European Commission

State of Health in the EU

Romania

Country Health Profile 2017

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

The Country Health Profile series

The *State of Health in the EU* profiles provide a concise and policy-relevant overview of health and health systems in the EU Member States, emphasising the particular characteristics and challenges in each country. They are designed to support the efforts of Member States in their evidence-based policy making.

The Country Health Profiles are the joint work of the OECD and the European Observatory on Health Systems and Policies, in cooperation with the European Commission. The team is grateful for the valuable comments and suggestions provided by Member States and the Health Systems and Policy Monitor network.

Contents

Data and information sources

The data and information in these Country Health Profiles are based mainly on national official statistics provided to Eurostat and the OECD, which were validated in June 2017 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 28 Member States unless otherwise noted.

To download the Excel spreadsheet matching all the tables and graphs in this profile, just type the following StatLinks into your Internet browser:
http://dx.doi.org/10.1787/888933593779

Demographic and socioeconomic context in Romania, 2015

		Romania	EU
Demographic factors	Population size (thousands)	19 815	509 394
	Share of population over age 65 (%)	17.0	18.9
	Fertility rate[1]	1.5	1.6
Socioeconomic factors	GDP per capita (EUR PPP[2])	16 500	28 900
	Relative poverty rate[3] (%)	19.8	10.8
	Unemployment rate (%)	6.8	9.4

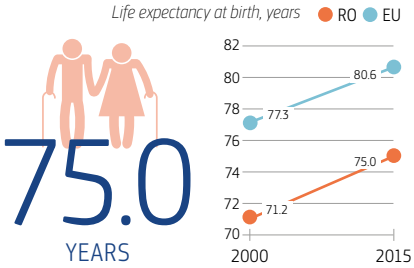
1. Number of children born per woman aged 15–49.
2. Purchasing power parity (PPP) is defined as the rate of currency conversion that equalises the purchasing power of different currencies by eliminating the differences in price levels between countries.
3. Percentage of persons living with less than 50% of median equivalised disposable income.

Source: Eurostat Database.

1 Highlights

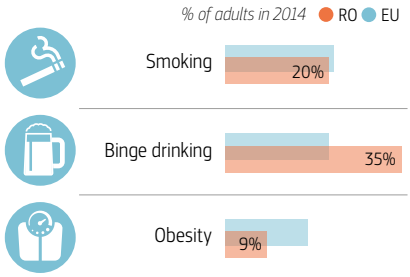
The health status of Romanians has improved, but life expectancy at birth remains among the lowest in the EU. Although people are living longer, coverage is not universal and socioeconomic inequalities in health persist. Reform of the health system has been constant but frequently ineffective, due in part to a high degree of political instability. Recent reforms have focused on introducing cost-saving measures, and improving access and efficiency.

Health status



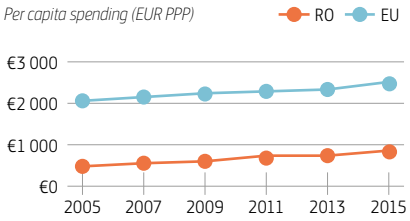
Life expectancy at birth was 75.0 years in 2015, up from 71.2 years in 2000. However, it still lags behind the EU average. Infant mortality is more than twice the EU average. Heart diseases and stroke are the biggest contributors to mortality and deaths from some cancers have increased sharply. Infectious diseases also pose a significant challenge, with Romania having the highest rate of tuberculosis in the EU, and over a third of all multidrug-resistant tuberculosis cases.

Risk factors



In 2014, 19.8% of adults smoked tobacco every day, just below the EU average but only a marginal improvement since 2008. Overall alcohol consumption is in line with the EU average but binge drinking among adults is very high (35%), rising to 53% for men, the highest in the EU. Obesity rates are increasing: 9.1% of adults were obese in 2014, compared to 7.9% in 2008 while rates among children have doubled over the last decade.

Health system

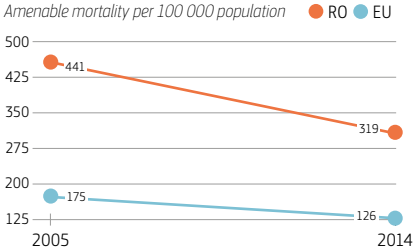


Per capita health spending of EUR 814 in 2015 is the lowest in the EU, and under a third of the EU average. This equals 4.9% of GDP – down from 5.7% in 2010 and well below the EU average of 9.9%. However, on a par with the EU average, 78% of health spending is publicly funded, despite the share of out-of-pocket spending having increased recently. The practice of informal payments, particularly for hospital-related care, is widespread and adds to the financial burden on patients.

Health system performance

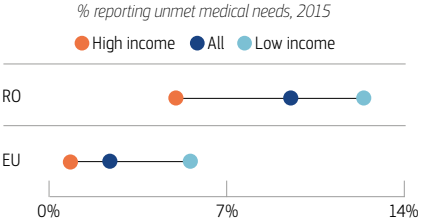
Effectiveness

Amenable mortality has fallen over the past decade but remains the highest in the EU for women and the third highest for men.



Access

Access to health care is especially poor in rural areas and is exacerbated by gaps in population coverage. Unmet needs for medical care are substantially above the EU average.



Resilience

Low funding and the inefficient use of public resources hamper the health system. There is a weak link between planning decisions and population health needs, owing to a lack of appropriate information systems.

2 Health in Romania

Life expectancy has risen quickly, but the gap between men and women is larger than in other countries

Life expectancy at birth in Romania rose by nearly four years between 2000 and 2015, to 75 years. Despite these gains, it remains nearly six years below the EU average and the fourth lowest among EU countries (Figure 1). As in most other countries, there is a gender gap, with women living 7.2 years longer than men; this is a much larger difference than the EU average (5.6 years). Similar inequalities exist between socioeconomic groups.

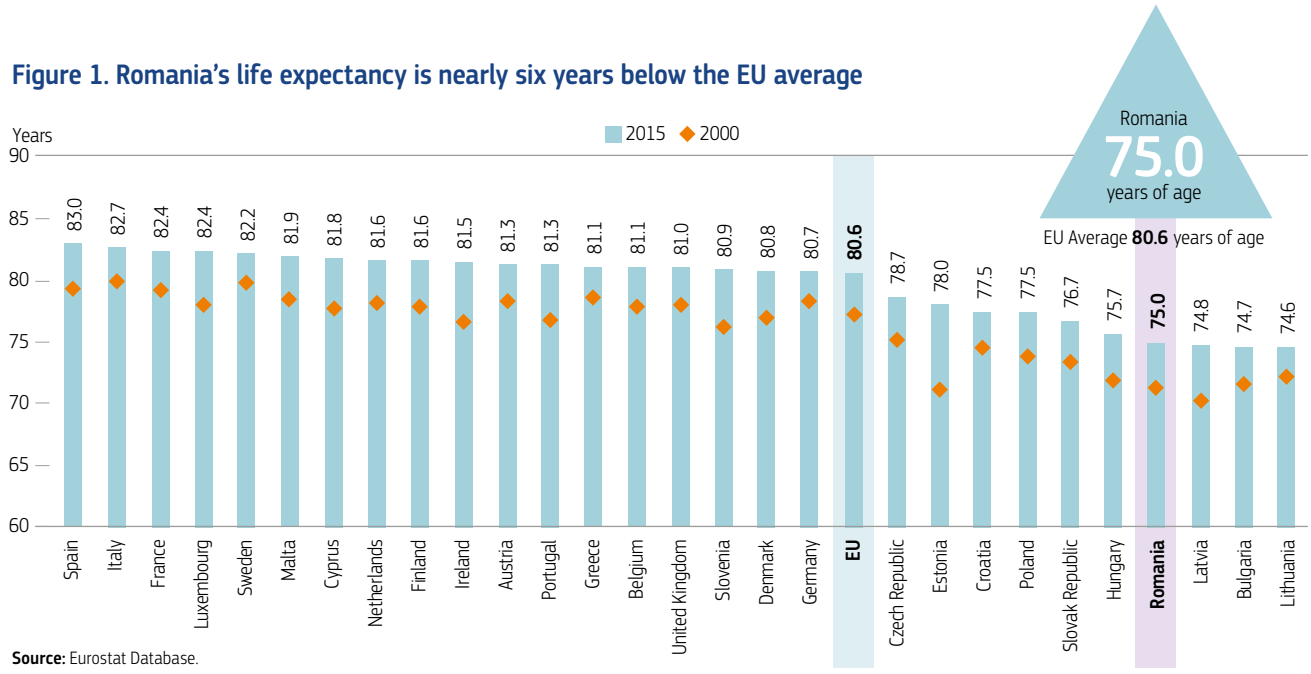
On average, the life expectancy of university-educated Romanians is six years higher than those with no more than lower secondary education.[1] At age 65, life expectancy is the second lowest in the EU, and not all remaining years of life are spent in good health. Romanian women can expect to spend just under one third of their remaining years free of disability, while the rate for men is about 40%[2].

Infant mortality represents a particular challenge for Romania: at 7.6 deaths per 1 000 live births, it was the highest in the EU and over twice the average of 3.6 in 2015.

1. Lower education levels equate to people with less than primary, primary or lower secondary education (ISCED levels 0–2) while higher education levels refer to people with tertiary education (ISCED levels 5–8).).

2. These are based on the indicator of 'healthy life years', which measures the number of years that people can expect to live free of disability at different ages..

