

ANALYSIS OF MANAGEMENT CHALLENGES IN THE ABSORPTION OF EUROPEAN FUNDS WITHIN ROMANIA'S HEALTHCARE SECTOR

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The article analyzes the management bottlenecks affecting the absorption of European funds within Romania's healthcare system, focusing on the discrepancy between record-high financing and low operational implementation capacity.

Keywords: Absorption of European funds, healthcare system, NRRP [National Recovery and Resilience Plan], operational capacity, administrative capacity, defensive bureaucracy, overregulation, centralized public procurement, political partisanship.

INTRODUCTION

The Romanian healthcare system finds itself at a historic crossroads, defined by a profound asymmetry between the availability of financial resources and the structural capacity to assimilate them. Within post-accession multiannual financial frameworks, but most notably through the simultaneous coupling of two financial instruments—the National Recovery and Resilience Plan [NRRP] and the European Structural and Investment Funds [ESI] via the Healthcare Operational Programme [HOP] 2021-2027—financial allocations intended for medical infrastructure, digitalization, and technological equipment have reached unprecedented levels. Nevertheless, the actual absorption dynamics indicate a chronic resistance within the public system, driven not by budgetary limitations, but by structural deficiencies in management.

This paper proposes a detailed critical analysis of the managerial, administrative, and political bottlenecks that jeopardize the utilization of European funds in the Romanian healthcare sector. The approach investigates the phenomenon from a systemic perspective, starting with the failure of strategic planning at the central level, moving through execution deficiencies at the beneficiary level [public hospitals], and concluding with the distorting influence of political partisanship and group interests. Concurrently, the paper provides a comparative perspective against models of best practices implemented in other states within the region, such as Poland and the Czech Republic, identifying the vectors of change necessary to reform the management of European fund absorption.

The conceptual framework of european fund management in healthcare.

Financial allocations earmarked for healthcare systems through cohesion policy and temporary recovery mechanisms represent the most complex test of administrative capacity for Member States in Central and Eastern Europe [Zaman and Cristea, 2011]. Unlike other socio-economic sectors, investments in hospital infrastructure and medical digitalization incorporate a high degree of technical complexity, a fragmented supply chain, and rigorous clinical standards interconnected with specific biosecurity rules and procedures.

In this context, Project Cycle Management [PCM] no longer constitutes a mere set of bureaucratic compliance procedures, but becomes a critical variable directly dependent upon the institutional stability and maturity of the contracting authorities.

The transition from the classic approach based on cost reimbursement [specific to Regional Operational Programmes or the Healthcare Programme 2021-2027 managed by MIPE] to the strictly performance-based architecture of the Recovery and Resilience Facility has fundamentally altered the rules of financial governance. Under the NRRP, payments are conditional upon the fulfillment of specific milestones and targets with firm deadlines, which cannot be extended beyond the year 2026. This temporal rigidity penalizes states characterized by reactive institutional cultures, where technical design and physical execution suffer from chronic delays [Bărbulescu, 2015].

The management of structural and cohesion funds in the healthcare sector is not merely an exercise in accounting compliance, but a complex process of strategic public management. It presupposes the existence of a continuous value chain, articulated upon four fundamental pillars:

1. Visionary programming: aligning financing priorities with actual epidemiological, clinical, and demographic needs;
2. Technical formulation: designing clear, predictable financing guidelines devoid of redundant requirements;
3. Operational execution: the beneficiaries' capacity to manage complex procurements and works contracts;

Monitoring and performance audit: evaluating the actual clinical impact, looking beyond formal document compliance.

In Romania, this value chain is deeply fragmented. Public management theory emphasizes that institutional efficiency directly depends on the stability of rules and the professionalization of the technical corps. When rules are unstable and human resources are subject to political fluctuations, the phenomenon of administrative paralysis occurs, wherein bureaucracy becomes a self-protection mechanism for officials facing risk, thereby blocking project advancement and expenditure settlement.

At the end of August 2026, centralized data from the Romanian Ministry of Health indicated that a nominal absorption rate of 91% had been reached for European funds under the NRRP [Ministry of Health, 2026]. This value represents a significant leap from the 66%

level recorded in the previous semester, an increase attributed by authorities to the unblocking of administrative procedures and the accelerated contracting of approximately 1,200 projects aimed at modernizing outpatient clinics, equipping medical units, and structurally digitalizing the healthcare system.

