Privatization and uneven dispossession in Romanian health care

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In the last two decades, medical anthropologists came to acknowledge that access to health services has been increasingly affected by health care privatization (Rylko-Bauer and Farmer 2002; Pfeiffer and Chapman 2010). They have also acknowledged that people might seek to access care by combining not only biomedical, folk and popular care (Kleinman 1978; Baer 2011), but also various biomedicines embedded in distinct socio-cultural contexts (MacFarlane and de Brun 2010). Few medical anthropological studies have, however, examined the increased pluralism induced by privatization inside biomedical care (Wegrzynowska 2016). In this article, we look at health care privatization in Romania and its impact on the manner in which patients access health services, most notably by combining recourse to public and private care.

We define health care privatization as covering not only the rise of private insurance, clinics or hospitals, but also the various processes leading to private interests and actors having an increased role in the delivery, funding and management of health services (see also Maarse 2006). In this perspective, health care privatization therefore also includes the disinvestment of states from health care as well as the introduction of private business management measures in public health services. Both processes clear the ground for a rise in private funding, management and provision of health services by restricting access to public care (Abadia-Barrero 2015; Lopez 2005; Becker 2007) and fostering the commercialization of care (Maskovsky 2000; Dao and Nichter 2016). Building on this encompassing definition, we adopt a political economy perspective that sees privatization as part of the larger process of "accumulation by dispossession" (Harvey 2004), fundamental to contemporary capitalist expansion. Dispossession affects social citizenship rights of access to the common good of public services (Marshall 1950), including the "commons" of public health care (Smith-Nonini 2006).

Linking privatization to capitalist dispossession allows us to see that, rather than being a one-way process, health care privatization is but one moment in a larger historical process whereby phases of capitalist expansion have led to various balances between public and private care, between universal extension and uneven dispossession of citizenship rights among different social groups. Indeed, private and public care have been combined since the rise of modern medicine in the nineteenth century. The balance between the two has tilted more to public care after the Second World War (following increased state intervention in health care, most notably in Europe) and back to private care since the 1970s (following the increased hold of neoliberal 'free market' policies on welfare arrangements).

In the last two decades, Central and Eastern Europe (CEE) is where health care systems in Europe (the locus of public health care par excellence) have been most thoroughly transformed (Andre and Hermann 2009). Given the importance of health care as a safety net for populations greatly affected by post-socialist neoliberal transformations (Bohle and Greskovits 2012), CEE health care systems have seen both repeated attempts at privatization and various forms of resistance to these attempts (Stan and Erne 2016, Hardy et al. 2014). This makes the study of health care privatization in CEE most interesting, as it offers an opportunity to observe a variety of actors, strategies and struggles at work in this process. We will inquire into the dispossession involved in health care privatization by looking at the case of health services in Romania.

We base the article on fifteen years of "intermittent fieldwork" (Buchovski 2004) conducted by both of us in Romania's health services. During our previous research (Stan 2007, 2010, 2012, 2015, 2016, forthcoming; Stan and Toma 2009; Stan and Erne 2016) we have approached dozens of patients, health care professionals and health care officials for both formal and informal conversations. Fieldwork was conducted in Bucharest, as well as in a middle-size city, a small town and a village in the southern part of Romania. In this article,

we sought to protect the participants' identity as well as enhance the heuristic value of their stories by constructing six composite characters that combine elements from various participants in a plausible but semi-fictional manner (Humphreys and Watson 2009). These 'ethnographic' characters will guide us through Romanian society and health services.

We start with a theoretical discussion of health care privatization as uneven dispossession, and present its impact on access to services in Romania. We then map social divisions in Romanian society, and introduce the six ethnographic characters in order to more concretely grasp the variety of social positions in contemporary Romanian society and the possible pathways people in these positions take in accessing health services. In the next sections, we focus on the blurring of the border between public and private care and the ways in which this blurring plays on how dispossession is responded to by different categories of people in Romania. We close the article with a discussion on the various moralities of care that have been mobilized in these responses, and conclude with considerations on what the Romanian case tells us about health care privatization and health care pluralism in contemporary world.

CONTEMPORARY HEALTH CARE PRIVATIZATION AS UNEVEN DISPOSSESSION

For Harvey, the "corporatization and privatization of public assets" (2004:75) of the last decades are to be understood as part of contemporary capitalism's response to its accumulation crises. This response took the form of accumulation by dispossession whereby various vulnerable groups are dispossessed of goods and services previously defined as commons (Smith-Nonini 2006) under public, common, collective or state property. The resulting transfer of assets from public to private (and most notably corporate) hands also challenges entitlement and access to public services. This is also

true most particularly in health care, where privatization has been tightly linked with the spoliation of access to public services. Indeed, privatization led to the retrenchment of public involvement in health care (following state disinvestment from health care), the commoditization of public health care (following business management measures) or the outright rise in importance of private health care insurance and providers.

Harvey understood the privatization of public services as being part of the larger process of accumulation specific to neoliberal capitalism. Some scholars have imagined a situation where the thorough privatization of care would lead not only to dispossession but also to the "destabiliz(ation) of the very process of social reproduction." (Frazer 2016:100) Ironically, it might be that this ultimate horizon of complete privatization is not necessarily what private businesses have in mind. True, nowadays private market actors seem more and more interested in getting involved in the provision and management of health services (Schmid et al. 2010; Lethbridge 2005). However, private businesses find the financing of health care profitable only in as much as they are able to externalize major health risks and their costs to the public purse (Rylko-Bauer and Farmer 2002; Waitzkin 1983). Health care privatization can thus never really be complete and may also involve a re-definition of what public and private health care stand for.

Health care privatization not only dissolves rights and entitlements to the commons, but also fragments rights among differently entitled social groups. Cuts to the funding of public health care units, means-tested access to publicly funded care and the rise in private provision, management and funding of care, whereby access became means-dependent, differently affect various social groups' access to health care. This results in a socially differentiated dispossession and an uneven citizenship space (Maas 2009). In this space, governments concede the granting of social citizenship rights (and

access to publicly funded services) to the most vulnerable categories in society only in as much as the latter actively strive to mold middle classes' "consumer citizenship" (Stan 2016) centered around "the free exercise of personal choice among a variety of options." (Miller and Rose 1993:98)

The apparent aim of health care privatization is to remove health services from the area of rights and entitlements to that of consumption and choice. In practice, given its incomplete character, health care privatization leads to a mixed regime combining citizenship rights and consumption choices, free access to health services and access privately paid for. Recourse to health services variously affected by commoditization can therefore be understood in relation to consumption practices (Miller 2012). Indeed, as consumption has become central to contemporary articulations of citizenship, health and health care (Petersen and Lupton 1996; Crowford 1980), looking at how consumption mediates social distinction may provide a fruitful frame for understanding practices of access to health services (Stan 2010; Horton 2013). Following Bourdieu (1986), we consider dispositions of adopting distinctive consumption and access patterns as being dependent on the positions of actors in larger social fields. These structurally situated positions and dispositions allow us, in the end, to account for the uneven manner in which dispossession affects and is responded to by actors variously situated in larger social fields.

In the next two sections we will look at the historically and spatially specific manner in which health care privatization unraveled in Romania and the way in which it led to uneven access to health care for different categories of population.

POST-SOCIALIST HEALTH CARE PRIVATIZATION IN ROMANIA

The health system that Romania inherited from the communist regime (1946-1989) was an eminently public one, as it was based on funding from the state budget, public provision and quasi-universal access to services. Privatization started at the beginning of the 1990s when doctors were allowed to 'go private'. It nevertheless remained rather limited during the first post-socialist decade, as 'liberal' medical practices were mostly concentrated in primary care and some specialisms such as gynecology and dentistry. In turn, public health services were affected more by the continuing low levels of healthcare expenditure rather than by any major organizational overhaul.

