

THE FAMILY DOCTOR BETWEEN PROFESSIONALISM AND ENTREPRENEURSHIP: CHALLENGES AND PERSPECTIVES IN ROMANIA

CECILIA IRINA RĂBONȚU,
PROF. PHD., „CONSTANTIN BRÂNCUȘI” UNIVERSITY OF TÂRGU JIU, ROMANIA
e-mail: cecilia.rabontu@gmail.com

ISABEL RABONTU
RESIDENT DOCTOR, FAMILY MEDICINE SPECIALIZATION
e-mail: isabel.rabontu98@gmail.com

Abstract

Entrepreneurship is an intrinsic component of family medicine practice in Romania, given that the family doctor combines clinical responsibilities with those associated with organizing and administering an independent medical practice. This paper analyzes the dual role of the family doctor as both a medical professional and an entrepreneur, with emphasis on the interaction between professional values, managerial responsibilities, the economic sustainability of the practice, and population access to primary health care services. The research is descriptive and exploratory and is based on an analysis of the specialized literature, the institutional and regulatory framework, as well as secondary statistical data provided by the National Institute of Statistics (INS) and the National Health Insurance House (CNAS). The results support the existence of a hybrid professional identity of the family doctor, within which professional and entrepreneurial logic coexist and condition one another. The physician must ensure patient well-being, quality and continuity of care, and clinical decision-making autonomy, while simultaneously managing costs, human resources, infrastructure, revenues, and the financial sustainability of the practice. The analysis of the evolution of independent family medicine practices highlights a decrease in their number from 10,652 in 2020 to 10,266 in 2023, followed by a moderate recovery to 10,394 practices in 2025. Significant territorial disparities persist, however, with approximately 60.2% of practices located in urban areas and 39.8% in rural areas in 2025. Different entrepreneurial risk profiles associated with market entry are also highlighted, depending on whether the physician chooses to take over an existing practice or establish a practice from scratch. The results of the analysis suggest that the development of family medicine in Romania requires not only adequate and predictable funding, but also policies aimed at reducing territorial disparities, facilitating market entry and practice transfers, reducing administrative burdens, and developing physicians' managerial and entrepreneurial skills. In this context, entrepreneurship should not be viewed as being in opposition to medical professionalism, but rather as a complementary dimension which, under an appropriate institutional and regulatory framework, can contribute to practice sustainability, service accessibility, and improved quality of primary health care.

Keywords: family medicine; entrepreneurship; medical practice; primary health care; professional autonomy; Romania.

JEL Classification: I15, L84.

1. Introduction

Family medicine is the central pillar of primary health care and a major determinant of the efficiency of modern health systems. The specialized literature emphasizes the role of this specialty in ensuring equitable access to medical services, in coordinating care and in preventing diseases. However, in Romania, the functioning of the health system is characterized by a predominant orientation towards hospital services, to the detriment of primary medicine, which limits the overall efficiency of the system.

Recent analyses conducted by the Organisation for Economic Co-operation and Development highlight that primary health care in Romania is underdeveloped and underutilized, contributing to low screening rates, poor management of chronic diseases and avoidable hospitalizations. At the same time, the uneven distribution of human resources represents a major challenge: most doctors

are concentrated in urban areas, while rural areas remain underserved. Another critical aspect reported in recent literature is the aging of the professional body and the decline in the attractiveness of family medicine for new generations of doctors. Although significant progress has been made in recent decades in terms of health indicators, the performance of the system remains below the average of developed countries in terms of access, quality and financing of medical services.

In this context, family medicine in Romania is distinguished by a specific organizational model, in which most doctors work in independent practices. This model involves not only clinical responsibilities, but also management and entrepreneurial responsibilities, transforming the family doctor into an economic agent.

The specialized literature highlights the fact that this duality – clinical and entrepreneurial – is characteristic of decentralized systems and requires the development of managerial skills complementary to medical ones.