Figure 1. Romania's life expectancy is nearly six years below the EU average



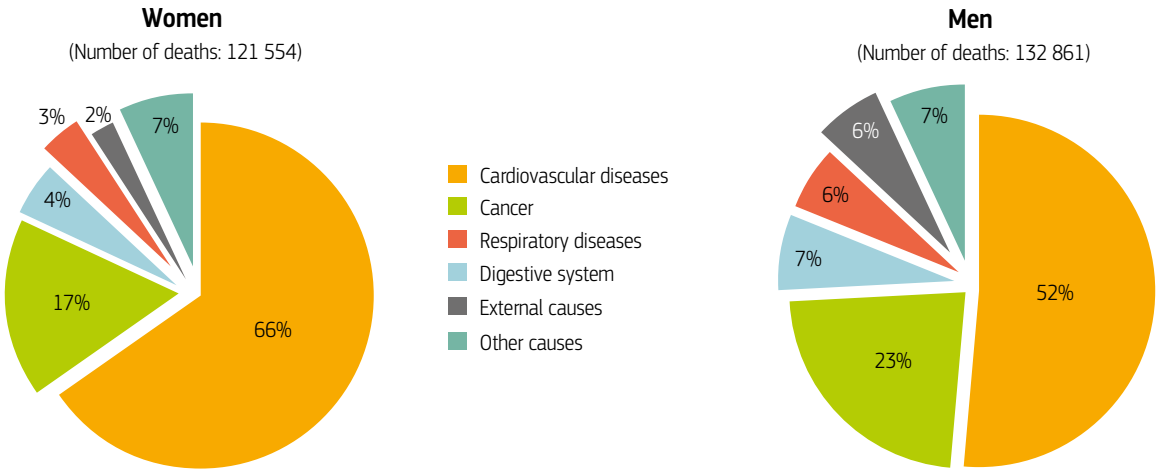
Source: Eurostat Database.

Cardiovascular diseases and cancer account for the majority of deaths

Most deaths in Romania are due to either cardiovascular diseases or cancer (Figure 2). The standardised death rate for Acute Myocardial Infarction (AMI) was the highest in the EU in 2014, much higher than the EU average, and cerebrovascular diseases (second highest in the EU) also contribute significantly to mortality. Taken together, these diseases of the circulatory system claimed the most fatalities in Romania, with a standardised rate of 951.3 deaths per 100 000 inhabitants in 2014, being two and a half times higher than the EU average (373.6) and the second highest in the EU after Bulgaria.

Taking a closer look at trends in more specific causes of death, heart diseases and stroke (cerebrovascular diseases) continue to be the most frequent causes of death, despite a reduction in the absolute number of deaths since 2000 (Figure 3). Lung cancer remains the most common cause of cancer mortality, with the standardised rate rising by 15% between 2000 and 2014. Mortality from colorectal cancer has also increased sharply since 2000, by more than 30%, despite efforts to strengthen the national cancer plan and the implementation of population-based screening programmes for breast, cervical and colorectal cancer (see Section 5.1).

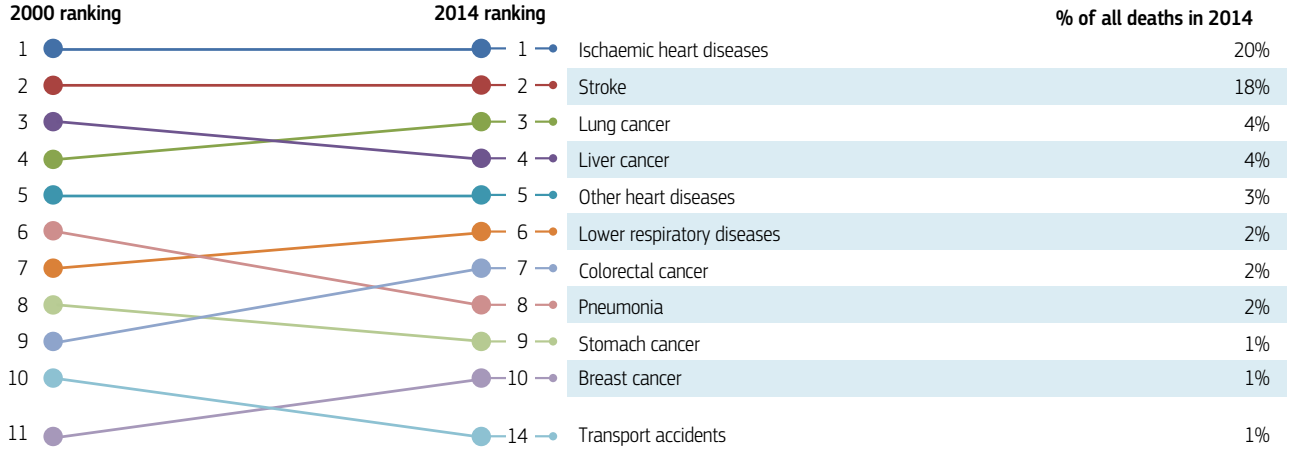
Figure 2. More women than men die of cardiovascular diseases while cancer deaths are higher among men



Note: The data are presented by broad ICD chapter. Dementia was added to the nervous system diseases' chapter to include it with Alzheimer's disease (the main form of dementia).

Source: Eurostat Database (data refer to 2014).

Figure 3. Mortality from many cancers has increased since 2000



% of all deaths in 2014	
Ischaemic heart diseases	20%
Stroke	18%
Lung cancer	4%
Liver cancer	4%
Other heart diseases	3%
Lower respiratory diseases	2%
Colorectal cancer	2%
Pneumonia	2%
Stomach cancer	1%
Breast cancer	1%
Transport accidents	1%

Source: Eurostat Database.

Musculoskeletal conditions and mental health problems are among the leading determinants of poor health

The leading determinants of disability adjusted life years[3] (DALYs) in Romania in 2015 were musculoskeletal problems (including low back and neck pain) and poor mental health (including depression) (IHME, 2016). Moreover, based on self-reported data from the European Health Interview Survey (EHIS), more than one in six Romanians lives with hypertension, one in twenty with diabetes, and one in twenty-five with asthma or other chronic respiratory diseases. Wide inequalities exist in the prevalence of these chronic diseases by education level. People with the lowest level of education are over four times more likely to live with asthma or other chronic respiratory diseases and more than twice as likely to live with hypertension as those with the highest level of education.[4]

3. DALY is an indicator used to estimate the total number of years lost due to specific diseases and risk factors. One DALY equals one year of healthy life lost (IHME).

4. Inequalities by education may partially be attributed to the higher proportion of older people with lower educational levels; however, this alone does not account for all socioeconomic disparities.

Infectious diseases, particularly tuberculosis, present major public health risks

Several infectious diseases still pose major threats to the health of the Romanian population. While the rate of newly reported cases of HIV remains below the EU average (a notification rate of 3.8 per 100 000 population compared to 5.8 in the EU), it has increased nearly three-fold since 2000. On the other hand, the rate of newly reported cases of tuberculosis has fallen substantially since 2003. But it is still by far the highest across all EU countries, at 76.5 new cases per 100 000 population in 2015 (ECDC, 2017a). Worryingly, Romania also notifies more than one third of all multidrug-resistant tuberculosis cases. Undiagnosed viral hepatitis also poses a significant problem with sub-optimal testing and surveillance making it difficult to quantify the scale of the issue.

Women report having good health less often but other differences are masked by a lack of data

Overall, the proportion of Romanians reporting they are in very good or good health (70%) is slightly higher than across the EU (67%) (Figure 4) but this average glosses over a substantial gender difference. Whereas three-quarters of men rate their health highly, less than two-thirds of women do. There is also the possibility that the Roma population, which makes up 3.3% of the total population (according to official figures), has different experiences regarding health. However, since Romania does not collect statistics on ethnicity (as this is legally prohibited), there is no recent information on Roma health status or indeed on exposure to risk factors (Section 3).

