to 7 % in 2014, it had rebounded to 21 % of the population in 2018. This is still markedly below the WHO target of 75 %, but is moving in the right direction. Barriers to higher vaccination rates include a lack of information about entitlements, and vaccinations not reaching marginalised groups. During the COVID-19 pandemic, in September 2020, the Ministry of Health announced the launch of a national free seasonal influenza immunisation campaign for the at-risk population (older people, people with chronic conditions, children, health workers and pregnant women). The Ministry bought 3 million doses of the vaccine: twice as many as in the previous year. In January 2021, the influenza vaccination programme was extended to the whole population. As in most other EU countries, only a few cases of influenza were reported in 2020.

Data on effectiveness and quality of care are often lacking

Data on quality of care are collected on a regular basis by the National Authority for Quality Management in Healthcare. The Authority is also in charge of hospital accreditation, and uses the data collected for this process. However, difficulties remain, as there is a lack of internationally comparable data on quality indicators for ambulatory and hospital care, including on avoidable hospitalisations and mortality following discharge for acute treatment.

5.2 Accessibility

The proportion of Romanians who lack social health insurance coverage is significant

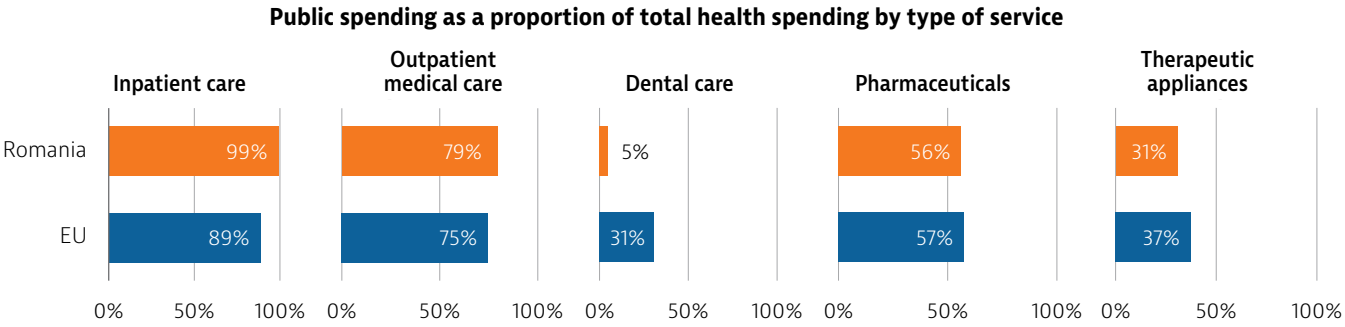
Despite compulsory SHI for those not granted exemptions, coverage gaps persist. In 2017, some 11 % of the population were estimated to be without insurance. From a survey published in 2017, uninsured people are thought to be mainly those living and working abroad, those with informal employment arrangements, unemployed people not registered for social benefits, and those lacking identity cards – particularly those among marginalised groups such as Roma communities. Estimating how many Romanians lack SHI coverage remains difficult because the millions of citizens with identity cards who work abroad are counted as permanent residents, but they appear in the statistics as being uninsured because they do not make SHI contributions (Rebeleanu & Toma, 2017).

Nearly all inpatient and outpatient services are covered under social health insurance

A comprehensive benefits package is guaranteed for all insured people in Romania. It includes health care services (prevention, outpatient, specialist and hospital care), pharmaceuticals and medical devices. The decision to add or remove services, medicines or devices from the package of benefits is made by the Ministry of Health and the National Health Insurance House, based on consultations with various entities. The National Agency for Medicines and Medical Devices is tasked with compiling a positive list of medicines (with input from its health technology assessment department).

In 2019, public financing covered 99 % of all spending on inpatient care in Romania – one of the highest rates in the EU (Figure 14). Public spending as a proportion of total spending by type of service was also above the EU average for outpatient care and almost the same as the EU average for pharmaceuticals. Coverage of dental care costs, however, remains one area that is well below average, as the benefits package guarantees full coverage only to children, war veterans and those with chronic conditions, and only 5 % of dental care is publicly funded (the EU average is 31 %). The situation is reflected in access metrics: some 5 % of Romanians reported unmet needs for dental care due to cost, distance or waiting times in 2019 – nearly double the EU average of 2.8 %.

Figure 14. Public spending on services and goods is above the EU averages for several functions



Note: 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. Therapeutic appliances refer to vision products, hearing aids, wheelchairs and other medical devices.
Source: OECD Health Statistics 2021 (data refer to 2019 or nearest year).

