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Analysis of National Health Strategy 2014-2020

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Abstract. *Health affects us all, so healthcare should involve us all. Health service providers have a duty to empower people to become more involved in their own healthcare, and in how services are delivered.*
National Health Strategy 2014-2020 is a proof of the commitment decision makers in the industry and the Government in its entirety to ensure and promote health as a key determinant of society development and socially inclusive, territorial and economic as an engine of progress and prosperity of the nation and not as a burden. It is a tool framework to allow articulation farm to the European context and strategic directions set out in the Europe Strategy 2020.
This study focuses on analyzing national health strategy and attempt to identify the key factors leading to the success of this strategy. Conclusions we reached in this paper led toward hypothesis that it is imposed involvement and responsible action of the institutional actors and professionals in achieving the proposed goals, from service providers and local health authorities and to the central structures involved in the current paradigm change in the health sector to one that better match the direction towards modernity, progress and development who wants Romanian society.

Keywords: Public health, health outcomes, responsiveness, equity and financial protection, financial sustainability.

JEL Classification: I18, H44, O38.

1. The current situation of the health sector in Romania

Accession to the European Union has made health and health services in the countries of the European Union to become the reference framework for citizens of Romania. Meanwhile, a new challenge is made by the health sector employment, freedom of movement gained with EU entry emphasizing the gap with existing predicament, when Romania was almost a third less health care in 1000 inhabitants, compared to the EU average, with the lowest number of doctors, dentists, nurses and pharmacists, reported the population of the EU. Romanian health system continues to rely on the hospital care as the main method of intervention, Romania still is one of the highest recorded rates of hospitalization in the EU and one of the highest in the world.

Although the financial efforts of the Romanian state grew significantly, both in absolute numbers and percentage, almost all revenue and expenditure doubling in the last four years for almost all categories of medical services, feeling short comings in the system continues to persist and worsen. Inefficient health system still responds major health problems of Romanians current model focusing on curative care and mainly on the hospital at the expense of outpatient and primary care.

Attempts to reform the hospital there were in previous years, but unfortunately, none of the projects started has been finalized. “An evaluation committee reviewed the health ministry for three months stage investment program, as well as their opportunity, given the current coverage of hospital services and the present condition of the buildings in which they operate hospitals.

The Commission has received advisory support of a technical team from the World Bank. The report’s findings show that in Romania, both at national and regional level, the number of beds per 1000 population is well above the European average, the number of hospitalizations per 100 inhabitants is also above the European average, and the time required rehabilitation and modernization of the sanitary unit is approximately 150% higher than the building and the equipment necessary medical and non-medical hospital with the same number of beds.” (www.who.int/governance/eb/who_constitution_ en.pdf, accessed on 19th of June 2014).

The National Health Strategy 2014-2020 has as a main base “equitable access to essential services, cost-effectiveness, evidence substantiation optimization of health services, with emphasis on preventive services and interventions, decentralization, partnership with all actors that can improve health.”(www.who.int/governance/eb/who_constitution_en.pdf, accessed on 19th of June 2014)

From the point of view of health condition, the Romanian population presents some of the most unfavorable indicators across the European area, not just in the EU. Data morbidity and mortality a mix of specific indicators developed countries cardiovascular mortality, growth of neoplastic diseases with specific indicators in May especially in developing countries, as well as the resurgence of infectious diseases.

Thus, although a slight improvement, the average life expectancy 71.7 years continues to be among the lowest in the region. Mortality ratios infant and maternal mortality, which

have a strong correlation with the performance of the health still places Romania on the last in the European Union.

The main causes of death in Romania are represented by cardiovascular diseases, followed by tumors, digestive diseases, injuries, poisoning and respiratory diseases. Note that unlike the tendency to reduce cardiovascular mortality in western EU in Romania there is a strong tendency to increase it. Regarding the deaths attributable to malignant disease, even if their frequency is below the EU average is avoidable deaths such as those noted in cervical cancer, something that is a direct indicator of the inadequacy of the health system to the real needs of the population.

It can thus be Romania finds that patterns of morbidity and mortality have undergone important changes in recent decades to increase the prevalence of chronic disease and mortality from these causes, in the context of increasing the share of elderly population with multiple action associated factors biological risk, environmental, behavioral and socio-economic impact of nursing.

EU analysis on avoidable deaths due to health system show, according to the two graphs below that Romania ranks first in the EU, at mortality in women and men. Moreover, the trend in this area is decreasing significant in all other EU countries, in Romania it is either reduced or stationary.