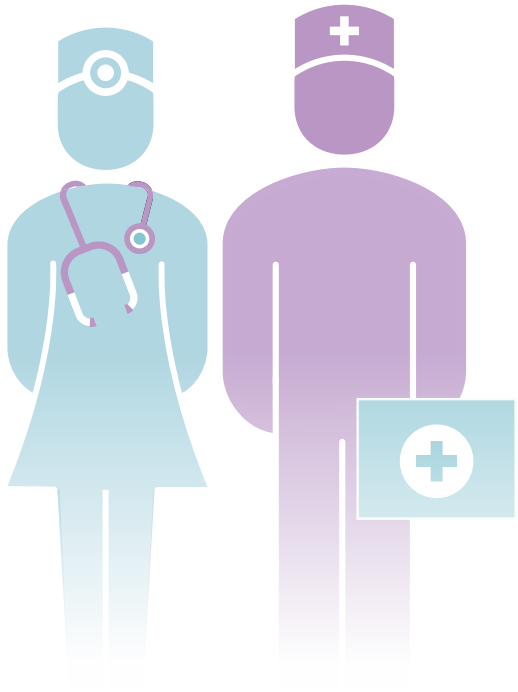
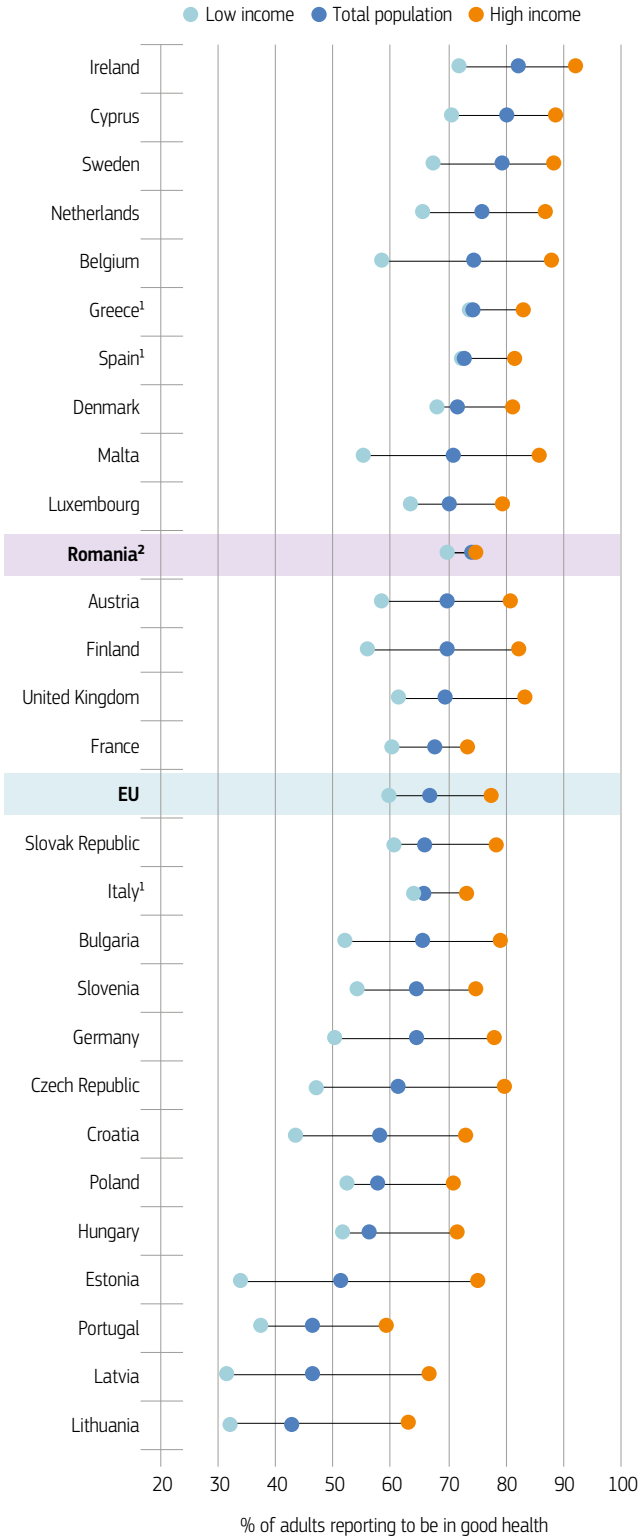


Figure 4. Average self-reported health status masks differences among genders and minorities



1. The shares for the total population and the low-income population are roughly the same.
2. The shares for the total population and the high-income population are roughly the same.

Source: Eurostat Database, based on EU-SILC (data refer to 2015).

3 Risk factors

Behavioural risk factors are major issues in Romania

More than 40% of the overall burden of disease in Romania in 2015 (measured in terms of DALYs) could be attributed to behavioural risk factors, including smoking and alcohol use, as well as dietary risks and low physical activity (IHME, 2016).

Smoking and binge drinking is widespread among men

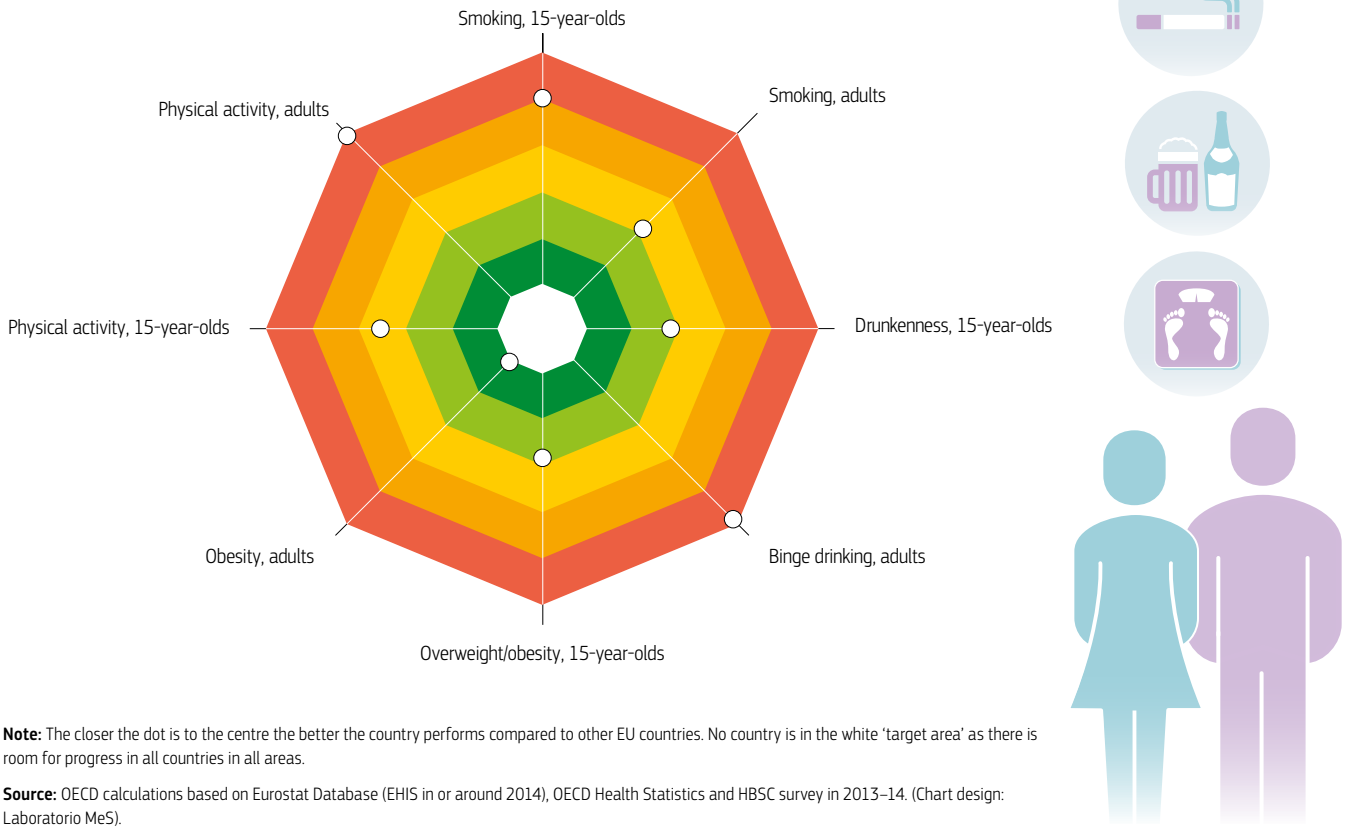
Approximately one in five adults in Romania reported smoking on a daily basis in 2014. This is almost equal to the EU average, but unlike in many other countries there has been little improvement since 2000. Gender disparities are pronounced, with four times as many men (32.2%) smoking as women (8.3%). Worryingly, smoking rates appear to be rising among young girls: 17% of 15-year-old girls said they smoked regularly in 2013–14, up from 12% in 2005–06.

Although overall alcohol consumption in Romania is on a par with the EU average (9.6 litres per capita compared with 10 litres in 2014), binge drinking[5] is a serious public health problem (see Section 5.1). Nearly 53% of men reported heavy episodic drinking in 2014 – the highest level across EU countries – while boys also consume alcohol more frequently than in other EU countries: 30% of 15-year-old boys reported in 2013–14 that they had been drunk at least twice in their life, compared with just 12% of 15-year-old girls.

Romanian adults have the lowest rate of obesity in the EU but problems are emerging among adolescents

Based on self-reported data (which tend to under-estimate the true prevalence of obesity), just 9.1% of Romanian adults were obese in 2014 – the lowest rate in the EU (see Figure 5). Among adolescents, overweight and obesity rates are also lower than the EU average, but have more than doubled over the past decade, rising from 7% in 2005–06 to 16% in 2013–14. This is of particular concern given that being overweight or obese during childhood is a strong predictor of overweight or obesity in adulthood.

Figure 5. Smoking and alcohol consumption are important risk factors for health in Romania



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.

Source: OECD calculations based on Eurostat Database (EHIS in or around 2014), OECD Health Statistics and HBSC survey in 2013–14. (Chart design: Laboratorio MeS).

4 The health system

The district level is important but remains under strong centralised control

Romania's Social Health Insurance (SHI) based system has remained highly centralised despite recent efforts to decentralise some regulatory functions. At the national level, the Ministry of Health provides overall stewardship, policy direction and regulatory oversight while locally, district public health authorities are responsible for delivering services. Similarly, the National Health Insurance House administers and regulates the SHI system through district-level branches that contract care.

Political and economic instability have contributed to low levels of health expenditure

At EUR 814 per capita (adjusted for differences in purchasing power), Romania spends under a third of the EU average, the lowest level of all Member States on health care (Figure 6). The share of GDP dedicated to health (4.9%) is also the lowest and significantly below the EU average of 9.9%. Health spending as a share of GDP has been decreasing steadily since 2010, reflecting the unstable political situation (see Section 5.3) and following spending cuts to meet fiscal deficit targets. Nevertheless, public sources account for 78% of total health financing (on a par with the EU average). Out-of-pocket payments are the second largest source of revenue for health care, and in 2015 reached 21% of expenditure for the first time (Figure 7). Although detailed data are not available, survey evidence indicates that informal payments, particularly for hospital care, are widespread and substantial (Tambor et al., 2014).

