Sabina Stan (DCU, Ireland) Moralities of care, accumulation by dispossession and the re-definition of informal exchanges in Romanian healthcare

The paper looks at widespread wrongdoing in Romanian healthcare in the form of informal exchanges (or 'petty' corruption) between patients and healthcare personnel. It argues for the need to understand these practices in the larger context of Romania's turn to a neo-liberal pathway of development after 2000. In doing so, the paper proposes to see informal exchanges in healthcare as articulating diverse 'moral economies' (Thompson 1971) and processes of accumulation by dispossession (Harvey 2004) following healthcare privatisation.

In contemporary neoliberal perspectives, wrongdoing in the form of corruption is essentially framed in terms of the opposition between the state and political elites on the one hand, and civil society, the market and consumer-citizens on the other. Political elites are constructed as inherently prone to corruption, while honest (middle-class) citizens and market actors are seen as opposing corruption by demanding the rule of law, private property and market behaviour (Stan 2012). In this view, anti-corruption campaigns are the crusade of civil society against parasitic, non-market clientelistic relations (Sampson 2005). The solution to corruption is, therefore, the extension of the realm of the market and the reduction of the realm of the state. The implicit opposition proposed in this view is that between two moralities: the morality of transparent and autonomous exchanges of the market, and the morality of opaque, power-based exchanges involved in corruption.

Critiques of the neoliberal transformation of healthcare have drawn on the opposition between market and non-market relations but have inverted the values they attached to the two terms. In medical anthropology, Kleinman saw caregiving as a moral experience close to gift-giving, which thus runs 'counter to the infiltration of the market model into even the most intimate parts of healthcare' (2013:5). While opposing what he sees as valuable non-market, reciprocal exchanges involved in care giving to corroding market exchanges in the delivery of healthcare, Kleinman also highlights the centrality of morality in the experience of care.

I would like to bring three caveats to this opposition, which, I think, would help us push the discussion on the moralities of exchanges taking place in healthcare further. First, it is not only non-market exchanges but also market ones that have moralities, as actually existing markets have always been embedded in various 'moral economies' (Thompson 1971). Thompson has shown that, during the 18th and 19th centuries' England, markets passed from 'the old moral economy of provision' to 'the new political economy of the free market' (1971: 136). But while the new political economy was disinfested of the 'intrusive moral imperatives' (1971: 90) of the old moral economy, it was not in the least moral-less. Rather, it invoked moral judgments on what constitutes desirable market exchanges, which were different from those previously prevalent in the traditional moral economy.

This also means that markets modelled after the ideal of the free market may be valued by various social groups according to various, and sometimes opposing, moralities. More particularly, subordinate groups may sometimes propose views of the free market that are contradicting the moral

claims of its defenders. Thompson's crowd, for example, embraced a moral economy that saw free markets as leading to less rather than more transparency. Fast forward to the end of the 20th century, this was also the case during the post-socialist transformation of former soviet countries towards the free-market (Mandel and Humphrey 2002). In Bulgaria, for example, some social groups experienced the market as a regime of power rather than of freedom, as it has brought a reduction in economic freedom as compared with the state-dominated system of socialist times (Kaneff 2002: 47).

Second, as economic anthropologists have long known, non-market exchanges may be reciprocal but also redistributive (Polanyi 1968) and thus involve not only equal relations (in reciprocal exchanges), but also un-equal ones (in redistributive exchanges). In fact, the 'moral economy of the English crowd in the 18th century' studied by Thompson (1971) centred on provision and paternalism, and thus on what we could call a morality of redistributive justice of the fair price. This morality has been echoed in post-socialist redistributions of collective land, when sections of the population invoked a 'distributive justice' rooted in the use (labour) of land during the socialist period rather than a 'repairing justice' rooted in pre-socialist property rights (Maurel 1995). In the area of healthcare, redistribution may be in fact relatively more important than reciprocity, as when healthcare services involve state redistribution of public services and doctors and patients engage in (usually unequal) informal exchanges.

In fact, we may go even further as see, with Parry (1986), the gift's relation to the imperative of reciprocity as being expressed to different degrees and in different ways in different historical contexts. In egalitarian societies, as gift giving also fills in political functions of redistributing scarce material resources among members, this imperative is strong and translates in Mauss' (1973) classical obligations of giving, receiving and giving back. In contemporary capitalist societies, where the state takes over these functions and where the individual is see as acting freely on the market, the gift is imbued by a parallel ideology of the pure, altruistic, free gift. Kleinman's view of care as altruistic gift giving has therefore to be situated in its historical context. However, if, following the discussion above, we consider moralities of market exchanges to be plural, we may expect moralities of gift exchanges to be plural as well – and this even in contemporary capitalist societies. One source of plurality could be the fact that gifts may be not only altruistic, but also sometimes involve 'predatory' exchanges in which the gift is, to begin with, taken or at least claimed, rather than given freely (Beaucage 1995).

Third, moralities and practices of exchange might diverge. As Thompson showed, during the 19th century the new economy of the free market worked following not so much, or not solely, the so called 'market laws' of supply and demand, but many times opaque interventions from various intermediaries willing to create shortages (1971: 91-94). As a result, the rise of the new economy led to markets becoming less rather than more transparent (1971: 93). As we live in a moment similar to the one analysed by Thompson, whereby free markets have been increasingly promoted as a model of social relations, claims to a morality of transparency in contemporary market exchanges put forward by neoliberal proponents might

similarly not be bore by empirical evidence.

This brings us in turn to re-consider the larger aim that we might wish to follow in using moralities as an analytic tool. Moral economies point us to the ways in which various groups of people normatively conceive of the manner in which various resources are to be exchanged in various areas of social life. But just acknowledging that different groups of people have recourse to different moralities is not enough. While moralities orient practices, we nevertheless also need to ask how different moralities co-exit and what are the processes that lead to a change in the configuration of practices of exchange and of the moralities that guide them. Moreover, as exchanges not only involve moralities but also lead to resources flowing in certain directions (i.e. in the hands of certain groups) rather than others, we should also inquire into the links between these changing configurations of exchange practices and moralities, on the one hand, and the distribution of resources among various groups in society, on the other.

Gupta offers an interesting analysis of the link between corruption and social struggles around distribution that could help us, I think, start to address these questions. He argues that, in the Indian case studied by him, the degree to which discourses of corruption and accountability become politically significant depends not only on pressures from obvious defenders of the free-market (most notably global organisations such as the World Bank or Transparency International), but also on the degree to which groups affected by corruption organise themselves at national, regional and local levels. For example, in the case of 'routinized practices of retail corruption', he (Gupta 2012: 99, 100) finds that urban, middle-class political activism at a national level and agrarian mobilisation at a regional level were important for making corruption and clean government an important political issue. Moreover, Gupta (2012: 99) invites us to understand these struggles in terms of the way citizenship came to be defined in India's populist democracy, as 'principally about inclusion [of marginalised groups] in the developmental project'. Demands to end corruption were, thus, informed by the very claims to inclusive citizenship (i.e. to an extension of state-directed redistribution of common goods) put forward by the Indian state.