The performance of the health sector in Romania can be measured on four different dimensions:
- Health outcomes;
- Responsiveness to beneficiaries;
- Equity and financial protection;
- Financial sustainability.

The functional analysis identified significant problems in all four areas. Even though significant progress has been made concerning the targeting system to this view, many of the features of the old system remain and have not been created some vital skills to enable the new system to work effectively.

Theoretically, the main responsibility of the Ministry of Health is to develop policies health at national level to regulate the health sector to establish organizational and functional standards and improve public health. In practice, Ministry and the 42 county public health departments continue to be responsible for operation of public hospitals and are deeply involved in financing activities based on advanced technology in the industry through an abnormally high number of National Health Programs.

These responsibilities distract Ministry of Health of the need to strengthen its capacity in policies and regulation and, therefore, its unit staffed policy and insufficient quality regulation is almost non-existent.

Network delivery of health services is strongly polarized by the assistance under hospitalization. The legacy of the communist period included a large number of hospitals and hospital beds that were operating in a fragmented structure and development insufficient to different levels of care. Romania has a high rate of hospitalization. Even if

government policy established during the last decade has been to reduce recourse to hospital services and increased use of family physicians and outpatient services have been little progress to date in the implementation of this change.

Health insurance system administered by the National Health Insurance (CNAS), a quasi-independent central body, with 42 houses county insurance health, responsible for contracting services to healthcare providers. Starting on January 1, 2004, contributions were collected centrally by a special body of the Ministry of Finance and Insurance county homes health are only responsible for receiving contributions from people self. Although almost the entire Romanian population of 22 million inhabitants has the right to benefits, but an estimated 11 million people do not pay insurance contributions Health, either because they are formally exempt payment (including pensioners, the unemployed, prisoners, military personnel, people on sick leave or maternity and pupils / students) or because operating in the black labor and do not contribute. For those legally employed, the overall contribution rate insurance, calculating employers and employees together, is currently 11% of the salary of a taxpayer. It is relatively low.

Below is the legislative cadre for health sector from Romania: Within 8 years, for example, the health reform law no. 95/2006 was amended 48 times, mainly through secondary legislation, ad hoc, last moment (see Table 1). More importantly, the use of secondary legislation has become more rather than the exception, most recently in an attempt to override laws Parliament approved or implement new laws without waiting for approval Parliament (World Bank, 2010, p.14).Legislation ad-hoc, last minute, prevent and stakeholders in contribute to health policy development, and therefore limited able to reach consensus necessary to ensure the successful implementation of health reforms.

Table 1. Amendments to Law no. 95/2006

1.	correction published in the Official Gazette of Romania, Part I, no. 391 of May 5, 2006
2.	Government Ordinance no. 35/2006
3.	Government Ordinance no. 72/2006
4.	correction published in the Official Gazette of Romania, Part I, no. 823 of 6 October 2006
5.	Government Emergency Ordinance no. 88/2006
6.	Government Emergency Ordinance no. 104/2006 * rejected by Law. 284/2007
7.	Government Emergency Ordinance no. 122/2006 * rejected by Law. 147/2007
8	Government Emergency Ordinance no. 116/2006
9.	Law no. 34/2007
10.	Government Emergency Ordinance no. 20/2007
11.	Law. 147/2007
12.	Law. 264/2007
13.	Government Emergency Ordinance no. 90/2007
14.	Law. 281/2007
15.	Law. 284/2007
16.	Law. 388/2007
17.	Government Emergency Ordinance no. 93/2008
18.	Law. 157/2008
19.	correction published in the Official Gazette of Romania, Part I, no. 608 August 15, 2008
20.	Government Emergency Ordinance no. 170/2008
21.	Government Emergency Ordinance no. 162/2008
22.	Government Emergency Ordinance no. * 192/2008, repealed by Ordinance a Government no. 226/2008 (# M24) and rejected by the Law no. 121/2009