However, a critical evaluation requires a dissociation between the formal contracting rate [legal commitments] and the actual financial execution rate [payments and completed fieldwork]. This positive dynamic in official figures conceals severe portfolio adjustments made over the past three years to avoid the automatic de-commitment of funds. To keep milestones within the parameters agreed upon with the European Commission, Bucharest authorities have repeatedly resorted to removing projects from financing that were evaluated as immature or incapable of completing civil construction works within the NRRP calendar limits.

A documented case is represented by the national network of family planning and primary healthcare clinics, where, due to massive delays in public procurement for specific fittings and equipment, the initial funds of approximately 10 million euros were completely eliminated from the NRRP structure. These projects were subsequently transferred to the other financial instrument, the EU's European Structural and Investment Funds (ESI)—the Healthcare Operational Programme, thereby relieving pressure on NRRP milestones but exposing the system to a systemic risk of financial penalization and fragmentation.

Similarly, the successive restructurings of the list of new or fully rehabilitated hospital units under Component C12 - Health of the NRRP directly reflect the failure of initial strategic planning. Legislative amendments implemented via emergency ordinances to cut or redirect sums intended for hospitals deemed "non-priority" or blocked in the incipient phases of tendering [Europa Liberă România, 2024] demonstrate that the public system in Romania tends to prioritize scriptural compliance to the detriment of long-term structural impact across the territorial medical network.

Strategic management and institutional instability at the central level. Discontinuity of public policies and the resetting of priorities.

At the level of central public administration, the primary managerial problem is the absence of a linear vision immune to electoral cycles. The Ministry of Health, in its capacity as the line authority or strategic beneficiary, has undergone repeated institutional transformations and reorganizations, which have severely fragmented institutional memory.

Each change in the political leadership of the Ministry of Health has brought about a re-evaluation of the priority project portfolio. This practice has directly affected projects of critical importance, such as the Regional Emergency Hospitals [Iași, Cluj, Craiova]. Originally conceived within previous multiannual financial frameworks, their technical documentations were subjected to successive revisions driven by the shifting strategic visions of different ministerial cabinets [Eurohealth Observatory,

2026]. Consequently, entire programming periods were lost in the design phase, and initially estimated costs became anachronistic relative to developments in the construction market.

Project management in Romania suffers from a fragmentation of competencies between the Ministry of Investments and European Projects [MIPE] and the Ministry of Health. The impermissibly slow establishment and operationalization of dedicated structures, such as the National Agency for the Development of Infrastructure in Healthcare [ANDIS], demonstrated the difficulty of transferring technical competencies from the ministerial bureaucratic apparatus to a specialized structure. Instead of acting as a catalyst, ANDIS faced human resource bottlenecks and delays in the actual takeover of large projects during its initial phase, perpetuating decisional ambiguity in relations with beneficiaries and consulting firms [G4Media, 2023].

Project Management Units [PMUs] are often populated by officials lacking specific competencies in complex public procurements for medical equipment or hospital civil engineering. The cumulative pressure of European rules and national legislation generates a phenomenon of "defensive bureaucracy," in which administrative decisions are systematically postponed out of fear of financial corrections imposed by audit bodies or investigations by judicial institutions [Androniceanu, 2017]. The fluctuation of human resources in leadership positions further undermines institutional memory and project continuity, causing complex technical analyses to be restarted from scratch.

The discrepancy between scriptural absorption and physical implementation generates grave consequences at the macroeconomic and structural levels. Firstly, the repeated elimination of immature financing lines from the NRRP and their forced transfer to classic cohesion programmes places massive pressure on the general state budget, which must cover non-eligible expenses or penalties resulting from terminated contracts. Within a context marked by a persistent budget deficit exceeding the limits of the European Stability and Growth Pact, the inability to attract non-reimbursable funds for modernizing critical medical infrastructure compromises the country's fiscal position [Gănescu, 2013].

Secondly, the phenomenon of regional systemic inequity in access to quality healthcare services is deepening. Major university centers [Bucharest, Cluj-Napoca, Iași], which possess relatively more robust local administrative apparatuses and a superior capacity to attract external experts, succeed in bringing major hospital infrastructure projects to fruition. Conversely, peripheral or economically disadvantaged counties fail to implement NRRP investments due to a chronic incapacity for management. Thus, European funds, originally conceived as instruments for recovery/resilience, convergence, and cohesion, paradoxically risk acting as vectors of polarization for the quality of medical care across the national territory.