Gupta thus highlights the processes through which the distribution of common resources, of which the state is the conduit and guarantor (i.e. citizenship), are politicised through collective struggles and the moral discourses on corruption on which they draw. I propose, however, to move from Gupta's focus on discourses and his reliance on an underlying Foucauldian view of the state as an abstract and inherently disciplining political form, to a focus on practices and a view of the state as an arena of social struggle over the distribution of common goods (Bourdieu et al. 1994). At least in theory, contemporary states define citizenship as including not only civil and political rights, but also social rights (Marshall 1950) of access to decent income, housing, employment and (at least in Europe) healthcare, and seek to insure this access though state-directed income redistribution and provision of public services. In as much as corruption is seen in contemporary capitalist societies as an illegitimate and illegal drain on public resources, corruption practices and discourses can be seen as participating in struggles over the definition and distribution of the common goods of citizenship.

Schneider and Schneider's (1976, 2005) historical analysis of Sicily's political economy offers a brilliant example of how corruption and wrongdoing may take part in struggles over citizenship. Indeed, they showed that, in Sicily, ruling elites sought to maintain their dominance by using illegal relations and exchanges (mafia) to stifle labour protest intended to bring about a more inclusive definition of citizenship. But Schneider and Schneider's analysis points us not only towards struggles in general but towards a specific type of struggles, those that various social classes in society wage over the distribution of common goods. In a similar fashion, Thompson showed not only that the market have been embedded in different moralities across time and among various social groups. He also highlighted that the market and its moralities have been 'an arena of class war' (Thompson, 1971: 12) between classes engaged in collective action. Indeed, Thompson showed that the 'old moral economy' crucially informed the English crowd's collective action in opposition to the defenders of the free market economy.

In his analysis of contemporary capitalism, Harvey (2004, 2005) links class conflict with new modes of capitalist accumulation in ways that are highly relevant for understanding contemporary wrongdoing in healthcare and public services in general. Thus, for Harvey, last decades' 'corporatisation and privatisation of public assets' (Harvey 2004: 75) (including healthcare privatisation) are to be understood as part of contemporary capitalism's response to its accumulation crises. This response also takes the form of 'accumulation by dispossession' whereby various vulnerable groups are dispossessed of goods previously defined as being under public, common, collective or state property. The resulting transfer of assets from public to private (and most notably corporate) hands challenge entitlement to public services and reconfigure citizenship. It is also accompanied by 'cannibalistic as well as predatory practices' (most notably on the part of finance capital) which are thus to be seen as being internal to rather than outside capitalism (Harvey 2004: 75). Finally, for Harvey, the changing nature of capitalist accumulation leads to new forms of resistance to it, most notably in the form of 'a gathering storm of opposition to the deepening of accumulation by dispossession' (2004: 83). Certainly Thompson would have agreed with him.

In order to understand wrongdoing in the Romanian healthcare sector, I will adopt a historical perspective that links the changing nature of informal exchanges and of moralities attached to them, on the one hand, with changing citizenship configurations and struggles waged around entitlements to healthcare services since the fall of the Communist regime at the end of the 1980s. The paper starts by describing the configuration of citizenship and informal relations during the socialist period and then looks at the dismantling of the socialist worker-citizenship and at the new role played by informal exchanges during the 1990s. It then links the rise of neoliberal citizenship during the economic boom (2000–08) with the increasingly divergent nature of informal exchanges, attending particularly to how they help to reproduce or, alternatively, temper inequalities of access to services. The paper then turns to the austerity period that followed the boom, and shows that the consolidation of neoliberal citizenship and the accelerated privatisation of healthcare have led to informal exchanges taking forms that

are intimately imbricated with the public–private mixes to which these reforms have given rise. It also shows that the intensification of union and popular protest against these reforms has triggered increased government attempts to identify informal exchanges as corruption and to use them to justify further privatisation of healthcare.

WORKER-CITIZENSHIP, THE ECONOMY OF FAVOURS AND INFORMAL EXCHANGES DURING SOCIALISM

During the socialist period, the regime's worker-citizenship was built around access to and security of employment, and also included free and universal access to healthcare and education, as well as access to a variety of subsidised services such as rented accommodation or holidays in socialist resorts (Kideckel 2001). However, Romania's focus on developing heavy industry and the resultant low levels of healthcare expenditure led to access to healthcare being informed by various inequalities, such as that between urban and rural areas and between workers in different sectors of the economy.

Informal exchanges between patients and healthcare personnel played an important role in moderating these inequalities. Together with other informal exchanges, these were part of the larger socialist 'economy of favours' (Ledeneva 2014). Based on networks of personal relations and exchange of favours among family, friends, neighbours and work colleagues, the economy of favours helped compensate for the occasional bottlenecks in the distribution of goods in the socialist economy (Sampson 1983, 1986). Moreover, because favours involved the creative use of whatever resources and services various employees controlled in their workplaces, the economy of favours also had a relatively equalising effect on access to goods and services, thereby 'reducing the privilege gap between insiders and outsiders of the centralised distribution system' (Ledeneva 2014: 16).

Although it involved the appropriation of public goods, the economy of favours differs in important ways from forms of corruption in capitalist societies. This is because 'the nature of formal constraints' (Ledeneva 2014: 17) framing the socialist and capitalist societies are different. In socialist societies 'the lack of private property or clear divisions between the public and the private' provided 'a degree of entitlement to whatever the economy of favours had to offer' (2014: 17). Accordingly, during socialism the 'misrecognition game' construed favours as the 'selfless redistribution of public funds for a moral cause' (i.e. as access to goods and services to which one was already entitled), thus serving to distance many ordinary exchanges of favours from self-serving corrupt practices (2014: 17).

Moreover, during socialism wrong-doing was not understood only as it is in capitalist corruption, with reference to the expected behaviour of a particular sector of the society (i.e. public servants misusing public resources for private gain). Instead, it was understood with reference to the expected entitlements of worker-citizens (i.e. their misuse of collective resources for personal gain beyond what they were normally entitled to through their employment). This meant that, given that all socialist enterprises were part of the collective good, the potential realm of economic wrong-doing was extended beyond public servants to include all employees.

The Communist regime came, therefore, to be caught between, on the

one hand, its embedding of socialist worker-citizenship in entitlement to a package of goods and services and, on the other, its inability to ensure that everyone had access to this package. As a result, recourse to informal exchanges 'was prosecuted by authorities in only selective campaigns' (Ledeneva 2014: 16). Interestingly, a 1978 report found that most cases prosecuted through the law on illicit gains concerned ordinary workers, with cadres constituting only 1.3 per cent of total cases (Evz.ro 2008). The regime, therefore, did not only allow the economy of favours to compensate for the deficiencies in resource allocation. It also used the potential threat of prosecution as a means to discipline not so much its cadres as various sections of its population, most notably the potentially contentious working class[1].

Doctors were well placed to attract a relatively larger share of resources exchanged informally, as they could dispense services vital to all citizens. Some doctors, especially those involved in what was seen as more critical hospital care, were much better placed than ordinary workers to informally appropriate goods that they could later give to others as favours or sell on the black market. Especially in urban areas, some prestigious doctors managed to live in large villas and have a higher standard of living than ordinary workers, despite their salaries not being markedly higher than what those workers got.

Thus, during socialism the medical profession faced the continuous under-funding of healthcare services and the accompanying low levels of wages in the sector, but their participation in the economy of favours gave at least some of them access to a wider range of goods as well as money. In these cases, doctors were able to enrich themselves beyond their wages. This differed from what the economy of favours could provide for ordinary workers, thus opening doctors to accusations of bribe-taking and illicit gain. Because of the risk of such accusations and the threat of legal sanctions, doctors protested against depressed employment and working conditions mostly at an individual level, through being slack at work or by emigrating, rather than by engaging in collective action.

