ABSTRACT

Title of Dissertation: **Curative Politics and Institutional Legacies: The Impact of Foreign Assistance on Child Welfare and Healthcare Reform in Romania, 1990-2004** ***A Cautionary Tale***

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Western democracies, especially the United States, increasingly utilize foreign assistance to influence the policies of developing nations ("curative politics") despite extensive literature that this assistance is often ineffective. Cross-national data on the impact of bilateral and multilateral aid are cautionary, but these studies put the interaction between donors and recipient governments in a black box, obscuring empirical dynamics that condition success—or failure—in reform outcomes.

Using a "controlled comparison" of two cases in which international donors have tried to steer reform in Romania between 1990 and 2004, this paper asks: *How* does foreign assistance influence the process of indigenous reform? By selecting two cases (child welfare and healthcare reform) in the same country, during the same period, macro-economic and political factors can be controlled, allowing an analysis that highlights critical differences in domestic interests, institutions, and international engagement.

The dissertation concludes that foreign assistance is beneficial when credible international commitments spur difficult, complex change. However, the rational

tendency of organized interests to undermine reform—especially if the extraction of rents is allowed by partial reform—is a strong countervailing current. Foreign assistance, too often fixated on teleological end-states and normative goals, is inefficient when: 1) Reform recommendations rely on national legislation, with little attention to intra-governmental bargaining, especially regarding budgets; 2) Reform plans fail to anticipate short-term "winners" and ignore financial incentives to subvert reform; and 3) Donors exaggerate the break between past and present, missing opportunities to better understand contemporary constraints as a function of historical legacies.

Although the ideology of state socialism was defeated in Romania in 1989, post-communist reform left bureaucratic coordination in place, especially in the provision of public services. With norms such as the reliance on soft-budget constraints maintained, and without competition or independent monitoring to enforce accountability, outside attempts to help reorganize health services failed. Performance-based conditionality tied to credible international threats led child welfare reform beyond stalemate, although deep change in the form of employment cuts or financial decentralization was resisted.

Curative Politics and Institutional Legacies:
The Impact of Foreign Assistance on Child Welfare and Healthcare Reform in Romania, 1990-2004
A Cautionary Tale

By

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Preface

One hot Romanian morning in summer 2004, my friend Annie and I brought our nine children to the biggest, nicest public swimming pool in Bucharest. She wanted to enroll her four children in lessons; mine were already installed. We stood at the pool's gate reading the rules regarding class size, payment, pool hours, and pre-enrollment requirements.

For each rule Annie read aloud, I explained how the pool community *really* worked. "Two-week classes are limited to ten students per one-hour class," she recited. There are around twenty children per class; most parents stay and watch, so it's safe, I explained.

"60,000 lei [$2 USD] per session. Payment required if student misses a class." We pay 100,000 lei [$3.25] but never pay if we miss a class, I corrected.

"Classes: 14:00-15:00. Pool maintenance: 15:00-16:00." Not really, I said. The teachers use maintenance time as class time. That way they can teach more children. If you're late for the 2:00 session, you stay for the 3:00, which is good for us because we're late a lot.

"Medical certificates required for each session." Never, I contradicted again. It's too time consuming and expensive. The teachers don't ask for them, but they won't let anyone who is coughing get in the pool.

By the end of our exchange, Annie was really annoyed. "This is what I hate about Romania. No one follows the rules. It's confusing and perverse," she grumbled. Annie's husband was an American law enforcement advisor to the Romanian government. I had heard him make similar remarks about the Romanian legal environment.

In that instant, I saw how remarkably relevant my dissertation research is to real life. Within the ideal framework of pool regulations, the primary players, parents and teachers, negotiate agreements that are mutually beneficial. In exchange for more money than they are supposed to get, the teachers offer a more flexible schedule and don't penalize students for absence. By not requiring medical certificates, transaction costs are reduced for parents, representing a savings of money and time. Parents have no financial incentive to push sick children to swim—what parent would do that anyway?

The exchange is premised on significant discretion for individual teachers—who collude to offer similar pricing and pool-time arrangements—and low enforcement by pool administrators or Ministry of Sport inspectors. In terms of health and safety, the summer pool community is largely self-policed. Teachers are drawn from elite national squads, so they take pride in maintaining an attractive pool, sharing life-

guarding responsibilities, and providing excellent instruction. As a parent, I could only assume they also knew how to manage the chlorine.

Whether teachers pass along a sufficient part of their earnings to administrators who keep the water flowing, parents have no idea. The facility's larger financial posture is beyond us and probably beyond the teachers' understanding too. What was important was that the summer swimming lesson arrangement had achieved equilibrium. Neither parents nor teachers had any reason to abandon agreements—except Annie, for whom the pool's reliance on informal practices suggested inadequate attention to proper health and safety controls. Similarly, as I will explore, foreign donors are often more fixated on what is wrong, technically and in terms of law abidingness, in many public policy sectors than the central government is itself. But that might be because foreign advisors are unencumbered, whereas government actors are tied to all the people already at the pool—making money, socializing, learning, and functioning within ongoing, living institutions.

The interaction between well-meaning foreign advisors focused on end-states and government agents embedded in domestic relationships driven by chronic scarcity is what I am interested in exploring in this dissertation.

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For much of the time I was conducting field research on this topic (2001-2003), I was working at the U.S. Agency for International Development (USAID) Mission in Romania, first as a program development advisor, then as the senior democracy advisor. In the first position, I had to work on a five-year plan for U.S. Government assistance to Romania. In the second, I managed programs in the democracy portfolio, including USAID's largest program in the region of support to local government. This experience convinced me that there was precious little learning on the dynamics of institutional change driving the expenditure of foreign assistance dollars. Rather, the Mission set up a framework of admirable goals—Increase Effectiveness of Local Government Service Provision; Increase Involvement of Civil Society in Local Decision Making—toward which you could only hope your field programs were heading.

The origins of the intellectual inquiry that became this dissertation lie in an attempt to understand the real-world, empirical mechanisms of governance, which could help explain why the best-laid plans elaborated in multilateral and bilateral conference rooms so often appeared to take a different course in real time. I intentionally selected case studies outside the area of my professional responsibility in order to maintain a line between work and research. However, the phenomenon revealed in a closer look at child welfare and healthcare held true in the programs I oversaw for the U.S. Government—namely, a disconnect between agreements achieved between donors and central government versus program results implemented by sub-national, especially local, organizations; reform goals blocked by organizations of interest that gained authority and rent in the first stages of change; the inability of public entities to maintain hard budget constraints; and rational attempts, by organizations and

individuals, to secure resources through the exploitation of public assets in ways that dated back to the communist era. In systems of governance far more than in public opinion or preferences, the old system was dying hard.

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My two case studies focus on important policy regimes. The health of a population is an essential aspect of any nation's human capital; citizens are deeply concerned, with good reason, about the healthcare regime on which they must rely. Health is a public policy issue in which most every household has a stake. Child welfare as a policy regime normally affects a society's most vulnerable, and often marginalized, population. Because it became an international symbol of Nicolae Ceausescu's perverse disregard for human life, the Romanian child welfare system gained unusual prominence worldwide—and became a powerful magnet for donor attention.

Dissecting how foreign assistance has, and has *not*, influenced change in these sectors should yield useful lessons for other development schemes. In the required survey course, GVPT 799, Karol Soltan emphasized that dissertations should confront political problems that *matter.* All along, that challenge has motivated my research.

Dedication

Pentru familia mea.

