"BABEȘ-BOLYAI" UNIVERSITY
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AVATARS OF MEDICAL INFORMAL ECONOMY IN POST-SOCIALIST ROMANIA

PhD THESIS SUMMARY

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By reopening the discussion on the conceptual opposition between the notions of "gift" and "commodity", I have used this paper to document the means through which the main social actors involved in the informal practices that are prevalent in the field of medical care – the patient, the carer, the medical team, political decision-makers – understand, reproduce, legitimize or condemn the circuit of these practices.

As anticipated within the title of the doctoral thesis, my goal is to show that the object of informal exchanges has its own "social life" (Appadurai, 2006), one that is extremely volatile and permanently updated based on the type of relationship which it is meant to institute. The object by which we can classify the various forms of informal transactions or relationships has a character that is neither unified nor stable. It oscillates between multiple units of exchange in a system based on three coordinates: (1) the degree of sociability that the exchange aims to retain; (2) the level of conditioning that lies at the root of the exchange (voluntary versus direct constraint in initiating the exchange), as well as (3) the (lack of) attachment to those social prescriptions that classify the various forms of exchange, easily spotted when following the social dramaturgy (Goffman, 1956) of the trio that consists of "to demand" – "to give" – to receive.

Pendulating between anthropological curiosity and the internalization of professional conduct, the research is formed by hybridizing the emic and etic perspectives. My field access, initially through my training as a nurse in public university hospitals and then as a fully-fledged medical professional in the private sector, has allowed me to become immersed in the field by unique means. I have devised a type of research design that facilitates a deep understanding of the significations, context and dynamism of informal payments, allowing for a rendition of the ways through which structural aspects interact with process-related aspects in generating these informal payments. Thus, my methodological toolset is dominated by the most meaningful instrument of qualitative research – participative observation, stabilized through the in-depth interview. The anthropological site was comprised of three (private and public) hospital departments defined by a high level of dependency on medical

care, through which complex and recurrent social interactions are woven between the patient, his carers and the medical team: Nephrology, Surgery, Obstetrics and Gynaecology. The infrastructure of the paper is established through 60 (semi-structured) in-depth interviews: 24 interviews have been performed with patients, 7 – with carers, 16 – with doctors and 9 – with nurses. I've also interviewed 1 gate security guard, 1 stretcher-bearer and 2 orderlies. In order for certain discursive productions to be adopted, instituted and internalized in what we end up calling common or shared reality, we need to undertake numerous extractions, overlaps and violent exclusions, later presented as having an almost natural character. Therefore, the Foucauldian discourse analysis (Foucault, 1999) has allowed the revealing of the processes of power involved in the means through which the correct phraseology in the field of medical informal economy becomes articulated. Throughout the process of creating this research, I have made discursive analyses on four different types of empiric material: the reform programmes for the strategic domain of Healthcare proposed by the World Bank and World Health Organization between 1990 and 2020; Transparency International reports on the level of corruption; legal texts on the reforms, restructuring and administration of the medical field and of health insurance policies in the public-private continuum (1990–2000) and, last but not least, the media interventions by politicians, Government policy-makers and healthcare specialists.

In the first chapter of the paper, titled "Recurring Measures, a New Social Pathography: Reformism, Economic Duality and the Rescaling of Informality", I followed the means through which the implementation of public healthcare reforms and the open, often preferential, support of the private medical infrastructure, as well as the creation of a communication channel between the two sectors through dual medical practice and the reimbursement of private medical services using public funds, create new instances by which informality is diversified and reinforced. Beyond the concrete level, of the practical functioning of the public healthcare system and the public-private economical hybrids, political stakeholders prove to have a two-layered degree of ignorance on a discursive level: (1) they rush to label the entire medical informal economy as a form of the wide-spanning concept of "corruption", entirely disregarding the means through which the systemic configuration itself encourages informality, oftentimes in its abusive forms and (2) there is no openness towards understanding the evidence on the multiple shapes of informality, especially those found at the level of hospitals.

In Chapter II, entitled "The Manufacturing of Meaning: Semantic Ambiguities and Classification Struggles in Post-Socialist Informal Medical Economy", I embark in a process of revealing the ways in which liberal political agendas, and later neo-liberal ones, state the rules and create the formal semantic registries in the field of medical informality, that allow the existence of a border between the act of "giving" as an act of constituting and instrumentalizing a type of social capital and a strict, legalist approach that classifies any supplementary payment or "attention" as an act of bribery. The medical economy based on gift-giving disappears from the public, formal semantic registry around the year 2014, when politicians begin the crusade against informality, but at the same time persists and become proliferated by the social actors that entertain the domain of medical informality. The persistence of informality in the healthcare sector should not be understood as a failure to legislate certain practices that cannot be shaken off because of a liberalization deficit, but must rather be understood precisely as means to indigenize the process of liberalization in the market of health "services". The semantics of the official discourse on bribery does not possess an ounce of sensitivity towards the ambivalence that the social actor feels towards informal medical payments. The political agenda, strongly focused on imagining medical services in accordance with the strategic interests of a free market, transparent and ruled by supply and demand, criminalizes informality and considers that, in its absence, the system would be relieved of a burden that stems for the socialist period. My position is that in post-socialism, we cannot justify the persistence of informal payments as a consequence of the insufficient liberalization of the medical service market, but instead we should see them as adaptative strategies employed by the social actor when faced with growing inequality in the level of access to healthcare services.

Although they are extremely useful towards understanding the phenomenon of informal exchanges in the post-socialist healthcare system, macrostructural explanations do not entirely cover the internal mechanisms that produce and reproduce informal exchanges as a whole. The object of trade in these exchanges has an uncertain character, possessing ambivalent, oftentimes paradigmatic traits – sometimes those of trade items, sometimes those belonging to the anthropological category of gift giving and receiving. The object of the informal exchange has a hybrid form that results from the simultaneous existence of the two exchange units. Thus, the third chapter of the paper, entitled "Extra Payments as a Means of Bypassing the Medical Gaze" is an ethnographic documentation of an avenue that has not been yet taken into account in studies on the genesis or the stakes of informal payments in the

field of healthcare. Informal medical exchanges based on gift-giving incapsulate the capacity to produce a gap between the "medical gaze" and a more humane way of looking at the disease – affective neutrality becomes an illusory act of aligning to the humanity of the person asking for the doctor's expertise (it doesn't need to be an honest gaze, but at least a mimetic, convincing one). With the acceptance of the gift, the doctor commits to stepping outside professional boundaries, looking after the patient in a thorough manner within every dimension that is implied by the patient's status (biological, social, cultural). A gift ransoms the singularity of the human face (Levinas, 1969), outclassing the "medical gaze".

Informality in the field of medical care is an astute method through which the patients tackle a difficult situation in which they are rendered vulnerable, deprived of control over their own bodies, lead into solitude and transformed into a diagnosis, a procedural object that represents a target for the medical authority, all this within a healthcare system that already faces critical structural issues: under-financing, under-sizing (contrary to the official discourse that uses the narrative of the oversized system to further reduce the infrastructure of specialist ambulatories and hospital units), lack of medical personnel, the incapacity to maintain drug supplies, dated technology, the externalization of para-clinic investigations (among others) towards the private sector, leading to oligopoly situations, the almost total lack of medical coverage in rural areas, the politization of the system, and this list of critical systemic flaws can be even further extended.