At the beginning of the 2000s, a new health care law transformed Romania's health services into a national health insurance system mainly funded by the National Health Insurance Fund (NHIF), giving access to services mostly based on employment-related contributions. The law introduced patient choice in accessing doctors and health care units, thus bringing the first seeds of consumerism into the system. It also made provisions that the national health insurance covers a population larger than the narrow group of 'contributors' to the NHIF. Nevertheless, its focus on employment-based entitlement led to some categories of population being excluded from accessing public health services - for example, the long-term unemployed who have ceased to receive unemployment benefits (Bara et al. 2002). Moreover, the liberalization of doctors' choice in locating their practices led to a declining presence of doctors in primary and secondary care in deindustrialized small towns and more isolated villages. In locations where insufficient numbers of doctors and health care units combined with declining wages, rising unemployment levels and the fall of public transport infrastructure, the local population's access to health care was drastically diminished.

The 2000s also saw the rise of the first private 'corporate' health care units. This rise was given a boost in 2006 by new legislation, which allowed public health care units to "externalize medical and non-medical services" to private providers (MS 2006), and private

health care units to contract services with the NHIF (PR 2006). At the same time, this legislation further restricted access to public health care. Indeed, it lowered the number of categories of people covered by national health insurance but exempt from contributing to the NHIF. It also distinguished between a "basic services package" available to 'insured' citizens, and a very limited "minimal services package" available to 'non-insured' ones, and restricted to care for life-threatening emergencies, epidemic/infectious diseases and birth (Vladescu et al. 2016:57).

Health care privatization accelerated after the 2008 financial crisis and the drastic austerity policies adopted in its wake (Trif 2013). After the right-wing government's attempts at an overhaul, privatization failed at the beginning of 2012 due to popular street protests (Poenaru 2013). Subsequent governments continued privatization in a more piecemeal, but nevertheless steady manner. During the first half of the 2010s, they managed to close a number of local public hospitals and introduce financial discipline and reduce hospital beds in the remaining public hospitals (Vladescu et al. 2016). They also introduced co-payments for inpatient care and required all pensioners except the most destitute to contribute to the NHIF. The result of these transformations has been the continuation of state disinvestment in public health care.

At the same time, private health care became dominant in primary and secondary care, accounting, in 2014, for 53% for primary and 61% for secondary care, of the total number of units in each sector (INS 2017, SAN 101B). These figures are probably an underestimate, as, while most 'public' primary or secondary care units are situated in public locations, mostly belonging to local authorities, for all other purposes they function as independent, 'private' liberal practices (Vladescu et al. 2016). Moreover, the number of private hospitals also rose spectacularly, caming to account, by 2015, for around a third of the total number of hospitals in the country (INS 2017, SAN 101B).

Nowadays private health care in Romania combines a private 'corporate' health care sector, including large private health care chains mostly owned by investment funds, and a private 'liberal' health care sector covering a myriad of small-scale, entrepreneurial medical practices. A significant part of services offered in the private sector, both liberal and corporate, is covered by public funds, mostly from the NHIF (SAR 2013). Large health care chains also offer so-called 'private medical packages' (*abonamente medicale private*) to the employees of mostly large and medium private companies. Medical packages cover pre-agreed yearly bundles of services in pre-selected private clinics and hospitals and have mostly a preventative rather than risk-responding character (Calin 2016). Private insurance packages have also been developed by large health care chains, as well as private insurers, but they are offered mostly to larger, and richer, multinational corporations active in the IT, banking or telecommunications sectors (Calin 2016). Private insurance is therefore still very limited in Romania, rising, during the last decade, to a mere 0.1% of total health expenditure (Vladescu et al. 2016).

…AND POST-SOCIALIST INEQUALITIES OF ACCESS TO HEALTH SERVICES

The rise in the number of private health care facilities has thus probably improved access to health services for the more privileged categories of the population. A 2013 study commissioned by the private health care chain Medlife (2013) claimed that, while 42% of respondents would choose to go to a private hospital if need be, preference for private hospitals was higher among people in the 18-29 age bracket, residents of big cities and the capital, those with third level education, and those with a monthly income above 222 euro.

The increase in private health care has not, however, led to an improvement of overall access to services in Romania. This is also partly due to the limited overall capacity of private

hospitals: in 2015, they accounted for only 5% of the total number of hospital beds in Romania (INS 2017, SAN102B). They also focused on day surgeries and day care (Vladescu et al. 2016:79) leaving public hospitals as default options for providing care for acute cases. All in all, Romania's private health care sector seems to have tailored down its recourse to health care personnel and instead concentrated on offering quicker access to better technology than the one available in the public health care sector. Even by its own 'market' standards, by mid-2010s the part of private sector in the total value of health services in Romania has been estimated at a mere 11% (Calin 2016).

It is therefore no wonder that, despite the rise of private health care, in recent years overall access to services has actually diminished. Romania has historically displayed very low health care expenditure rates. For most of the 2000s, these rates hovered around 5% of the GDP, a level almost half of the 2015 EU average of 9.9% (OECD 2016:117). In 2014, Romania's health expenditure per capita was the lowest in Europe, at 390 euros (Eurostat, hlth_sha11_hp). This resulted in lower than the EU average numbers of doctors and nurses per 1000 population (2.7 versus 3.5 doctors and 6.2 versus 8.4 nurses, in 2014) (OECD 2016:158) and one of the lowest per capita rates of MRI units and CT scanners in Europe (at, respectively, a third and a half of EU averages in 2014) (164).

Insufficient health care resources and the privatization of health services resulted in access to health care in Romania being both deficient and highly uneven. The 2013 Eurobarometer on patient satisfaction (EC 2014) found out that only 25% of Romanian respondents considered the overall quality of health care in their country to be good, as opposed to the EU average of 71%. By mid-2010s, while the urban population had relatively high rates of coverage with national health insurance (94.9%) and of registration with a family doctor (86%), the rural population had considerably lower rates (at 75.8% and respectively 66%) (OECD 2016:152; CNAS 2016). Particularly affected by deficient access

to services were the 'uninsured', including informal workers in small self-subsistence agriculture, self-employed workers, unemployed people not registered for unemployment or social security benefits, and members of the discriminated Roma minority who lacked identity cards (Vladescu et al. 2016). In 2013, self-reported unmet needs for medical examination for reasons of being too expensive, too far to travel or waiting lists rose to 10.4% of the population of 16 year old and older, almost three times higher than the EU28 average (Eurostat, hlth_silc_08). The rate was even higher for those in the lowest income quintile (14%), and dramatically higher for the elderly in that quintile (34%) (Eurostat, hlth_silc_08).

The continuous underfunding and fragmentation of public health services in Romania led also to sometimes low-quality and inadequate care even for those who can access these services. In response, many patients and their families sought to access better or quicker services by having recourse to formal payments for private care or to informal payments for public care (called, in local parlance, *șpagă)* (Stan 2012). A 2013 study (ASSPRO 2013:3) found that significant proportions of adult users who had consulted physicians or had been admitted to hospital in the previous year also paid for their visits, either formally (42% and 50% of respondents, respectively) or informally (29% and 42% respectively) (4). In the same time, as informal payments are means-dependent, recourse to them also serves to reproduce rather than challenge inequalities of access to public health services in Romania (Stan 2012).

Inequalities of access resulting from health care privatization have to be placed in the larger context of social inequalities current in Romanian society, a topic to which we will turn in the next section.