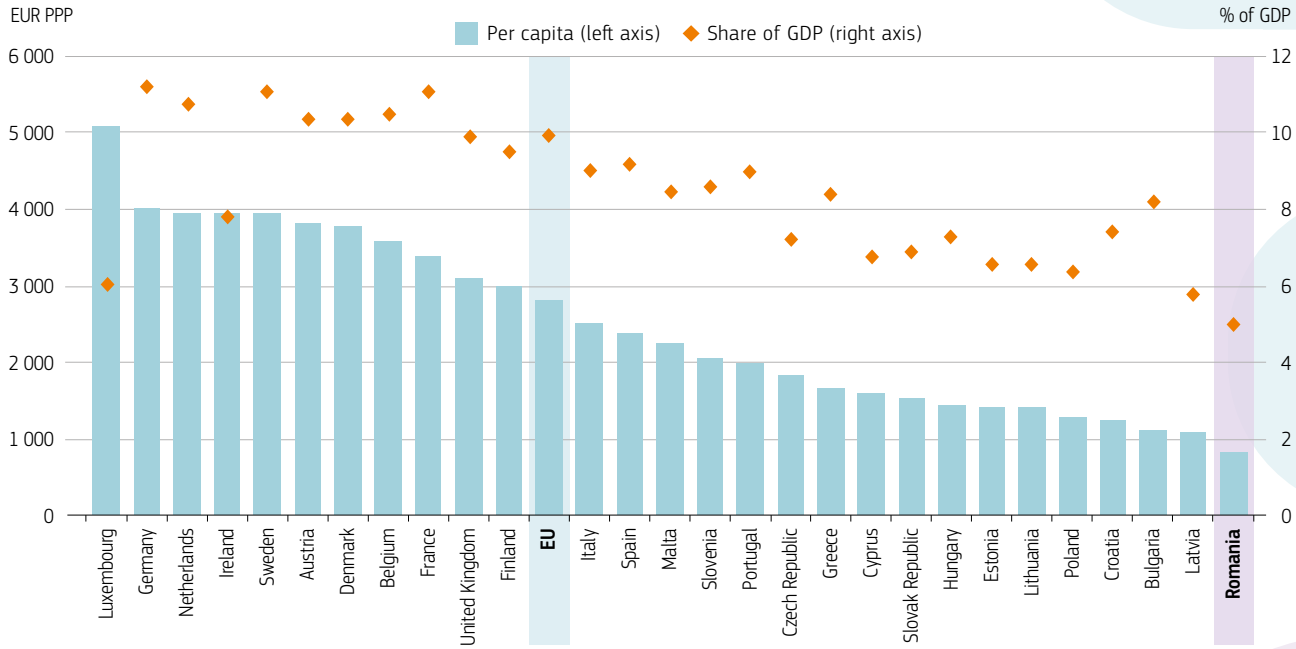
Population coverage is not universal

Social Health Insurance (SHI) is compulsory but covers only around 86% of the population. This figure may be misleading, however, as a very significant number of Romanians (between 3 and 4 million) are working abroad but are still counted as being in Romania. Insured individuals are entitled to a comprehensive benefits package while the uninsured are entitled to a minimum benefits package, which covers life-threatening emergencies, epidemic-prone/infectious diseases and care during pregnancy (see Section 5.2).

A mix of payment methods is used to pay providers

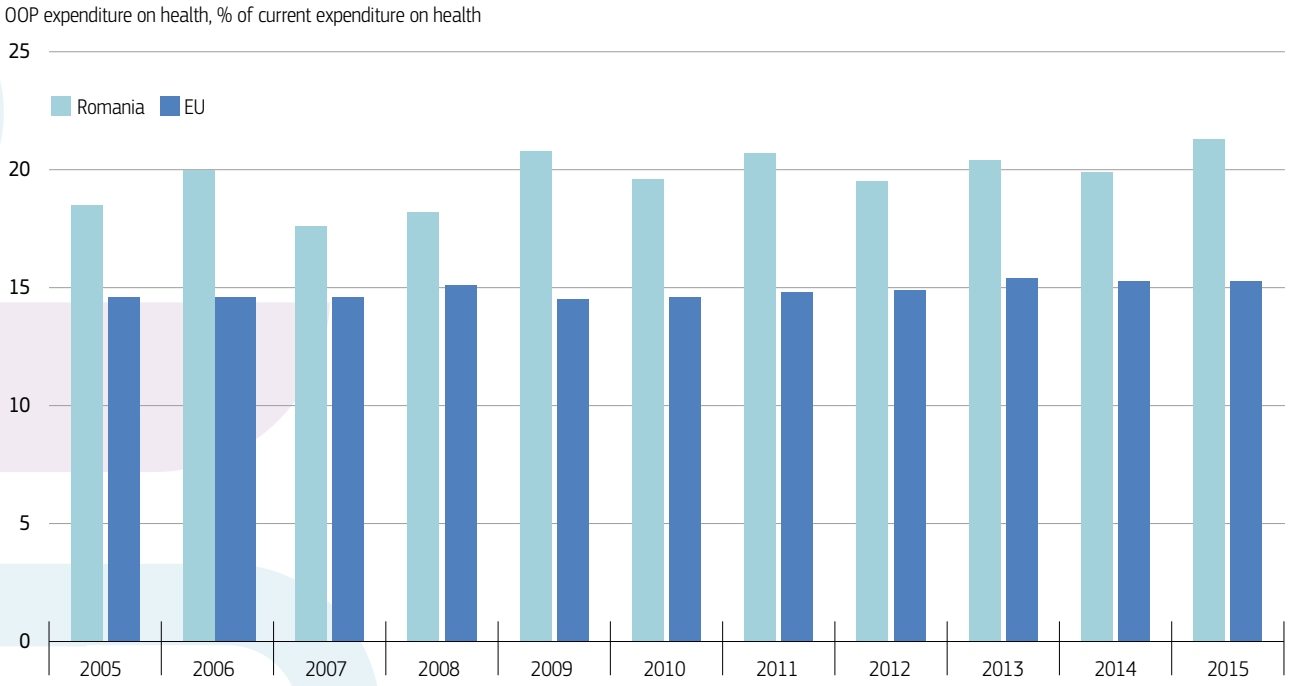
Health care is purchased through contracts between the district-level health insurance branches and providers following a standard Framework Contract. Primary care physicians own their practices and receive payments based on a mix of age-weighted capitation and fee-for-service. Ambulatory (or outpatient) care specialists who own their own practice are paid on a fee-for-service basis. Specialist

Figure 6. Romania has the lowest health expenditure in the EU



Source: OECD Health Statistics, Eurostat Database, WHO Global Health Expenditure Database (data refer to 2015).

Figure 7. Out-of-pocket expenditure in Romania remains high compared to the EU average



Source: OECD Health Statistics, Eurostat Database, WHO Global Health Expenditure Database.

services provided in hospital ambulatory units, however, are covered by the funding formula for hospitals which makes prospective payments based on a mix of payment methods, including the Romanian DRG system. All hospital doctors, including specialists offering ambulatory care in hospitals, are salaried, as well as nurses in both public and private facilities.

There is a shortage of medical staff, especially in deprived regions

The numbers of physicians and nurses are relatively low compared to EU averages: 2.8 doctors per 1 000 population compared to 3.5 in the EU, and 6.4 nurses per 1 000 population vs. 8.4 in the EU (Figure 8). This is despite steadily increasing numbers of nursing graduates and efforts to increase medical graduates after a decline from 2010 to 2013. Two factors contributing to these low numbers are the high rates of health workers who have emigrated over the past decade (and particularly after EU accession in 2007) and the fall in public sector salaries as a response to the economic crisis, which has seen health care staff leave the sector.

Infrastructure is underdeveloped

In line with the government's commitment to strengthen the role of primary care, the total number of hospital beds has decreased, with significant cuts in acute bed numbers over recent decades. However, bed numbers have fluctuated from 2005 and in 2015 were well above the EU average, with some 500 acute beds per 100 000 population compared to 396 in the EU.

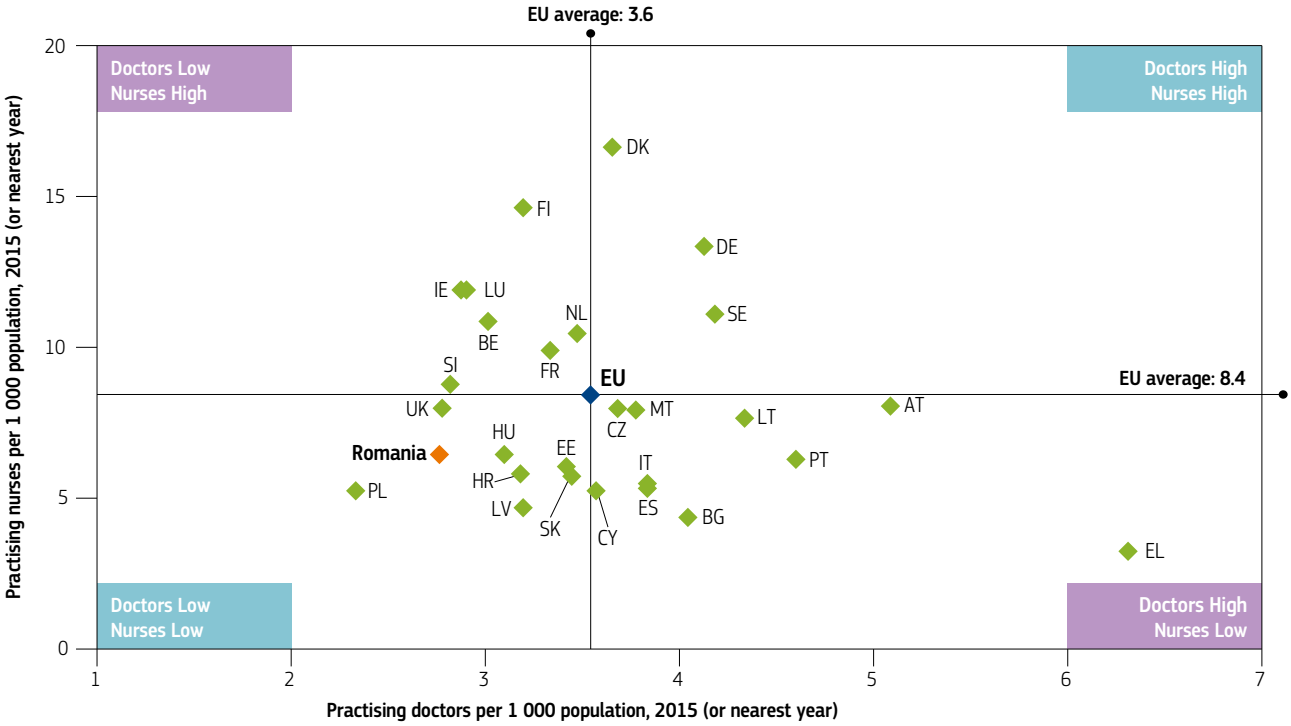
Hospitals are evenly distributed across the country, although there are some questions around accessibility in rural areas (Section 5.2). There is no official information available on the condition of public hospital buildings but there are government concerns. There are plans to build three hospitals, replacing old obsolete buildings, located in the regions with greatest needs,using EU funding mechanisms.