Table of Contents

List of Tables

Chapter One
Introduction

Problem Statement

Western democracies, especially the United States, increasingly utilize foreign assistance to influence the policies of developing nations and to promote economic growth and democratic institutions (Lancaster, 2000; Carothers, 1999; Potter, Goldblatt, Kiloh, and Lewis, 1997; Smith, 1994). Fascinating cross-national data have been generated in the last ten years specifying which institutions, or aspects of governance, are most essential to improve economic performance and increase political accountability (Berthelier, Desdoigts, and Aoudia, 2004; Kaufmann, Kraay, and Zoido-Lobaton, 2003, 2002, 2000; Rodrik, Subramanian, and Trebbi, 2002; Knack, 2001; Campos, 2000; Mehrez and Kaufmann, 1999; Knack and Keefer, 1995). This research is particularly relevant to bilateral and multilateral foreign assistance programs criticized for being ineffective (Lovell, 2005; Perkins, 2004; Collier, 2002; Collier and Dollar, 2001; Dollar and Svensson, 2000; Durbarry, Gemmell, and Greenaway, 1998; Burnside and Dollar, 1997; Boone, 1996; Hadjimichael et al., 1995; Mosley, Hudson, and Horrell, 1987; Dowling and Hiemenz, 1983; Bauer, 1976; Voivodas, 1973). The problem with most studies of the impact of foreign aid is that they put the interaction between international donors and recipient governments in a black box, obscuring empirical dynamics that condition success—or failure—in reform outcomes. Using a controlled comparison of two cases in which international donors tried to steer reform in the Romanian child welfare and healthcare sectors between 1990 and 2004, this dissertation investigates the impact of foreign assistance on indigenous reform, and the role of organized

domestic interests, local decision-making institutions and procedures, and legacies of the past in redirecting reform initiatives. Micro-institutional case studies of reform offer instructive lessons for donors—and insight into the political nature of institutional change.

Rational choice and historical institutionalism provide the intellectual framework for the inquiry, and help explain how a combination of donor leverage (exerted, or not, through Euro-Atlantic institutions), stakeholder rational interest (which finds entry points into political and budgetary decision making, or not) and institutional legacies drove reform outcomes. Although the radical transformation of child protection and healthcare is indisputably complicated, studying this process is simplified because the politics of reform involves a limited number of actors.

When I began intensive field research, in 2001, it was not clear whether either case study would represent a successful example of post-communist reform. The two major donors deeply involved in child welfare reform, the European Union (EU) and the United States (U.S.), were locked in an intense debate regarding inter-country adoption, with the EU promoting a moratorium on foreign families adopting Romanian children, and the U.S. favoring the continuation of this practice as a partial solution to Romania's social problem of abandoned children living in state-run institutions. The only thing the donors agreed on was that Romania had made insufficient progress in closing large, state institutions for abandoned children and developing family-oriented, community-level alternatives. From the Romanian government's perspective, the child welfare issue was a top political priority, with

Cabinet-level attention, and the government was frustrated with donor discord (Coman, 2005).

In healthcare, a complex reform program approved in 1997 successfully raised more revenue but there was confusion regarding the roles and responsibilities of new health insurance funds versus the Ministry of Health (MOH) and Ministry of Finance (MOF), which had dominated the sector for decades before reorganization. A positive sign of reform progress in 2001 was top level participation—including the Minister of Health herself—in a new donor-inspired program to confront hospital inefficiency by assigning prices to hospital services.

What was clear, though, was the comparability of the two sectors. In both cases: 1) Decision making and finance had been highly centralized before the initiation of reform. 2) Despite the contribution of hundreds of millions of dollars in humanitarian initiatives between 1990 and 1997, donor programs had not had a substantial impact on institutional performance. 3) The primary method for "engineering" deeper institutional change was donor-recommended legislation approved in 1997. 4) After the implementation of legislative change, reform was derailed by organized professional interests that extracted significant rents by taking advantage of procedural uncertainty, access to decision making, and political veto points. 5) Despite the much ballyhooed reforms, many institutional attributes and norms that characterized both sectors under communism continued, including resource insecurity, collusion between management and mid-level public employees to secure resources, low enforcement of formal rules, wide discretion on the part of

unit managers, and inattention to conflicts of interest. Table 1 presents a schematic representation of the comparability of child protection and healthcare.

Table 1
Comparability of Child Welfare and Healthcare Institutions

	CHILD WELFARE INSTITUTION	HEALTHCARE INSTITUTION
	1990: Baseline	
Decision making	Centralized	Centralized
Financing	Centralized	Centralized
Dominant governing institution	No – Multiple ministries	Yes – Ministry of Health
Dominant service delivery institution	Yes – Residential institution	Yes – Hospital
Dominant profession	Medical	Medical
	1990-1996	
Decision making	Centralized	Centralized
Financing	Centralized	Centralized
Dominant donor(s)	No: Multiple donors - NGOs, multilateral, bilateral	Yes - World Bank
Humanitarian aid?	Yes – Target: improve institutional infrastructure; provide goods to residential homes	Yes – Target: improve institutional infrastructure; provide goods to clinics/hospitals, including drugs & contraceptives
Dominant technical advice?	Promoted decentralization	Promoted family physicians as gatekeepers, a kind of decentralization
Legal reform?	Yes – International conventions signed; inter-country adoption laws adopted	No – Attempted in Senate
Development of local reform champions?	Yes – Social work renewed as a profession, supported by donors	Yes – Institute of Health Services Management supported by donors
	1997-2001	
Decision making	Dominated by executive; increased input from counties	Divided between new National Health Insurance House and district-level HIHs, Ministry of Heath, and Ministry of Finance
Financing	Divided between national, county, and local budgets	Mandatory contributions from employers/employees; small percentage from national budget
Dominant donor(s)	Yes – European Union followed by USAID	Yes – World Bank
Dominant organization, benefited by partial reform?	Yes – Romanian Adoption Committee and members of adoption agency boards	Yes – Doctors based in hospitals
Legal reform?	Yes – 1997: Redefined rights of the child and prioritized local care	Yes – 1997: Adopted mandatory payroll tax to finance healthcare;

	solutions including domestic adoption	established Health Insurance House system to negotiate contracts; designed family doctors as gatekeepers to healthcare system
Humanitarian aid?	Minimal	Minimal
	2001–2004	
Donor assistance made conditional?	Yes	No
Credible rewards for successful reform?	Yes	No
Short-term winners beat?	Yes	No
Reform results: technical success?	Yes	No
Reform results: financial success?	Yes, in that Romanian government effort secured significant, ongoing donor dollars, and costs per child in the system decreased, but can't prove that reform led to more domestic financial efficiency.	Yes, in that reform increased revenue available to healthcare. No, in that reform did not lead to improved domestic financial efficiency.

Source: Author

Methodology

The policy sectors investigated, child welfare and healthcare, are fit for comparison because the respective reform agendas are distinct, involving different constellations of strategic actors on the domestic and international sides, but they are both aspects of the nation's social welfare regime. As well, the impetus for a great variety of bilateral, multilateral, and non-governmental foreign donors to get involved was, in both cases, humanitarian and political. By selecting two cases in the same country and during the same period, political and macro-economic factors can be controlled, allowing a narrative that highlights variables constraining or facilitating reform. These are not marginal targets for foreign aid: Between 2002 and 2003, for example, approximately 30% of bilateral donor dollars entering Romania were expended on health and child welfare (Organization for Economic Cooperation and Development [OECD)], 2005b).

Sources for the case study research include participant interviews, donor reports, newspaper accounts, and annual statistical summaries in addition to secondary literature.

Case studies are useful for theory testing, and the comparative method, using a small number of cases, is especially beneficial in trying to discern causal relations. Among the strategies of controlled comparison, a classic approach (described by John Stewart Mill) is the method of difference. Here, the substantial comparability of child welfare and healthcare allow me to hone in on critical differences in how reform initiatives were promoted by donors and processed by recipient institutions and interests. My objective is to account for positive change in the child welfare—an example of success in implementing a reform strategy recommended from abroad—and unsuccessful reform in the field of healthcare.