A DIVIDED SOCIETY

Ten years since its accession to the EU in 2007, Romania still lags behind most EU countries in terms of the quality of life of its inhabitants. True, in the last decades Romania has managed to significantly improve the health record of its population. Nevertheless, the country still displays significant gaps with EU averages for life expectancy (75 as compared to 80.9 in 2014 [OECD 2016:57]), average healthy life years (57 as compared to 62 in 2012 [Eurostat, hlth_hlye]) and age standardized mortality rates per 100000 population (1500 as compared to 1000 [OECD 2016:61]). Moreover, since the 1990s, Romania's birthrate fell dramatically and the country provided the "largest migration wave in the EU in decades" (Ban 2016:68), with between 2 and 3 million Romanians (or more than 10% of its resident population) currently living across the EU. As a result, Romania underwent one of the most dramatic demographic declines in the EU and the world, losing almost 12% of its population between 2000 and 2015 (OECD 2016:193).

Two decades of neo-liberal dis-embedded (Ban 2016) and dependent development (Bohle and Greskovits 2012) led, by mid-2010s, to Romania displaying a GDP per capita of only 57% of the EU average (Eurostat, tec00114) and median hourly employee earnings of 2.03€ (or six times lower than the EU average) (Eurostat, earn_ses_pub2s).

The country is still feebly urbanized by European standards, with 44% of its population still living in the countryside in 2016 (INS 2017, POP105A). Rural-urban and regional divisions in living standards and wages are important, most notably between de-industrialized small towns and villages in north-eastern and southern regions, and the capital and more developed cities. By mid-2010s, Bucharest attracted 59% of FDI in Romania (NBR 2016:11) and displayed an average net wage twice the level current in Romania's poorest counties (Romania Insider 2016). At the same time, more than two thirds of the rural population had no toilet and/or bathroom in their house (INS 2017, CAV102O).

Romania's employment structure displays a decreasing, but still important share of agriculture (28% of total employment in 2013), most notably in the form of self-employment on small subsistence farms (INS 2015, 102). Rising FDI and migrant remittance flows led, during the 2000s economic boom, to a considerable rise in the contribution of services and construction sectors to total employment (at, respectively, 44% and 7% in 2013). These sectors many times offer informal, precarious employment at minimum wages or below (Trif 2013; INS 2016). Currently accounting for 21% of total employment, industry has been restructured away from socialist times' extractive and heavy industry, towards equipment, machinery and automotive industries (accounting for 14% of Romania's industrial employment in 2013) and textile, leather and clothing industries (11%) (INS 2015:122, 123). Wages range from above the average in the unionized automotive sector, to average and below average in the non-unionised components manufacturing and clothing industry (INS 2016). While the private sector accounts for the bulk of employment, public sector employment is still important (covering 31% of employees) (INS 2015:104), although its employment and wage levels have been hit hard by austerity policies.

Although in the last few years Romania's economy has recovered, displaying above-average GDP growth rates and low unemployment rates (EC 2016), its profile is still one of a generally impoverished and also deeply unequal society. In 2014, Romania had the highest income quintile share ratio in the EU (Eurostat 2016). This is no wonder after a decade of flat taxation (introduced in 2005, currently at 16%) and is reflected in a share of employee compensation in the GDP significantly lower than the EU average (Eurostat 2017, tec00013). In 2015, half of the population in the 15-64 age bracket lived with an annual income of less than 2,415 euro, that is approximately, 200 euros per month (Eurostat, ilc_di05). In the same year, 37% of the population was at risk of poverty (as compared to the EU average of 24%)

(Eurostat, ilc_peps01) and less than a third (31%) of households could afford to pay for a week-long holiday (INS 2017, CAV101G).

In order to comprehend better the inequalities in living standards and access to health care current in contemporary Romania, we turn now to our six ethnographic characters. We look at the manner in which their positions in Romanian society link with their various patterns of consumption and access to public and private health care. We are aware that, while these characters are variously situated in the Romanian society, they do not exhaust all the divisions that crisscross it. However, they do capture some of the most striking divisions, that is in terms of urban and rural locations, income levels, employment status, and age.

SIX ETHNOGRAPHIC CHARACTERS IN SEARCH OF ACCESS TO HEALTH CARE

The Corporatist: Adina

Eastern European operations' director at a major multinational company, Adina is a successful and materially well-off 'corporatist' living and working in Bucharest. For members of Romania's "comprador bourgeoisie" (Sampson 2002) such as Adina, life in Bucharest has many similarities to the one her peers lead in other European 'global cities' (Sassen 1992). Indeed, her hefty monthly wage of several thousand euros places her in the top income decile and allows her to lead a sophisticated cosmopolitan life. This combines an intensive international work schedule with ownership of an expensive car and villas, outsourcing of domestic work to expensive restaurants, cleaning companies and domestic workers, and shopping in boutique and artisan specialty shops both in Romania and abroad. Single and in her late 30s with few family obligations, Adina accesses health services in ways similar to other services - as a knowledgeable and exigent consumer. In addition to being covered by the

NHIF, she also has, through her company, a generous private insurance package covering access to prestigious private hospitals and clinics in Bucharest and around the country. On top of that, Adina could, at any time, pay out of her own pocket for almost any health service offered by the latter outside her insurance plan, or again by private health clinics abroad. Thus, Adina very rarely accesses public health services, and mostly relies on those offered in the private health care sector.

The Public Service Professional: Magdalena

Forty-five year old Magdalena works as senior researcher for one of Romania's national research institutes, is married to an IT specialist working for a government agency with whom she has two school-aged children. Their household draws on Magdalena's wages of around 1000 euros/month and income from international research grants, and her husband's much more modest earnings of around 500 euro/month. Magdalena's life-style echoes Adina's in that it combines a hectic work programme, ownership of a car, a house and an apartment in Bucharest, and regular holidays in Romania and abroad. But while she and her family regularly engage in mass consumption in the capital's shopping markets, they also follow the low-waged bulk of Romania's population in buying goods in cheaper local shops or directly from local farmers. The occasional restaurant outing and 'help' from a neighbor or her mother with domestic chores are complemented by Magdalena's heavy involvement in food preparation, cleaning and childcare. Similarly to her mixed consumption pattern, Magdalena's access of health services is also more varied than Adina's. Indeed, as a public service employee, she is covered by the NHIF but, unlike Adina, neither by private insurance nor by a private medical package. She thus combines, for herself and her family, access to public services with occasional recourse to private services for which she pays out-of-pocket.

The Midsize City Private Sector Employee: Denisa

Fifty year old Denisa lives in a midsize city 100 km from Bucharest and has worked for more than a decade as an accountant for the county branch of a multinational insurance company. Denisa's wage of around 450 euro/month helps her cover basic amenities, goods and services, but gives her only limited leeway for engaging in consumption for recreational or status purposes. Thus, Denisa's tight budget allows her only very occasionally to eat out, pay for domestic work, go on holiday in Romania or abroad, or renovate the studio her parents bought for her in the 1990s. This is despite Denisa living alone and thus not having, up to very recently, any family obligations. Denisa's access to health services combines coverage by the NHIF with the private medical package offered by her company, covering care provided in private clinics and hospitals in both her home city and the capital. She occasionally tops up these services by paying out-of-pocket for private health services outside the package. However, given the more limited development of private health care in her home city, and the more distant health services available in Bucharest, Denisa, like Adina, is not able to avoid public health care altogether.