21.	Government Emergency Ordinance no. 162/2008
22.	Government Emergency Ordinance no. * 192/2008, repealed by Ordinance a Government no. 226/2008 (# M24) and rejected by the Law no. 121/2009
23.	Government Emergency Ordinance no. 197/2008
24.	Government Emergency Ordinance no. 226/2008
25.	Government Emergency Ordinance no. 227/2008
26.	Law. 121/2009
27.	Government Emergency Ordinance no. 69/2009
28.	Government Emergency Ordinance no. 88/2009
29.	Government Emergency Ordinance no. 104/2009
30.	Law. 329/2009
31.	Government Emergency Ordinance no. 114/2009
32.	Government Emergency Ordinance no. 1/2010
33.	Law. 11/2010
34.	Law. 91/2010
35.	Government Emergency Ordinance no. 48/2010
36.	Government Emergency Ordinance no. 58/2010
37.	Government Emergency Ordinance no. 72/2010
38.	Law. 165/2010
39.	Government Emergency Ordinance no. 82/2010
40	Government Emergency Ordinance no. 107/2010
41.	Government Emergency Ordinance no. 117/2010
42.	Government Emergency Ordinance no. 133/2010
43.	Law. 276/2010
44.	Emergency Ordinance no. 32 of 23 March 2011
45.	Law no. 194 of November 7, 2011
46.	Emergency Ordinance no. 71 of November 20, 2012
47.	Order no. 1503/1009 of December 11, 2013
48.	Order no. 648/406 of June 3, 2014

For the purposes of this strategy, responsibility is defined as the relationship standing of the entity to which it is responsible, for example, health authority, and the responsible entity, for example, the manager. "Quality is defined in terms of access, efficiency, capacity, safety and focus on the patient" (Leatherman and Sutherland, 2005).

"It involves the entity responsible should give account of how to use public resources and actions that the undertaken to meet the goals that are requested. May also involve, and the entity to which it is liable is tasked to impose sanctions and apply them when necessary." (Dixon et al., 2010, pp. 82-89).

Responsibility is interpreted increasingly more as a tool essential to improve health system performance in that it reduces abuse and ensure compliance with procedures and standards (Brinkerhoff, 2004, pp. 371-379).Across the world, governments feel the need clearly locate responsibility for their actions (Tuohy, 2003, pp. 195-215).

Crisis of current financial help increase accountability detection and therefore reduce waste or misuse of resources, malpractice or negligence. "In addition, a good stewardship involves ensuring that the mechanisms determining the responsibilities are correct and do not exclude certain groups" (Travis et al., 2002).

2. Responsibility relationships in the Romanian health system

Our first remark was that the system is intuitive too complex, which interviewees confirmed by national and local hospitals. We had group discussions with representatives from county to county public health authority, you county council, town hall and the home county health insurance, as well as hospital managers. In these discussions, our question "Who is the owner/the head of health units? The answers were different, and even contradictory, reflecting a low level of understanding about who is responsible for what. Based on these findings, the National Health Strategy 2014-2020 has been developed that can be used as a starting point in improving the functioning of the health system in Romania.

3. The actors identified in the National Health Strategy 2014-2020

For implementation of the National Health Strategy, the Ministry of Health will collaborate with other partners from inside of health system: National Health Insurance House, College of Physicians from Romania, Institutes of Public Health, County Directorates of Public Health, professional associations, non-governmental organizations active in health domain; and with partners from outside of health system: Ministry of Public Finance, Ministry of Environment, Ministry of Education and Research, Ministry of Agriculture, Forests and Rural Development, Ministry of Labor, Social Solidarity and Family, Ministry of Transport, Ministry of European Integration, Ministry of Justice, Ministry of National Defense, Ministry of Administration, non-governmental active in other domains than health domains.

4. Strengths of the National Health Strategy 2014-2020

We can consider strengths: the new Law on healthcare reform, the relatively high number of service suppliers for each type of medical care and the existence of medical centers of excellence which leads to an inflow of patients, regardless of the area they live in.

The analysis started drafting the National Strategy for the analysis of relevant data on demographic indicators, health indicators of the population, material, human and financial. The analysis also took into account information provided by local authorities, which are closest to citizens and better knowledge of local needs and consultations with representatives and beneficiaries of the health system.

Developing this strategy is essential in obtaining structural funds for health, which is a first, given that health has not received the financial year being able to access European funds. Primary objective of the strategy is to improve health population, and this should be reflected in increased life expectancy, preventing and reducing illness and therefore the quality of life.

Paper presented chasing three major strategic areas, namely: public health - the manner in which address key public health issues; health services - how shall ensure access to services and optimization services offer their award levels; measures cross - sectoral approach involving impacting the health system, including institutional capacity at all levels and investment needs, such as those in information systems and infrastructure. In public health, the National Strategy puts prevention as a priority that will underpin the whole approach in the field. Prevention is found in all parts of the strategy.