The delivery of primary and community care is particularly fragmented

Primary care is provided by family medicine physicians who usually operate in solo practices. However, despite a formal gatekeeping role, they do not play a pivotal role in coordinating care. Direct access to a specialist is possible for certain conditions and there is evidence of overuse of ambulance services, bypassing primary care. Fragmentation is increased by the fact that specialised ambulatory (or outpatient) care is provided through a network of hospital outpatient departments and polyclinics, specialised medical centres, centres for diagnosis and treatment, and individual specialist physician offices.

Inpatient care is provided by a large hospital network, but despite strong central direction hospitals vary in terms of size, competencies and catchment areas. Public health services are delivered by District Public Health Authorities and other specialised institutions with some public health provision in the primary care setting but again, without a strong coordinating or prevention function.

Figure 8. Physician and nurse numbers in Romania are considerably below the EU average

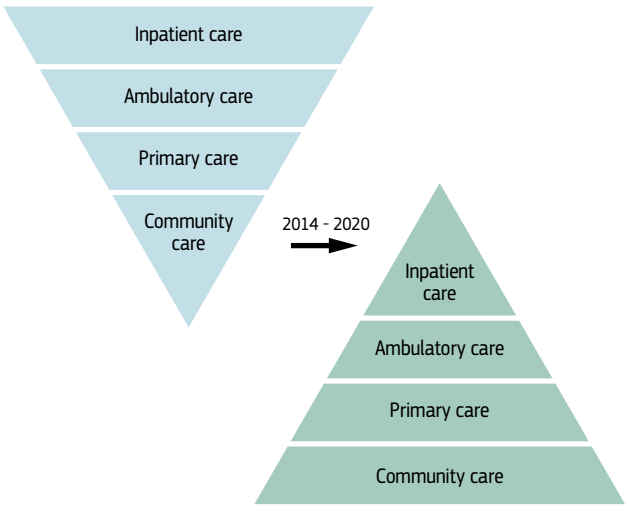


Note: In Portugal and Greece, data refer to all doctors licensed to practice, resulting in a large overestimation of the number of practising doctors (e.g. of around 30% in Portugal). In Austria and Greece, the number of nurses is underestimated as it only includes those working in hospital.

Source: Eurostat Database.

The health system is characterised by a lack of integration between different sectors (primary, hospital and public health) and by the underdevelopment of care continuity (Figure 9). The government recently responded with an Emergency Ordinance on Community Care (Emergency Ordinance 18/2017) which promotes some of the goals in the National Health Strategy (Box 1) and seeks to stimulate better coordination of care through the creation of new 'integrated community centres'.

Figure 9. The National Health Strategy 2014–2020 provides a vision on health care services provision



Source: Ministry of Health (2014).

BOX 1. THE 2014–2020 NATIONAL HEALTH STRATEGY

The key medium-term planning tool in the health sector is the National Health Strategy (Ministry of Health, 2014) which focuses on: public health, health services and system-wide measures, setting key objectives for each.

Public health goals are to improve the health and nutrition of mothers and children; reduce communicable disease mortality and morbidity; and slow the growth in non-communicable diseases. The *health services* stream aims to ensure equitable access to high quality and cost-effective services, while *system-wide* measures address planning capacity and seek to strengthen it at the organisational level (national, regional, local), and for operational areas, such as cancer control, hospital services and human resources. There are also commitments to increase efficiency through eHealth and reduce inequities in access by developing the health care infrastructure.

Implementation of the Strategy is one of the conditions for accessing new EU funding. Efforts are currently under way to make the Strategy operational, including by developing specific plans for the priorities of prevention, cancer, diabetes, cardiovascular disease and rare diseases. A monitoring framework will facilitate implementation (Ministry of Health, 2016).

5 Performance of the health system

5.1 EFFECTIVENESS

Amenable mortality for women is the highest in the EU

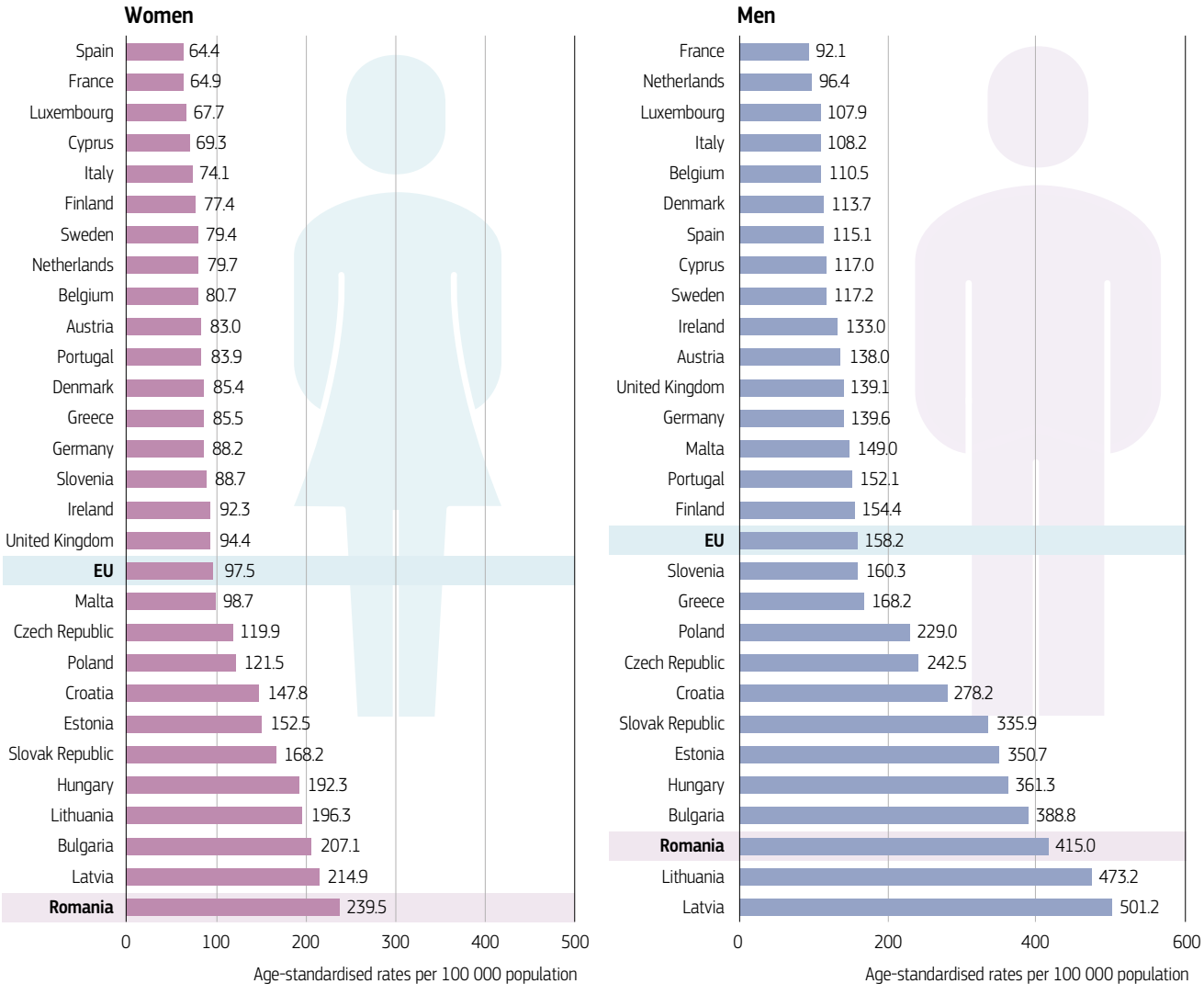
Amenable mortality sheds some light on the effectiveness of a health system. In Romania, mortality that could have been avoided through appropriate health care interventions is the highest in the EU for women and the third highest for men, after Latvia and Lithuania (Figure 10). About 53 867 deaths were deemed to be avoidable in 2014. Ischaemic heart diseases accounted for 31.4% of these amenable deaths. Other important causes of amenable deaths were cerebrovascular diseases (23% of the total) and hypertensive diseases (12.9% of the total).

Screening programmes have not functioned adequately

Even though they have been declining in recent years, particularly among people under 65, Romania has always had among the highest levels of cervical cancer mortality across the EU. This has been attributed to a lack of systematic screening and poor coverage. For example, in 2014, 27% of women aged 20–69 reported that they had been screened for cervical cancer over the last three years (EHIS). Poor quality of screening practices also play a role (IARC, 2017).

7. Amenable mortality is defined as premature deaths that could have been avoided through timely and effective health care.