The Midsize City Manufacturing Worker: Florina

Florina lives in the same midsize city as Denisa, where she works as an employee for a small clothing manufacturer subcontracting for top brands such as Armani and Prada. In her mid-thirties, Florina is married to a worker in a small local company subcontracting component manufacturing for the German automotive industry and together they have two young children. Owners of an apartment bought by their parents in the 1990s, as well as of a second

hand car, Florina's and her husband's combined income is around 900 euro per month. This leaves them almost no leeway in engaging in consumption other than of most basic goods. This includes buying cheaper products from local stores and peasant markets and the occasional discounted goods from the city's shopping markets. They even have to supplement shopping with produce from the small agricultural plot Florina's mother has in a nearby village. This is also where Florina, her husband and their children spend most of their holidays. Her family mainly access public health care, with very occasional recourse to out-of-pocket payments, mostly for private medical tests.

The Small Town Self-Employed Worker: Vlad

Vlad lives in a town around 40 km from Denisa's and Florina's midsize city and 200 km from Bucharest. Single, in his mid thirties, he lives in an apartment situated close to the house of his widowed mother. Vlad works as a self-employed construction worker who somehow always managed, given his good local reputation and extensive personal network, to get mostly informal jobs in the city, small towns and villages of the county and even occasionally in Bucharest. Even during the crisis, Vlad managed to maintain a viable, if unsecure, income stream. His consumption pattern reflects the one adopted by many Romanians involved in the construction sector, including the renovation of his apartment and of his mother's house, and reasonable levels of mass consumption in local shopping markets. This is combined with more traditional consumption practices, relying on intensive vegetable and fruit production on his mother's land, both for his and his family's personal use, and for occasionally selling out on local peasant markets. Vlad rarely takes holidays, given that his rather hectic work life strings one construction job after another. Because as a self-employed worker Vlad is not

obliged to contribute to the NHIF, he has chosen not to do so and thus he relies on few, if any, paid private health services.

The Rural Pensioner: Dragostina

With her son having died some years ago and her grandson living in Italy and very rarely visiting her, Dragostina lives alone in her small hut in a semi-alpine village situated 30 km away from Vlad's small town and more than 60 km away from Denisa's and Florina's city. A widow in her 80s, she retired from her catering job in the local rehabilitation center a while ago. She draws on a state pension of about 120 euro per month. Dragostina barely manages to cover the costs for very basic food, house utilities, medicines and trips to the nearby town's doctors. She has managed to maintain a network of friendly neighbors who occasionally help her with food, money or transport. She also assiduously attends mass services at the village church, which frequently end with food sharing for the soul of the dead (*pomană*). As a low-income pensioner, Dragostina has gratuity for her NHIF coverage. While this means most services are, at least in theory, free at the point of delivery, Dragostina has still to fund from her own pocket part or all of the costs of some medical tests and medicines.

These stories give us an incomplete, but nevertheless relevant snapshot of both Romania's social divisions and of some of the main ways in which its population accesses health services nowadays. As seen in these examples, Romania is a divided society with differential engagement in consumption and access to health care. This engagement follows the rule of 'the greater the means at disposal, the less engagement with public health care'. In order to understand better how variously positioned Romanians combine public and private care, let us see in more detail how public and private care have been re-defined and re-combined in concrete practices of access to health services.

BLURRING PUBLIC/PRIVATE DIVISIONS AND PATHWAYS OF DISPOSSESSION IN ROMANIA'S HEALTH CARE

The result of health care privatization in Romania is a system where public and private health care are more and more entangled with each other, and hence also where the frontier between them has many times become blurred.

Most doctors in primary and secondary care working in the private liberal practices that dot Romanian villages and small towns contract out most or even sometimes the entirety of their services with the NHIF. Thus, 'public' primary and secondary care came to stand in this case for services publicly funded but privately delivered. In bigger cities, the champions of private corporate health care, namely private health care chains, discursively place themselves in opposition to state involvement in health care. Nevertheless, the recent rise in importance of private hospitals and clinics has been due to the rise in the number of both private medical packages and of services contracted with the NHIF (SAR 2013). Thus, the 'private' has been mixed with the 'public', with care being alternatively seen as 'public' (because is paid by public funds) or 'private' (because it is delivered in a private health care setting).

In the other direction, public hospitals have developed private practice on their premises, by being allowed to charge for some of their services, to reserve beds and wards for private, fee-paying patients, or again to rent out some of their facilities to private health care providers (e.g. laboratory services). Here the 'public' has been mixed with the 'private', with care alternatively being seen as 'private' (because patients have to pay for it privately) or as 'public' (because care is delivered in a public setting – and, as some critics argue, draws on publicly funded infrastructure and doctors). In addition, many doctors working in public

hospitals also work in private clinics (Stan 2012), and see both public and private patients, depending on the location (see, for similar practices in the NHS, Dusheiko 2014).

The blurring of what 'public' and 'private' health care stand for happened therefore differently in different health care sectors (primary, secondary, tertiary) and locations (rural and small towns versus bigger cities). The result is a complex combination of public and private elements in the funding and delivery of health care. This configuration goes from 'fully public' health care (involving both public funding and public delivery, mostly in public hospitals) to 'fully private' health care (involving both private funding and private delivery, mostly in corporate clinics and hospitals). In between, we find various combinations such as the publicly-funded private delivery of liberal medical practices in primary and secondary care and of some services delivered in corporate clinics and hospitals, or the privately-funded public delivery of paid services offered in public hospitals.

Restrained Access, Şpagă and the Dispossession of Public Health Care

The blurring of the private-public frontier in health care is a direct result of the health care privatization and the dispossession of public care it involves. It is also responded to differently through strategies deployed by different categories of population, strategies going from refraining from accessing health care, to 'lifting-off' (Sampson 2002) from public care and 'hooking-up' to private care.

Dragostina offers a telling example of refraining from accessing health care. For at least a decade, Dragostina has had serious circulatory and heart problems. During this period, she has been registered with the local GP practicing in the commune dispensary. While the practice is private, all its services are contracted with the NHIF. Even if doubting the doctor's competency, Dragostina continued to be his patient. Contrary to some of her more fortunate

neighbors, she finds it difficult to travel further away to GPs situated in nearby communes or towns or again to summon the means necessary to pay for private medical care in the city. Dragostina needs a GP for recurrent referrals to the specialist doctor in town, for the monthly re-issuing of her prescriptions and for maintaining maximal NHIF coverage for her numerous medicines. This is why she tries to have a good relation with her GPs, and takes șpagă with her when she goes to the doctor – albeit, given her meagre income, mostly in the form of goods such as coffee or local produce such as cheese.

After obtaining the referral, and if she is fit enough, Dragostina then travels to town to see the specialist doctor. In order to do that, she may avail of her neighbors' transport offers, hitch a lift or take the local private mini-bus. The specialist doctor's practice is 'private', although, given that her clientele is mostly from the cash-strapped population of the town and its neighboring villages, she contracts out most of her services with the NHIF. Dragostina manages most of the time to get to see the specialist doctor on scheduled consultations, and on these occasions she also obliges with in-kind șpagă. Nevertheless, a few times per year when feeling really bad Dragostina calls the ambulance to bring her to the municipal hospital in the nearby town. There she is admitted for one or two weeks, during which she gets a series of tests, treatment, as well as food and shelter. Dragostina personally knows many of the nurses and doctors working in the hospital. She tries to give to the doctor who treats her monetary as well as in-kind șpagă in the hope of obtaining longer stays and more thorough medical investigations and interventions while in the hospital. Lately, Dragostina felt weak and, when unable to get to town, postponed her regular visit to the specialist doctor. Sometimes she also postponed the visit to the GP, and even, due to lack of money did not buy her medication. However, even in dire straits, Dragostina has always had recourse to traditional herbal remedies for more minor health problems such as colds or infections.