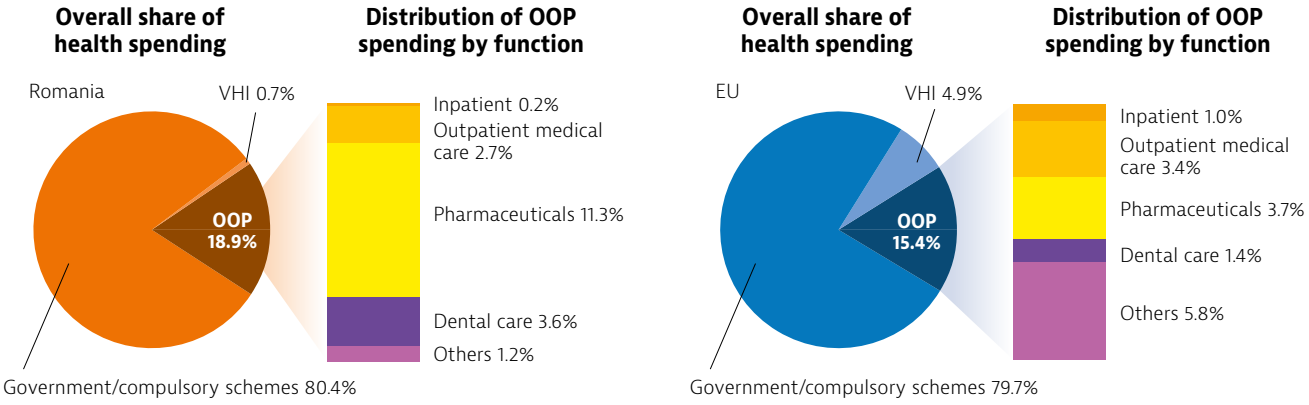
Coverage for COVID-19 has been universal and unconditional

The Ministry of Health and the NHIF covered all costs resulting from COVID-19-related care, regardless of residence or insurance status. Free testing is only possible with a physician's referral, while voluntary tests must be paid for out of pocket. People with suspected COVID-19 are also provided with quarantine services and assistance if they are unable to manage by themselves.

Out-of-pocket payments have remained high but stable

At 18.9 % of current expenditure on health in 2019, OOP payments in Romania have remained relatively unchanged since 2005 (see Section 4), and are above the EU average (Figure 15). OOP payments are dominated by pharmaceutical spending, which can limit access to essential medicines. Infectious disease treatments have been added to the reimbursable pharmaceutical list, meaning that medicines to treat symptoms of COVID-19 are now reimbursed.

Figure 15. Nearly two thirds of all formal out-of-pocket spending goes on pharmaceuticals



Note: The EU average is weighted. VHI = voluntary health insurance, which also includes other voluntary prepayment schemes.
Sources: OECD Health Statistics 2021; Eurostat Database (data refer to 2019).

However, while cost remains an important barrier to accessing medicines, so do supply constraints that lead to shortages. In October 2019, Romania restricted exports of certain cancer drugs for six months, to try to stem domestic shortages due to parallel trade. Export restrictions were also put in place for COVID-19-related drugs and consumables during 2020 (see Section 5.3).

Pharmaceutical policy in Romania has sought to contain irrational use of medicines, support the greater use of generics, and control prices. While price controls have ensured that Romania is among the countries with the lowest pharmaceutical prices in the EU, this has encouraged parallel trade exports that have compromised sustainability (Radu, Pana & Furtunescu, 2018). Ensuring the sustainability of pharmaceutical supply in Romania aligns with the

aim of the European Commission's pharmaceutical strategy for Europe to secure effective and affordable medicines in the EU (European Commission, 2020). Romania is also one of the members of the Valletta Declaration – a multi-country collaboration in Europe that uses health technology assessment, information sharing and collective negotiations to procure new medicines and therapies at reasonable prices for citizens. This alliance focuses in particular on products with substantial budget impact.