To function effectively in this complex environment, family doctors need to develop, in addition to clinical competencies, a set of essential managerial skills. First, financial management becomes indispensable, involving the ability to understand and manage budgets, operational costs and financing mechanisms specific to the health insurance system. Second, leadership and teamwork skills are necessary for the effective coordination of medical and auxiliary staff, as well as for managing conflict situations in a constructive way.

Strategic and systemic thinking also allows the family doctor to understand the role of the practice within the health system and the community, facilitating adaptation to legislative, economic and technological changes. Last but not least, quality management is an essential component, aiming to maintain high standards of patient safety and efficiency of the medical act.

At the same time, recent trends at European and international level indicate a strategic reorientation towards the consolidation of primary medicine, the digitalization of services and the increase in the efficiency of health systems. In Romania, these directions overlap with the need to adapt family medicine practices to a dynamic economic and legislative environment, which amplifies the role of entrepreneurship in medical practice.

The family doctor therefore occupies a hybrid position, balancing the professional vocation of medicine with the practical demands of running an economic entity.

2. Family medicine between profession and entrepreneurship

DeCamp and Snyder Sulmasy (2021), in the article “Ethical and Professionalism Implications of Physician Employment and Health Care Business Practices”, consider that in the operation of a family medicine practice, economic interests and business mechanisms are legitimate, but they should not subordinate the patient’s interests. They also show that financial incentives can produce different behaviors: fee-for-service payment may encourage the provision of additional services, while capitation payment may create the opposite incentive.

Pirouzi, Harwood & Scahill (2026), in the article “Exploring entrepreneurship among general practitioners: a scoping review of education and practice”, explain the dual role of physicians as both clinicians and business owners. Thus, the physician must simultaneously manage clinical activity and the financial, legal, operational and personnel complexity of the practice. In addition, many physicians enter this position without formal training in management, finance or entrepreneurship. A paradox therefore arises: in order to fulfill their professional mission, physicians must ensure the economic sustainability of the organization through which they provide medical services.

A relevant paper is “Physicians' entrepreneurship explained: a case study of intra-organizational dynamics in Dutch hospitals and specialty clinics”, in which authors Wout T. Koelewijn, Matthijs de Rover, Michel L. Ehrenhard and Wim H. van Harten (2014) interpret the transition of physicians toward entrepreneurial roles as a form of hybridized professionalism:

economic logic does not automatically replace medical professionalism; rather, elements of “business logic” are integrated into the existing professional logic.

In the case of the Romanian family doctor, hybridization is even institutionalized. The physician must simultaneously be a clinician, a contractual provider for the public insurance system, an employer, a resource manager, an administrator of the practice infrastructure, and the person responsible for the financial viability of the practice.

The entrepreneurial role of the family doctor can be both a source of conflict with the values of medical professionalism and a condition for exercising it autonomously and sustainably. For example, conflict arises when the physician must decide between allocating additional time to a complex patient and the need to maintain practice productivity. However, entrepreneurial competence can have the opposite effect as well: a well-managed practice, with sufficient staff, technology and stable financial resources, can allow the physician greater professional autonomy, not less. Thus, the family doctor may find themselves successively in the situations presented below.

Table 1. HYBRID PROFESSIONAL IDENTITY OF THE FAMILY DOCTOR

Professional logic	Entrepreneurial logic
Patient well-being	Practice sustainability
Quality of medical care	Efficiency/productivity
Clinical autonomy	Financial constraints
Equity and access	Costs and revenues
Time required for the patient	Time management
Continuity of care	Business continuity
Professional ethics	Economic rationality

In view of the above, practice management becomes the mechanism for reconciling the two logics. In this context, Romania becomes a very interesting case. In other systems, a family doctor may be an employee and may remain largely separate from the entrepreneurial function. In the Romanian independent-practice model, the physician is directly exposed to both logics: they must provide services in accordance with professional and contractual obligations, while simultaneously generating sufficient revenue for salaries, utilities, equipment, consumables, digitalization and the operation of the practice. This gives rise to situations such as role conflict, professional identity issues, autonomy, professional satisfaction, managerial skills, financial pressure, bureaucracy, the relationship with CNAS, personnel management and rural–urban differences.