CITIZENSHIP AND INFORMAL RELATIONS DURING POST-SOCIALISM (1990-2000)

After the fall of the Communist regime in 1989, Romania had a centre-left government led by what is known nowadays as the Social Democratic Party (*Partidul Social Democrat*, PSD), and it adopted a gradualist approach to the transition to a market economy. This was combined with neo-corporatist industrial relations and a weak state, which could neither resist labour's demands nor manage to build an institutional configuration favourable to labour (Bohle and Greskovits 2012). The abrupt

[1] Class differences also existed in socialist societies, most notably between direct producers (or workers) and central redistributors (the party and state nomenklatura) (Verdery 1991). However, we cannot say that the appropriation of common resources by the latter, including initial nationalisations and collectivisations, have been 'accumulations by dispossession' (Harvey 2004) of the same kind as postsocialist privatisations (Chari and Verdery 2009: 14, 16). In fact, if socialist accumulation was predicated on redistribution and the commitment to 'provide welfare to all citizens' (Chari and Verdery 2009: 15), it follows that it was of a kind different from the capitalist accumulation intended to increase profit that is Harvey's accumulation by dispossession.

dismantling of the planned economy and the partial liberalisation of prices at the beginning of the decade prompted massive lay-offs and a sharp fall in real wages. This was only partially compensated by the redistribution of co-operative lands and the return of former workers to the countryside and the reinvigoration of subsistence agriculture (Stan and Erne 2014).

During the first half of the 1990s, job insecurity and loss thus led to a practical dismantling of worker-citizenship. Facing massive social upheaval, post-socialist governments chose, nevertheless, not to challenge access to healthcare but instead maintain its role in post-socialist citizenship. The organisation of healthcare thus underwent few significant changes during this period. However, decreasing levels of expenditure and wages in the sector led to new forms of action on the part of healthcare workers. Both doctors and nurses joined free trade unions, although their political leanings and forms of protests differed. Federatia Sanitas, the nurses' union, entered into alliances with the ruling Social Democrats, while the Romanian Federative Chamber of Doctors Union (*Camera Federativă a Sindicatelor Medicilor din România*, CFSMR) sided with right-wing opposition parties.

With the reinstatement of private property and the dismantling of state and co-operative property, the realm of wrong-doing came to be redefined in ways that resemble the definition of corruption in capitalist societies, as a matter regarding the public sector rather than the mass of employees. At the same time, decreasing expenditure and wage levels adversely affected the quality of public healthcare, and informal exchanges were important for securing good care. It is in this context that we have to understand CFSMR's claim to have obtained, by the mid-1990s, the exemption of doctors from accusations of *luare de mită* (bribe taking) (CFSMR 2011). Indeed, even though most doctors continued to be public employees in the 1990s, a legislative document deemed doctors to be not public servants but liberal professionals (PR 1995). However, the status of doctors employed in public healthcare units remained ambiguous. Not only were various legislative documents subject to different interpretations by different judges, the label 'liberal professional' hardly fit the fact that so many doctors were public-service employees. The fact that doctors were not charged with *luare de mită* in the 1990s probably is due more to the government's willingness to turn a blind eye to informal exchanges in the healthcare sector than it is to the supposed re-labelling of doctors working in public healthcare units as liberal professionals.

During this same period, the growing availability of consumer goods led to an increasing use of money in informal exchanges, along with the continued use of goods and services. Informal exchanges in healthcare thus started to diverge, depending on what categories of patients and of doctors were involved in them. Poorer patients and doctors at the bottom of the medical hierarchy lacked the money that would buy the post-socialist consumerist abundance, so much of what patients gave was goods, for instance imported coffee and whiskey, but also things like eggs or cheese produced by subsistence farmers. Better-off patients and doctors at the top of the medical hierarchy increasingly came to use money in their informal exchanges, even if consumer goods complemented it in the form of gifts of gratitude. Thus, the *atenții* (attentions) that those patients gave to doctors more and more were talked about as *șpaga*, informal prestations of

considerable value, whether as money or as luxury goods (Stan 2007).

After the victory of the right-wing coalition Romanian Democratic Convention (*Convenția Democrată Română*, CDR) in the election at the end of 1996, Romania accelerated the privatisation of state companies and the liberalisation of the economy. This led to a new round of inflation, rising unemployment and falling wages, as well as increased labour protest. By the end of the 1990s, worker-citizenship was in tatters, with real wage levels only 60 per cent of what they had been in 1989 and job security surviving only in the public services (Stan and Erne 2014). To replace that citizenship, the CDR government proposed a post-socialist citizenship predicated on fostering entrepreneurial skills in the capitalist market, which was expanding because of privatisation.

This post-socialist entrepreneur-citizenship rested on the retrenchment of public services and the questioning of universal entitlement to them. Thus, the 1997 law on social health insurance (PR 1997) changed the funding of Romanian public healthcare services from the state budget to a National Health Fund (NHF), which collected contributions from both employers and employees. Entitlement to public healthcare services came, then, to be based on employment, which in turn depended on an increasingly compressed labour market. The 1997 law also turned patients into consumers, as it gave those seeking healthcare the freedom to choose among doctors and healthcare units, and it introduced contractual relationships between the NHF (as purchaser) and healthcare providers.

Because it was adopted in a period of social upheaval, the 1997 law was not as thorough-going as it might have been. In particular, it included among those deemed to be insured, and thus eligible for healthcare covered by the NHF, some who were not, in fact, contributing employees. These included those up to 26 years of age if not in employment, the spouses, parents and grandparents of contributing insured persons and members of families receiving social benefits (PR 1997). Nevertheless, some people had no access to insured services and had to pay for healthcare themselves.[2] These included, for example, the long-term unemployed who had ceased to receive unemployment benefits, those living in areas lacking providers of primary healthcare services, those working in the informal economy and those engaged in subsistence agriculture (Bara et al. 2002: 21).[3]

INFORMAL EXCHANGES AND ENTREPRENEUR-CITIZENSHIP DURING THE ECONOMIC BOOM (2000–08)

After its victory in the 2000 elections, the PSD government committed itself more firmly to the process of European accession and managed to turn Romania away from the 1990s development model that combined crumbling socialist industries and subsistence agriculture. In its place, it opted for peripheral neoliberal development (Bohle and Greskovits 2012). That involved encouraging foreign firms to set up businesses that employed low-

[2] In 2004, 34 per cent of Romania's total healthcare expenditure was from private sources (Vladescu et al. 2008: 45), which at that time were mainly patients making out-of-pocket payments.

[3] The 1997 law allowed self-employed persons and farmers to avail themselves of the national health insurance, given that they pay their contribution. However, because of their very low income levels, few of them did so. At the end of the 1990s, subsistence agriculture rose to around 40 per cent of total employment (Stan and Erne 2014: 29)

skilled, low-paid workers, reducing the welfare state still further and facilitating the construction of housing, paid for with household debt (Stan and Erne 2014). This was coupled with the maintenance of the neo-corporatist industrial relations of the 1990s, which insured some wage increases during the boom years of 2000–08.

The result was a turn from internal urban–rural migration to temporary out-migration, mainly to other European countries (Sandu 2005). That migration became an important exit strategy for Romania's disenfranchised working class, as well as an important source of funds for Romania's new development model. Remittances also fed into the public-services informal exchanges, as they meant that households with migrant members were more likely to have the resources needed to engage in *şpaga* and so gain access to better education and healthcare services.