Deficient administrative capacity at the beneficiary level [public hospitals].

While problems at the central level are structural, bottlenecks at the final beneficiary level county, municipal,



or clinical institutes take on a purely operational dimension. Hospital management in Romania is not configured, in terms of resources and organizational charts, to absorb large-scale European funds.

Public healthcare units face a chronic inability to recruit and retain specialists in complex public procurement, civil engineers, legal experts specialized in European administrative law, and experienced project managers. Salaries in the public sector, though improved for medical personnel [physicians and nurses], remain extremely rigid and unattractive for technical experts in the field of project management. Consequently, tender evaluation committees at the hospital level are often composed of physicians, financial directors, or general administrative staff who do not possess the necessary expertise to analyze highly complex technical offers for medical equipment or structural consolidation works.

To compensate for the lack of qualified internal personnel, hospital management resorts to outsourcing project writing and implementation services to private consulting firms. Although this practice is legitimate in theory, in reality, it generates a series of severe managerial risks:

- "Template" Projects: Consulting firms frequently deliver boilerplate financing applications that are poorly adapted to the actual clinical, epidemiological, and staffing realities of the beneficiary hospital;
- Unrealistically Assumed Indicators: Driven by the desire to secure project approval, consultants insert highly ambitious outcome indicators into financing applications. Later, during the implementation and sustainability phases, the hospital discovers it cannot fulfill these indicators (for example, treating a specific number of patients with a technology for which the hospital lacks certified doctors), which triggers the risk of retroactive financial corrections;
- Absence of Knowledge Transfer: Total outsourcing prevents the development of an internal culture of project management within the hospital, leaving the unit vulnerable and dependent during subsequent calls for projects.

In project management, the proactive identification of risks [financial, logistical, legal] and the establishment of contingency plans are mandatory. In Romanian public hospitals, risk management is almost exclusively reactive. Issues are addressed only after they have already transformed into open crises: contractors entering insolvency, delivered equipment that cannot be installed because the space is not ready, or legislative updates that invalidate the eligibility of certain expenditures.

Lack of project maturity in the public procurement system

One of the most severe diagnoses delivered by audit bodies, including the European Court of Auditors, relates to the inclusion of "immature" projects within financing axes—meaning projects that exist merely as concepts or feature deficient technical documentation [European Court of Auditors, 2024].

Time pressure, generated particularly by the extremely tight deadlines of the NRRP, led authorities and hospitals to approve hastily prepared feasibility studies. These documents frequently display major deficiencies:

- Underestimation of Budgets: Project cost estimates were calculated based on historical prices for construction materials and medical equipment, failing to anticipate the sharp inflation of recent years. When projects are put out to tender for execution, no construction firm submits bids, viewing the starting price as financially ruinous. Tenders are repeatedly canceled, consuming precious months from the project calendar.
- Technical Discrepancies: Errors from the design phase [the omission of utility networks, underestimation of soil bearing capacity, etc.] are discovered only during the construction phase, requiring site instructions, contract modifications, and additional costs that exceed the eligibility thresholds established by the financing contract.

In the healthcare sector, where technical specifications require a rigorous definition of equipment performance, contracting authorities lack the expertise necessary to formulate award criteria based on the best price-quality ratio. Consequently, they resort to the restrictive criterion of the "lowest price," which attracts either inferior quality equipment with high subsequent maintenance costs or prolonged appeals from market competitors. The National National Council for Solving Complaints [CNSC] and the courts of appeal thus become collateral actors dictating the implementation calendar of healthcare projects—a mechanism that completely undermines the logic of performance-based planning imposed by the RRF [Profiroiu et al., 2020].

The national public procurement system is perceived by hospital managers as an environment of maximum legal insecurity. Poorly drafted technical specifications give rise to successive waves of complaints filed by bidders with the National Council for Solving Complaints [CNSC] and, subsequently, with the Courts of Appeal. Administrative litigation can prolong the contract award phase for equipment or works by periods ranging from 6 to 18 months. Within the framework of European financing, these delays are fatal, often leading to de-commitment phenomena (the automatic de-commitment of funds) or to the necessity of salvaging projects by removing them from stringent European axes and moving them onto national budgets, requiring a massive effort from the state treasury [News.ro, 2026].