A first main direction in public health to reduce the incidence of untransmisible which is currently the major causes of morbidity, disability and mortality, such as cardiovascular and cerebro-vascular diseases, cancer, digestive diseases, respiratory diabetes. This will be achieved through measures such as risk assessment and active surveillance of the population through primary prevention services, early stage disease detection and intervention of organized population screening (secondary prevention) expansion and diversification of services that can be offered the family medicine and specialist access to diagnostic and treatment procedures in interventional cardiology, cardiovascular surgery.

Another course of action refers to reducing mortality and morbidity due to communicable diseases, their impact on the individual and society, and long-term reduction in the incidence of targeting them. In this area, the Strategy aims to ensure national immunization program performance and recovery of national vaccine production capacity, maintaining adequate rates of detection and successful treatment for tuberculosis, treat as public health priorities of hepatitis B and C, by the action coordinated and consistent in this area, keeping the Romania country profile with reduced incidence of HIV through comprehensive measures for prevention and mitigation Other priority areas The Strategy highlights the public health chapter are improving health and nutrition of women and children, mental health and rare diseases.

Components are grouped into five strategic objectives of the Ministry of Health multiannual plans: National Plan for Prevention; The National Oncological Disease Control; National Plan for control of diabetes; The National Cardiovascular Disease Control; National Plan for Rare Diseases.

The *opportunities* of this strategy are the following:

- Possibilities to diversify products of medical services;
- EU membership requires the adoption of standards and recommendations that are aimed at increasing the efficiency and quality;
- Interest in public-private partnerships;
- Continuous development and improvement of health sector financing;
- Conducting laboratory consulting services;
- The possibility of attracting structural funds to finance the rehabilitation, modernization and equipping of health;
- Agreement and support of the Ministry of Health and Local Authorities Implementation of private health insurance as a result beneficial.

5. Weaknesses of the national health strategy 2014-2020

First one is the necessity of increasing the financing level of the Romanian health care system. According to some interviews taken to policymakers in the healthcare field, the transition to the new system was performed without a very clear analysis of the implications of various European models in the Romanian context and it has rather consisted of preferences of clerks and officials within that government for the German health care insurance model. In fact, during the period following the ’89 moment, in Romania there were not many trained specialists in the health care management or health care policies field.

The lack of an unique built-in information system interconnecting all medical services suppliers as well as the institutions with responsibilities in health insurance, allowing a better management of available funds and, at the same time, providing an "intelligent" method to store data that would lead to a database allowing long term synchronic and diachronic analyses and forecasts that would increase system adaptability to the real needs of people.

There is a lack of real financial and managerial autonomy, impairing all major aspects of the activities of qualified institutions within health care system, from functional organization, to collection, financing, contracting, settlement, information and others.

There is high incidence of contagious and chronic diseases. The low living standard and the lack of information are some of the reasons why statistics rank us among the “foremost” as regards severe contagious diseases such as AIDS, syphilis, TB, Hepatitis C or chronic diseases such as diabetes. This also leads to an increase of pressure over the system, i.e. the continuous increase of medical services demand following the constant deterioration of population health condition.

The incidence of problems related to the ignorance of services related to family planning, a problem with multiple consequences, from the large number of abortions due to the lack of information, thus problems that are not only related to health but also to demographic aspects, to STDs.

Inefficient health system still responds major health problems of Romanians current model focusing on curative care and mainly on the hospital at the expense of outpatient and primary care. With half the population living in rural areas where hospitals are practically nonexistent function, this lead to major problems in the availability of basic health services. Financing the health system continues to be inadequate and used in an inefficient way.

Despite an increase in total health expenditure share of GDP, the level of funding health system in Romania remains low in a European context, especially given long period of chronic underfunding and lack of investment in health. In addition to underfunding is can speak of an arbitrary use of resources; allocation of resources between different regions, between different types of health services and between health care is inefficient and unfair. Do not be achieved using cost-effectiveness studies for allocation resources; their allocation is not transparently and not based on clear and consistently used. This situation

coupled with a lack of clear and consistent criteria performance in the health institutions make it difficult to implement systems effective management effective managers reward