Figure 10. Amenable mortality is the highest for women and third highest for men in the EU



Source: Eurostat Database (data refer to 2014).

Breast cancer mortlity has historically been lower in Romania than in other EU countries and, while mortality has been declining among younger women since the late 1990s, it continues to rise among women aged 65 and over. This can be explained, in part, by opportunistic mammography screening not reaching the target population (only 6.6% of women aged 50–69 in Romania reported having had a breast cancer screening over the past two years in 2014, compared to around 65% in the EU). In response, the implementation of the recent 2016–2020 National Integrated Multiannual Plan for Cancer Control includes innovative strategies on diagnosis, treatment and care of the most common cancers.

Vaccination rates have fallen

Vaccination coverage for children has been declining, with vaccination rates against diphtheria-tetanus-pertussis and poliomyelitis and measles immunisation coverage among 1 year olds falling by 10 percentage points since 2000. This is particularly relevant for Romania, which has a high rate of measles infections, being at the top of the ECDC's priority-country list for measles. This questions the effectiveness of preventive services but the probable causes behind this trend include the fact that there have been no reported cases of certain vaccine-preventable diseases (e.g. diphtheria, poliomyelitis) in recent years, thus increasing complacency about the need to vaccinate, and the influence of the anti-vaccine movement. Delays in procuring vaccines and an increase in the number of seasonal cross-border migrants are also contributory factors as the children of these migrants may not follow the same vaccination schedule as settled children.

For adults, there has been a dramatic decrease in influenza vaccination among older people. The take-up rate of only 10% in 2015 contrasts markedly with the rate of 54% in 2007.

Preventable mortality is also high, particularly for alcohol-related causes of death

Romania has high smoking rates among men and deaths due to lung cancer, particularly among women and men over 65, have been steadily increasing and account for 4% of all deaths (2014). Romania's standardised death rate for mortality related to alcohol abuse (42 per 100 000) is the highest among EU countries.

A number of measures have been implemented to reduce the prevalence of smoking in the population, including laws restricting the consumption of tobacco (since 2002) and banning smoking in all indoor public spaces (since 2016). The 2016 law also prohibits the sale of tobacco products in all health and education facilities. On the other hand, there is no national plan to tackle alcohol consumption. Instead, education and information campaigns are conducted by NGOs such as the Alliance for Fighting Alcoholism and Addictions.

Despite recent efforts aimed at modifying diet through healthy eating campaigns, the average diet in Romania is considered to be relatively unhealthy. It is characterised by high consumption of animal fats and high-caloric food with high sugar and salt content. Certainly, poor diet is regarded as one of the key factors driving high rates of cardiovascular disease and has also been linked to the recent increase in obesity in adolescents (see Section 3).

The government is tackling some of the weaknesses of prevention but there is still unequal

There is recognition that the performance of preventive services is 'suboptimal' (Ministry of Health, 2014). In response, the National Health Strategy 2014–2020 includes efforts to improve health education, health lifestyles and inter-sectoral cooperation, especially for the benefit of vulnerable groups, i.e. the Roma, the elderly and low income groups. This is in addition to targeting areas like maternal and child health, reproductive health and communicable diseases (see Box 1). The Strategy also indirectly addresses key health determinants, including economic development, transport infrastructure, environment, social inclusion and living standards. The National Sustainable Development Strategy 2013–2020–2030 includes a further range of activities that seek to reduce environmental hazards and to improve health and well-being.

Nonetheless, access to health promotion and education, as well as to disease prevention, continues to be unequal, with certain vulnerable groups, such as Roma populations and homeless people, having poorer access (see Section 5.2).

There is little data on the impact of preventive measures or the quality of care

Although the preventive component of health programmes is being strengthened and national initiatives are in place to screen for cardiovascular disease risk factors, cancer and other conditions, there are no publicly available data on the impact of these activities on morbidity and mortality rates.

BOX 2. ANTIMICROBIAL RESISTANCE POSES A CONSIDERABLE RISK

Antimicrobial resistance (AMR) is a major public health threat. Romania has some of the highest levels of antimicrobial resistance in the EU. Surveillance data show that in 2015, 24.7% of Klebsiella pneumoniae bloodstream infections were resistant to carbapenems, a major last-line class of antibiotics to treat bacterial infections. This percentage is much higher than the EU/EEA median (0.5%) and the third highest in the EU/EEA (ECDC, 2017b). The Romanian government is now taking steps to develop a national action plan on AMR.

Data on the quality of health care services in Romania also remain scarce. Data used in international comparisons of health care quality, such as the in-hospital case-fatality rate for acute myocardial infarction or ischaemic stroke, are not available for Romania. Moreover, the data that are collected, such as rates of nosocomial infections in hospitals, are not reliable. The National Authority for Quality Management in Health Care, established in 2015, is developing a quality assurance strategy and will expand the accreditation process from hospitals to all health care providers.

5.2 ACCESSIBILITY

The numbers working abroad make it difficult to assess coverage

As mentioned in Section 4, SHI covers only around 86% of the Romanian population. However, because so many Romanians are working abroad but still counted as being in Romania (3–4 million) few definitive conclusions can be drawn about coverage. Notwithstanding this, data show that the proportion of the population covered is higher in urban areas (94.9%), compared to rural areas (75.8%).

Besides the Roma population with no identity cards, there are additional groups of the population that do not contribute to the health fund and hence remain uncovered (e.g. people working in agriculture; those employed 'unofficially' in the private sector; the self-employed; and the unemployed who are not registered for benefits). There are initiatives to improve access for Roma communities; for example, the Roma health mediator programme and a new project to create community health care centres are expected to provide better coverage for all vulnerable populations with restricted access to health care.

The insured have a comprehensive package but the uninsured have only minimum cover

According to the law, every insured person has access to the same comprehensive basic benefits package, regardless of their income or socioeconomic status. The uninsured, by contrast, have access only to a minimum benefits package, including emergency care, treatment of communicable diseases and care during pregnancy.

There are no clear criteria for what is included but certain services are excluded, such as those covered by the occupational accidents and diseases insurance fund, very expensive technologies and treatments deemed non-essential, such as cosmetic surgery or in vitro fertilisation. There is a positive list for pharmaceuticals, published by the National Agency for Medicines and Medical Devices with input from the newly created HTA department (see Section 5.3).

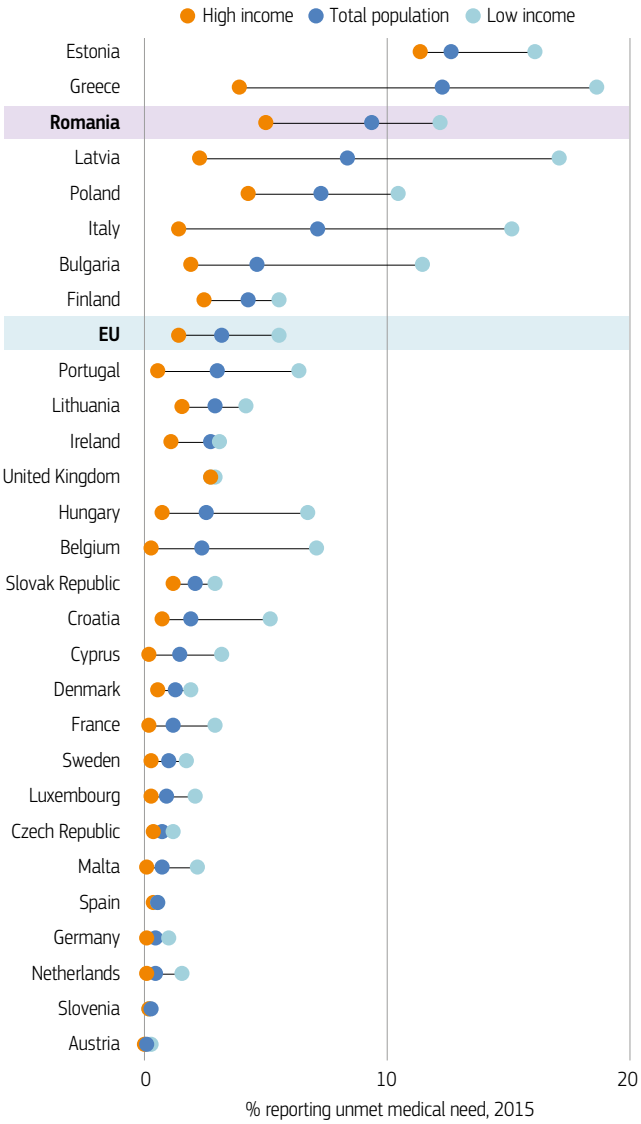
Unmet medical needs are decreasing over time

There is inequity in access to health care, with differences among various socioeconomic groups (the unemployed and self-employed, pensioners, agricultural workers, and the Roma population) and between urban and rural areas. In 2015, 9.4% of Romanians reported unmet medical care needs because of cost, geographical barriers or waiting lists, compared to an average of 3.2% in the EU. This figure is slightly lower than in 2007, when 12.3% of respondents reported having unmet needs for one of these reasons (Figure 11).

Cost sharing exists for various services

Cost sharing poses potential barriers to accessing care. Co-payment rates varying from 10% to 80% apply to pharmaceuticals as well as to rehabilitation services. In addition, contracted private providers can charge extra for the services they provide. In 2013, the government introduced co-payments for hospital care, charging patients up to EUR 2.50 per discharge, but with a range of exemptions (e.g. children and young people up to 26 years old in education; patients covered by specific national programmes; pregnant women without income; and pensioners with income below the taxation threshold). What is more, from 2017 pensioners on low incomes are exempt from income tax and health insurance contributions.