Excessive bureaucracy and deficiencies in the management and control system.

The institutional control architecture for European funds in Romania is characterized by a deeply defensive administrative culture focused on process and form to the detriment of outcomes and clinical performance.

Managing Authorities in Romania tend to add extra requirements, rules, forms, and layers of

control beyond those expressly mandated by European Commission regulations [European Institute of Romania, 2012]. This phenomenon of overregulation is officially justified by the desire to prevent fraud and audit errors; however, its actual effect is the administrative suffocation of the beneficiary. To clear a single expenditure, a public hospital must submit a massive volume of supporting documents, minutes, certified photocopies, and progress reports, navigating redundant bureaucratic circuits.

Financial flows within European-funded healthcare programmes present major synchronization bottlenecks. The verification of reimbursement or payment claims submitted by hospitals often takes months within the Managing Authority structures. During this interval, hospitals lack the liquidity [working capital] to pay construction contractors or suppliers of high-tech medical equipment. Contractors, unable to cover their operational costs and invoices from subcontractors, slow down or halt their activity on hospital construction sites [News.ro, 2026]. This perverse dynamic transforms an ostensibly funded project into an abandoned construction site due to strictly administrative cash-flow considerations.

The influence of political partisanship and group interests.

A critical analysis of European fund absorption management cannot be complete without evaluating the political economy dimension of the Romanian healthcare system. Political partisanship represents a major disruptive variable that interferes with the economic and medical rationality of fund allocation.

The appointment of public hospital managers based on political criteria rather than authentic management competitions rooted in rigorous performance indicators structurally weakens the quality of project implementation. A manager whose job stability depends on local or central political backing will tend to prioritize decisions with short-term electoral impact over the complex, long-term strategic decisions required for EU fund absorption. Furthermore, the lack of tenure stability among interim-appointed managers compromises continuity in project management; a contract signed by one manager may be re-evaluated or blocked by their successor due to internal political rivalries.

European funds intended for healthcare are sometimes viewed at the local level as resources for consolidating the political capital of county or municipal leaders. This vision distorts the allocation criteria established in Regional Healthcare Masterplans:

- **Fragmentation of Resources:** Instead of concentrating funds on strengthening major emergency hospitals capable of providing high-performance medical care for entire regions, political pressure is applied to disperse funds into modernizing small, town, or municipal hospitals for purely electoral reasons [Calea Europeană, 2025]. These units receive advanced medical technologies and expensive equipment that remain unutilized due to a lack of qualified medical personnel to operate them, representing a major failure of investment management;

- **Personal and Group Interests in Contract Awards:** Tenders for consulting, design, and execution in hospital infrastructure are vulnerable to local networks of influence. Construction firms lacking actual technical capacity or experience specific to hospital environments win large contracts due to political connections. The failure of these firms to execute works to mandatory European standards leads to contract terminations, protracted litigation, and ultimately, the loss of external financing [News.ro, 2026].

A comparative perspective: Romania vs. Poland and the Czech Republic.

To understand the specific nature of the bottlenecks in Romania, it is useful to look at a comparative analysis with Poland and the Czech Republic—Member States that underwent similar transitions but developed significantly higher-performing models for managing European funds in the healthcare sector.

The Polish Model: Centralization of Procurements and Professionalization of the Technical Corps. Poland identified early on the risk that individual local or regional hospitals would be overwhelmed by the complexity of large-scale medical public procurements.

- **The Centralization Mechanism:** Polish authorities delegated the management of major procurements for heavy medical equipment and infrastructure projects to specialized central public procurement units acting at the national or voivodeship level. These structures negotiate massive framework agreements with global medical technology manufacturers, securing substantially lower prices and ensuring high-level technical standardization. Local hospitals are relieved of the risk of award litigation; they simply place subsequent orders within these secured global agreements.
- **Personnel Policy:** Teams within the Managing Authorities and central procurement units are exempt from the rigid salary scales of general administration, benefiting from compensatory packages tied directly to project performance and the volume of funds attracted. This allowed Poland to attract specialists from the private sector, minimizing technical errors in specifications and the rate of administrative appeals.

The Czech Model: Integrated Digitalization and Normative Predictability. The Czech Republic grounded the success of its absorption on eliminating physical bureaucracy and ensuring maximum stability within its legislative framework.