The neoliberal turn also resulted in the gradual but steady transformation of the Romanian healthcare sector. At the beginning of the 2000s, doctors practising in primary and secondary care ceased to be public employees and instead became free practising professionals, and more and more of them set up their own private, entrepreneurial practices. By 2007, 45 per cent of general-practice and family-medicine surgeries and 92 per cent of polyclinics were private (INS 2013: 258). Overall, by 2008 19 per cent of all healthcare employees were in the private sector (my calculations based on INS 2016). In contrast to the situation in primary and secondary care, even at the end of 2000s most doctors in tertiary healthcare were employed in public hospitals.

The 2004 elections brought to power a right-wing coalition government and a right-wing president, Traian Basescu. This inaugurated the 'Basescu era' (2004–14) (Poenaru and Rogozan 2014), which saw the extension of neoliberal reform. In their first year in power, the new government adopted a personal and corporate flat tax set at 16 per cent, which benefited business and the new 'comprador bourgeoisie' (Sampson 2002) that became politically powerful. This tax reform was also a blow to public services and to the marginalised classes dependent on the social wage provided by these services, for under-funding now became structural.

The new government radically changed both the healthcare sector and people's access to it. Concerning the sector, the 2006 law on healthcare reform (PR 2006) said that private healthcare providers could contract services with the NHF, which pitted state service units against private ones (MS 2013). Another 2006 law allowed public healthcare units to 'externalise medical and non-medical services' (MS 2006; all translations from the Romanian are by the author), so that hospitals and other units could contract them out. Concerning access, the government further reduced citizens' entitlement to public services and social benefits, now increasingly vilified as Communist-era dependency on the state (Goina 2012). Thus, the 2006 law on healthcare reform stipulated that those insured with the NHF should have access to a defined 'basic package of services', while non-insured citizens should have access to only a 'minimal package of services': emergency services and treatment for contagious diseases (PR 2006). As well, it reduced the number of categories of people considered to be insured but exempt from paying into the Fund.

These changes meant that 'the right to healthcare services provided by

state healthcare units' contained in Romania's constitution (CR 2003: Art. 47) referred to a shrinking pool of public healthcare services (Vladescu and Astarastoae 2012). Also, they led to the uneven, and structurally based, distribution of healthcare services across the country. In contrast to large cities, many de-industrialised small towns and rural areas became healthcare deserts. Together with the decline of public transport, the shortage of medical personnel meant the greater isolation of an increasingly ageing population.[4] A 2007 study of healthcare in the relatively rich North-West development region found that 16 per cent of the active population was not covered by national health insurance and almost 4 per cent were not registered with a GP (Rat 2008: 20).

It is in this period also that informal exchanges in the healthcare sector continue to diverge even more visibly than before, leading to their different articulation with the rising structural inequalities of access to healthcare services mentioned above. Thus, on the one hand, poorer patients continued to engage in informal exchanges, but complemented their limited cash with goods that they produced themselves or obtained through other informal exchanges. As well, they tried to invoke a morality of redistributive justice by insisting that the value of informal prestations should be a function of a patient's capacity to give, and that doctors should expect little or nothing from those who were less well off (Stan 2007). In as much as these claims succeeded in giving poorer patients access to (better) health care services, informal exchanges contributed to at least partially alleviate inequalities of access to healthcare services.

However, on the other hand, the rising comprador bourgeoisie fuelled by Romania's new development model increasingly resorted to a strategy of 'lift-off' (Sampson 2002) from public services into private healthcare either in Romania or abroad. Moreover, as we have already seen, when they had recourse to *şpaga*, this was more often than not of a (relatively considerable) monetary nature. These practices also started to be replicated by the larger, and rising, new middle class, including many Romanian migrants abroad (Stan 2015). Having recourse to private healthcare and *şpaga* payments as strategies of social mobility, middle class Romanians drew in their healthcare seeking practices on a morality of 'choice' consonant with neoliberal promotion of consumerism in healthcare and public services in general (Stan 2015).

As a result, most informal exchanges initiated by middle class patients, as well as *şpaga* payments on the whole, contributed to exacerbate rather than alleviate structural inequalities of access to healthcare (Stan 2012, 2015). The same 2007 study cited above found that 46 per cent of respondents who had been hospitalised or had a close family member hospitalised during the previous 12 months had offered money to doctors or nurses in order to receive better care (Rat 2008: 23–24). However, recourse to informal payments differed by class: 59 per cent of respondents in the richest quintile said that they had made such payments, but only 37 per cent of those in the poorest quintile did so (Rat 2008: 24).

[4] In 2012, 94 per cent of the population in urban areas had access to NHF services but only 75 per cent in rural areas had the same (MS 2014).

HEALTHCARE REFORMS AND INFORMAL EXCHANGES DURING AUSTERITY

A year after being returned to power in 2008, the government signed an agreement with the IMF, which led to drastic austerity reforms. More specifically, in 2010 the government cut wages in the public sector by 25 per cent and restricted the filling of positions that became vacant. The neo-corporatist social partnership model was thrown out with the adoption of a new Labour Code, which considerably restricted collective bargaining rights and trade union membership (Trif 2013).

These developments resulted in a deterioration of wage levels and working conditions in the healthcare sector, despite considerable levels of labour militancy on the part of healthcare unions, particularly Sanitas and its umbrella confederation Fratia (Stan and Erne 2016). The government took the opportunity of austerity to try to increase state withdrawal from, and privatisation of, healthcare. They proposed to get private insurers to manage the NHF, as outlined in the 2011 law on healthcare reform, to close local hospitals, to introduce co-payment for admission to public hospitals, to use private beds in public hospitals as a means of supplementing doctors' income, to turn public hospitals into associations and foundations, to realise the ambulatory turn in financing healthcare services (described below) and to introduce financial discipline in public hospitals. Following union and popular protests, the Ministry of Health temporarily abandoned or diluted these proposed reforms. Most notably, popular street protests in January 2012, in reaction to the 2011 law, led to the law's suspension, as well as to two government reshufflings and, at the end of 2012, the election of a PSD government. In 2013 a series of protests conducted by a coalition of trade unions and professional organisations led to a new collective agreement in the healthcare sector, an increase in wages for resident doctors and the opening of new positions, as well as the temporary dropping of the idea of turning public hospitals into associations and foundations (Stan and Erne 2016).

In spite of the protests, the privatisation of the Romanian healthcare sector continued and the austerity period saw a surge in the number of private hospitals. By 2012, 23 per cent of the 473 hospitals in the country were private (INS 2013), and the proportion of those in the sector working in private units rose accordingly. The result of the austerity reforms was that the previous combination of low wages, secure employment and tolerated informal exchanges in the sector was replaced by sharply lower wage levels and increasingly flexible employment in both public and private healthcare. As we will see later, this was to be complemented by increasing government intolerance of informal exchanges in the healthcare sector.

By the beginning of the 2010s, as subsistence agriculture started to lose its importance as a buffer against unemployment, out-migration became one of the acknowledged components of the entrepreneur-citizenship offered by the regime, with Basescu publicly thanking migrants for not being a burden on Romania's unemployment fund (Daily Mail 2012). This citizenship also was increasingly divisive, as marginalised classes were vilified as scroungers living off the public resources produced through the efforts of honest entrepreneurs and as ungratefully voting for the PSD candidate in the 2014 presidential elections (Poenaru 2014). This vilification

was also manifest in the healthcare sector, as more and more in the public arena advocated abolishing the remaining categories of people who were treated as insured even though they were exempt from paying contributions (Vladescu and Astarastoae 2012). If they were to be treated as insured, they should pay.