Unmet medical care needs have declined, but remain high

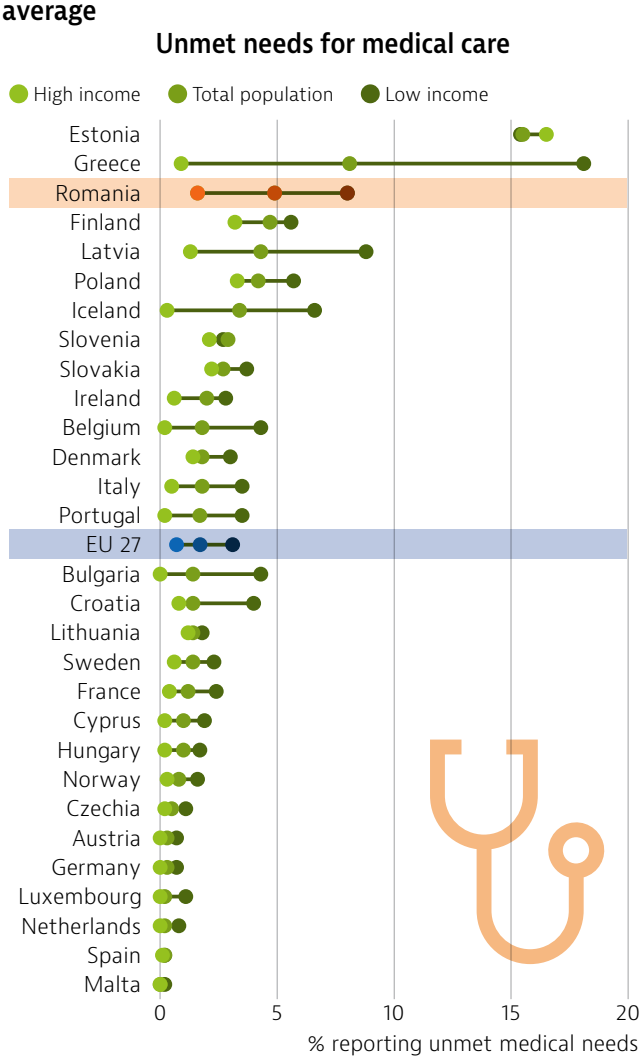
About 4.9 % of Romanians reported unmet medical care needs in 2019 (Figure 16). Although ranking third highest in the EU after Estonia and Greece, this rate has more than halved from a high of 12.2 % in 2011, albeit with important differences between income groups. Just 1.6 % of those in the highest income quintile reported having unmet medical needs, as opposed to 8 % (down from 16.2 % in 2012) of those in the lowest.

The demand for COVID-19-related care and the introduction of containment measures during the pandemic were drivers of delayed consultations and treatment, as well as for increasing levels of unmet needs. Survey evidence shows that 29 % of Romanian respondents reported forgoing medical care during the first year of the pandemic, compared with 21 % across the EU (Eurofound, 2021).[3] No data on waiting times for elective care are available, so it is difficult to identify where the most pressing needs exist. Measuring waiting times could provide useful insights to target improvements in access to care.

Disparities in access to care are persistent

As many rural areas are underserved, Romanians living in these areas continue to face unequal access due to imbalances in the distribution of the health workforce across the country. Access challenges are further exacerbated by poor transport infrastructure. In 2018, with support from the World Bank, the Ministry of Health issued an order to create and operate new mobile medical units. In mid-2019, efforts were made to improve access by extending the validity of referrals from 60 to 90 days, facilitating access to care for uninsured pregnant women, and increasing the scope of day services in hospitals. Meanwhile, 30 % of survey respondents reported using teleconsultations to access health services during the COVID-19 pandemic (Eurofound, 2021). This shows the potential for remote consultations as one mechanism for improving access to care.

Figure 16. Only in high-income groups are unmet needs for medical care comparable to the EU average



Note: Data refer to unmet needs for a medical examination or treatment due to costs, distance to travel or waiting times. Caution is required in comparing the data across countries as there are some variations in the survey instrument used.
Source: Eurostat Database, based on EU-SILC (data refer to 2019, except Iceland 2018).

5.3 Resilience

This section on resilience focuses mainly on the impacts of, and responses to the COVID-19 pandemic.[4] As noted in Section 2, the pandemic had a major impact on population health and mortality in Romania, as in most EU countries, with the official number of 34 500 COVID-19 deaths by the end of August 2021 likely to be the result of substantial under-reporting. Measures taken to contain the pandemic also had a significant impact on the economy. However, while Romanian GDP fell by 3.9 %, this was less than the average decrease of 6.2 % in the EU.