- **Complete Digitalization of the Project Cycle:** Dissimilar to Romania, where IT systems for fund management [such as MySMIS] often coexist with the requirement to submit physical documents, the Czech Republic utilizes fully integrated IT platforms. The relationship between hospital, contractor, supplier, and the Managing Authority is natively digital. Invoices, payment orders, progress reports, and site

instructions are uploaded, verified, and approved automatically through compliance algorithms and qualified electronic signatures. The average settlement time for an invoice is kept below the 30-day threshold, eliminating cash-flow bottlenecks on construction sites [News.ro, 2026].

- **Predictability of Guidelines and Rules:** In the Czech Republic, eligibility rules established at a programme's launch remain unchanged throughout the entire implementation period of the projects. In Romania, frequent legislative changes issued via Government Emergency Ordinances or executive instructions from MAs during contract execution force hospitals to constantly revise their internal documentation, generating significant uncertainty and operational delays.

ment period for beneficiaries and contractors to a maximum of 30 days, following the model successfully implemented in the Czech Republic;

Depoliticization and Professionalization of Hospital Management. Genuine administrative reform requires the mandatory introduction of hospital management contracts based exclusively on certified technical competencies, prohibiting the practice of interim appointments based on political partisanship. Project management teams within hospitals must be financially incentivized through flexible bonus mechanisms funded directly from the technical assistance lines of European programmes, contingent upon meeting milestones and adhering to project execution schedules.

CONCLUSIONS

The critical analysis of the current state of affairs

Comparative Analysis Table

Management Indicator	Romania	Poland	Czech Republic
Operational Procurement Model	Totally decentralized; each hospital manages major tenders individually.	Centralized through national agencies and voivodeship framework agreements.	Assisted decentralization with rigorous standardization of technical specifications.
Degree of Digitalization	Hybrid; administrative IT platforms paired with redundant document requirements.	High; IT systems linked to structural performance indicators.	Fully integrated; exclusively digital, automated payment and control flows.
Stability of the Regulatory Framework	Low; recurrent modifications of guidelines during project implementation.	High; predictable rules negotiated at the beginning of the financial exercise.	Maximum; normative stability guaranteed through public management legislation.
Human Resource Management	Politicized at the hospital level; poorly compensated and unstable technical staff.	Professionalized; technical teams compensated at private market levels.	Professionalized; stability of the civil servant corps guaranteed by law.

Strategic directions and recommendations for the reform of absorption management.

1. For Romania to overcome its state of chronic underperformance in attracting European funds for the medical sector, a paradigm shift in public management is imperative. Three immediate structural interventions are required:
2. Expanding the Centralized Public Procurement Model. Public hospitals in Romania must be relieved of the technical and legal burden of individually managing major infrastructure and advanced medical technology projects. ANDIS must function as a true delivery agency, taking on the role of sole contracting authority for all investments exceeding a certain financial threshold. This would allow for the standardization of specifications, drastically reduce the risk of appeals, and achieve significant economies of scale with international suppliers;
3. Complete Digitalization and Debureaucratization of Financial Flows. It is urgent to completely eliminate redundant paper-based verifications and simplify control procedures by applying the principle of self-declaration, paired with sampling and risk-analysis-based auditing. IT monitoring systems must be interconnected with the databases of the Ministry of Finance and ANAF to ensure real-time payment traceability, reducing the expense reimburse-

ments that Romania's performance deficit in absorbing European healthcare funds is not a financial issue, but represents a systemic failure of institutional and public management. The massive allocations provided through the NRRP and the Healthcare Operational Programme risk being partially wasted—turning into financial corrections or unfinished projects—due to the chronic inability of the administrative apparatus to modernize itself.

Strategic fragmentation at the central level, weak administrative capacity, and a lack of experts at the hospital level, combined with domestic bureaucratic rigidity and the destructive interferences of local and central political partisanship, keep Romania in a state of underdevelopment regarding its healthcare infrastructure.

The comparison with models developed by Poland and the Czech Republic clearly demonstrates that success does not depend on the volume of funds, but on the intelligence of the management architecture: the centralization of complex procurements, the complete digitalization of processes, and the insulation of technical structures from daily political pressures. Without a courageous commitment to these structural managerial reforms, the Romanian healthcare system will remain trapped in a painful paradox: suffering from an acute lack of modern infrastructure while returning or blocking billions of euros in European budgets.

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