The story of Dragostina highlights the consequences of health care privatization for the poorest and most vulnerable categories of population in Romania's villages and small towns. Here, state disinvestment from health care has led to attempts to alleviate the insufficient care provided through the NHIF with informal exchanges in the form of șpagă. It also led to occasional postponing of accessing health care, and even to by-passing it altogether and having recourse to traditional herbal treatments.

Dragostina's aim is to stick as much as possible to health care covered by the NHIF. Her reduced access to medical health care is a result of her incapacity (due to age, illness and material means) rather than her unwillingness to attend scheduled consultations. A similarly limited access is experienced by sections of the population that are in a slightly better material position than Dragostina, most notably among precarious and low-waged workers. For example, both Vlad and Florina and her family see themselves as 'young' and 'fit', and seek to reduce their contact with health services as much as possible. Florina, in particular, minimally engages with either public or private health care, and when she does it would mostly be in order to address her children's health problems. And, like other young and middle-aged men in Romania, Vlad boasts of 'not having seen a doctor' in a long time and having stopped his NHIF contributions. As we have seen above it is the less fortunate categories of Romania's population that lack coverage by the NHIF, mostly because of the lack of formal employment and the unwillingness to direct scarce or insecure means to contributions. In case of more serious illnesses, they could end up either as recurrent 'social cases' (Friedman 2009) in public hospitals or as fee-paying patients of private health services. In case of sickness, Vlad would join, at least initially, the latter category, but if his fortune were to turn, he would possibly have to join the destitute battalions of the first.

Lifting-off, Hooking-in, and the Crossing of Public-Private Care Borders

In contrast to this strategy of refraining from accessing medical health care, the relatively better-off sections of the population in Romania's cities have been to various extents able to both hook-in to private care and lift-off from public care. For example, in the last years Denisa has had various back, eye and heart problems. She has travelled at least one or two times annually for medical tests at one of the most famous private clinics in Bucharest, as she has trusted what she sees as better technologically equipped facilities in the capital more than those available in the private sector in her city. In addition, she has also used her private medical package to see specialist doctors, and thus in the last years her involvement with public health services has been minimal.

This process of hooking-in to private care and lifting-off from public care is even more advanced among the upper middle-classes living in the capital and the bigger cities of Romania. This category disposes of both more means and a wider range of available services to replace what they see as unsatisfactory care covered by the NHIF with fully private care in corporate clinics and hospitals. A telling example is Adina who, in the last years, has done all her annual tests and occasional consultations for minor health problems at one of the private clinic contracting with her private medical insurance. Moreover, when she was diagnosed with uterine fibroma, Adina was treated at a private hospital in Bucharest and at the AKH hospital in Vienna, which is well known in Romania. Her involvement with public health care has thus been nil.

However, even among the more fortunate Romanians, avoiding public health care entirely has not always been possible. If the means at disposal are more moderate and in case of serious illness, the solution to health problems might reside in a more arduous quest for accessing any available health care and thus, in the process, combining private and public

health care. In this case, patients often get caught in the blurring of the border between public and private health care highlighted above.

The story of Magdalena is telling in this respect. For a number of years, Magdalena has suffered from various circulatory and heart conditions, which sometimes worsen following increased stress brought on by work and family problems. In one such moment of crisis, Magdalena first chose to consult a specialist doctor in a private clinic, thinking this would speed up her access to care. However, contrary to her expectation of being prescribed medicines, she was told she needed, for a start, to lose weight. In response to her calls for a quicker fix and her disputing that her problems were solely due to her being overweight, she was referred for additional tests. This led to considerable overall costs, amounting, according to her, to more than 2000 euro. The apparent inability of these tests to solve her problems, as well as Magdalena's unfavorable evaluation of the technology available in the clinic led her to then turn to public care.

She had her GP refer her to a specialist doctor working in one of Bucharest's public hospitals. Unfortunately, she was unable to arrange an appointment or see the doctor. She therefore then appealed to one of her friends, a doctor and former official in one of Romania's health agencies, to recommend her to another specialist doctor working in a public hospital. The specialist doctor made a quick echography and prescribed her some medication, which Magdalena considered effective. But Magdalena would have liked to have more thorough investigations in order to address more adequately the range of problems she was confronted with. Hoping to persuade the doctor to refer her to more tests, Magdalena gave him 'something in an envelope' (monetary șpagă) and this despite having long since found the giving of șpagă stressful given her confusion about its proper nature, time, location, and modalities. The doctor took the envelope but, nevertheless, resisted her pleas. He said that hospital admission was the only way to have more investigations covered by the NHIF.

However, he also claimed that her condition did not warrant hospitalization, except for her being brought to the hospital by ambulance.

Looking for yet another pathway to access the care she deemed necessary, Magdalena turned to her local pharmacist, who recommended to her a young specialist doctor working in a public hospital but who also gave consultations and made medical tests at home. Given that he also charged less than the private clinic she initially attended, Magdalena finally went to see him. The doctor met her either in the public hospital as an informal patient (for which she would give him a monetary șpagă the amount of which she would have to gauge from 'prices' practiced by friends and acquaintances with other doctors) or at home (for which she would pay a fixed and pre-agreed price).

Far from being exceptional, Magdalena's hopping from public to private care is quite widespread. It was similar, for example, to the manner in which her mother dealt with her own spine problems. Indeed, the mother would give her specialist doctor either șpagă, when seeing him in the public hospital, or the price of the consultation, when seeing him in the private clinic where he worked after his shift in the public hospital. Magdalena, of course, helped her with most of the money involved in these payments. As for her own health problems, they were at least partially tackled by finally also going to see a nutritionist and starting a cure that helped her lose weight. Having found the pharmacist's counsel valuable, Magdalena also brought her friends to him for advice on specialist doctors as well as on cheaper medicines to take for their own health problems.

Family Obligations and the Repossession of Public Care

Magdalena's story shows that even the better-off sections of the Romanian population have to combine public and private health care and that even they sometimes refrain from

medical care by drawing on alternative means (such as advice from pharmacists). It also shows that even for them avoiding public health care completely is not always possible. This is revealed most acutely when other members of the family, most notably elderly parents, get sick and need to be cared for. Thus, Magdalena's recourse to 'private' corporate care and Dragostina's reliance on 'public' care covered by the NHIF have been many times combined in the same family.

For example, if Denisa usually avoided public care when dealing with her own health problems, the situation changed when her grandfather and her father in turn got sick. She and her close family became actively involved in having them admitted to public hospitals and in caring for them during the last months of their life. Denisa was nevertheless less inclined than Dragostina or Magdalena to give șpagă to the hospital personnel. This limited recourse to șpagă exposed her to experience both excellent treatment and conditions in the smaller town hospital where her father recovered from his heart operation, and what she saw as appalling treatment and conditions in the county hospital where he was operated on.

This opens interesting questions about the ability of Romania's new middle-classes to shield themselves from the dispossession of public care. Indeed, while more șpagă giving would have probably helped Denisa to make the health personnel in the county hospital provide better and timelier care to her father, that would have only partially alleviated the general conditions resulting from the structural underfunding of many Romanian public hospitals. Given that her private medical package did not also cover her parents, and that her own income was limited, she could not take them out of public health care. This was also partially the case for Magdalena, whose mother was also operated on for her spine problem in a public hospital and who continued to see specialist doctors in public hospitals.