Moreover, during the 2010s the spread of private clinics and hospitals introduced additional inequalities of access to healthcare. Better-off patients could use the private sector, as they would be able to afford the co-payments needed to supplement the costs covered by the NHF (MS 2013). However, in 2013 the Ministry of Health estimated that only 20 per cent of the population could afford the necessary co-payments (MS 2013), which is not surprising in view of the fact that, at the beginning of 2010s, 42 per cent of the population was at risk of poverty and social exclusion (MS 2014).

Finally, inequalities also rose in accessing public healthcare. These inequalities were fuelled by the rising importance of money in *şpaga* that now took an additionally nasty turn. Indeed, the deterioration of wages in public hospitals led to a rise in predatory informal exchanges whereby some healthcare personnel, most notably doctors (Stan 2012), engaged in what in local parlance is called 'the conditioning of the medical act'. The morality which healthcare professionals invoked for legitimising their acceptance of *şpaga* payments have been, especially in the face of consistently low wage levels in the healthcare sector after the fall of socialism, that of a just payment for their work and gift of life to patients. However, predatory *şpaga* practices increasingly questioned the legitimacy of healthcare professionals to just retribution and served to bring ever-larger parts of middle classes into the mire of a morality of 'choice' and of preferred recourse to private rather than public healthcare services.

It is in this context that *şpaga* also entered as a powerful signifier in debates around healthcare reforms. Thus, the two authors of the 2011 healthcare reform law (Vladescu and Astarastoae 2012) said that the introduction of regulated competition among private insurers was a means to eradicate *şpaga* in public hospitals. Those authors and, subsequently, the Ministry of Health (MS 2013), made the same case for the ambulatory turn mentioned above. That referred to shifting many of those with chronic conditions from hospitals to outpatient care, and because outpatient services were primarily private, it would effectively privatise a substantial amount of healthcare. In addition, the authors of the 2011 law argued that eliminating *şpaga* would eliminate inequalities of access to healthcare services (Vladescu and Astarastoae 2012), thus blaming those inequalities on *şpaga*, rather than on the neoliberal healthcare reforms.

The existence of *şpaga* in the healthcare services in the 2010s does not indicate that greater privatisation would eradicate informal exchanges. Especially in rural areas and small towns, *şpaga* persisted in both primary and secondary healthcare, in both the public and the private sectors that catered to the poorer population of these areas. Indeed, being usually small entrepreneurial practices, private units in these areas rarely had patients who could afford out-of-pocket costs for treatment, and instead contracted a lot of services with the NHF. As well, doctors would refer patients who needed specialist work to services that also were contracted out with the Fund. The overall effect is that *şpaga* served to ensure not only better care, but also that

patients' consultations would be reimbursed through the NHF rather than leaving them out-of-pocket.

The other area where we find *şpaga* is public hospitals. Following measures allowing them to charge patients for services not found in the basic NHF package, public hospitals also came to resemble small-scale entrepreneurial practices in their combination of services covered by the NHF (and thus, in principle, free at the point of delivery for insured patients) and those covered by out-of-pocket payments. Here we find the same functions of *şpaga*: to ensure better care, to have medical consultations reimbursed by the NHF rather than being paid out-of-pocket and to have doctors refer patients to specialist services that are contracted out with the Fund.

The only area where *şpaga* is not known to be widespread, despite occasional claims to the contrary, is in the big private medical centres and hospitals, what I call corporate healthcare. In these, corporate control seeks to make sure that resources flow into the company's pockets, not those of the staff, and *şpaga* is effectively forbidden, even in cases where patients are willing to give it. However, some of the doctors working in private corporate care also work in public hospitals and could engage in shuffling patients between the two systems and, in the process, draw on *şpaga*.

Thus, an additional manipulation of the fuzzy border between private and public care is found in situations where doctors working both in public hospitals and private clinics shuffled patients between the two in a bid to increase their income on the back of public funding. These doctors could refer patients they first see in their private practice to the public hospital, thereby transferring some of the costs related to treatment to the public system (where they could also pocket *şpaga* for their interventions). In the other direction, the same doctors could refer their patients from the public hospital to their private practice, where they could sometimes cover part of the costs through the NHF and also charge patients co-payments (MS 2013).

Thus, the forms taken by *şpaga* are closely related to the manner in which the Romanian healthcare system has been reshaped over the past few decades, most notably in the specific mixes of public and private care and funding in both public and private healthcare units. These public-private mixes point us to the process whereby state disengagement from the funding and delivery of healthcare and the concomitant rise in private involvement in the same resulted in a tortuous, but steady, accumulation by dispossession. Indeed, increasing vulnerable sections of the Romanian population have seen their access to free public healthcare services curtailed. In the same time, funding from public sources (i.e. from the NHF) and private sources (in the form of formal out-of pocket and informal *şpaga* payments from patients) have been redirected into the pockets of private entrepreneurs and corporations active in the healthcare sector. But *şpaga*'s embeddedness in these private-public mixes also points us to the fact that wrongdoing in in the form of 'petty corruption' in healthcare may take forms that are 'neither commodities not gifts' (Stan 2012) and that sometimes take predatory forms that reinforce inequalities of access to healthcare.

PROTEST AND THE CRIMINALISATION OF INFORMAL EXCHANGE IN AUSTERITY TIMES

During the austerity period, diminishing healthcare expenditure and commitment to a radical neoliberal agenda led right wing governments to seek to increasingly re-direct the flow of resources circulating through *şpaga* payments from the private pockets of healthcare professionals receiving these payments to those of private corporations active in the healthcare sector.

A case in point concerns what has been seen by many union leaders as the political use of corruption accusations in order to discipline the labour movement and to de-legitimise its demands for higher wages in the public sector. In 2010, new laws on corruption and the integrity of those engaged in 'public functions and dignities' identified union leaders among those so engaged. One year later, the National Agency for Integrity (*Agenţia Naţională de Integritate*, ANI) undertook to verify the wealth of fifteen union leaders (Adevarul 2011). Union leaders saw this as a government attack on the labour movement, meant to discredit union leaders active in the 2010 street protests organised by Romania's main union confederations. A trade union leader described the ANI's action against union leaders as 'a follow-up of last year's protests. All [union leaders] on the list have been very active in trade union actions' (Adevarul 2011).

Also in 2011, the National Anti-Corruption Directorate (*Direcţia Naţională Anticorupţie*, DNA) staged a *flagrant* (sting operation) that caught Marius Petcu, the leader of Sanitas union federation and of the Fratia union confederation, taking bribes from a private businessman for the building of a new training centre for Sanitas (ARC 2011). Petcu was arrested for corruption, convicted and sentenced to seven years in prison. Petcu's daughter, as well as other insiders and sympathisers of Sanitas, claim that his prosecution was politically motivated, as his arrest took place 'only eight days after the demonstration where Marius Petcu announced a general strike in the healthcare sector' (Petcu 2013).

Austerity also saw the intensified use of claims that healthcare employees, and especially doctors working in public hospitals, were profiting from untaxed informal payments to counter the assertion that wages in the sector are too low (Stoica 2012). Many doctors saw these claims as a media campaign against the medical profession. As one commentator put it, 'in the case of doctors, demonising them has become a national sport' (Ene Dogioiu 2013a). For another commentator, 'the medical profession is widely seen as corrupt', and 'the venal doctor ... has become a fixture of sting operations by tabloid papers and the TV news' (Stancu 2014). The Romanian media has become concentrated in the hands of a few powerful people with close links to the country's main political parties (ref?), and many doctors saw the media corruption stories as a sign of the links between media owners and a government seeking to discredit doctors' claims for better wages and working conditions.