There is a limited access, marked by inequities in health service quality, the main differences emerging between rural and urban. Crude death rate was rural almost 2 times higher than in urban areas, both because of a higher degree population aging, but also because of deficiencies in providing health services necessary. Providing rural population with doctors is over 3 times lower than average rate of physicians in urban areas, with nearly 100 locations with no doctor. At the same time, there are important regional differences in coverage areas worst covered by medical personnel in rural areas are the North and East. Two-essential elements of any model of good practice for the purposes of policy development are: Policies should be based on solid evidence (or at least to find the source of information in evidence). There must be a process of policy formulation and systematic official to include stakeholders. Romania has a regulatory basis for policy-making process. As in other areas, however, the quality of health policy making remains low compared to other EU countries and health policies are rarely based on solid evidence. Policies are not based on the analysis of qualitative data in the field. No CNAS and no other major stakeholder does not contribute data or evidence in the decision making process and the data are not sufficiently used in the negotiation of the National Framework Contract.

Any unit, department or division within the Ministry of Health is not responsible for health data analysis. The 30 strong units of analysis devotes special CNAs verification of financial information submitted by healthcare providers. This absence of any formal process, systematic policy formulation has various adverse effects, including stimulating a sense of instability in the sector. Human resource management in the health sector is weak, while the compared with European countries to ensure the population of Romania with doctors and nurses health is below European averages. Besides the uneven territorial distribution medical staff and failure is also noted particularly for specialized personnel preventive sectors, medical, social, public health and health care management, inadequate weight support staff, medical staff focus on urban and in hospitals.

Other problems relate to the lack of incentives for choosing a medical career and support young specialists, poor organization of training and postgraduate doctors, low wages and lack of connection between performance medical and official income etc.. All this reveals major dysfunction in the planning process and training of medical personnel aspects of several institutions which have coordinated policies consistent field. Simultaneously, the educational model of health is poor performance, none of the Romanian medical institutions not being in top 500 in the world, none of the existing major rankings

Another problem is the lack of integration of health services under the so as to ensure continuity of care. The health system in Romania works the sectors independent of each other. Primary care has functional links with the hospital, and the health promotion and disease prevention with the curative. The model requires no specialized services and lead interdisciplinary teams he not including patients in an integrated approach. Incentive scheme in operation no encourages any integrated approach to care, and this will only be detriment of the patient. In the context of long-term care facilities, care at the home, as

well as social services are poorly developed and there is thus a viable alternative part of hospital services that may be taken as more efficient institutions.

Poor management of health information when there are multiple parallel systems of coordinated and controlled by different owners (Ministry Public Health and subordinate units, the National Health Insurance, hospitals, private clinics, research institutes and education), accompanied by the absence of standards (definitions, indicators, encodings, lists) led to duplication reports on the occurrence of inconsistencies of data loss or inaccessibility of information, with a major impact on the functionality of the health system. Lack of functional health information makes impossible the existence of a viable insurance quality health services at all levels of health care.

Inter-sectoral collaboration is inappropriate, relevant and high levels of determinants other than health that negatively impact the health of population in Romania and which programs is developed and effective action. Below there are the threats of this strategy:

- The risk of failure due to the development strategy of subjective conditions;
- The risk of decreased number of patients with demographic decline;
- The interruption of supply due to reduced credibility of suppliers due to the existence of historical debt;
- Reducing the number of beds nationally;
- Social with child abandonment cases in hospital;
- Free movement of persons and facilities created after Romania joined the European Union to fill jobs induce migration risk personnel, especially of highly qualified and efficient;
- Labor migration of young;
- Increased collateral costs induced either by covering the treatment of rare, but very serious, either because the policies applied by some distributors of medicines lack of specific training in healthcare administration at the local;
- Increasing the pressure of the aging population on the workforce and the state pension system.

Conclusions

There are five main financing methods of health care systems: financing from the state budget; financing through social health insurance; financing through private health insurance; financing There are two aspects that must be emphasized: first, in many cases, there are many financing sources of health care expenses; secondly, none of these methods is ideal and cannot provide a magical solution to solve the severe problems the health care financing confronts with, especially in poor countries through direct payments; community financing. Each of them presents their own characteristics. Leading ability is reflected in the ability to transform strategic vision of evidence-based policy well considered and effective. Most developed countries and international organizations have turned their attention in the last decade the development of standards and strategies to create better policies. To improve evidence-based policy making from the health sector in Romania, a team in the Ministry of Health could bring together

epidemiologists, public health specialists, economists, statisticians, operational researchers and sociologists, together with other experts They may also contact CNAS and could benefit from the contribution of the National School of Public Health, National Institute of Public Health and other institutions. Romanian healthcare system manages to respond just to a certain extent to current needs and expectations of the population, while facing mainly managerial, structural and financial problems. There are multiple causes and many alternatives, it need to fight against corruption, politicization, incompetence and inefficiency specific to health system now, along with an efficient use of available resources, motivation of medical personnel and professionalizing the health management, assert by their importance as a basis for modernization and sustainable development of Romanian healthcare system on long term. Further qualitative studies on patients, health professionals and decision-makers would be useful to augment this information and allow documented, evidence-based decisions for next health reforms.