This points yet to a larger issue of the private corporate sector. Despite its impressive growth, it has, up to now, only very partially managed to match public hospitals in the

provision of highly specialized medical care needed in the treatment of acute patients such as Magdalena's and Denisa's parents. This is why even a highly paid employee such as Adina could not completely shield her family from public health care, and this despite her never having had recourse to public health care for her own health problems in the last years,. However, after being diagnosed with cancer and prescribed an operation, her mother was admitted to the county hospital in her home city. Much like Magdalena, but drawing on a much higher income, Adina could complement public care for her mother with hefty șpagă for health care personnel in the public hospital, consultations at a private clinic and private nurse and domestic care help once her mother got back home to recover. Adina could also obtain in exchange of the very substantial șpagă she paid to the lead specialist doctor, that he include her mother among those benefitting from higher levels of coverage of medicines by the NHIF – a substantial bonus given their high costs. Thus, if in today's Romania money can buy better private care, what they could not buy was Adina's and her family's complete insulation from any interaction with Romania's public health services.

What we could call the 'public-private biomedical pluralism' of combining public and private care is therefore generalized across the various sections of Romanian society. As we have seen above, differently situated patients variously enact these combinations in their attempts to access health services in a context of dispossession of public care. In order to better understand the reasons behind these various enactments let us now look at the manners in which patients draw on various moralities of care, as well as the ways in which these moralities articulate with the patients' positions in the Romanian social and political spaces.

THE MORAL ECONOMY AND THE NEW POLITICAL ECONOMY OF CARE

During the economic boom of the 2000s, large parts of Romania's rising new middle-class for the first time accessed and become fascinated with private corporate care. More particularly they have been enthralled with the new ('hotel like') buildings and facilities of corporate medical centers, as well as with the 'choice' and the medicalized approaches to bodies, health and illness that private health care offered to them. The most fortunate sections of the population, like Adina and Magdalena, have been able to more thoroughly lift-off from public, NHIF funded health care and hook-in to private corporate care.

Displaying choice in the form of accessing private corporate health care became a means to display one's upward social mobility. Important sections of Romania's middle-classes stressed choice as an indicator of their ability to access good health services and 'good life' in general. They thus adopted a deeply consumerist 'new political economy' (Thompson 1971) of care resonant with neoliberal calls for 'healthism' in the 'new public health' (Petersen and Lupton 1996; Crowford 1980).

By contrast, even during the 2000s' economic boom, other parts of the population could not partake in Romania's regained prosperity, and were obliged, given their low incomes, to access public, NHIF covered health care. For them, the only means to recalibrate increasing inequalities in access to care and to respond to the dispossession of public care was to use șpaga as a means to access better, timelier care in the public sector. Moreover, the value they placed on the right to access health care translated not only in their attachment to public care as a means of redistributing health care to the whole population, but also in the way they conceptualized șpagă. For them, șpaga itself was a means to alleviate, through redistribution, inequalities produced by post-socialist transformations. Șpaga has long been accepted by the bulk of the low-waged Romanian population not only as a means for the patients to express gratitude for the doctors' gift of life, but also as a way to compensate for the latter's notoriously low wages (Stan 2007, 2012). Moreover, șpaga was to function as a

redistribution mechanism also among patients. As Dragostina once said, "the doctors should take [șpagă] from those [patients] who have [the means] but not from those who don't." Thus, behind the attachment to public health care we discern a 'moral economy' (Thompson 1971) of care centered on the redistributive justice (Maurel 1995) of redirecting common resources towards the most vulnerable categories of the population.

Austerity put a brake on the consumerist drive of Romanian middle-classes, and led many of them to social stagnation if not downward mobility – as manifested in lower wages, down-grading of employment conditions and redundancies in both private and public sectors (Trif 2013). Part of Romania's middle-classes, like Magdalena, came back to public services as a default option for their health problems. For others, like Denisa, contact with public services following sickness of parents resulted in a renewed consciousness of the public character of health care. But this did not mean that they would automatically adopt the redistributive moral economy of their parents. Indeed, while Denisa came to re-affirm her right to public, NHIF covered care, she saw this right as deriving from her contribution to the NHIF.

This reflects a new 'accounting' approach to rights: "I pay (contribute) therefore I'm entitled to access (quality) public services." Usually this approach does not acknowledge the low wage levels in the health care sector, and does not conceive of șpagă as a redistributive mechanism. Instead, it follows official discourse in seeing șpagă as a means of illegitimate enrichment for doctors, which has to be eradicated either through severe sanctions or through health care privatization (Stan n.a.). While this approach recognizes public health services' role as a safety net, it does not so much cut with the neoliberal consumerist political economy of care as complements it. Indeed, while in this perspective care might also have to involve public funding and public provision of services, the principle at the basis of access is a consumerist one (i.e. payment) (see also Rivkin-Fish 2005 for similar developments in

Russia). Nevertheless, neither has middle-class 'consumer citizenship' emerged unaffected from the crisis and austerity. Indeed, post-austerity middle-classes have had to face a restricted set of choices and to tame their choice discourse with the recognition of the importance of rights for accessing care.

The contrast between the moral economy of redistributive care, and the new political economy of consumerist care points to a political divide. It is a divide between two different views of access to care in general, and of entitlement to public services more particularly. What we could call the 'restrictive' view has been carried over by Romania's successive right-wing governments, cosmopolitan elites, the 'comprador bourgeoisie' and what we could call the 'comprador precariat' (the two latter categories including the higher and lower paid employees of multi-national companies, international organizations and NGOs). It advocates that entitlement to access care should be solely based on payment, either in the form of contributions to the NHIF, for public care, or of out-of-pocket payments, for private services. This is a divisive as well as restrictive view in as much as it opposes those 'with (material) possibilities' and those without, contributors to the NHIF and non-contributors, and disqualifies the latter from receiving public health care other than the one offered by the 'minimal package'.

The second, 'redistributive' view has been carried over by the country's new proletarians (working in services, constructions and subcontracted industrial manufacturing) and old socialist classes (including employees of state enterprises, public sector employees, pensioners, and workers on small subsistence farms), as well as by some trade unions active in health care and, decreasingly and unevenly, by Romania's left-wing governments. It favors universal access to public care based on needs rather than means, and the continuation of the redistributive, inclusive character of public health services in Romania. Despite it being seemingly widespread among the lower ranks of the Romanian population, this view currently

lacks a powerful collective voice to ensure the future safeguarding of the public character and redistributive remit of Romania's health care.

CONCLUSIONS

Neo-liberal health care privatization led in Romania to a dispossession of public health care that has intensified in time but has also unevenly affected various sections of its population. Thus, cosmopolitan middle-classes sought to lift-off from public care and hook-in to private corporate care. By contrast, the large majority of low-waged Romanians have confronted the overall diminished availability of public care either with attempts to retain their access to the latter or by restricting and even abandoning their engagement with health care altogether. Health care privatization has thus, at least in the boom years, been experienced in contrasting ways by the two groups. Cosmopolitan middle-classes saw it as providing increased choice in accessing care and an additional avenue for expressing their upward social mobility. Low-waged Romanians, by contrast, experienced it as a barrier to accessing care and as reflecting their diminished social position in Romanian society. After the 2008 crisis, increased social inequalities led to both resistance to further privatization and the consumerist reconsideration of public care by the better-off sections of the population.