3. Situation of family medicine practices in romania

From an economic perspective, the family medicine practice can be analyzed as a micro-enterprise that operates within a regulated institutional framework, with the public health insurance system as its main financier. The income structure is determined by a mixed mechanism, based on per capita payment and per service payment, which requires the doctor to adopt strategic decisions regarding the organization of the activity, the dimensioning of the volume of services and the efficient allocation of resources (Organisation for Economic Co-operation and Development [OECD], 2025). In this context, entrepreneurial skills – such as financial management, strategic planning, optimizing the use of resources and the ability to adapt to legislative changes – become essential to ensure the economic sustainability of the practice (Saltman, Rico & Boerma, 2006).

A central element of entrepreneurship in family medicine is the physician's decision-making autonomy. This is manifested in the possibility of organizing the work schedule, investing in infrastructure and technology, including the digitalization of medical services, as well as developing complementary services adapted to the needs of the community. Professional autonomy can favor innovation and increase the quality of medical care, but it is conditioned by the physician's ability to

reconcile economic objectives with the ethical and deontological principles of the profession (Starfield, Shi & Macinko, 2005). On the other hand, the exercise of entrepreneurship in this field is limited by a series of structural constraints. Significant dependence on public funding, a restrictive regulatory framework and a high level of administrative bureaucracy reduce decision-making flexibility and can inhibit entrepreneurial initiatives (OECD, 2025). In addition, legislative instability and financial pressures generated by increasing operational costs and the need for continuous investment transform the management of the practice into a complex process, characterized by uncertainty (European Commission & OECD, 2023).

Another relevant aspect is the impact of the entrepreneurial dimension on access to medical services. In rural areas or in disadvantaged areas, the reduced economic viability of practices can discourage entrepreneurial initiative, thus contributing to the perpetuation of inequalities in the distribution of health services (OECD, 2025). In this sense, the entrepreneurial decisions of doctors are influenced not only by economic factors, but also by the socio-demographic characteristics of the communities served.

Table 2. Evolution of independent family medicine practices in Romania

Year	Total practices	Change from previous year	Annual variation
2020	10,652	—	—
2021	10,470	−182	−1.71%
2022	10,444	−26	−0.25%
2023	10,266	−178	−1.70%
2024	10,299	+33	+0.32%
2025	10,394	+95	+0.92%

Source: National Institute of Statistics (INS), Activity of the health and health care network, 2021–2025 editions; INS TEMPO-Online, SAN101A; authors' calculations.

During 2020–2024, the number of independent family medicine practices in Romania recorded an overall downward trend. According to data from the National Institute of Statistics, their number decreased from 10,652 units in 2020 to 10,299 units in 2024, representing a reduction of 353 practices, or approximately 3.3%. The sharpest decline during the period analyzed occurred in 2023, when the number of practices decreased by 178 units compared with the previous year. In 2024, a slight reversal of the trend can be observed, with the number of practices increasing by 33 units.

Table 3. Evolution of family medicine practices by residential area

Year	Total independent family medicine practices	Urban	Rural	Urban / Rural (%)
2020	10,652	6,385	4,267	59.9% / 40.1%
2021	10,470	6,333	4,137	60.5% / 39.5%
2022	10,444	6,296	4,148	60.3% / 39.7%
2023	10,266	6,182	4,084	60.2% / 39.8%
2024	10,299	6,194	4,105	60.1% / 39.9%
2025	10,394	6,261	4,133	60.2% / 39.8%

Source: National Institute of Statistics (INS), Activity of the health and health care network, editions for 2020–2025; INS TEMPO-Online; authors' calculations.

The trend is interesting for the argument concerning the physician-entrepreneur. The number of independent practices fell from 10,652 in 2020 to 10,266 in 2023, i.e. by 386 practices (−3.6%). After 2023, however, a moderate reversal occurred: 10,299 in 2024 and 10,394 in 2025.

