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# Neoliberal Citizenship and the Politics of Corruption

## Redefining Informal Exchange in Romanian Healthcare

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In contemporary neoliberal perspectives, corruption is essentially framed in terms of the opposition between the state, political elites and public employees on the one hand, and civil society, the market and consumer-citizens on the other. Public services are by default constructed as breeding grounds for corruption, while honest (middle-class) citizens 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, to redraw the boundary between state and market, and public and private sectors, by extending the first and reducing the second.

This view acknowledges that corruption is a battleground of social struggles. Anthropological studies of corruption have, however, proposed that the manner in which this happens may in reality be more complicated than that. The most notable such studies have come from a renewed interest in political anthropology among those studying post-socialist and post-colonial societies, and calling for an anthropology of the state (Verdery 1996; Gupta 2012). Akhil Gupta in particular argues that the degree to which discourses of corruption and accountability become politically significant depends not only on pressures from global organizations such as the World Bank or Transparency International, but also on the degree to which groups affected by corruption organize themselves at national, regional and local levels. For example, in the case of the 'routinized practices of retail corruption' in India, Gupta (2012: 99,

100) finds that urban, middle-class political activism at a national level and agrarian mobilization at a regional level were important for making anti-corruption and clean government an important political issue. Most interestingly, Gupta also finds that these groups demanded an end to corruption in the name of the inclusive citizenship put forward by India's populist democracy. In this case, therefore, struggles around corruption were not so much about retrenching the realm of the state as about extending it, most notably by extending access to the public goods and services distributed by the state (i.e. citizenship). In a similar vein, we could read Schneider and Schneider's (2005) analysis of mafia practices in Italy as illustrating another possible use of corruption in struggles around citizenship. In this case, ruling elites encouraged corruption in order to maintain their dominance, most notably by stifling labour protest intended to bring about a more inclusive definition of citizenship. In contrast to neoliberal views on corruption, these studies show that corruption and demands to end it may be pursued by a variety of actors using a variety of means.

The link between struggles around corruption and citizenship is important. Indeed, it draws our attention to the state as being not only and automatically a breeding ground for corruption (as in neoliberal perspectives) but also an arena of social struggle over the distribution of common goods (Bourdieu, Waquant and Farage 1994), which constitute both the substance of citizenship and the object of corrupt practices. Struggles around corruption, including around identifying its nature, location and culprits, may thus take several possible forms, which need to be studied empirically rather than assumed.

This chapter uses informal exchanges (or 'petty corruption') in the Romanian healthcare sector to investigate the links between corruption and neoliberal citizenship regimes, and to illustrate its contested character in post-socialist contexts. Given its role in the social reproduction of capitalist societies (Navarro 1976), and given that access to it has traditionally been seen as an important citizenship entitlement in Europe, healthcare offers a useful vantage point for grasping struggles over citizenship in the region.

In recent decades, reforms across Europe have aimed to commodify healthcare, and so challenge entitlement to healthcare services and reconfigure citizenship. I want to situate informal exchanges in Romanian healthcare in the larger context of that rise of neoliberal citizenship and healthcare reform, which has been attended by increasingly unequal access to services, by worsening employment conditions in the sector and by protest against those reforms among the public and those in the sector.

I treat neoliberalism as a set of policies that seek to encourage the development of the 'free market' by reducing state involvement in various parts of the economy and the society. In public services such as healthcare, these policies include measures such as cuts in public spending, the introduction of new public management and the privatization of service delivery, management and funding. By using the term 'neoliberal' I do not assume that all policies come as a coherent package to be adopted in one go. Rather, I contend that, while they have often been adopted and implemented in a patchy and uneven manner, these policies have also contributed in various ways to extending the realm of the market in health services. Finally, this chapter does not argue that informal exchanges are a novelty generated by neoliberal policies. Rather, it contends that their form and the way various actors in society engage with these exchanges are embedded in the larger policy frame of particular historical periods. A period dominated by neoliberal policies is one of them, and the chapter seeks to unearth what is specific about informal exchanges and corruption at this time.

In order to do this, I adopt a historical perspective that links citizenship configurations to the changing nature of informal exchanges since the fall of the Communist regime at the end of the 1980s. The chapter 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 chapter then turns to the austerity period that followed the boom, and shows that the consolidation of neoliberal citizenship and the accelerated privatizing 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 privatization 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 subsidized services such as rented accommodation and 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 informal exchanges in other areas, these were part of the larger socialist 'economy of favours' (Ledeneva 2014). Based on networks of personal relations and exchanges of favours among family, friends, neighbours and work colleagues, the economy of favours helped to 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 equalizing 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 socialist 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 citizens with 'a degree of entitlement to whatever the economy of favours had to offer' (ibid.). Accordingly, during socialism many citizens 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 distancing many ordinary exchanges of favours in which they were involved from self-serving corrupt practices (ibid.).

Moreover, during socialism, wrongdoing was not understood in the same way as 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). In addition, 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 wrongdoing 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 (*Evenimentul zilei* 2008). The regime, therefore, not only allowed the economy of favours to compensate for the deficiencies in resource allocation, but also used the potential threat of prosecution as a means to discipline various sections of its population – most notably the potentially contentious working class, and not so much the cadres.