While our analysis has focused on public-private biomedical pluralism, it has also revealed that the latter is encompassed in a larger health care pluralism whereby biomedicines are combined with non-biomedical care. Baer (2011:413) considered that the dominance of biomedicine in contemporary health care pluralism reflects "the interests of the corporate class", with non-biomedical types of care functioning as "concessions (made) to subordinate social groups in the interest of maintaining social order and the corporate mode of production." A similar argument could be made for private biomedical care and its articulation with a

continuing, albeit significantly altered, public health services. Following Harvey (2004), we could say that contemporary capitalist accumulation both alters public care through (uneven) dispossession and preserves it in order to insure its own maintenance. Public-private biomedical pluralism and its combination of lift-off, hook-in and restraint strategies are thus intrinsically linked with the uneven dispossession at the core of neoliberal capitalist accumulation.

The Romanian case illustrates the manner in which the rising involvement of private actors and interests in the provision, funding and management of care (what we have termed health care privatization) rests on the mutually reinforcing interplay of uneven dispossession of public care (following state disinvestment from health care) and uneven consumerism and commoditization of care (following the introduction of new public management in public care and the rise of private provision and funding of care). Certainly, the paces and practical manifestations of dispossession, consumerism and commoditization are locally specific and path dependent. The different measures involved in health care privatization have not been adopted in the same time or in the same manner across different locales. Nevertheless, they followed a common template, firstly probed in structural adjustment programs applied to Third World countries (Pfeiffer and Chapman 2010), and subsequently replicated in Second and First World ones (Harvey 2005).

Future research on health care privatization should therefore be comparative in the most extensive understanding of the term, i.e. spanning western and non-western, first, second and third world locations. In fact, the Romanian, and more largely European story of health care privatization, has parallels with both North American (where managed care Medicare [Lopez 2005] echoes the introduction of new public management in Europe's public health systems [Clarke et al. 2000]) and South American stories (where Colombian dispossession [Abadia-Barrero 2015] echoes European states' retrenchment from public health care [Andre

and Hermann 2009]). In the end, while contingent on local histories and paths of development, privatization also participates in a larger, global movement of capitalist dispossession. The way in which this dispossession is deployed and impacts on various categories of population is also a function of the concrete struggles various actors fight over the commons of public health care. Future research on the pathways and outcomes of health care privatization needs therefore to engage in the comparative study of these struggles.

Nancy Frazer (2016) claimed that, with health care and the body figuring among the last frontiers of capitalist accumulation, the latter risks undermining social reproduction beyond sustainable levels. While this would imply a possibly explosive end to neoliberal capitalism, an alternative scenario is, nevertheless, more probable. Indeed, we now face a system that might more readily implode due to its own internal contradictions (as in 1989) rather than being violently overturned (as in 1917) (Streek 2014). In the short to medium term, it is therefore probable that private health care will continue to grow, with the growth of its corporate arm depending on its success in capturing publicly collected funds (Waitzkin 1983). A progressively enfeebled public sector will also probably continue to provide for low-waged masses, with various local props (such as Romania's șpagă or Western European recourse to migrant domestic and health care workers, Lutz 2008) continuing to oil its creaking machinery. In these conditions, a turn away from health care privatization is possible only if the dispossessed channel their discontent and desire for a fairer system into viable collective and political action.

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REFERENCES

Abadia-Barrero, C.

2015 The Transformation of the value of life: Dispossession as torture. Medical Anthropology 34(5):389-406.

Andre, C. and C. Hermann

2009 Privatization of health care in Europe. In Privatization against the European Social Model. A Critique of European Policies and Proposals for Alternatives. M. Frangakis, Ch. Hermann, J. Huffschmid, and K. Lóránt, eds. Pp. 129-144. London: Palgrave Macmillan.

ASSPRO

2013 Formal and informal out-of-pocket payments for health services in Central and Eastern European countries. What are the actual patients' contributions? Policy Brief. https://ec.europa.eu/research/social-sciences/pdf/policy_briefs/policy-briefs-assprocee2007-02-2013_en.pdf.

Baer, H.

2011 Medical pluralism: An evolving and contested concept in medical anthropology. In A Companion to Medical Anthropology. M. Singer and P. Erikson, eds. Pp. 405-424. Oxford, UK: Wiley-Blackwell.

Ban, C.

2016 Ruling Ideas. How Global Liberalism Goes Local. Oxford, UK: Oxford University Press.

Bara, A-Cl., W. van den Heuvel, and J. Maarse

2002 Reforms of the health care system in Romania. Croatian Medical Journal 43:446-452.

Becker, G.

2007. The uninsured and the politics of containment in U.S. health care. Medical Anthropology Quarterly. 26(7):299-321.

Bohle, D. and B. Greskovits

2012 Capitalist Diversity on Europe's Periphery. Ithaca, NY: Cornell University Press.

Bourdieu, P.

1986 The forms of capital. Handbook of Theory and Research for the Sociology of Education. J. G. Richardson, ed. Pp. 241-258. New York: Greenwood.

Buchovski, M.

2004 Hierarchies of knowledge in Central-Eastern European Anthropology. The Anthropology of East Europe Review 22(2):5-14.

Calin, G.

2016 Un milion şi numărăm în continuare. Ce planuri are Fady Chreih pentru rețeaua de sănătate Regina Maria. Business Magazin, 3 October, 31(587):13-21.

Clarke, J., S. Gewirtz, and E. McLaughlin

2000 New Managerialism, New Welfare? London: Sage.

Crowford, R.

1980 Healthism and the medicalization of everyday life. International Journal of Health Services 10(3):365-388.

CNAS (Casa Naţională de Asigurări de Sănătate)

2016 Sinteza evaluării activităţii desfăşurată de furnizori pe tipuri de asistenţă medicală în anul 2015. Bucharest, Romania: CNAS.

http://www.casan.ro/media/pageFiles/SINTEZA%20%20an%20%202015.pdf.

Dao, A. and M. Nichter

2016 The social life of health insurance in low- to middle-income countries: An anthropological research agenda. Medical Anthropology Quarterly 30(1):122–143.

Dusheiko, M.

2014 Patient choice and mobility in the UK health system: Internal and external markets. Developments in Health Economics and Public Policy 12: 81-132.

EC (European Commission)

2014 Eurobarometer. Patient Safety and Quality of Care. Brussels, Belgium: EC.

http://ec.europa.eu/health//sites/health/files/patient_safety/docs/ebs_411_factsheet_ro_en.pdf.

EC (European Commission)

2016 Country Report Romania 2016. Brussels, Belgium: EC.

http://ec.europa.eu/europe2020/pdf/csr2016/cr2016_romania_en.pdf.

Eurostat

http://ec.europa.eu/eurostat/data/database.

Eurostat

2016 S80/S20 Income Quintile Share Ratio. Eurostat. http://ec.europa.eu/eurostat/web/gdp-and-beyond/quality-of-life/s80s20-income-quintile.

Frazer, N.

2016 Contradictions of capital and care. New Left Review, July-August:99-117.

Friedman, J.

2009 The 'social case'. Illness, psychiatry, and deinstitutionalization in postsocialist Romania. Medical Anthropology Quarterly 23(4):375–396.

Hardy, J., M. Calveley, J. Kubisa, and S. Shelley

2014 Labour strategies, cross-border solidarity and the mobility of health workers. European Journal of Industrial Relations 20(1):1–19.

Harvey, D.

2004 The 'new' imperialism: accumulation by dispossession. Socialist Register 40:63-87.

Harvey, D.

2005. A Short History of Neoliberalism. Oxford, UK: Oxford University Press.

Horton, S.

2013 Medical Returns as class transformation: Situating migrants' medical returns within a framework of transnationalism. Medical Anthropology 32(5):417-432.

Humphreys, M. and T. Watson

2009 Ethnographic practices: From 'writing-up' ethnographic research to 'writing ethnography'. In Organizational Ethnography: Studying the Complexities of Everyday Life. S. Ybema, D. Yanow, H. Wels, and F. Kamsteeg, eds. Pp. 40-55. London: Sage.