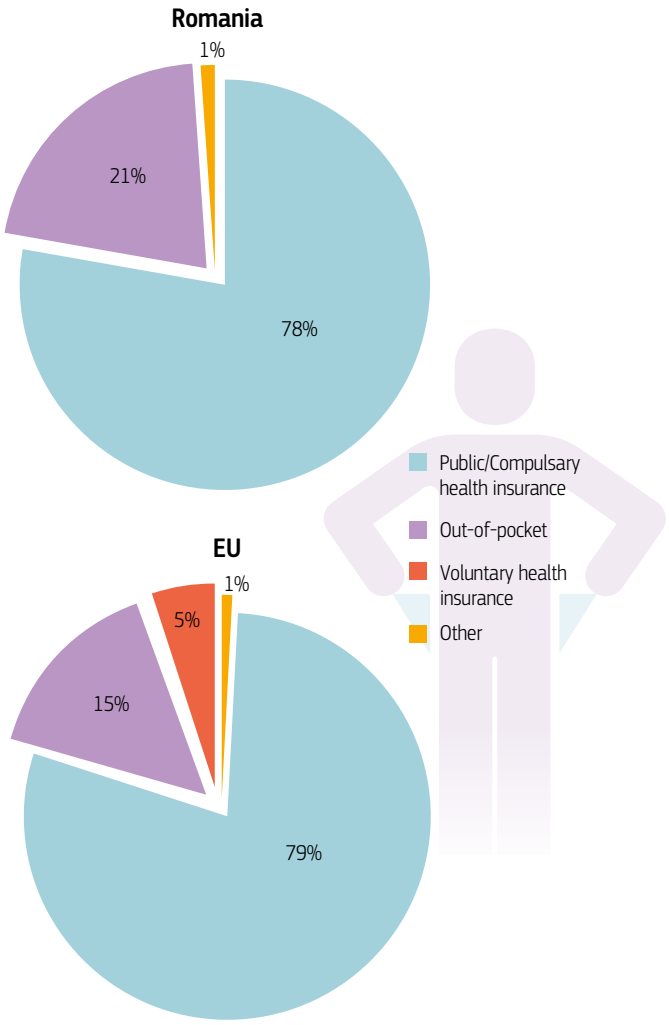
Figure 11. Unmet needs for medical care in Romania vary substantially by income group



Note: The 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 2015).

Figure 12. Out-of-pocket payments have a greater role in Romania than on average in the EU



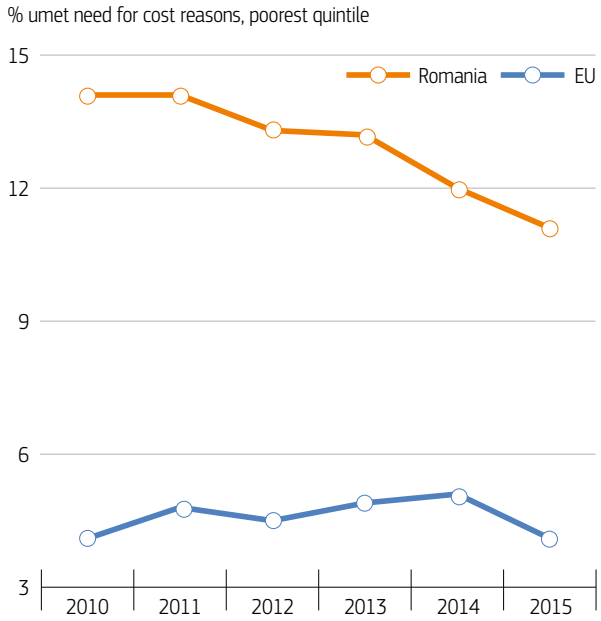
Source: OECD Health Statistics, Eurostat Database (data refer to 2015).

Affordability is the main reason for perceived unmet health care needs

Out-of-pocket medical spending in Romania represents 21.3% of total health expenditure (see Section 4 and Figure 12), up from 18.5% in 2005. The highest share of out-of-pocket medical spending is dedicated to pharmaceuticals (70.8% vs. 44.2% in the EU). Out-of-pocket payments in Romania include co-payments and direct payments for services not covered by SHI, as well as informal payments (see Section 4). However, only 1.7% of final household consumption is spent on out-of-pocket payments for medical care, below the EU average (2.3%). The magnitude of out-of-pocket payments is difficult to assess accurately (because of informal payments and underreporting of incomes by private providers) but is expected to decrease following the introduction (in 2014) of further penalties for those accepting money 'under the table'.

As in most other EU countries, unmet care needs are reported more often by poor people: 11.1% of people from low-income households reported going without a medical examination when needed for financial reasons, more than twice the EU average (4.1%). However, this percentage has been decreasing since 2007, when it was 19.3% (Figure 13).

Figure 13. Unmet needs for medical care due to costs are decreasing over time for the poorest population



Source: OECD Health Statistics.

Access to health care resources is unequal

Levels of unmet needs due to geographical barriers are some of the highest in the EU for the lowest income groups (0.8% compared to an average of 0.2% in the EU). The differences in access are largely about the gap between rural and urban areas and are explained by the unequal distribution of health workers and facilities across the country for all types of care. Although public hospitals are nominally evenly spread across the country, 90% are in urban areas and private hospitals are almost exclusively in larger cities and the more affluent areas. The Danube Delta and remote mountain regions face particular challenges. Geographical barriers to access are exacerbated by the costs of travel, the time involved and the poor transport infrastructure, with lack of transport frequently cited as causing unmet needs.

Measures to tackle shortages of health professionals in rural areas are undeveloped but steps have been taken in recent years to incentivise delivery of more primary care services in rural settings, such as the revision of the benefits basket and the proportion of spending on primary care and ambulatory services (2014–15). Early efforts include increasing the fee-for-service share of primary care providers' salary from 30% to 50% (2011) and reimbursing telemedicine in remote areas (2013).

Access to medicines is a major challenge

The list of reimbursed drugs was not updated between 2008 and 2015, which meant that patients did not have access to new treatments during that period. Current efforts to give better access to medicines are complicated by concerns that the low prices of some medicines compared to other EU countries may lead to parallel exports, undermining access within Romania. In response, the Ministry of Health has obtained EU approval to stop parallel exports of vaccines for a limited period (2017). There is also some anecdotal evidence that cost is creating a major obstacle to access for certain new treatments.

5.3 RESILIENCE

The health system remains underfunded

Macroeconomic policy since 2008–09 (following the economic crisis) has combined an ambitious package of macrostabilisation and structural measures, and has been supported by the IMF, the European Commission and the World Bank (2011). Reforms are expected to reduce pharmaceutical expenditure as well as to improve overall health system funding. Other efficiency-oriented objectives are to implement eHealth solutions, shift resources from hospital-based care towards preventive and primary care; and to centralise procurement procedures. However, there is a lack of administrative capacity and where EU funds are available the absorption of resources has been slow.

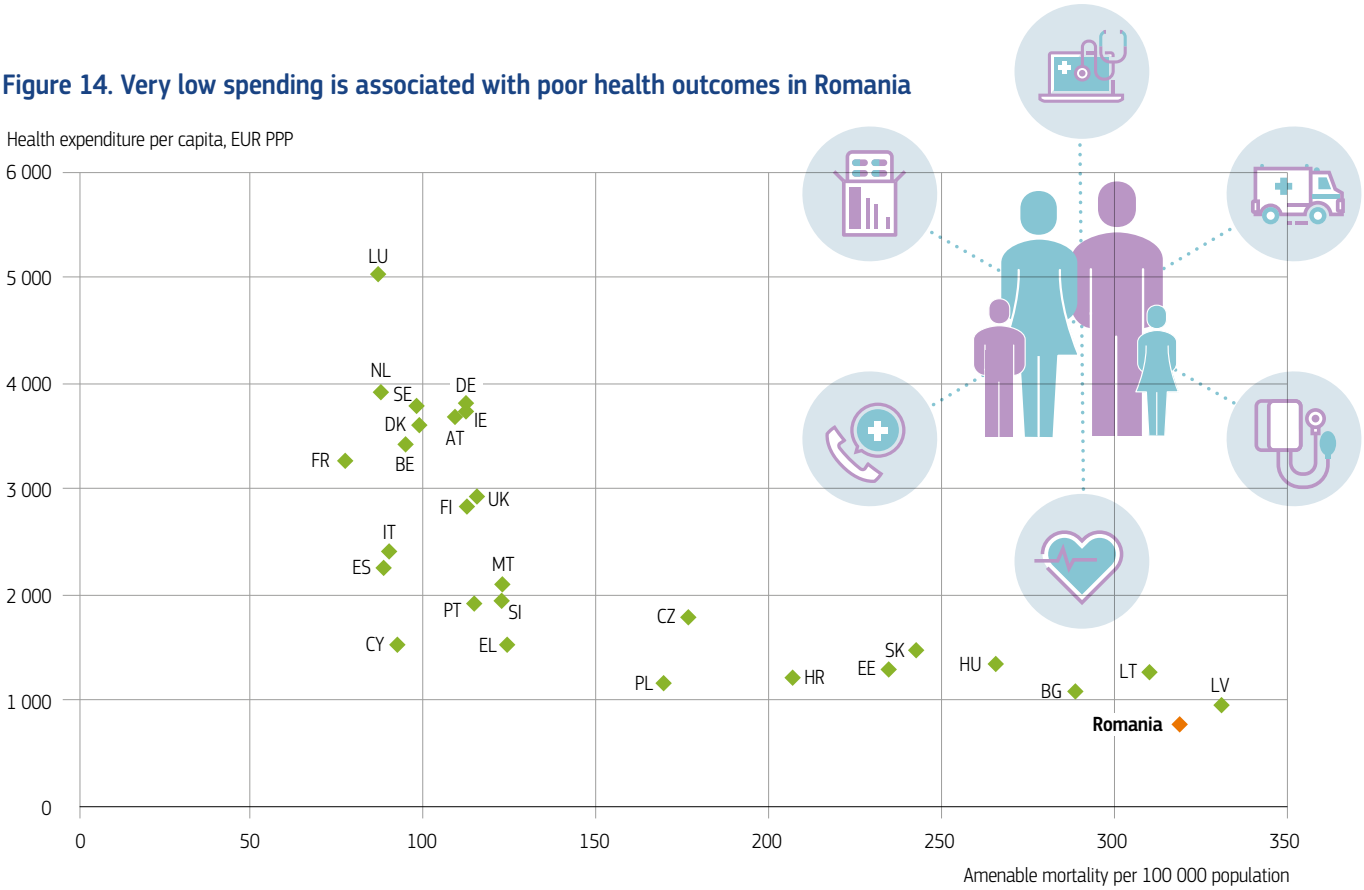
Nevertheless, Romania's new government (since December 2016) has increased the budget for health in order to address underfunding and to achieve key objectives such as bolstering health workforce capacity (see below) and improving access to medicines (see Section 5.2).