Indicators of Success

Economists Yingvi Qian and Chenggang Xu (1998) developed a useful distinction between successful outcomes and unsuccessful ones. They consider a *successful outcome* one that engenders both technical and economic success, while an *unsuccessful outcome* can be either an overt technical failure or a technical success but an economic failure. In these two case studies, quantitative indicators support the conclusion that child welfare reform has been a technical and economic success, whereas healthcare reform has been neither.

There are at least three quantitative indicators of successful reform in Romania's child welfare regime: 1) Fewer children lived in residential childcare

institutions in 2004 than in 1990. 2) More abandoned children were cared for in family-like settings in 2004 than in institutional settings. 3) The rate of child abandonment in 2004 was lower than in 1990. In 1990, approximately 150,000 children lived in state-run institutions. In December 2004, the number was down to 32,679[1] children protected in state or private institutions (out of a national population of some 5 million minors) and 50,239 children under age eighteen protected in substitute families, of which 34,405 were living with their extended families or other individuals/families and 15,834 were in foster care—a form of child protection that did not exist in 1990. These indicators of progress were goals heavily promoted by outside actors, including multilateral donors such as the EU, international financial institutions (IFIs) such as the World Bank, bilateral development agencies funded by at least fifteen nations including the United States,[2] and non-governmental organizations (NGOs) from around the world.

The objective of a responsible national or local child welfare system is to protect the best interests of a child at risk for physical or psychological harm. It is widely agreed that big, old-fashioned orphanages are detrimental to a child's normal development, and a variety of schemes for providing family-like settings for abandoned children are preferred over institutions. The existence of a growing variety of these alternatives in Romania is both a socially beneficial reform and a financially efficient one: Almost every alternative service is less expensive for government to

[1] All statistics: National Authority for the Protection of Children's Rights (ANPDC, 2004) confirmed by European Commission, 2004.
[2] There is no comprehensive database of donors, but I viewed documentary evidence of involvement by the following countries, confirmed by Coman (2005): Australia, Austria, Belgium, Canada, Denmark, France, Germany, Japan, Luxemburg, the Netherlands, Spain, Sweden, Switzerland, the United Kingdom, and United States.

provide than assuming full care and responsibility for an abandoned child (Wulczyn, Orlebeke, and Haight, 2000). In December 2004, the average cost per child/month in foster care was $246 USD; in state-run day care centers, $163 USD; in state-run institutions, $312 USD; but in mother/baby centers, the cost was $368 USD (National Authority for the Protection of Children's Rights, 2004). This last option is financially efficient in the long term since the purpose is to prevent abandonment by giving at-risk mothers and infants time to bond (typically six months) while being supported financially.

While child welfare reform has largely succeeded, healthcare reform has largely failed. Some important health outcomes improved between 1990 and 2004, but other indicators reflect little improvement in the overall health of the Romanian population. In 2004, infant mortality rose to 16.8 deaths/1,000 births, the highest rate in Europe (*Agence France Press*, 2005). There was an explosion of infectious diseases including tuberculosis (twice as many new cases per capita as in any other Central or Eastern European [CEE] country), and sexually transmitted diseases. Child and maternal mortality rates improved, but remained unacceptably high. The maternal mortality rate was five times higher than the EU average, for example (Galan et. al., 2003). Stagnant since the 1970s, life expectancy was stuck at about 68 years for males, significantly lower than life expectancy in the EU and CEE (Peretianu, 2004).

Regarding policy reform, within five years of sweeping legislative change enacted in 1997 to turn the Semashko[3] Soviet-style healthcare system into a German-

[3] In 1918, in Moscow, Dr. Nikolai Semashko chaired a conference on medicine and public health that resolved that universal access to healthcare, funded by the central budget and managed by a central institution, would be the hallmark of Soviet healthcare. This system, under direct government control

inspired mandatory insurance system, progress had veered off course: Change recommended—in fact, directly inspired—by international donors was undermined by recentralization of decision making and finance as well as a hospital sector that would not give up power. Chronic debts generated by hospital overspending and run away drug costs placed healthcare on crisis footing. Reform goals related to increased efficiency, financial stability, and prioritizing the role of general practitioners over hospitals had not been achieved by the end of 2004. The public was overwhelmingly disappointed with government management of the sector (Metro Media Transilvania, et. al., 2004), as were medical professionals. Neither technical nor economic success had been achieved.

Explaining Reform Outcomes

What caused institutional reform to occur in child welfare but not in healthcare? This dissertation locates the answer within the framework of historical institutionalism. In the child welfare case study, donors and the Romanian government functioned within redefined Euro-Atlantic institutions and overcame rational local resistance to deep, structural change. Specifically, there are at least five reasons for the child welfare outcome manifest by the end of 2004:

1) Major donors had credible leverage over the central government as a function of the link created between child welfare and larger geo-political goals, namely North Atlantic Treaty Organization (NATO) membership and EU accession.

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with an extensive national network emphasizing workplace facilities, became the model for other countries in the Soviet sphere (Marrée and Groenewegen, 1997).

2) Despite decentralizing reforms in 1997, the institutional configuration of child welfare was still dominated by a powerful center, maintaining control over money (directly contributing over 40% of the child welfare budget and indirectly controlling donor contributions totaling 21%) and employment, much as it had under state socialism.
3) Besides a briefly successful inter-country adoption cabal that emerged between 1999 and 2001, there were few organized domestic interests, including professional organizations, with access to national level child welfare decision making.
4) The nature of the structural reform favored by donors reorganized child welfare in a way that *expanded* the sector, thereby protecting employment and allowing the central government to satisfy its main constituency, public employees.
5) Donors put their money where their mouths were: while making aid conditional, they also invested heavily in the deeper changes they required.

In contrast, in healthcare, foreign donors were *not* able to compel structural reform—and trump domestic stakeholders who were benefiting from partial reform. Donors offered concepts and technical assistance, but there was no "fear factor" to enforce compliance or cajole follow-through. Why not? There are at least three reasons: 1) absence of child welfare's "800-pound gorilla," the EU and the promise of EU accession; 2) lack of a unified position regarding the "best" way to organize healthcare; and 3) inexistence of a coordinating mechanism to pool donor power. First, the *Acquis Communitaire*, which guides the EU accession process, has no

chapter devoted to health. Thus, healthcare was never an EU priority, despite some activities that tangentially involved the field. Second, within the EU there are a range of national solutions. The British National Health Service and the German health insurance houses are considered to be rival models with unique and respective pros and cons. The Romanian reform program drew from both. A tacit assumption was held among donors that the politics of health would have to be worked out domestically, while donors concentrated on technical *pieces* of the reform puzzle. There were bilateral health reform–related activities led by governments that had very different healthcare systems at home. Therefore, in health reform, local actors drove outcomes within a political, or institutional, framework that allowed well-organized interests to exploit, especially, the budget process, while in child welfare, international agreements trumped local preferences, and the political, or institutional, process ultimately gave minimal access to interests that opposed closing state-run institutions and moving abandoned children into family settings.

Rational Interest and Constraints on Institutional Change: The Healthcare Case Study

The investigation of healthcare reform required a more detailed exploration of interactions within the domestic sector once it became clear that the contributions of foreign assistance were weak. As well, there was little secondary material on the problem. Therefore, this case study is a more lengthy narrative than the narrative in child welfare, yet, hopefully, it represents a more thorough exploration of the hypothesis: The extent to which organized interests influence reform outcomes

depends on institutional procedures that determine who has input into decision making, whether veto points exist (and who gets to use them), and the organizational skill of interests.