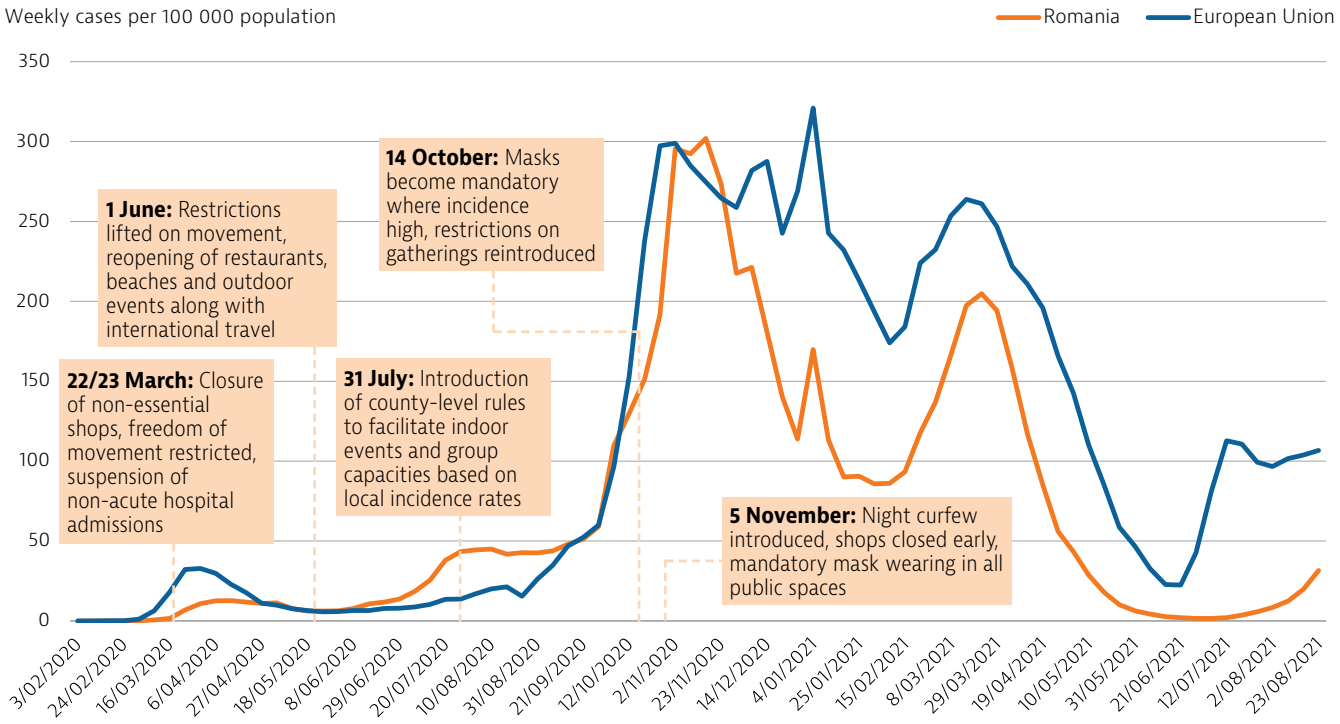
3. *The data from the Eurofound survey are not comparable to those from the EU-SILC survey because of differences in methodologies.*
4. *In this context, health system resilience has been defined as the ability to prepare for, manage (absorb, adapt and transform) and learn from shocks (EU Expert Group on Health Systems Performance Assessment, 2020).*

Romania's first responses to the COVID-19 pandemic were swift

Romania was impacted by COVID-19 relatively late in 2020. While COVID-19 was first identified in central Europe in January 2020, the first patients in Romania were not identified until 26 February. Romania swiftly imposed strict prevention measures, and in spring 2020 international flights were halted and borders closed. However, many of the 3 million Romanians living abroad (out of a total population of 19 million) returned home.

The number of registered COVID-19 infections and deaths grew slowly during spring 2020, but at a lower rate than in other EU countries. In summer 2020, mitigation measures were relaxed because infection rates were low and the economy was suffering (Figure 17). Romania then faced a second wave of cases in the summer, but it was during autumn and winter 2020 that the infection rates and COVID-19-related deaths increased significantly. In response, mitigation measures were reimposed, and eventually a full lockdown was ordered. Although infection levels in Romania were seemingly lower than the EU average during most of 2020, this is probably related to the country's testing policy and capacity, and the fact that many COVID-19 cases may not have been identified as such (see Box 1). After another surge in spring 2021, recorded case numbers began to decrease rapidly but began to steadily increase again from the summer 2021.

Figure 17. Recorded COVID-19 infection rates in Romania were generally below the EU average