In 2025 compared with 2024, there were +95 practices nationally (+0.9%), of which +67 were in urban areas and +28 in rural areas. The proportion remains very stable, at approximately 60% urban / 40% rural. However, the numerical distribution of practices does not mean equal access. Data for 2025 indicate approximately 6.4 practices per 10,000 inhabitants in urban areas, compared with only 4.5 per 10,000 in rural areas. One practice serves, on average, approximately 1,561 inhabitants in urban areas, compared with 2,244 in rural areas.

Table 4. Equal opportunities in access to family medicine

Indicator	Urban / Rural	Implication for equal opportunities
Family medicine practices, 2024	6,194 / 4,105	Greater concentration in urban areas
Share of total practices	60.1% / 39.9%	Unequal territorial distribution
Residents/practice, 2023	1,608 / 2,232	The rural practice serves ~39% more residents
Change in practices, 2020–2024	−3.0% / −3.8%	Somewhat greater deterioration in rural areas
Geographical access	More favorable / More difficult	Distance may become an additional barrier

Source: authors' contribution

The problem becomes even more evident if we move from the number of practices to the actual number of physicians. CNAS reported, for the third quarter of 2025, the existence of 176 localities without a family doctor and without a branch office of a family medicine practice from another locality. This is a direct expression of territorial inequality in access.

The analysis of the family medicine network from the perspective of equal opportunities highlights the existence of significant territorial disparities between urban and rural areas. Although access to primary health care represents a right available to the population regardless of place of residence, the actual ability to use services is not evenly distributed. INS data indicate a higher workload for family medicine practices in rural areas, with one practice serving a significantly larger number of inhabitants than in urban areas. In addition, the existence of localities without a family doctor means that distance and transport availability become additional factors of inequality. Consequently, urban–rural disparities represent not only a problem of medical infrastructure distribution, but also one of equal opportunities for effective access to health services.

In 2026, this relationship becomes even more evident, because CNAS changed the funding structure: 25% per capita and 75% for medical services, compared with the previous model, which was more oriented toward payment for enrolled patients. From 2027, the planned ratio is 20%/80%.

CNAS data for the first quarter of 2026 highlight the dual nature of the family doctor's activity. On the one hand, the physician is a provider of medical services; on the other hand, they manage an economic structure that must ensure its financial sustainability. Based on the points actually achieved nationally and the values established for 2026, the funding corresponding to the per capita and per service components can be estimated at approximately RON 1.256 billion in the first quarter. Relative to the 9,050 contracts in force, this corresponds to an average benchmark of approximately RON 46.3 thousand per month per contract. This amount does not represent the

physician's personal income, but the gross revenue related to the contracted activity, from which the practice's operating expenses and tax obligations are financed.

4. Takeover/sale of a family medicine practice (praxis)

In Romania, taking over a family medicine practice (praxis) is a legal mechanism distinct from simply “buying a practice”. According to Order No. 1,322/2006, “praxis” does not mean only the furniture or equipment of the practice. It brings together the professional-use assets, the practice infrastructure, and the clientele represented by patients and other beneficiaries of the services. Retirement is expressly provided as a situation in which activity ends, while sale is one of the legal ways of taking over the activity of the practice.

The regulation provides that the activity may be taken over by a specialist in family medicine or by a health care unit specializing in family medicine that meets the legal requirements; after Romania's accession to the EU, takeover is reserved for physicians certified in the specialty of family medicine, in the organizational forms permitted by law. Law No. 95/2006 establishes the general principle: when the holder ceases activity, the existing practice may be taken over by another family doctor through the transfer of the professional-use assets. The new holder must inform the Public Health Directorate, the health insurance fund and the patients about the takeover.

Entering the Romanian family medicine market involves not only practicing medicine, but also assuming an entrepreneurial role, because the physician must organize and ensure the sustainability of their own practice. Essentially, there are two main ways of entering the market: taking over an existing practice and establishing a practice from scratch.