Within the political framework, heavily controlled by the institutions of executive authority, the healthcare budget-making and allocation decision points allowed little access to organized interests besides elite doctors associated with the hospital sector—who were often simultaneously political decision makers. This hospital-based constituency made strategic choices *within the political economy of healthcare* in the first years of reform implementation that maximized the freedom of doctors (to treat, to prescribe, to spend), then used the national budgetary system to confirm the legitimacy of hospital profligacy, a rational set of behaviors that directly contradicted the original goals of health reform. Once sanctified, the cycle of hospital overspending and pharmaceutical inflation was virtually impossible to break.

Donor programs first emphasized humanitarian aid, which was seized by recipients but had negligible impact on the institutions governing healthcare. Then, donors offered well-considered, but highly technical, policy recommendations that tended to be out of sync with the politics of reform. What we see in the healthcare sector is the process by which an "insider lobby" in Mancur Olson's phrase (2000), rationally subverts a plan for institutional change. Occupation-specific lobbies are able to organize for collective action and the impact harms efficiency. Interestingly, hospital doctors, at the heart of the problem, do not necessarily realize the impact of their daily decisions.

Angry at the MOF's cynical treatment of healthcare surplus, convinced that the sector was under-funded, not penalized for overspending, medical professionals based in hospitals made daily decisions that optimized their professional autonomy but jeopardized the financial stability of the entire national health system. The decisions that each doctor makes is rational. The cumulative effect of all these individual decisions is socially inefficient.

The Historical Legacy of State Socialism

One of the most important conclusions reached—not because it is surprising, but because it is so *palpable* yet often ignored in donor programming—is that the informal norms of state socialism continue to influence institutional design and performance years later. While exploring certain "unintended consequences" (in donors' eyes) in the evolution of child welfare and healthcare reform, patterns with antecedents in state socialism emerged, including these three tendencies: 1) Although reform initiatives typically start by enshrining the concept of decentralization in law, there is a discernible centripetal tendency in the implementation of reform, moving decision making back to the organizations of central government. 2) Sub-national organizations charged with managing financial resources are consistently incapable of maintaining hard-budget constraints. Instead of enforcing budget limits through regulatory or punitive action, central government tends to acquiesce, finding advantage in profligacy. 3) Central-level decision making is notably *ad hoc*, with Emergency Ordinances utilized by the Cabinet in order to bypass Parliament, laws

promulgated with minimal impact analysis, and changes announced without consultation with important stakeholders.

These patterns can be traced back to the political economy of state socialism. Central control, bureaucratic coordination, and managing uncertainty through the routine exploitation of soft-budget constraints were attributes of state socialism being utilized some fifteen years after the death of the old regime in the healthcare institution as well as in aspects of the child welfare institution. So was collusion at the enterprise level among managers and members to skim off state assets. Collusion served as a kind-of protection racket against economic uncertainty; today, donors call it corruption.

Following Douglass North's concept of institutional change and informal constraints (1990, 1993a, 1994a, 1997, 2000) in addition to notions he draws from cognitive science (1996, 1994b, 1993b; Denzau and North, 1993), it is clear that the informal norms of state socialism continue to influence institutional design and performance years later—an element of the Romanian reform story that donors find puzzling, even infuriating. The mental models that evolved in the forty-year course of state socialism in Romania included behavior that rationalized, even required, persistent aggrandizement of one's own organization or institutional sub-unit; disregard for budget limits; hoarding of information and goods; a tendency to revise and rework rules in a way that increases uncertainty; the use of public and work-related networks to increase personal/family "stability" (or "gain," in the view of analysts not experiencing profound shortage); and a complicated attitude toward the state of both dependence and rejection: A deep expectation that the state should

provide employment and services for free, such as health and childcare, coexists with a distain for ubiquitous state property, such that hospitals or state-run institutions for children are fair targets for rent seeking. This belief system informed how organizations and individuals adapted to, and adapted, formal post-communist reform initiatives.

There is no thick line between the past and present: the notion of a "collapse" of communism is the wrong metaphor. Institutions provide structure and some certainty in a fluid, uncertain time, so these patterns continued to define post-communist political interactions especially around policy implementation. Therefore, political development requires not just legislative change and institutional reform but changes in attitudes and the political culture—a conclusion that places limits on how much political development can be externally imposed.

A New Look at "Corruption"

For much of what is still not going right in Romania, observers sing one refrain: corruption. Often applied quite generally, it is not necessarily a useful category of understanding. Reports on Romania written by donors in the late 1990s constantly allude to rampant corruption and assert, explicitly or implicitly, that corruption inhibits or prevents achievement of program goals. However, I reexamine donor assumptions regarding corruption in light of the reform narratives developed in the case studies. It is certainly true that central governments, which systematically steal, are virtually hopeless candidates for foreign assistance as the World Bank outlines well in its 1997 *World Development Report*.

But the category "corruption" is being applied so freely that donors are missing important empirical dynamics: Rational actors assessing options in a resource-scarce, low-enforcement environment, faced with institutional incentives that reward overspending and organizational aggrandizement, will opt to ignore spending limits and position their organization advantageously, especially if intergenerational learning accepts these norms. As Douglass North was fond of saying, if piracy is rewarded, people will be pirates (North, 1993a). When public employees in a resource-poor environment employ public assets for some level of private gain, that's rational, especially if no one is enforcing rules that ostensibly prevent it. Also, behaviors described as "corrupt" are often related to helping gain positive advantage for one's *organization*, not necessarily one's self. This strategic positioning has a long, proud heritage, especially under state socialism, as I will explore in Chapter Six.

Today, using public assets, or public networks, for private or organizational gain is sanctioned in Romania by: 1) the commonly understood need for resources (by any means) and informal norms that accepted the use of public assets to survive under communism; and 2) a legacy that blurs the line between public and private property, allowing individuals to rationalize practices deemed corrupt in the West.

Healthcare in Romania, for example, is not in crisis because of petty "corruption." It has been overwhelmed by weak budget constraints; poor financial management at the level of the Ministry of Finance and individual hospitals; lack of competition; lack of procedural enforcement especially related to the framework contract; a high level of confusion regarding institutional roles and responsibilities,

which shrinks the planning horizon for all actors; and professional collusion between decision makers and a well-organized professional sector. Simply put, the national healthcare institution lacks the incentives to control costs! Corruption is more a symptom than a cause of dysfunction in Romanian healthcare. Bu corruption is so often evoked as a root cause of Romania's current problems that it merits consideration in the context of exploring the legacy of state socialism.

Development professionals should be discouraged from employing the corruption construct as a blanket excuse for programs not turning out as expected and hoped. The use of public resources for private and organizational gain should be included as an assumption in post-communist program planning. This expectation will, then, help development professionals shape programming to focus on the incentives within a policy regime, especially rules governing budget allocation and public procurement—rules which differ in every context, and every country.

General Conclusions

Foreign assistance is especially beneficial when credible international commitments spur difficult, complex change. However, the rational tendency of organized interests to undermine institutional reform—especially if opportunities to extract rent emerged in the first phase of reform implementation—is a strong countervailing current. Foreign assistance, too often fixated on teleological end-states and normative goals, is inefficient when: 1) Reform recommendations rely on national legislation, with little attention to domestic, intra-governmental bargaining, especially regarding budgets; 2) Reform plans fail to examine institutional procedures and vagaries that constitute

financial incentives for short-term "winners" to subvert reform; and 3) Donors exaggerate the break between past and present, missing opportunities to better understand contemporary constraints as a function of historical legacies.

With norms such as the reliance on soft-budget constraints maintained and little competition—or independent monitoring to enforce accountability—outside attempts to help reorganize health services failed. Performance-based conditionality tied to credible international threats led child welfare reform beyond stalemate, although deep changes in the form of employment cuts and financial decentralization are resisted. If donors are too mesmerized by Western models being promoted, too fixated on the end-states toward which assistance is driving, then much of the real-life institutional drama that intervenes as reform unfolds over time is lost—and donor expectations are foiled.