Doctors were well placed to attract a relatively large 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 doctors managed to live in large villas and have a prestigiously higher standard of living than ordinary workers, despite their salaries not being markedly higher than those of the workers.

Thus, during socialism the medical profession faced a continuous underfunding 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, either by 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 dismantling of the planned economy and the partial liberalization 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 cooperative lands, 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 job losses 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 maintained its role in post-socialist citizenship. The organization 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 protest differed. *Federatia Sanitas*, the nurses' union, entered into alliances with the ruling Social Democrats, while the Romanian Federative Chamber of Doctors Union (*Camera Federativa a Sindicatelor Medicilor din România*, CFSMR) sided with right-wing opposition parties.

With the reinstatement of private property and the dismantling of state and cooperative property, the realm of wrongdoing 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 fitted the fact that so many doctors were public service employees. The fact that doctors were not charged with *luare de mita* in the 1990s is probably due more to the government's willingness to turn a blind eye to informal exchanges in the healthcare sector than it is to the relabelling 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. Poorer patients and doctors at the bottom of the medical hierarchy lacked the money that would buy the post-socialist consumerist abundance; therefore, patients often offered goods as *spaga*; for instance, imported coffee or 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 exchange money, even if consumer goods complemented it in the form of gifts of gratitude. Thus, the *atentii* (attentions) that those patients gave to doctors were more and more talked about as *spaga* – 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 privatization of state companies and the liberalization 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 2016). 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 privatization.

This post-socialist entrepreneurial 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 thoroughgoing 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 twenty-six 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.<sup>1</sup> 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, van den Heuvel and Maarse 2002: 21).<sup>2</sup>

### **Informal Exchanges and 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 to consolidate the turn to peripheral neoliberal development (Bohle and Greskovits 2012) began by CDR. That involved encouraging foreign firms to set up businesses that employed low-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 steady but modest 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 likely to have the resources needed to engage in *spaga* and so gain access to better education and healthcare services.

The consolidation of the neoliberal turn in Romania's development model also led to healthcare being, at last, gradually but steadily transformed along the same lines. At the beginning of the 2000s, doctors practising in primary and secondary care ceased to be public employees and instead became free 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 Băsescu. This inaugurated the 'Băsescu era' of 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 marginalized classes dependent on the social wage provided by these services, for underfunding 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 'externalize 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 that allowed private providers to contract with the NHF 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 Astarastoe 2012). Also, they led to the uneven distribution of healthcare services across the country. In contrast to large cities, many deindustrialized 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.<sup>3</sup> A 2007 study of healthcare in the relatively rich north-west development region found that 16 per cent of the active population were not covered by national health insurance and almost 4 per cent were not registered with a GP (Rat 2008: 20). By contrast, 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.

The increasingly unequal access to healthcare was compounded by the differences in people's ability to make informal payments to get better care (Stan 2012). The same 2007 study found that 46 per cent of respondents who had been hospitalized or had had a close family member hospitalized during the previous twelve 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 had done so (*ibid.*: 24). Poorer patients still engaged in informal exchanges, but complemented their limited cash with goods that they had produced themselves or had obtained through other informal exchanges. As well, they tried to invoke notions of social 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).

## **Austerity, Healthcare Reforms and Informal Exchanges**

After the onset of the financial crisis and a year after being returned to power in 2008, the government signed agreements with the EU and 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 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 privatization 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 realize the ambulatory turn in financing healthcare services (described below) and to introduce financial discipline in public hospitals. Following union and popular protest, 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 reshuffles 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 organizations 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 2015).

In spite of the protests, the privatization 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 entrepreneurial

citizenship offered by the regime, with Bănescu publicly thanking migrants for not being a burden on Romania's unemployment fund (*Daily Mail* 2012). This citizenship was also increasingly divisive, as marginalized 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 was manifest in healthcare, 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 (Vlădescu and Astarastoea 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 (*ibid.*), 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 *spaga* that now took an additionally nasty turn. Indeed, the deterioration in wage levels 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' on receiving sums of money, which for poorer patients were often prohibitive.

### **Informal Exchanges and the Fuzzy Border between Private and Public Healthcare**

It is in this context that *spaga* entered as a powerful signifier in debates around healthcare reforms. Thus, the two authors of the 2011 healthcare reform law (Vlădescu and Astarastoea 2012) said that the introduction of regulated competition among private insurers was a means to eradicate *spaga* 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 privatize a substantial amount of healthcare. In addition,

the authors of the 2011 law argued that eliminating *spaga* would eliminate inequalities of access to healthcare services (Vladescu and Astarastoe 2012), thus blaming those inequalities on *spaga*, rather than on the neoliberal healthcare reforms and the depletion of public health services.

The existence of *spaga* in the healthcare services in the 2010s does not indicate that greater privatization would eradicate informal exchanges. Especially in rural areas and small towns, *spaga* persisted in both primary and secondary healthcare, in both the public and the private sector, that catered to the poorer population of these areas. Indeed, being usually small entrepreneurial practices, private practices 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 consultations and treatments to services that also were contracted out with the Fund. The overall effect was that *spaga* 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 *spaga* 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 *spaga*: 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 other specialist services that are also contracted out with the Fund.