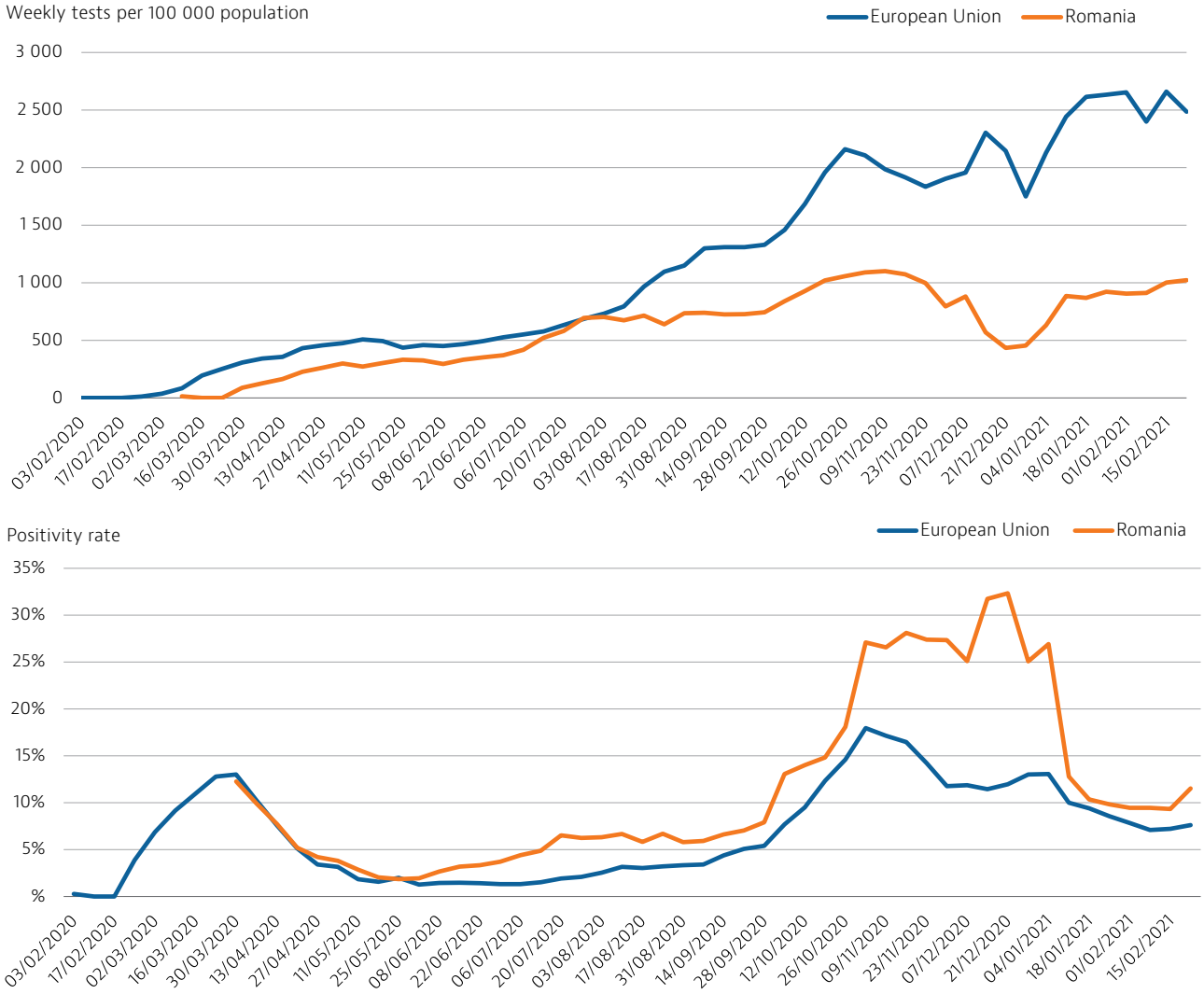


Note: The EU average is unweighted (the number of countries used for the average varies depending on the week).
Source: ECDC for COVID-19 cases and authors for containment measures.

Testing capacity has increased but has not kept pace with the EU average

Until March 2020, testing was only undertaken for people arriving from places with high infection rates or who were symptomatic. From mid-March, Romania adopted the ECDC testing protocol and delivered testing free of charge on referral. Residents and staff in long-term care, mental health and other social care facilities were prioritised for testing, and in October 2020, mandatory weekly testing of personnel in all these residential facilities was introduced. Testing capacity increased from one testing centre in February to 57 centres by July 2020 and 176 by the end of January 2021. Nevertheless, testing capacity was still too low to meet demand, and Romania had lower rates of testing than the EU average, particularly during the autumn and winter upsurge (Figure 18). High test positivity rates in Romania from the beginning of the pandemic show that testing capacity did not keep pace with the high levels of transmission of COVID-19 in the community. In the winter upsurge in 2020, more than one in four PCR tests conducted were positive. In January 2021, rapid antigen testing was added for some priority groups in an attempt to identify and isolate asymptomatic cases.

Figure 18. The gap with the EU in rates of testing for COVID-19 widened, despite high positivity rates



Note: The EU average is weighted (the number of countries included in the average varies depending on the week).
Source: ECDC.

The health workforce was a major bottleneck in provision of services during the pandemic

The biggest challenge in responding to the COVID-19 pandemic in Romania was securing sufficient health workforce (see Section 4). Intensive care unit (ICU) physicians, nurses and other specialised health care staff were particularly scarce. During spring 2020, health workers were redeployed from other specialties, but this was not a sustainable long-term solution. Romania hired and trained more staff, creating 2 000 temporary jobs. Funds for bonuses and in-kind incentives were provided to attract professionals. However, shortages that pre-dated the pandemic persisted, particularly after autumn 2020. As winter approached, and infection rates increased – including among health care workers – there were challenges in maintaining adequate staffing levels, which undermined access to services and quality of care.