But we have cut to the chase without introducing the case studies, or the origin of post-communist foreign engagement in the two sectors under consideration.

Background of the Cases and Foreign Involvement in Reforming Child Welfare and Healthcare

At a hearing of the Commission on Security and Cooperation in Europe[4] on September 14, 2005, members of Congress lashed out at the EU[5] (*Europa Libera*,

[4] The CSCE, or Helsinki Commission, is an independent U.S. Government agency established to monitor progress toward implementing the 1975 Helsinki Accords. Most of its members are drawn from Congress: nine from the U.S. Senate, nine from the U.S. House of Representatives, and one member from the Departments of State, Defense, and Commerce, respectively.

[5] The State Department's press release regarding the hearing summarizes the U.S. Government position: "Romanian Adoption Policy Examined as Human Rights Issue: Congressional Panel Criticizes EU Adoption Ban Pressure on Bucharest" (2005a, p. 1). In later chapters, the dispute will be discussed in greater detail. For their part, Europeans also refer to child welfare in Romania as a human rights issue. Earlier this year, a Council of Europe document declared, "The fate of children in

2005). In itself, that's not an implausible scene. But the hearing's subject, Romanian adoption policy, seems marginally relevant to trans-Atlantic security and cooperation, and the spectacle of U.S. officials struggling against the EU to define an aspect of a third country's *social* policy—well, that's just unusual.

It is not unusual when the international standing of post-communist Romania is under discussion: One of the defining political issues in Romania's relations with the West over the last fifteen years has been its child welfare policy. Normally, child welfare is a domestic problem, but it was catapulted into the world's consciousness when, in early 1990, repugnant images of thousands of abandoned children, tied to beds and fed like animals in forsaken state orphanages, were broadcast from re-opened Romania. Worst of all, the majority of these children weren't orphans at all, but unwanted children—"economic orphans" in the lexicon of the EU (Council of Europe, 2005).

The heart-breaking humanitarian crisis inspired a torrent of private, philanthropic, bilateral, and multilateral assistance. If ever there was a problem foreign assistance could fix—considering the dollar amount of donations, the army of paid and voluntary advisors eager to move to Romania in order to dedicate themselves to reform, and the explicit commitment by the Romanian government to fix the policy with guidance from abroad—it should be this one.

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institutions has ceased to be a matter for the social welfare field, and has now become, first and foremost, a human rights issue…" (2005). However, the European Commission had already deemed Romania's child welfare crisis a human rights issue within the EU accession process (1999b).

Sure enough, the contrast between Romania's child welfare regime[6] today and in 1990 is dramatic. Most state-owned facilities are now structured on the model of family-like residential units. A range of services are offered—from day care facilities to maternal-child shelters to more generous child allowances for poor families—to help prevent families from giving their children to the state. The government is party to international conventions governing the well-being of children that even the United States has not signed.[7]

When donors engaged with the child welfare system[8] in 1990, they quickly made the connection between child welfare and the healthcare system: Within the complicated division of authority over abandoned children, the Ministry of Health was charged with managing state facilities caring for infants and toddlers aged 0-3 years. These crucial years of child development were categorized mainly in medical terms, rather than psychosocial ones.[9]

In assessing the causes of Romania's high child abandonment rate and miserable reproductive health outcomes, many analysts concluded that Nicolae Ceausescu's ban on contraception and abortion, which extended from 1966 to 1989, was a driving factor (Dickens and Groza, 2004; Booth et al. 1999; Kligman, 1998).

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[6] Romanians use the term *child protection* (*protectie a copilului*), while the American system uses the term *child welfare*. The meaning is essentially the same.

[7] The main difference is that Romania is a party to the U.N. Convention on the Rights of the Child, which the U.S. has never signed.

[8] I use the term "system" in the sense of a network designed to deliver something or serve a common purpose, such as the telephone system or the highway system. When non-state actors become involved, including NGOs, adoption lawyers, potential parents, and so on, it is more descriptive to refer to a child welfare "regime," which I do as reform evolves.

[9] It must be noted that these medically oriented overseers managed to create Europe's largest pediatric AIDS population: Through the repeated use of intravenous needles and the overuse of transfusions (using untested blood) for any sign of ailment, including anemia and malnutrition, the Ministry of Health spread HIV/AIDS to over 4,000 children, most of whom lived in state care. To this day, Romania has the largest number of pediatric AIDS cases in Europe, accounting for over half of all European cases (Leigh, 1999).

The combination of "pro-natalist" policies and rapidly increasing national poverty throughout the late 1970s and 1980s[10] conspired to create families without means to care for unwanted children. Illegal abortions led to the highest maternal mortality rate in Europe between 1979 and 1989. About 85% of these deaths[11] were related to abortion, yielding maternal mortality ten times higher than any other European country (Centers for Disease Control and Prevention, 1995); the children of deceased women were often assumed into state care. In addition, children with disabilities (either as a result of weak neonatal care, insufficient maternal nutrition, or failed abortions) were almost automatically declared wards of the state and tracked into a dizzying array of special hospitals, homes, and residential schools.

The primary explanation for this inhuman crisis, besides these socio-medical factors, was an aggressive child welfare institution that asserted the priority of the state over families vis-à-vis the care of children. There are poor countries with big families all over the world. No where in, for example, Latin America or Asia, is it routine to turn babies over to the state never to see them again. In Romania, as part of the ideology of state socialism, institutions and rules governing the disposition of children were implemented that rationalized the warehousing of infants and children under state supervision. For example, children born with disabilities—ranging from hair lips to mild retardation to anemia—required a doctor's signature for parents to assume care. Very often, doctors withheld signatures and placed the children in institutions where, more often then not, the disabilities worsened (Booth et al., 1999). This institutional control of the child welfare domain was particularly difficult to

[10] Romania channeled national wealth to international lenders in order to pay back debt (Judt, 2001).
[11] In 1989, the rate was 169.4/100,000, which dropped to 83.6/100,000 in 1990 (Petre, 2002).

undo; from 1990 to 1996, most donor initiatives (inadvertently) contributed to the ongoing empowerment of state-run institutions.

In 1990, confronting this complex of child abandonment and health-related issues, many donors introduced aid programs to address reproductive health and health service delivery, alongside programs to add heating facilities to orphanages, train new social workers, and introduce play therapy. Although the origin of donor-sponsored health programs was related to child welfare, health reform efforts broadened in 1991 with a major $150 million World Bank loan. One of its first analytical products was a 400+ page report compiled by the University of Leeds and King's Fund College and delivered to the Ministry of Health in 1993 (World Bank/Government of Romania, 1993). It provided a detailed plan for the transformation of health delivery, financing, human resources, and technology—a soup-to-nuts scheme that aimed to turn a highly centralized, ministry-dominated system into a decentralized, family physician–friendly model.

These were the beginnings of child welfare and healthcare reform in post-communist Romania. Fifteen years later, reform programs in the two sectors appear to have taken markedly divergent paths. What can we learn from a side-by-side comparison of child welfare and healthcare reform in Romania between 1990 and 2004? This is the substance of my dissertation, explored in detail in Chapters Three through Six.

So What? Global Trends in Foreign Assistance

The foreign aid that flowed into Romania in order to support reform goals is much like foreign assistance dispersed around the world: a combination of loans to the central government, grants to indigenous organizations, technical assistance implemented by expatriate advisors and consultants, and training opportunities (both in-country and abroad) provided to local people. It would be beneficial if in the process of dissecting the course of reform in child welfare and healthcare—and how foreign assistance helped, hurt, or didn't do much at all—some observations can be applied to other reform efforts.