INS (Institutul Național de Statistică)

2015 Anuar Statistic 2015. Bucharest, Romania: INS.

INS (Institutul Național de Statistică)

2016. Câștigul Salarial Mediu Lunar. Bucharest, Romania: INS.

http://www.insse.ro/cms/ro/content/ca%C8%99tigul-salarial-mediu-lunar-35.

INS (Institutul Național de Statistică)

2017 Tempo Online. http://statistici.insse.ro/shop/.

Kleinman, A.

1978 Concepts and a model for the comparison of medical systems as cultural systems. Social Science and Medicine 12(2B):85-95.

Lethbridge, J.

2005 The promotion of investment alliances by the World Bank: Implications for national health policy. Global Social Policy 5(2):203–25.

Lopez, L.

2005 De facto disentitlement in an information economy: Enrollment issues in Medicaid managed care. Medical Anthropology Quarterly 19(1):26-46.

Lutz, H.

2008 Introduction: migrant domestic workers in Europe. In Migration and Domestic Work. A European Perspective on a Global Theme. H. Lutz, ed. Pp. 1-10. Farnham, UK: Ashgate.

Maarse, H.

2006 The privatization of health care in Europe: An eight-country analysis. Journal of Health Politics, Policy and Law 31(5):981–1014.

Maas, W.

2009 Unrespected, unequal, hollow? Contingent citizenship and reversible rights in the European Union. Columbia Journal of European Law 15:265-280.

MacFarlane, A. and T. de Brun

2010 Medical pluralism in the Republic of Ireland: Biomedicines as ethnomedicines. In Folk Healing and Health care Practices in Britain and Ireland: Stethoscopes, Wands, and Crystals. S. McClean and R. Moore, eds. Pp. 181-200. New York: Berghahn.

Marshall, T. H.

1950 Citizenship and Social Class. Cambridge, UK: Cambridge University Press.

Maskovsky, J.

2000 "Managing" the poor: Neoliberalism, Medicaid HMOs and the triumph of consumerism among the poor. Medical Anthropology 19(2):121-146.

Maurel, M-C.

1995 Temps de la decollectivisation. Revue d'études comparatives Est-Ouest 3:5-14.

Medlife

2013 Studiu Medlife, IMAS. https://www.medlife.ro/comunicat-de-presa/studiu-medlife-imas-67-dintre-romani-au-fost-cel-putin-o-data-la-medic-ultimele.

Miller, D.

2012 Consumption and Its Consequences. Cambridge, UK: Polity.

Miller, P. and N. Rose

1993 Governing economic life. In Foucault's New Domains. M. Gane and T. Johnson, eds. Pp. 75-105. London: Routledge.

MS (Ministerul Sănătăţii)

2006 Ordin Nr. 886/2006. Bucharest, Romania: MS. http://lege5.ro/Gratuit/geydcnbrgm/ordinul-nr-886-2006-privind-externalizarea-serviciilor-medicale-si-nemedicale-din-unitatile-sanitare.

NBR (National Bank of Romania)

2016 Foreign Direct Investment in Romania in 2015. Bucharest, Romania: NBR. file:///Users/sabinastan/Downloads/eFDI2015.pdf.

OECD (Organization for Economic Co-operation and Development)

2016. Health at a Glance: Europe 2016. State of Health in the EU Cycle. Paris, France: OECD Publishing.

Petersen, A. and D. Lupton

1996 The New Public Health. Health and Self in the Age of Risk. London: Sage.

Pfeiffer, J. and R. Chapman

2010 Anthropological perspectives on structural adjustment and public health. Annual Review of Anthropology 39:149-65.

Poenaru, F.

2013 Romanian protests from the love of democracy to the hatred of politics. CritCom, 2 October. http://councilforeuropeanstudies.org/critcom/romanian-protests-from-the-love-of-democracy-to-the-hatred-of-politics/

PR (Parlamentul României)

2006 Legea nr. 95 / 2006 privind reforma în domeniul sănătăţii. Monitorul Oficial. 28 April, 372. http://www.cdep.ro/pls/legis/legis_pck.htp_act_text?idt=72105.

Rivkin-Fish, M.

2005 Women's Health in Post-Soviet Russia. The Politics of Intervention. Bloomington, IN: Indiana University Press.

Rylko-Bauer, B. and P. Farmer

2002 Managed care or managed inequality? A call for critiques of market-based medicine. Medical Anthropology Quarterly 16(4):476–502.

Sampson, S.

2002 Beyond transition: Rethinking elite configurations in the Balkans. In Postsocialism: Ideals, Ideologies and Practices in Eurasia. C. M. Hann, ed. Pp. 297-316. London: Routledge.

SAR (Societatea Academică din România)

2013 Raport Anual de Analiză și Prognoză – România 2013. București: SAR.

Sassen, S.

1992 The Global City: New York, London, Tokyo. Princeton, NJ: Princeton University Press.

Schmid, A., M. Cacace, R. Gotze, and H. Rothgang

2010 Explaining health care system change: problem pressure and the emergence of 'hybrid' health care systems. Journal of Health Politics, Policy and Law 35(4):455–86.

Smith-Nonini, S.

2006 Conceiving the health commons: Operationalizing a "right" to health. Social Analysis: The International Journal of Social and Cultural Practice 50(3):233–245.

Stan, S

(forthcoming) Neoliberal citizenship and the politics of corruption: redefining informal exchange in Romanian health care. In Economy, Crime and Wrong in a Neoliberal Era. J. Carrier, ed. Oxford, UK: Berghahn.

Stan, S.

2016 Transnational patient mobility and health care mobilities and governance processes in Europe: Towards a rising European health care system? Paper presented at the IMTJ Academic Conference, Madrid, May 25-26.

Stan, S.

2015 Transnational health care practices of Romanian migrants in Ireland: Inequalities of access and the privatization of health services in Europe. Social Science and Medicine 124:346-355.

Stan, S.

2012 Neither commodities nor gifts: Post-socialist informal exchanges in the Romanian health care system. Journal of the Royal Anthropological Institute 18(1):65-82.

Stan, S.

2010 Corruption, class formation and the anthropology of neoliberalism. Paper presented at the Biannual conference of the European Association of Social Anthropologists (EASA), Maynooth, Ireland, August 24-27.

Stan, S.

2007 Transparency: Seeing, Counting and Experiencing the System. Anthropologica 49(2):257-273.

Stan, S. and R. 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 22:167-183.

Stan, S., and V. V. Toma

2009 High-tech Romania? Managerialism, the market and informal relations in the informatisation of the Romanian health care system". Anthropology in Action 16(1):56-71.

Streek, W.

2014 How will capitalism end? New Left Review 87:35-64.

Thompson, E.P.

1971 The moral economy of the English crowd in the eighteenth century. Past and Present 50:76-136.

Trif, A.

2013 Romania. Collective bargaining institutions under attack. Transfer: European Review of Labour and Research 19(2):227–237.

Vlãdescu, C., S.G. Scîntee, V. Olsavszky, C. Hernández-Quevedo, and S. Sagan

2016 Romania: Health system review. Health Systems in Transition 18(4):1–170.

Wegrzynowska, M.

2016 Transnational health care practices in the enlarged Europe: The case of Polish migrant women in Ireland and their pregnancy and childbirth practices. PhD Thesis. School of Nursing and Human Sciences, Dublin City University, Dublin, Ireland.

Waitzkin, H.

1983 The Second Sickness: Contradictions of Capitalist Health Care. New York: Free Press.