The number of intensive care unit beds doubled during the pandemic

The Romanian health care system has a large number of hospital beds, but providing sufficient numbers of ICU beds equipped with ventilators to meet the surge in demand during the various waves of COVID-19 has proved a significant challenge. Of around 4 000 ICU beds available prior to the pandemic, about half were equipped with ventilators and only a proportion were allocated to COVID-19 patients, according to the number of cases. The number of ventilators were increased through international procurement, national production and redeployment from the military. Modular hospitals were built, and five mobile ICUs were procured with support from local authorities, non-governmental organisations and other donors. Approximately EUR 44.5 million released by the government to manage the COVID-19 outbreak (of a total of EUR 74.5 million) was allocated to ICU departments. Despite this, on 1 November 2020,

only 1 250 ICU beds were available to treat COVID-19 patients. This capacity was further expanded to 1 550 ICU beds in 2021 to meet ever growing demand – double the number in the country at the beginning of the pandemic (740 beds in March 2020).

Romania quickly mobilised resources, but winter brought more challenges

Like other EU countries, Romania faced a shortage of PPE at the beginning of the pandemic. The government simplified national procurement legislation and established the National Office for Centralised Procurement at the Ministry of Health. Emergency appeals were sent out to other countries for help with procuring PPE, ventilators and medicines; these helped to bridge initial shortages. PPE was also provided through the European Commission's centralised procurement mechanism. To avoid waste and shortages, the Centre for Surveillance and Control of Communicable Diseases issued a set of minimal criteria for rational use of PPE, based on WHO recommendations. The shortage of pharmaceuticals and medical devices was mitigated by a 12-month ban on the export of drugs, diagnostic and treatment devices and consumables.

In addition, Romania reorganised the provision of inpatient care, designating certain hospitals, wards and outpatient facilities exclusively for the care of COVID-19 patients, and deploying the military to assist with equipment needs. During spring and summer 2020 (the first wave), the country had sufficient – sometimes unused – bed capacity for the treatment of COVID-19 patients, but the second upsurge of the virus during winter 2020 posed additional challenges to the stretched health care system.

Primary care physicians played a central role in managing suspected and confirmed COVID-19 cases

From the early stages of the pandemic, many COVID-19 cases were managed in primary care. Symptomatic individuals were instructed not to attend health clinics but to contact their GPs by telephone. GPs would then refer patients for testing, monitor them at home or refer them to hospitals, as necessary. GPs also reported confirmed cases to public health authorities to initiate contact tracing. A national treatment protocol was developed and periodically updated, based on WHO and ECDC recommendations.

Like other countries, Romania introduced new tools for the provision of virtual non-COVID-19 health services in the first phase of its response to the pandemic. Access to services was also enhanced by the simplification of administrative procedures for virtual consultations, easing the process for GPs to prescribe medicines for patients with chronic conditions, and extending the validity of certain medical documents, such as referrals.

Special measures protected residents and staff of long-term care facilities

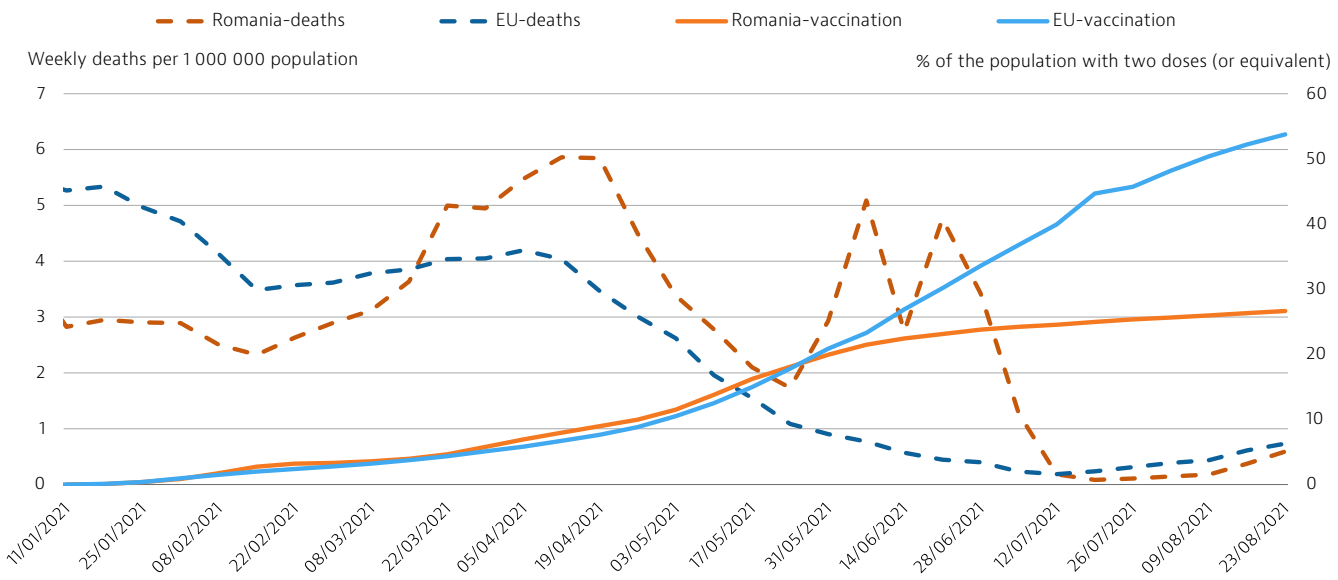
Romania developed specific care plans for vulnerable people living in long-term care facilities. Free face masks, gloves, hygiene products and food were distributed to residential facilities for older people, children and adults with disabilities, and other vulnerable groups. Furthermore, in October 2020 facilities were allowed to set shift work patterns to reduce potential exposure among residents in response to the local epidemiological situation. However, according to national statistics, by 16 May 2020, as many as 10 % of the deaths caused by COVID-19 were among residents of facilities for older people and people with disabilities.