This exercise is valuable because bilateral and multilateral assistance is increasing. According to the Organization for Economic Cooperation and Development's (OECD) Development Assistance Committee (DAC), which coordinates the aid policies of twenty-two members and tracks Overseas Development Assistance (ODA)[12] flows, global foreign assistance increased by 4.6% in 2004 to $78.6 billion USD, which follows a 4.3% increase between 2002 and 2003 (OECD, 2005a). Of the twenty-two DAC members, fifteen countries increased aid flows after controlling for inflation. Approximately 20% of ODA is provided by IFIs, primarily the World Bank which provided $20.1 billion to 245 projects worldwide in 2004 (World Bank, 2005a).

Since the Second World War, U.S. foreign policy has doggedly pursued the assumption that financial and technical assistance provided to allies can change the course of domestic policy in countries ranging from Japan to Columbia, from Haiti to

[12] The OECD defines foreign assistance as ODA, which consists of grants or loans that one government or multilateral organization provides to a developing country in order to promote economic development and social welfare. ODA includes concessional assistance as well as loans of which at least 25% is given in the form of a grant.

Iraq. Under George W. Bush's administration, development assistance has attained an even more paradigmatic role (National Security Council, 2002; U.S. Agency for International Development [USAID], 2002).

Besides the United States, which created USAID in 1961, most industrial democracies created national entities between 1960 and 1975 to lead bilateral development efforts, prompted in some places by changing colonial relationships and supported by a growing body of academic research on development and modernization (Carothers, 1999; Potter, Goldblatt, Kiloh, and Lewis, 1997; Smith, 1994; Huntington, 1991, 1968; Almond and Coleman, 1960). Although the bilateral development programs of different countries have different orientations, they generally use the same methods to channel aid: grants to government organizations or NGOs, technical assistance, study tours, and in-country training. Although this dissertation largely concentrates on three donors—the EU[13], the United States, and the World Bank—because they assumed the highest profile roles in the sectors I examine, conclusions are applicable to foreign assistance offered by other bilateral and multilateral donors.

Numerous studies regarding the impact of foreign aid on economic development have reached consensus that a state's governing institutions must be suitably mature and free of corruption for international assistance to make a significant positive contribution (Tanzi and Tsibouris, 2001; Knack, 2001; Chhibber,

[13] According to the OECD's most recent ODA summary (2005b), the European Community led, by far, all donors in assistance to Romania, providing $275 million USD between 2002 and 2003. Japan and the United States were virtually tied for second place, giving $50 million USD and $49 million USD, respectively. Although it is impossible to know how much foreign assistance has been received by the child welfare and healthcare sectors between 1990 and 2004, guesstimates range from $800,000,000 to $1.5 billion.

1998; World Bank, 2002d, 1998, 1997; Ades and DiTella, 1997; Brunetti, Kisunko, and Weder, 1997; Commander, Davoodi, and Lee, 1996; Dia, 1996). The critical impact of efficient governing institutions on aid effectiveness is now acknowledged in presidential announcements. In July 2005, in anticipation of the G-8 summit, President Bush announced his intention to double aid to Africa, raising U.S. assistance to $8.6 billion in 2010 from $4.3 billion in 2004 (Associated Press, 2005). The President said:

> Over the decades we've learned that without economic and social freedom, without the rule of law and effective, honest government, international aid has little impact or value. But where there's freedom and the rule of law, every dollar of aid, trade, charitable giving, and foreign and local investment can rapidly improve people's lives. Economic aid that expects little will achieve little. Economic aid that expects much can help to change the world. (President George W. Bush, 2005)

It's encouraging that the White House speechwriting team absorbs lessons from studies by the World Bank.[14] But the final sentences in the passage quoted above are worrisome: "Economic aid that expects little will achieve little. Economic aid that expects much can help to change the world." Without overburdening this speech, based on the case studies in this paper, it is exactly the big think, blueprints, and meta-solutions that miss the mark in *curative politics*. This dissertation seeks to demonstrate that for change to succeed, donors must focus on institutional relationships and political and administrative procedures governing money, keeping a

[14] Further evidence of this intellectual reliance can be traced to 2002 when the president announced the creation of the Millennium Challenge Account, a U.S. Government–supported investment and development fund that explicitly ties increased aid to national performance on indicators of democratic governance and economic freedom generated by the World Bank, Freedom House, and the International Monetary Fund. Learning about foreign aid *has* moved from academic and IFI circles to political ones, but not deeply or widely enough.

wary eye on organized interests that benefit from early phases of reform and insisting that donor investments be tied to measurable goals.

With the rush of assistance to post-communist countries after 1989, Western advisors have recommended a plethora of substantive legal and policy reforms to transitioning countries not always giving sufficient attention to: 1) the decision-making processes, procedures, and incentives that shape, in critical ways, the implementation of reform; 2) the strategic interactions between governing institutions and local stakeholders that drive outcomes; and 3) the strong incentives that "partial winners" have to stall reform somewhere between reform initiation and the achievement of public goods.

A reoccurring assumption is that getting the right laws—modeled on functioning Western regimes—in place, will yield desired reform results. Reform prescriptions are often presented as end-states that obscure the process by which change is sorted out. The impact of donors on domestic political relationships (at central and local levels), the key roles played by institutions implementing policy change, and the importance of budget procedures in creating incentives that favor, or work against, reform have too often been ignored.

Curative Politics

This is where the notion of "curative" politics comes from: Too much foreign assistance, emphatically normative and driven by a notion of full health, is administered like a seventeenth-century cure for deleterious symptoms with scant

attention to an accurate diagnosis of the patient.[15] As well, the language and posture of foreign aid often assumes that the recipient government's institutions are sick.[16] This metaphor, paradoxically, confounds the assistance effort because, as I hope to show, the recipient institutions are quite alive and thriving—not always thriving in ways that contribute to the common good, but thriving in the sense that they are functioning, rationally, to secure resources and maximize opportunities to increase authority. The curative politics of foreign aid (practiced in North America, Western Europe, and the Asian Pacific countries such as Japan and Australia with traditions of engagement in bilateral development) contributes to partial, naïve, and misleading assessments of what development fixes to offer. The case studies I treat constitute an autopsy of this outmoded form of treatment.

International actors do many good things, no doubt. Humanitarian assistance is welcomed by those in immediate need; individuals on fully sponsored trips to see life in more settled countries usually appreciate the investment. In the fields of basic healthcare, including immunization and services such as water sharing schemes, foreign donors present convincing data linking assistance to improvements in human welfare (USAID, 2002; Congressional Budget Office, 1997; Gordon, Gwin, and

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[15] The Oxford English Dictionary (1944) defines "curative" as having the tendency or power to cure disease, from "cure" a Middle English word first used in a medical sense in 1592. Earlier, the word signified caring for the spiritual interests of a parish (think of a curé or curate) or removing an evil. To "cure" is also a process of preserving meat. So, a "cure" is generally used to describe a process of change in which one agent works on another to fix a problem—spiritual, medical, or chemical.

[16] This analogy occurred to me long before I read Jeffrey Sachs' latest book *The End of Poverty: Economic Possibilities for Our Time* (2005a) in which he develops the concept of "clinical economics" to describe a "new method" for development economics. He writes, "Development economics today is not like modern medicine, but it should strive to do so. It can improve dramatically if development economists take on some of the key lessons of modern medicine, both in the development of the underlying science and in the systemization of clinical practice, the point where science is brought to bear on a particular patient" (Sachs, 2005a, p. 75). For Sachs, the "particular patient" is whatever nation, or government, he is advising. This passage represents a contemporary example of *curative politics* from one of its best-known practitioners.

Singing, 1996). In beneficial scenarios, foreign and multilateral donors play the role of presenting policy alternatives normally articulated in national parliaments or through electoral contests in the West. International actors also sometimes represent the voices of average people, clients for state services, who are frustrated with the lack of transparency or accountability but have few mechanisms for articulating this frustration. What donors are distinctly *not* good at is anticipating how local organizations, through local institutions, will absorb, and refract, change.