This view was not entirely unwarranted. Since 2009 several stings in which doctors working in public hospitals were caught receiving and even asking for *şpaga* have been conducted by the DNA and have appeared prominently in newspapers and on television. More importantly, the DNA's efforts to include doctors working in public hospitals in its anti-corruption campaign ultimately led the agency to request a clarification of their legal

status. At the end of 2014, the High Court of Appeal and Justice responded by stating that doctors working in public hospitals are civil servants and thus are forbidden to accept 'supplementary payments and donations' from patients (Dolana 2015). For the first time, therefore, doctors working in public hospitals were clearly identified as being subject to Penal Code stipulations on *luare de mită* (bribe taking).

In parallel with the DNA's efforts, right-wing commentators in the media blamed the ills of the healthcare sector on those in it, rather than on government policies toward it. One of the most vocal, President Basescu, said that the problems arise not only because of informal payments, but also because of mafia-like structures connected to various political interests, by which he apparently meant those opposed to his government and its austerity policies. In a speech in August 2010, Basescu said that he knows doctors who are 35 or 40 years old who leave the country not because they cannot succeed on a material level, but 'because of stifling structures that do not permit new doctors to progress in their career' (Agerpress 2010). Other right-wing commentators echoed this, saying that doctors leave the country 'because here their chances of professional development are blocked by the clans that took control over most of the hospitals' (Ene Dogioiu 2013a). That same commentator (2013c) referred to those who for the last 23 years [i.e. since 1989] kept the Romanian healthcare system on the breakdown line, humiliate doctors, humiliate patients, drain the money of healthcare into private pockets and have transformed the system in a feud of all sorts of mafias. A former president of the NHF, and member of Basescu's party, declared at the end of 2013 that 'the interests in the healthcare system and in education are enormous because they produce enormous benefits for "health barons" [*baronetul sănătății*]. For this reason it is difficult to change something' (quoted in Ene Dogioiu 2013b).

These allegations of what is seen in Romania as 'big' corruption resonate with the populist discourse of President Basescu, who presented himself as a modern crusader against corruption and the 'wretched system' (*sistemul ticăloșit*) who, like the national hero (and the historical figure behind Bram Stoker's Dracula) Vlad the Impaler, impales corrupt politicians (Leca 2012). More interestingly, Basescu claimed that the 2012 protests against the 2011 law were the work of 'the mafia system [*sistemul mafiot*] in health' (Fierbinteanu 2014). In his view, then, opposition to the further privatisation of the sector sprang from the desire to continue to receive gifts and bribes. Following this logic, Basescu later on implicitly acknowledged his government's attempts to make *șpaga* illegal and presented them as a legitimate response to protesters' refusal to acquiesce to the reform law of 2011: 'I have a lot of respect for doctors, but I assure them that if they had not rejected so vehemently the healthcare law proposed in January 2012, they would have earned as much as they earn now in the context where they have the risk of prosecution' (Fierbinteanu 2014).

It is not clear that the protests of January 2012 against the 2011 law have the potential to sustain an alternative view of the problems that Romania's healthcare system confronts. Doctors were not prominent in the protests, which were dominated by the remnants of the old socialist classes (workers, intellectuals and pensioners) and the newly disenfranchised middle classes of post-socialist neoliberal times (Stoica 2012). The demands of these

two groups reflected their different positions in Romanian society as well as their different views of citizenship. The new middle classes, represented by various NGOs, were moved to protest mainly because of what they saw as the undemocratic behaviour of Romanian politicians (Gotiu 2012). They wanted Basescu and his PDL government to step down, and many condemned the political class as a whole. Many protesters from the old socialist classes wanted this and more. They held that the last 20 years had seen the abusive and illegitimate appropriation of state assets by the new ruling elite who were plundering the country. Thus they also demanded job creation and decent wages, the end of healthcare privatisation, increased funds for education and healthcare and the return of the control of the country to its ordinary citizens.

The alliance of these two segments of the society and their two moralities was too fragile to survive. In autumn 2013 there were two important protests in Bucharest that met neither physically nor symbolically: against the Rosia Montana gold mining project and the Pungesti Chevron fracking project, and against employment and working conditions in the healthcare sector. Between them, they managed to reduce the anticipated degradation of the environment and of employment and working conditions in healthcare, but they produced no united front that could significantly alter the direction of reforms in these two areas.

CONCLUSION

In Romania, many patients have traditionally framed their recourse to informal exchanges in terms of a redistributive 'moral economy' (Thompson 1971) of care provided in public units. This moral economy came to be challenged by healthcare privatisation. Thus, richer patients increasingly 'lifted-off' from public healthcare and instead promoted a neoliberal market morality of 'choice' based on the use of private means for private care. In parallel, continued depressed wages for healthcare personnel led a few of them to engage in predatory forms of exchange that further exacerbated poorer patients' dispossession of public care. Finally, Romanian governments used the austerity following the 2008 financial crisis as an opportunity to speed up healthcare privatisation. In doing this, they aimed both to give the final blow to redistributive moralities of care and to channel the flows of accumulation by dispossession away from the pockets of healthcare personnel and into those of private corporations active in healthcare. While popular protests gave voice also to redistributive moralities of care, they managed merely to slow down but not stop or reverse the accumulation by dispossession through healthcare privatisation.

This paper has described the evolving links among citizenship, neoliberal reform and the configuration of informal exchanges in the Romanian healthcare sector. That description shows that economic wrong-doing in the form of petty informal exchanges in healthcare is not so much a legacy of socialism (see also Zerilli 2013) as it is a function of the evolving re-configurations of citizenship during the post-socialist period. These re-configurations were driven in part by the desire to commodify healthcare work and to privatise access to healthcare services, and they have been resisted by sections of the public and those in the sector. That resistance reflected ideas about what citizenship and work in the sector should entail, and also ideas about whether or not informal exchange should be a criminal

offence. What I have described for Romania shows that the nature of and reaction to informal exchange in the healthcare sector reflect both economic and political forces at work in the country.

Informal exchanges in Romania's public service resemble what is described in Eastern (Stepurko et al. 2015) and even Southern Europe (Mossialos et al. 2005). One might, then, be tempted to treat what I have described as characteristic of areas that are peripheral to global capitalism. However, the link between those informal exchanges and the mixture of private and public realms that is a recurring feature of neoliberal reforms suggests that the periphery of global capitalism that is pertinent is not the geographical one of regions like Eastern and Southern Europe. Rather, it may be the political-economic one of the fuzzy border between the public and the private, a border that neoliberal reform has made more common even in the heartland of global capitalism.

Contemporary capitalist processes of accumulation may therefore embed wrongdoing not only in the quarters of finance capital, but also in the quarters of public services that are currently one of the main targets of accumulation by dispossession. As several anthropologists have shown, in egalitarian societies, predation may function as a mechanism of enforcing equality and checking the rise of unequal power relations (Clastres 1974, Lee 1979, Beaucage 1995). However, as the case of informal exchanges in the Romanian healthcare sector shows, when gift exchanges combine unequal redistributive relations (e.g. between doctors and patients) with predation, they may translate in unequal power relations that reproduce rather than challenge inequalities of access. But this does not mean that the ultimate source of these inequalities is to be found, as proponents of neoliberal reforms claim, in non-market exchanges. Rather, it is processes of accumulation by dispossession that structurally produce inequalities in the first place. Invocations of the transparent morality of the market as well as of the pure gift may thus also be used by governments as a pretext to further this dispossession even more deeply.