Health workforce capacity is being targeted

A key government objective is to improve health workforce retention rates, reflecting the fact that Romania has had relatively low numbers of physicians and nurses compared to other EU countries (see Section 4) and increasing numbers of specialist physicians migrating (since EU membership in 2007). New initiatives also respond to repeated strikes by health care professionals in 2015.

There is a commitment to tackle the most common causes of dissatisfaction, such as low salaries (relative to non-health professions and the national average income) as well as low social status and recognition. Attention will also be given to other key

Figure 14. Very low spending is associated with poor health outcomes in Romania



Source: OECD Health Statistics, Eurostat Database, WHO Global Health Expenditure Database (data refer to 2014).

factors, such as limited career development opportunities and poor working conditions (particularly the lack of equipment and supplies). The government has pledged a gradual increase in salaries and improved working conditions and has taken legal steps to increase publicly employed health professionals' salaries (see also Box 3). Despite these measures, average health care workforce incomes in Romania remain very low compared to other EU Member States.

BOX 3. MEASURES TO BRING BACK ROMANIAN DOCTORS FROM ABROAD

The current government's policy agenda includes measures to ensure proper human resources for health. The new National Centre for Human Resources will have a remit to assess human resource needs, coordinate training and guide career development. Legislation to set up the new centre and its responsibilities has yet to be published but the Minister of Health has publicly announced its establishment and commitment to assisting all Romanian doctors who are currently practicing abroad and who wish to return to Romania if certain conditions change, including remuneration levels.

There is scope to use information and policy levers better to encourage improvement

Romania spends very little on health care and has among the worst amenable mortality rates in Europe (Figure 14). There is clearly scope to do better but persistent low funding has undermined the system and the overuse of hospital care has created inefficiencies and, perversely, limited access to quality care (European Commission, 2017). There are policies in place to address these challenges, but more specific measures are needed, supported by better information flows.

A strategic approach to prescribing could add to efforts on generics

Regulation of the pharmaceutical market has so far been more reactive and ad hoc than a comprehensive policy. Despite measures to encourage generic prescribing, there is underuse of generics, which has been attributed to the claw-back tax requiring the repayment of a percentage of profits from manufacturers and distributors, the price-setting procedures and a lack of incentives. In

addition, there are currently no specific strategies or guidelines to improve prescribing. A defined pharmaceutical policy with clear and agreed objectives would be an asset.

Health Technology Assessment is still at an early stage of development

More could also be done to exploit health technology assessment (HTA). There have been HTA initiatives from the early 1990s, but it was not until 2011, when Directive 2011/24/EU on patients' rights in cross-border health care had to be transposed into Romanian law, that HTA activities really started to develop. They have become the main tool for compiling the list of reimbursable medicines (in part in response to the Directive on regulating pricing) and define the criteria for evaluation and inclusion. Even so, HTA efforts have concentrated on pharmaceutical products with no methods in place for other technologies (diagnostic procedures, surgical interventions, screening, etc.), although there are plans to develop these as part of a World Bank project.

There are no clear criteria for resource allocation and reliable information is rarely available

The methods used for allocating health sector resources between different types of health care are unclear and are not based on evidence of cost-effectiveness. The weak link between population health needs and planning decisions is aggravated by the lack of appropriate information systems, with a high degree of data fragmentation and duplication of data collection.

The reimbursement of hospital care (which accounts for more than one third of the health care budget) is based on a diagnostic-related groups mechanism. Moreover, a lot of data on hospital care are available. However, these are rarely used for analysis and decision-making purposes. The continued reliance on acute hospital care while primary care and community services remain underdeveloped (see Section 4) is a clear example of suboptimal resource allocation, although some evidence does suggest that avoidable hospitalisation is less than 7%, and comparable with other EU countries (Ciutan et al., 2016). There are also examples of costly equipment being procured but not used, because of lack of appropriate staff or funds for installation or consumables.

National health strategies and plans are in place, but there are gaps

The current National Health Strategy is the first to have an allocated budget. During 2016, eight regional plans were developed to reorganise the health system in accordance with the national strategic objectives. There has also been some work on specific plans for distinct diseases or services although these are not yet complete. In addition, new policies aim at attracting physicians to rural areas and halt migration of health care workers (see above) but there is no overarching policy for planning human resources in the health care sector or for addressing skill mix. Further, there are no systems in place aimed at ensuring an equitable distribution of capital across the country and across various levels of care.

There is a need to improve transparency

Corruption is perceived as a major concern for the health sector (as well as an obstacle to economic development), with widespread informal payments accounting for a substantial share of health care spending (see also Box 4). The National Health Strategy 2014–2020 recognises the need to address this but also to improve transparency in decision-making and to boost citizens' involvement. Patients' associations are increasingly part of the policy-making process. However, performance is not generally evaluated and it is difficult to assess whether wider government objectives are being met.

BOX 4. **INFORMAL PAYMENTS IN HEALTH CARE CONTINUE TO BE A PROBLEM IN ROMANIA**

A Special Eurobarometer Report on corruption published in 2014 indicates that informal payments in health care are widespread in Romania. For example, over a quarter of Romanian respondents (28%) reported that they had to give an additional payment, valuable gift or make a hospital donation as part of their use of public health care services. In fact, 50% of Romanian respondents (compared to 19% across EU countries) said that they felt they had to make the extra payment or gift before the care was received. In contrast, 28% said they made the informal payment or gift after care was provided. Moreover, about one fifth of respondents in Romania (19%) said that they had been asked to go to a private consultation with the doctor in order to be treated in a public hospital.

6 Key findings

- While a high proportion of the Romanian population assesses itself as enjoying good health, life expectancy at birth remains nearly six years below the EU average and is one of the lowest in the EU. There have also been some unfavourable trends, including rising mortality rates for the most common causes of death (cardiovascular diseases and lung, breast and colorectal cancers), increasing numbers of new HIV/AIDS cases and falling immunisation rates.

- Binge drinking among men is a serious public health problem, with the highest level in the EU but no national programme in place to tackle it. More positively, the number of daily smokers is in line with the EU average and the obesity rate among adults is the lowest in Europe. Still, behavioural risk factors contribute to more than 40% of the overall burden of disease in Romania.

- Romania's health system is characterised by low funding and inefficient use of public resources, with the lowest spending per capita and as a share of GDP in the EU. There is a lack of universal coverage, although the non-covered population does have access to a minimum package of benefits. There are also inequities with regard to access to services between the rural and urban populations and for vulnerable populations. Recent efforts include the creation of community care centres to improve access, including for the Roma population.

- Out-of-pocket spending comprises one fifth of total health care expenditure, and includes direct and informal payments. The latter are thought to be widespread and substantial, but nevertheless difficult to estimate, obstructing reliable calculations of the true share of private expenditure on health. Affordability is the main reason for reported unmet health care needs.

- The efficiency of the health system is constrained by delays in shifting from inpatient and hospital care to outpatient and primary care. Strengthening primary care has been on the policy agenda since 1990, but primary and community health care services are still under-provided and under-used, and there continues to be inappropriate use of inpatient and specialised outpatient care, including care in hospital emergency departments.

- Efforts to improve the system are hampered by lack of information. There are insufficient data to assess quality of care and health technology assessment is still at an early stage of development. There are no clear criteria for resource allocation and insufficient evidence is available to improve cost-effectiveness. Nor is there a system in place to ensure an equitable distribution of health facilities and human resources across the country, to overcome inequities between rural and urban areas.

- There are, however, a number of initiatives to improve the health system. Romania's National Health Strategy sets out strategic objectives in the areas of public health and health care services, and is supported by the development of eight regional plans to reorganise health services and direct investment towards disadvantaged areas. A National Authority for Quality Management in Health Care has been established and the new government is addressing the conditions of the health workforce and access to medicines.

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Country abbreviations

Austria	AT	Denmark	DK	Hungary	HU	Malta	MT	Slovenia	SI
Belgium	BE	Estonia	EE	Ireland	IE	Netherlands	NL	Spain	ES
Bulgaria	BG	Finland	FI	Italy	IT	Poland	PL	Sweden	SE
Croatia	HR	France	FR	Latvia	LV	Portugal	PT	United Kingdom	UK
Cyprus	CY	Germany	DE	Lithuania	LT	Romania	RO		
Czech Republic	CZ	Greece	EL	Luxembourg	LU	Slovak Republic	SK		

European Commission

State of Health in the EU

Country Health Profile 2017

The Country Health Profiles are an important step in the European Commission's two-year *State of Health in the EU* cycle and 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. This series was co-ordinated by the Commission and produced with the financial assistance of the European Union.

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