Outline of the Dissertation

Following the literature review in Chapter Two, in Chapter Three we consider the explanatory power of electoral politics vis-à-vis the evolution of policy changes in child welfare and healthcare between 1990 and 2004. Many political observers of post-communist Romania describe change in terms of the rivalry between leaders and political formations with ties to the old regime (which governed 1990-1996 and 2000-2004) versus political parties that can be considered part of a democratic opposition, which governed between 1996-2000 and recaptured power in late 2004. It is certainly true that soon after the opposition coalition came to power in 1997, we quickly saw passage of important legislative reforms in child welfare and healthcare. But implementation was problematic between 1996 and 2000 much as it was before. The discussion concludes that in terms of institutional reform, electoral politics has weak explanatory power.

However, the political need for central government to remain attentive, and work through, sub-national government entities has an interesting impact on the

implementation of foreign aid. In the second part of Chapter 3, we examine the interaction between donors, central government, and sub-national units with special attention to the overwhelming concern among domestic organizations to secure resources. This rational concern dominates inter-governmental relations and helps explain some executive level behavior that donors consider ambivalent.

But the two-level bargaining approach, while interesting, is episodic. It does not explain outcomes in a way that is tied to the procedural rules governing interactions between organized interests and institutions. In Chapters Four and Five, we attempt to penetrate the conditions for success and failure in social welfare reform promoted by foreign actors by tying performance outcomes back to institutional rules and procedures, especially procedures governing budget allocation. In both case studies, data drives analysis whenever possible, because numbers offer insights that point back to politics. Looking for the institutional antecedents of dysfunction described in Chapters Five and Six sends this investigation to the legacy of state socialism in Chapter Six, where reference to the institutional past allows a deeper understanding of post-communist reform patterns; informal norms, mental models, and ideology help explain how the past continues to inform the present. Operationally relevant conclusions are presented in the final chapter.

Chapter Two
Literature Review

Institutional Theory and New Institutional Economics

Institutional theory is the cradle of this dissertation, which is not to say much. At the core of the new institutionalist approach is recognition that politics often entails the adjudication of conflicts of interests or preferences within an institutional framework that *itself*—via its rules, procedures, incentives, loopholes, and enforcement mechanisms—helps determine political outcomes. Rules do not *determine* outcomes—this is not a deterministic theory—but rules (i.e., institutions) comprise an essential frame of reference within which political decision makers and organized interests function, making certain strategies or tactics optimal or not. Within this scholarship, the individual is assumed to be rational and instrumental. This assumption can be confusing, because much of the literature talks about institutions constraining or facilitating individual and corporate actors, so it seems to be about structures, not choice. Yet individuals create institutions and change them, even as they function within them. Although two distinct intellectual strands in the study of institutions, rational choice (RC) institutionalism and historical institutionalism, are purportedly moving closer together (Soltan, Uslaner, and Haufler, 1998), I will discuss institutional theory and RC separately in order to clarify their respective contributions to this dissertation.

Political economist Douglass North provides the most salient definitions of institutions and institutional change (1990, 1993a, 1994a, 1997, 2000), definitions that have probably launched thousands of dissertations. Institutions include the formal

and informal constraints devised to shape human interaction, and the enforcement characteristics of both. Formal constraints include constitutions and laws; informal constraints include codes of behavior, norms, and unwritten customs. The major role of institutions is to reduce uncertainty by providing a stable structure to human interactions. Institutions define incentives that shape the choices made by organizations and individuals. Ultimately, these choices generate efficient or inefficient outcomes.

North recognizes that institutions are always evolving, which means that choices available to individuals are continually altering. Organizations—groups of individuals bound by common purpose to achieve certain objectives—are important agents of institutional change since they are created in response to institutional constraints and, in turn, their activity causes institutions to evolve. Institutional change is typically incremental: "Marginal adjustments to the complex of rules, norms, and enforcement that constitute the institutional framework… Stability is accomplished by a complex set of constraints that include formal rules nested in a hierarchy, where each level is more costly to change than the previous one" (1990, p. 83). For North, the "complex mix" of formal and informal constraints, together with enforcement, are the critical elements in producing efficient—or inefficient—outcomes (1990, pp. 83, 53).

When change is dramatic and conclusive, such as the revolutionary actions that ended communism, North refers to "discontinuous institutional change." He suggests, in just a few paragraphs on the subject in *Institutions, Institutional Change, and Economic Performance*, that radical chance is rarely as dramatic as it first

appears because although formal rules can change overnight, informal constraints never do. Thus, informal constraints, especially those imbedded in culture, will reassert themselves to structure "basic exchange problems among the participants be they social, political, or economic. The result over time tends to be a restructuring of the overall constraints… to produce a new equilibrium that is far less revolutionary" (North, 1990, p. 91).

North is especially interested in tracing how institutions affect economic performance. At the heart of this investigation is, again, the relationship between formal and informal constraints. The final paragraph explicitly points future investigators toward an exploration of the relationship between formal and informal constraints: "One gets efficient institutions by a polity that has built-in incentives to create and enforce efficient property rights. But it is hard—maybe impossible—to model such a polity with wealth maximizing actors unconstrained by other considerations… Informal constraints matter. We need to know much more about culturally derived norms of behavior and how they interact with formal rules to get better answers to such questions" (North, 1990, p. 140).

An extremely important point that North makes in his Nobel Prize lecture and elsewhere (North, 1993a, 1993b) is that institutions are not usually created to be socially efficient. Formal rules, especially, are created to serve the interests of organizations with the bargaining power to make (or strongly influence the making of) new rules. What we will see in the healthcare case study, in Chapter 5, is an excellent example of an organization with significant bargaining power (doctors) and access to central-level decision making, influencing the implementation of rules in a

rationally self-serving way *within* a formal, technical framework promoted by donors—with results that grossly disappoint donors.[17]

North's theory is now widely accepted. For example, Chhibber (1988) offers as an aside, "Institutional change is difficult, because it involves changes in the formal rules. Informal norms change even more slowly" (p. 45)—a synopsis of North's observations. What remains far less explored is the dynamic between formal rules and informal norms.

The importance of focusing on change within a theory of institutions stems from the fact that change, or evolution, represents the dynamic and, therefore, living aspect of the theory. It follows that through a study of change, the investigator has an opportunity to see the components of institutional power and the relative importance of these for living decision makers. Change is also key to the issue of performance since poorly performing institutions might be reformed if the dynamics of institutional change are better understood. For North, it is the continuous interaction between institutions and organizations that shapes the institutional evolution of an economy (1994a, 1994b)—and an institutional policy regime in the cases here. North suggests that empirical research is essential to test his theory and push it further. He asks:

> If poor countries are poor because they are the victims of an institutional structure that prevents growth, is that institutional structure imposed from without or is it endogenously determined or is it some combination of both? The systematic study of institutions should answer these questions. Specifically, we must develop empirical data on transaction and

[17] In its latest country assistance evaluation, the World Bank (2005b), which was the lead donor for healthcare reform throughout the 1990-2004 period, called the performance of its major health reform loan (1991-1999) "moderately unsatisfactory," summarizing: "Health sector financing reform limited. Urban/rural disparities remain large." The same language was used to describe "progress" between 2000 and 2004.

> transformation costs in such economies and then trace the institutional origins of such costs… Still to be undertaken is systematic empirical work that will identify the costs and underlying institutions that make economies unproductive. (North, 1990, p. 135)

Chhibber concludes succinctly, "Empirical work on institutions and institutional change has been scanty" (1998, p. 37). This type of empirical effort is at the center of my dissertation.