REFERENCES

Adevarul 2011. Averile a 15 lideri sindicali sunt verificate de ANI. *Adevarul* (16 Feb.). http://adevarul.ro/news/eveniment/averile-15-lideri-sindicali-verificate-ani-bogdan-hossu-ordin-primit-sus-1_50acee6e7c42d5a6638c0f07/index.html (accessed 22 June 2015)

Agerpress 2010. Presedintele Colegiului Medicilor, mahnit de declaratiile lui Traian Basescu. *Ziare.com* (5 Aug.). www.ziare.com/social/spital/presedintele-colegiul-medicilor-mahnit-de-declaratiile-lui-traian-basescu-1033658 (accessed 22 June 2015)

ARC (Alianta pentru o Romanie Curata) 2011. Marius Petcu, fost lider CNSRL Fratia, condamnat la sapte ani inchisoare pentru coruptie. *Romaniacurata.ro* (8 Dec.). www.romaniacurata.ro/marius-petcu-fost-lider-al-cnslr-fratia-condamnat-la-sapte-ani-inchisoare-pentru-coruptie/ (accessed 30 March 2016)

Bara, Ana Claudia, Wim van den Heuvel and Johannes Maarse 2002. Reforms of the health care system in Romania. *Croatian Medical Journal* 43 (4): 446–52.

Beaucage, Pierre 1995. Donner et prendre. Garifunas et Yanomamis. *Anthropologie et societies*, 19: 95-117.

Bohle, Dorote and Bela Greskovits 2012. *Capitalist diversity on Europe's periphery*. Ithaca, NY: Cornell University Press.

Bourdieu, Pierre, Loïc Waquant and Samar Farage 1994. Rethinking the state: genesis and structure of the bureaucratic field. *Sociological Theory* 12 (1): 1–18.

Chari, Sharad and Katherine Verdery 2009. Thinking between the posts: postcolonialism, postsocialism, and ethnography after the Cold War. *Comparative Studies in Society and History* 51 (1): 6–34.

CFSMR (Camera Federativa a Sindicatelor Medicilor din Romania) 2011. *Organizare Interna*. Bucharest: CFSMR. www.cfsmr.ro/subpagina/organizare-interna (accessed 22 June 2015)

Clastres, Pierre 1974. *La société contre l'etat. Recherches d'anthropologie politique*, Paris: Editions de Minuit.

CR (Constitutia Romaniei) 2003. *Constitutia Romaniei*. https://www.ccr.ro/constitutia-romaniei-2003 (accessed 22 June 2015)

Daily Mail 2012. Romanian president praises countrymen for doing British jobs in attack on 'lazy Westerners'. *Mail Online* (6 Aug.) www.dailymail.co.uk/news/article-1300807 (accessed 22 Feb. 2016)

Ene Dogioiu, Ioana 2013a. Cea mai justificata greva din lume. *Ziare.com* (24 June). www.ziare.com/social/spital/cea-mai-justificata-greva-din-lume-1242666 (accessed 22 June 2015)

Ene Dogioiu, Ioana 2013b. Dezvaluiri grave in sanatate: De ce mor pacientii? De ce tac medicii? *Ziare.com* (4 Dec.) http://www.ziare.com/social/spital/dezvaluiri-grave-din-sanatate-de-ce-mor-pacientii-de-ce-tac-medicii-cat-si-cine-fura-interviu-1271086 (accessed 22 June 2015)

Ene Dogioiu, Ioana 2013c. Medicina pentru export. *Ziare.com* (27 July). www.ziare.com/stiri/spitale/medicina-pentru-export-1248291 (accessed 22 June 2015)

Evz.ro 2008. Controlul averilor, un veac de esecuri. *Evenimentul zilei* (7 Aug.) www.evz.ro/controlul-averilor-un-veac-de-esecuri-815433.html (accessed 22 June 2015)

Fierbinteanu, Cristian. 2014. Băsescu: sistemul mafiot din sănătate a stimulat bine Piaţa Universităţii împotriva Legii Sănătăţii. *Mediafax* (27 Apr.). www.mediafax.ro/politic/basescu-sistemul-mafiot-din-sanatate-a-stimulat-bine-piata-universitatii-impotriva-legii-sanatatii-12534702 (accessed 30 March 2016)

Goina, Calin 2012. 'Cine nu sare, nu vrea schimbare!' O analiza a miscarilor de protest din ianuarie-ferbruarie 2012 din Cluj. In *Iarna Vrajbei Noastre: Protestele din Romania, Ianuarie-Februarie* 2012 (eds) Catalin Augustin Stoica and Vintila Mihailescu, pp. 198–231. Bucharest: Paideia.

Gotiu, Mihai 2012. 'PDL și USL, aceeași mizerie!' Ce vor protestatarii: Lista de la Cluj. *Voxpublica* (16 Jan.). http://voxpublica.realitatea.net/politica-societate/psd-si-usl-aceeasi-mizerie-ce-vor-protestatarii-lista-de-la-cluj-72824.html/attachment/proteste-cluj (accessed 22 June 2015)

Gupta, Akhil 2012. *Red tape: bureaucracy, structural violence and poverty in India*. Durham, NC: Duke University Press.

Harvey, David 2005. *A Brief History of Neoliberalism*. Oxford: Oxford University Press.

Harvey, David 2004. The 'new' imperialism: accumulation by dispossession. *Socialist Register*: 63-87.

INS (Institutul National de Statistica) 2013. *Anuarul statistic 2013*. Bucharest: INS.

INS (Institutul National de Statistica) 2016. FOM103C - Civil economically active population by activities of national economy at level of CANE Rev.1 section and ownership type. Tempo Online. Bucharest: INS. http://statistici.insse.ro/shop/index.jsp?page=tempo3&lang=en&ind=FOM103C (accessed 30 March, 2016).

Kaneff, D. 2002. The shame and pride of market activity: morality, identity and tradition in postsocialist rural Bulgaria. In Mandel, R. and C. Humphrey (eds.). *Markets and Moralities. Ethnographies of Postsocialism*. Oxford: Berg: 33-52.

Kideckel, David 2001. The unmaking of an East-Central European working class: knowledge and subalternity in post-socialist/neo-capitalist societies. In *Postsocialism: ideals, ideologies and practices in Eurasia* (ed.) Chris Hann, pp. 114–32. London: Routledge.

Kleinman, Arthur 2013. "From illness as culture to caregiving as moral experience', *New England Journal of Medicine*, 368, 15, April 11: 1376-1377.

Leca, Iulian 2012. Traian Basescu si sistemul ticalosit. *Ziare.com* (22 Oct.) www.ziare.com/basescu/presedinte/traian-basescu-si-sistemul-ticalosit-1197106 (accessed 22 June 2015)

Ledeneva, Alena 2014. Economies of favors or corrupt societies? *Baltic Worlds* 1: 13– 21.

Lee, Richard Borshay. 1979. *The !Kung San: Men, Women and Work in a Foraging Society*. Cambridge: Cambridge University Press.

Mandel, R. and C. Humphrey (eds.). 2002. *Markets and Moralities. Ethnographies of Postsocialism*. Oxford: Berg.

Marshall, T. H. 1950. *Citizenship and Social Class*. Cambridge: Cambridge University Press.

Maurel, M-C. 1995. Temps de la decollectivisation. *Revue d'etudes comparatives est-ouest* 3: 5-14.

Mauss, Marcel. 1973. *Sociologie et anthropologie*, Paris: PUF.