The COVID-19 vaccination rollout was well planned, but vaccine hesitancy has stalled progress

The COVID-19 vaccination campaign started relatively well in Romania. It prioritised the health and social care workforce, before moving to the population at greatest risk (elderly people, patients with chronic conditions and disabled people) and finally the general population. It was supported as early as December 2020 by a comprehensive and coherent communication strategy implemented by the government. An official website provided information on vaccine safety and effectiveness, adverse reactions, and myths and facts.

Responsibility for ensuring the logistics, stocking, supply and human resources of the vaccination rollout was shared by the Ministry of Health, the Ministry of National Defence, and the Ministry of Internal Affairs. All necessary materials for administering vaccines and first aid devices for managing adverse effects were centrally procured through the National Office for Centralised Procurement. Vaccination was financed and conducted solely within the public sector. In order to provide access to vaccines for essential workers, mobile vaccination teams were used to reach people in health care settings, residential care homes and private homes. Despite this rapid start, the vaccination rate slowed by the time 20 % of the population had been given two doses (Figure 19). Improving logistics to reach rural communities appears to be a key factor in strengthening the programme, but there is also considerable vaccine hesitancy and resistance to vaccination that needs to be overcome.

Figure 19. The vaccination programme lost momentum, and coverage is limited



Note: The EU average is unweighted (the number of countries used for the average varies depending on the week).
Sources: ECDC for COVID-19 cases and Our World In Data for vaccination rates.

The pandemic stimulated development of electronic information systems

Despite significant investment in modern information and communication technologies over the past decade, there is a high degree of data fragmentation and duplication of data collection in the Romanian health system. During the pandemic, new electronic information systems were created to improve the management of stretched health resources. By the end of October 2020, an electronic information system was set up to improve communication between laboratories, district public health authorities, GPs and patients. As a result, diagnostic tests are processed within 24 hours, with the results sent automatically by email and text message to the tested person and to their GP (or the health authority if the patient is not enrolled with a GP). The district public health authorities send isolation orders to patients who test positive and to their GPs. In the absence of other events, the patient's file is closed automatically after 14 days. The system links hospital and outpatient COVID-19 services. In the inpatient setting, an electronic centralised operational coordinating centre was created by the Ministry of Health to report bed occupancy on a daily basis, to facilitate resource management.

To support the vaccination rollout, a special COVID-19 module was created in the National Electronic Vaccination Registry, managed by the National Institute of Public Health. The Registry provides data to monitor vaccine stocks, their distribution and utilisation (including the number of lost doses), the number of vaccinated people and any adverse events. After the vaccine has been administered, the person who received it is issued a vaccination certificate.

These rapid developments in electronic information systems during the pandemic give Romania the opportunity to align its digital health development strategy to the European Health Data Space initiative (European Commission, 2021b), which aims to promote health data exchange and support research on new preventive strategies, as well as on treatments, medicines, medical devices and outcomes.