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. Thus, 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 *spaga* 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).

The only area where *spaga* 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 *spaga* 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, as I described, could engage in shuffling patients between the two systems and, in the process, draw on *spaga*.

Thus, the forms taken nowadays by *spaga* are closely related to the manner in which the Romanian healthcare system has been reshaped over the past few decades, most notably in terms of the specific mixes of public and private provision and funding seen above. This means that, while already present during socialist times, current *spaga* practices could only very partially be considered as a 'legacy of socialism'. Instead they should be seen as also including important elements of 'innovation' that triggered the neoliberal transformation of the Romanian healthcare sector.

### **Protest and the Criminalization of Informal Exchange in Austerity Times**

There is more to *spaga* than simply a question of how its forms reflect neoliberal healthcare reforms. Indeed, the ways in which *spaga* has been used in media debates and some state actors' interventions in the healthcare sector speak to us also of struggles around healthcare reforms and of *spaga*'s role in attempts to contain union and popular protest.

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 its leaders. 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 (Agentia Nationala 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 the union leaders who were active in the 2010 street protests organized 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' (ibid.).

Also in 2011, the National Anti-corruption Directorate (Directia Nationala Anticoruptie, DNA) staged a *flagrant* (sting operation) that caught Marius Petcu, the leader of both the Sanitas union federation and 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 sympathizers 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 were 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, demonizing 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, 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 *spaga* 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 are thus forbidden to accept 'supplementary payments and donations' from patients (*Hotnews* 2015). For the first time, therefore, doctors working in public hospitals were clearly identified as being subject to laws against *luare de mită*.

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 Băsescu, 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, Băsescu said that he knew of doctors who were 35 or 40 years old who were leaving 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 were leaving 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 referred to ‘those who for the last twenty-three years [i.e. since 1989] have kept the Romanian healthcare system on the breakdown line, have humiliated doctors, humiliated patients, and drained the healthcare money into private pockets, transforming the system into a feud of all sorts of mafias’ (Ene Dogioiu 2013c). A former president of the NHF, and member of Băsescu’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 anything’ (quoted in Ene Dogioiu 2013b).

These allegations of significant corruption resonate with the populist discourse of President Băsescu, who presented himself as a modern crusader against corruption and the ‘wretched system’ (*sistemul ticăloșit*), and who, like the national hero Vlad the Impaler, impales corrupt politicians (Leca 2012). More interestingly, Băsescu claimed that the 2012 protests against the 2011 law were the work of ‘the mafia system [*sistemul mafiot*] in healthcare’ (Fierbinteanu 2014). In his view, then, opposition to the further privatization of the sector sprang from the desire to continue to receive gifts and bribes. Following this logic, Băsescu later on implicitly acknowledged his government’s attempts to make *spaga* 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’ (ibid.).

It is not clear if the protests of January 2012 against the 2011 law had 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. Many of the middle-class protesters were among the better-off patients who had already lifted off from public health services and would have agreed on the president's view that the latter's problems lay in the informal exchanges between doctors and patients. While agreeing on that point with the president, the 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 Băsescu and his PDL government to step down, and many condemned the political class as a whole. Protesters from the old socialist classes wanted this and more. Many of them were among the poorer category of patients who understood informal exchanges not so much as the justification for the privatization of an inherently corrupt public healthcare sector, but as a means to fairer access to services. For them, the problem of the Romanian healthcare sector lay in the retrenchment of state involvement in the sector, as they held that the previous twenty 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 privatization, 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 country 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 and the Pungesti Chevron fracking projects, 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**

This chapter has described the evolving links among citizenship, government policies and the configuration of informal exchanges in the Romanian healthcare sector. That description shows that post-socialist informal exchanges in healthcare are not so much a legacy of socialism (see also Zerilli 2013) or an invariant and intrinsic characteristic of the state and its public services as a function of the evolving reconfigurations of citizenship and the struggles that social

actors wage around it. Indeed, these reconfigurations were driven in part by the desire to commodify healthcare work and to privatize 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. Echoing points made in this volume's Introduction, 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 exchange in Romania's public service resembles what is described in Eastern Europe (Stepurko et al. 2015) and even Southern Europe (Mossialos, Allin and Davaki 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 that informal exchange 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 border between the public and the private – a border that neoliberal reform has made evermore fuzzy, even in the heartland of global capitalism.

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## Acknowledgements

This work was supported in part by the European Research Council grant 'Labour Politics and the EU's New Economic Governance Regime (European Unions)', grant agreement ERC725240.



**European Research Council**

Established by the European Commission

## Notes

1. In 2004, 34 per cent of Romania's total healthcare expenditure was from private sources (Vladescu, Scintee and Olsavszky 2008: 45), which at that time was mainly patients making out-of-pocket payments.
2. 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).
3. In 2012, access to NHF services covered 94 per cent of the population in urban areas but only 75 per cent in rural areas (MS 2014).

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