Mossialos, Elias, Sara Allin and Konstantina Davaki 2005. Analysing the Greek health system: a tale of fragmentation and inertia. *Health Economics* 14 (S1): S151–68.

MS (Ministerul Sanatatii) 2006. *Ordin Nr 886/2006*. Bucharest: Ministerul Sanatatii. http://lege5.ro/Gratuit/geydcnbrgm/ordinul-nr-886-2006-privind-externalizarea-serviciilor-medicale-si-nemedicale-din-unitatile-sanitare (accessed 22 June 2015)

MS (Ministerul Sanatatii) 2013. Comunicat de Presa: Finantarea din Fondul Unic de Asigurari Sociale de Sanatate a furnizorilor de servicii medicale din sistemul privat. 16 January. Bucharest: Ministerul Sanatatii. http://www.ms.ro/index.php?pag=62&id=12329&pg=1 (accessed 22 June 2015)

MS (Ministerul Sanatatii) 2014. *Strategia nationala de sanatate 2014–2020*. Bucharest: Ministerul Sanatatii.

Navarro, Vincente 1976. *Medicine under capitalism*. New York: Prodist.

Parry, Jonathan. 1986. The gift, the Indian gift and the 'Indian gift'. *Man* 21 (3): 453-73.

Petcu, Ana-Maria 2013. Dreptate pentru tatal meu. *Mariuspetcu.blogspot* (19 May). http://mariuspetcu.blogspot.no/2013/05/dreptate-pentru-tatal-meu-oamenii-sunt.html (accessed 22 June 2015)

Poenaru, Florin 2014. Câteva observații după alegeri. *CriticAtac* (17 Nov.) www.criticatac.ro/26782/cateva-observaii-dup-alegeri/ (accessed 6 Mar. 2016)

Poenaru, Florin and Costi Rogozan (eds) 2014. *Epoca Traian Băsescu: România în 2004–2014*. Cluj: Editura Tact.

Polanyi, Karl 1968. The substantivist revolution. In *Economic anthropology: readings in theory and analysis* (eds) E. Le Clair & H. Schneider, 122-43. New York: Holt, Rinehart & Winston.

PR (Parlamentul Romaniei) 1995. Legea 74/1995 privind exercitarea profesiunii de medic, înfiinţarea, organizarea şi funcţionarea Colegiului Medicilor din România. *Monitorul Oficial* 149, 14 July. Bucharest: Monitorul Oficial RA. http://lege5.ro/Gratuit (accessed 22 June 2015)

PR (Parlamentul Romaniei) 1997. Legea nr.145 din 24 iulie 1997, Legea asigurărilor sociale de sănătate. *Monitorul Oficial* 178, 31 July. Bucharest: Monitorul Oficial RA. www.cdep.ro/pls/legis/legis_pck.htp_act_text?idt=2557 (accessed 22 June 2015)

PR (Parlamentul Romaniei) 2006. Legea nr. 95 / 2006 privind reforma in domeniul sanatatii. *Monitorul Oficial* 372, 28 April. Bucharest: Monitorul Oficial RA. www.cdep.ro/pls/legis/legis_pck.htp_act_text?idt=72105 (accessed 22 June 2015)

Rat, Cristina 2008. Unequal security within public health care systems: a case study of the North-West development region of Romania. Presented at the annual conference of The Human Development and Capability Association, New Delhi (10–13 September). http://socialzoom.com/echiserv/eng/C%20Rat%202008%20HDCA.pdf (accessed 22 June 2015)

Sampson, Steven 1983. Bureaucracy and corruption as anthropological problems: a case study from Romania. *Folk* 25: 63–96.

Sampson, Steven 1986. The informal sector in Eastern Europe. *Telos* 66: 44–66.

Sampson, Steven 2002. Beyond transition: rethinking elite configurations in the Balkans. In *Postsocialism: ideals, ideologies and practices in Eurasia* (ed.) Chris Hann, pp. 297–316. London: Routledge.

Sampson, Steven 2005. Integrity warriors: global morality and the anti-corruption movement in the Balkans. In *Corruption: anthropological perspectives* (eds) Dieter Haller and Cris Shore, pp. 103–130. London: Pluto Press.

Sandu, Dumitru 2005. Dynamics of Romanian emigration after 1989: from a macro- to a micro-level approach. *International Journal of Sociology* 35 (3): 36–56.

Schneider, Jane and Peter Schneider 2005. The sack of two cities: organized crime and political corruption in Youngstown and Palermo. In *Corruption: anthropological perspectives* (eds) Dieter Haller and Cris Shore, pp. 29–46. London: Pluto Press.

Schneider, J. and P. Schneider. 1976. *Culture and Political Economy in Western Sicily*. New York: Academic Press.

Stan, Sabina 2007. Transparency: seeing, counting and experiencing the system. *Anthropologica* 49 (2): 257–73.

Stan, Sabina 2012. Neither commodities nor gifts: post-socialist informal exchanges in the Romanian healthcare system. *Journal of the Royal Anthropological Institute* 18 (1): 65–82.

Stan, Sabina 2015. Transnational healthcare practices of Romanian migrants in Ireland: inequalities of access and the privatisation of healthcare services in Europe. *Social Science and Medicine* 124 (C): 346–55.

Stan, Sabina and Roland Erne 2014. Explaining Romanian labor migration: from development gaps to development trajectories. *Labor History* 55 (1): 21–46.

Stan, Sabina and Roland Erne 2016. Is migration from Central and Eastern Europe an opportunity for trade unions to demand higher wages? Evidence from the Romanian health sector. *European Journal of Industrial Relations*, 22(2): 167–183.

Stancu, Elena 2014. Mass exodus: why corruption in Romania's healthcare system is forcing its doctors to work abroad. *The Independent* (2 Jan.). www.independent.co.uk/news/world/europe/mass-exodus-why-corruption-in-romanias-healthcare-system-is-forcing-its-doctors-to-work-abroad-9035108.html (accessed 22 June 2015)

Stepurko, Tetiana, Milena Pavlova, Irena Gryga, Liubove Murauskiene and Wim Groot 2015. Informal payments for health care services: the case of Lithuania, Poland and Ukraine. *Journal of Eurasian Studies* 6 (1): 46–58.

Stoica, Catalin. A. 2012. Fetele multiple ale nemultumirii populare: o schita sociologica a protestelor in Piata Universitatii din ianuari 2012. In *Iarna vrajbei noastre: protestele din Romania, ianuarie–februarie 2012* (eds) Catalin Augustin Stoica and Vintila Mihailescu, pp. 19–79. Bucharest: Paideia.

Thompson, E.P. 1971. The moral economy of the English crowd in the Eighteenth century, *Past & Present* 50: 76-136.

Trif, Aurota 2013. Romania: collective bargaining institutions under attack. *Transfer: European Review of Labour and Research* 19 (2): 227–37.

Verdery, Katherine 1996. *What was socialism and what comes next*? Princeton, NJ: Princeton University Press.

Verdery, Katherine 1991. Theorizing socialism: a prologue to the 'transition'. *American Ethnologist* 18 (3): 419–39.

Vladescu, Cristian and Vasile Astarastoae 2012. Policy and politics of the Romanian health care reform. *Romanian Journal of Bioethics* 10 (1): 89–99.

Vladescu, Cristian, Gabriela Scintee and Victor Olsavszky 2008. Romania: health systems review. *Health Systems in Transition* 10 (3): 1–172.

Zerilli, Filippo 2013. Corruption and anti-corruption local discourses and international practices in post-socialist Romania. *Human Affairs* 23 (2): 212–29.