Investment in health infrastructure has benefited from European Structural and Investment Funds

Romania has benefited from European Structural and Investment Funds for prevention and primary care programmes (see Section 5.1); these have facilitated investment in the health sector. For example, in 2018, 0.6 % of the country's GDP was allocated to capital infrastructure and equipment in the health sector, which is well above the EU average of 0.4 %. This represented 10 % of total health expenditure – higher than any other EU country. Romania has also requested EUR 14.3 billion in grants and EUR 15 billion in loans under the EU Recovery and Resilience Facility. The health component of the Romanian plan aims to increase access to medical services for prevention, diagnosis and early treatment, as well as reducing rural/urban disparities in access to medical services – particularly for underserved rural communities. This will be achieved by strengthening the primary care network in rural areas and neonatal care facilities nationwide.

6 Key findings

- Life expectancy at birth in Romania increased by more than four years between 2000 and 2019, but declined by 1.4 years in 2020 because of the impact of the COVID-19 pandemic. It remains among the lowest in the EU. Risky health behaviours account for more than half of all deaths. Romanians report relatively high rates of tobacco smoking, unhealthy diet, alcohol consumption and low physical activity. Overweight, obesity, and smoking rates among adolescents are also high, and have been growing continually over the past two decades.

- Per capita spending on prevention is the second lowest in the EU. This meant that, prior to the pandemic, public health was under-resourced and underperforming. For example, among older people the seasonal influenza vaccination rate had declined considerably from just over half of the target older age group in 2007 to around one fifth in 2018. Health spending on primary care is also the lowest in absolute terms among EU countries. The weakness of primary care and prevention may explain Romania's high mortality rates from both preventable and treatable causes, with the latter the fourth highest in the EU in 2017.

- Overall, Romania has significantly increased its health spending but remains the EU country with the second lowest health expenditure, both on a per capita basis and as a share of GDP. Romania has high levels of public financing for inpatient and outpatient care, but out-of-pocket costs are also high, particularly for outpatient medicines. Nevertheless, all COVID-19 treatment and services are provided free of charge, including medicines.

- Romania trains large numbers of health care practitioners, but emigration of medical staff has contributed to health workforce shortages in the country, and the numbers of physicians and nurses per capita are well below the EU averages. This adversely affects access to care and contributes to waiting times. The state of the health workforce was also a key concern in pandemic preparedness.

- Romania managed to increase its testing capacity significantly during the first wave of the COVID-19 pandemic, but testing rates remain low compared to the EU average. High positivity rates in the second and third waves indicate that testing capacity has not kept pace with the speed of community transmission. In addition, the pressures placed on hospitals by the pandemic undermined access to non-COVID-19 care. In the second half of 2020, the number of excess deaths in Romania was much higher than the number of reported COVID-19 deaths, indicating that COVID-19 deaths were being undercounted.

- Shortages faced during the pandemic stimulated the creation of several electronic information systems to manage the stretched health resources better. For example, a system for diagnostic testing was set up to improve communication between laboratories, district public health authorities, general practitioners and patients. An electronic centralised operational coordinating centre now reports on bed occupancy on a daily basis to facilitate resource management. Remote care was also developed to replace some face-to-face visits, and this could support improved care provision for underserved communities in the future.

- The COVID-19 vaccination campaign began relatively well in Romania, although it was delayed by supply issues. It has been supported from its inception with a comprehensive and coherent communication strategy implemented by the government, but vaccine hesitancy has still severely limited coverage and the vaccination programme appears to have lost momentum.

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Country abbreviations

Austria	AT	Denmark	DK	Hungary	HU	Luxembourg	LU	Romania	RO
Belgium	BE	Estonia	EE	Iceland	IS	Malta	MT	Slovakia	SK
Bulgaria	BG	Finland	FI	Ireland	IE	Netherlands	NL	Slovenia	SI
Croatia	HR	France	FR	Italy	IT	Norway	NO	Spain	ES
Cyprus	CY	Germany	DE	Latvia	LV	Poland	PL	Sweden	SE
Czechia	CZ	Greece	EL	Lithuania	LT	Portugal	PT		

European Commission

State of Health in the EU
Country Health Profile 2021

The Country Health Profiles are an important step in the European Commission's ongoing *State of Health in the EU* cycle of knowledge brokering, produced with the financial assistance of the European Union. The profiles are the result of joint work between the Organisation for Economic Co-operation and Development (OECD) and the European Observatory on Health Systems and Policies, in cooperation with the European Commission.

The concise, policy-relevant profiles are based on a transparent, consistent methodology, using both quantitative and qualitative data, yet flexibly adapted to the context of each EU/EEA country. The aim is to create a means for mutual learning and voluntary exchange that can be used by policymakers and policy influencers alike.

Each country profile provides a short synthesis of:

- health status in the country
- the determinants of health, focussing on behavioural risk factors
- the organisation of the health system
- the effectiveness, accessibility and resilience of the health system

The Commission is complementing the key findings of these country profiles with a Companion Report.

For more information see: ec.europa.eu/health/state

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