Strategic responsiveness proposed for healthcare sector expresses a differentiation and adaptation driven by demand from environment, and from this perspective we are able to examine a variety of strategic organization behaviors for example, whether a health institution anticipates or reacts to discontinuities in the environment. The management of this kind of university is able "to work today for tomorrow".

References

Allen, R. and Tommasi, D. (eds.), 2002. *Administrarea cheltuielilor publice.* Pro Transilvania. Bucharest.

Androniceanu, A., 2008. *Noutati in management public.* Third edition. Universitara. Bucharest.

Ansoff, I. and McDonnell's, E.J., 1990. *Implanting Strategic Management*. Prentice Hall. New York.

Bartoli, A., 1997. *Le managements dans les organisations publiques.* Dunod. Paris.

Barzelay, M., 2002. *The New Public Management.* University of California.

Brinkerhoff, D., 2004. Accountability and health systems: toward conceptual clarity and policy relevance. *Health Policy and Planning*. 19(6). pp. 371-379.

Dixon A., 2010. The Accountability Maze in the Reformed NHS: The experience of foundation trusts, *Journal of Health Services Research and Policy.* www.kingsfund.org.uk/.../ Liberating%20the%2.

Dobrotă, N., 1999. *Dicţionar de economie.* Economică. Bucharest.

Fayol, H., 1949. *General and Industrial Management, Original work published in 1916 with the title: "Administration Industrielle et Générale".* Pitman. London.

Galbraith, J.K., 1982. *Ştiinţa economică şi interesul public.* Politică. Bucharest.

Harvey, L., Locke, W. and Morey, A., 1997. *Enhancing Employability, Recognising Diversity.* www.qualityresearchinternational.com/

Kevin P. Kearns, 1998. Institutional Accountability in Higher Education: A Strategic Approach, *Public Productivity and Management Review* (Lead Article). Vol. 22. No. 2.

Lane, J.E., 2000. *The Public Sector, Sage Publications.* London. Thousand Oaks. New Delhi.

Leatherman, S. and Sutherland, K., 2005. *The Quest for Quality: a Chartbook on Quality of Care in the UK, London* The Nuffield Trust.

Parlagi, A., 2000. *Dicţionar de administraţie publică.* Economică. Bucharest.

Peters T.J. and Waterman, R.H. Jr., 1982. *In Search of Excellence: Lessons from America's Best-Run Companies*. New York. Warner Books.

Popescu, L.G., 2011. *Strategic Responsiveness and Market Repositioning in Higher Education.* LAP Lambert Academic Publishing.

Provan, K.G. and Milward, H.B., 2001. *Do Networks Really Work? A Framework for Evaluating Public-Sector Organizational Networks.* Public Administration Review. Vol. 61. Issue 4.

Sidney G. Winter, 2003. *Strategic Management Journal, Special Issue: Why is there a resource-based view? Toward a theory of competitive heterogeneity.* Vol. 24. Issue 10.

Teece, D.J., 1997. *Dynamic capabilities and Strategic Management.* Oxford University Press.

Travis, P., Egger, D., Davies, P. and Mechba, A. 2002. *Towards better stewardship: concepts and critical issues.* Geneva: OMS. http://www.who.int/healthinfo/paper48.pdf, accessed on 19.06.2014.

Tuohy, C. 2003. Agency, Contract, and Governance: Shifting Shapes of Accountability in the Health Care Arena. *Journal of Health Politics, Policy and Law.* Vol. 28. No. 23. pp. 195-215.

Weber, M., 1922. *Wirtschaft und Gesellschaft. Mohr*: Tübingen. Germany.

World Health Report, 2000. *Health Systems: improving performance.*

World Bank, 2010. *Romania. Functional Review Center of Government Final Report.*

ec.europa.eu

www.globalqualityvillage.com

www.ms.ro

www.oxfordjournals.org

www.praxiom.com

www.who.int