Taking over an existing practice allows the physician to enter an already functioning structure, which may have infrastructure, staff, organization, reputation and an established patient list. This option reduces the risk of the initial period, but involves the cost of acquiring the practice and the risk that some patients may choose another physician, because the patient list is not an asset over which the physician acquires a property right.

Establishing a practice from scratch involves a higher entrepreneurial risk. The physician must invest in infrastructure and equipment, organize the activity, hire staff and, above all, gradually build a patient list. During this period, the practice incurs operating costs even if the revenues generated through the usual funding mechanisms have not yet reached a level sufficient to ensure sustainability.

To reduce this entry barrier, the health insurance system provides support mechanisms for newly entering family doctors, with more favorable conditions for establishment in rural areas and, especially, in localities without a family doctor. Thus, the public financier temporarily assumes part of the risk associated with the period of establishing the practice and building the patient list. From an economic perspective, the choice can be summarized as follows:

TAKEOVER OF AN EXISTING PRACTICE

- **higher acquisition investment, but lower entry risk**

PRACTICE FROM SCRATCH

- **no acquisition cost for the practice, but higher risk in building the patient base and achieving sustainability**

Therefore, market entry for a family doctor represents both a professional and an entrepreneurial decision. The physician must assess not only the professional opportunity and the needs of the population, but also the potential size of the patient list, location, initial investment, operating costs, staff availability, financing mechanisms and the practice's capacity to become economically sustainable. This stage clearly highlights the dual identity of the family doctor: medical professional and entrepreneur.

5. Conclusions

The analysis shows that entrepreneurship in family medicine is not a secondary dimension of professional activity, but an intrinsic component of the organizational model of primary health care in Romania. The family doctor who works in an independent practice simultaneously performs the role of medical professional and manager of an economic entity, being responsible both for the quality and continuity of patient care and for the financial and organizational sustainability of the practice.

This duality supports the existence of a hybrid professional identity, in which professional and entrepreneurial-managerial logic are not necessarily antagonistic. Patient interests, clinical autonomy, quality of medical care and ethical principles coexist with the need to manage the practice's costs, personnel, investments, time and revenues. Under these conditions, entrepreneurial skills may constitute not only a source of pressure on the physician, but also an instrument for protecting professional autonomy and creating the conditions necessary for providing quality medical services.

From an economic perspective, the major dependence of practices on public funding and the change in the payment structure emphasize the need for managerial skills. The shift toward a higher share of fee-for-service payment strengthens the link between the activity actually provided and the practice's revenues, which may influence the organization of activity, time and resource management, and the economic strategy of the practice. It is therefore necessary to maintain a balance between economic incentives and the principles of medical professionalism, so that efficiency objectives do not prevail over the patient's interests.

Another relevant dimension is the market entry of new family doctors. Taking over an existing practice and establishing a practice from scratch involve different entrepreneurial risk profiles. Taking over a practice facilitates access to an already functioning structure and an established patient list, but requires an initial investment to acquire the practice. Establishing a practice from scratch eliminates this acquisition cost, but transfers to the physician the risk associated with building the patient list, making initial investments and reaching a level of activity that ensures economic sustainability. Support mechanisms for newly entering physicians, especially in underserved rural localities, are therefore important instruments for reducing entry barriers.

In conclusion, the family doctor in Romania should be viewed not only as an individual provider of medical services, but as a professional-entrepreneur who manages a medical organization in a highly regulated market dependent on public funding. The viability of the practice and the quality of medical care are, from this perspective, interdependent. The challenge for public policy is to create a framework in which entrepreneurial initiative and economic sustainability support, rather than compromise, professional autonomy, equitable access and the patient's interests.

In this regard, strengthening family medicine requires not a choice between professionalism and entrepreneurship, but the development of a model in which the two dimensions complement one another. The physician's ability to integrate clinical competencies with managerial ones may become one of the determining factors of practice sustainability and, implicitly, of the performance of primary health care in Romania.

6. References

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