Chhibber (1998) also provides an example of how the lack of research on institutional change allows important analysts like him to make overbroad statements that do not track with important cases. He states, for example: "Typically, the groups in society that benefit from the existing rules and control the power of the state are likely to resist changes in the formal rules. Hence institutional change is a slow deliberate process or it occurs in discrete jumps through war, revolution, or upheaval" (p. 45). Some analysts (Campos, 2000) recognize that while institutional change may be slow in the developed world, it can be fast-paced in transitioning economies. In post-communist Romania, the political elite have often led efforts to change formal laws—radically and rapidly—at the behest of foreign donors. Change has hardly been a "slow and deliberate process"; rather, it is a chaotic and confusing series of initiatives that have hardly affected informal norms within institutional settings.

Douglass North is one of a legion of academic institutionalists—be they further termed historical, sociological, RC, or simply new—who share the analytical assumption that institutions structure political, economic, and social behavior and outcomes; therefore, institutions are at the center of their investigations and theories about politics. Two reviews of this sprawling literature (Peters, 1999; Hall and Taylor, 1998) demonstrate the many divergent versions of institutional theory. Two

key differences in institutional approaches pertinent to this inquiry emerge in these reviews: 1) the degree to which institutions are perceived to be mutable, and 2) the relative weight given to values and norms versus formal rules as instruments of constraint. Some institutional approaches assume that since institutions move toward a state of equilibrium, since they are stable when they serve to reduce uncertainty, institutions are slow to evolve (Krasner, 1984; Steinmo et al., 1992). RC institutionalists tend to assume that institutions are highly mutable, non-equilibrium structures because institutions and rules are created by individuals who can, then, change them. In this approach, rules are constantly being negotiated between individuals who make strategic decisions based on their expectations regarding how others will behave (Riker, 1980; Ostrom, 1990; Grafstein, 1992; Geddes, 1994).

Institutional design choices are therefore subject to revision in order to shift the incentive structure motivating individuals.

In transition economies,[18] the degree of institutional mutability is startling, and the stated motivation for replacing laws or regulations is often, explicitly, to change behavior by changing incentives. At the same time, informal norms are slow to change and can constitute a set of institutional constraints not immediately apparent, especially if desirable formal (legal) constraints are in place. Thus, this dissertation is oriented within a framework that accepts institutions as undergoing continual, intentional and unintentional, change, focusing on the actor-driven dynamics inside political institutions and state administration that promote or inhibit

[18] A transition economy is one in which the economy is in the process of being transformed from state ownership to private ownership, in varying degrees. The term is most often used to refer to the experience of post-communist countries.

change, *within a context that also privileges values and norms (for example, norms regarding acceptable behavior) derived from historical legacies.*

Peters (1999) finds that many versions of institutionalism suffer from weak methodology and a lack of rigor in measuring the phenomena they seek to describe (p. 145). He also concludes that future institutionalist research should focus more on the formation and transformation of structures and on testing theory (p. 150). This dissertation aims to respond by detailing the design and redefinition of institutions and by specifying the relative role of formal rules and informal norms.

One of the most empirically grounded theorists, Elinor Ostrom, offers a strong research model. Ostrom sets out to learn from the real-world experiences of people facing common-pool resource problems. She shows that institutional design can help overcome the collective action problem. Early in *Governing the Commons* (1990), she emphasizes that the researcher must move back and forth between theory and practice. In organizing her field research, she assumes multiple levels of analysis: At an operational level, the investigator assumes that the technology and institutional rules are known and unchanging. However, the rules governing operational choice differ from collective-choice rules, which vary from constitutional-choice rules. For Ostrom, institutions are the set of working rules that define participation, procedures, and pay-offs in some arena.

Ostrom draws an important distinction between formal rules and working rules:

> Working rules may or may not closely resemble the formal laws that are expressed in legislation, administrative regulations, and court decisions. Formal law obviously is a major source of working rules in many settings,

> particularly when compliance to them is actively monitored and sanctions for non-compliance are enforced. When one speaks about a system that is governed by a 'rule-of-law,' this expresses the idea that formal laws and working rules are closely aligned and that enforcers are held accountable to the rules as well as others. (1990, p. 51)

Rules can change but that is not always beneficial: "Changing the rules at a level of analysis will increase the uncertainty that individuals will face. Rules provide stability of expectations, and efforts to change rules can rapidly reduce that stability" (Ostrom, 1990, pp. 53-54).

There have been almost continual changes in the formal rules governing some institutions in transition countries. How have these affected the operational level where working rules structure decision making? Like North (1990), Ostrom concludes that both structures and values figure into the strategic calculation that leads to the resolution of collective action problems. Ostrom (1990) is primarily interested in how people overcome the difficulty of organizing collectively to solve problems. Her research interests flow from the paradoxical collective action problems memorably identified by Mancur Olson in *The Logic of Collective Action* (1965): 1) Since an individual can't be excluded from enjoying a public good, such as clean air, once it is achieved, she has no strong incentive to personally work toward the goal if others are already organized. 2) If others are not already organized to achieve the public good, there is no strong incentive for the individual to join the campaign since the marginal contribution of one individual, next to the cost of participation, argues against participation.

Thus, it is not rational for the individual to participate in achieving the good at issue—unless the group is small and able to organize because members have strong

personal incentives to participate. Although, superficially, *cooperation* to achieve a public good seems self-evident and underlies political approaches such as interest group politics, cooperation is *unlikely* when seen through the RC prism. Individuals or groups who benefit from public goods they did nothing to earn are termed "free riders." In the case of child welfare, the Romanian government can be considered a free rider, during some phases of reform, when it benefits from donor funding without implementing changes that would make the sector more efficient. In the healthcare case study, we will see how doctors overcome barriers to organization—and effectively block the achievement of efficiency in healthcare allocation.

Some of Ostrom's most provocative research involves close study of small groups. The case studies in this dissertation involve large, complex institutions. In a comparative study of Soviet institutional collapse, Solnick (1998) employs a research model that more closely approximates mine. His "micro-institutional" approach involves studying three Soviet institutions overseeing youth policy in order to describe in minute detail the trajectory of hierarchical breakdown. He theorizes that the devolution of control within communist hierarchies, as well as information asymmetries between high-level and street-level decision makers, led to widespread opportunism, expropriation of organizational assets, and, ultimately, institutional disintegration—an overlooked phenomenon in most explanations of Soviet collapse. Instead of concentrating on elite politics, Solnick convincingly points to destabilizing forces within state institutions by utilizing a micro-institutional analysis within an institutional framework to explain motivation and change-making behavior.

Solnick borrows insights from new institutional economics, one branch of which uses principle-agent theory to analyze problems in political economy. Managers of state institutions and employees are conceptualized as having principle-agent relationships determined by two primary factors: the assumption that opportunism exists on both sides, and that both are constrained by bounded rationality, which entails lack of full information on the part of decision makers. Although organizations are supposed to enforce constraints on the opportunism of agents (as employees), the reality of bounded rationality makes full monitoring impossible. Solnick (1998) cites studies of local Soviet party officials demonstrating that opportunism on the part of some local bureaucrats allowed them not only to benefit from chaos, but encouraged them to help create it! Assuming that bureaucrats are opportunistic, the prediction must be made that bureaucrats will ignore established rules if so doing furthers their self-interest and the risks of enforcement are low.

In the chaotic transitional environment of post-communist Romania, internal enforcement governing personnel has been weak and bureaucratic discretion wide. Therefore, the new institutional paradigm predicts that opportunistic agents will pursue self-interest, including job security, resource control, and organizational prestige, instead of necessarily following formal rules, many of which are new, untried, and even contradictory. This is what we find in both case studies.

New Institutional Economics (NIE), a termed coined by economist Oliver Williamson in 1975, is a field of political economy that assesses institutional arrangements using techniques such as transaction cost analysis, principle-agent theory, bounded rational choice models, and the logic of collective action. The

diverse economists working under the general NIE banner share an assumption that institutions matter, and that the relationship between institutions and economic performance constitutes a critical set of public policy questions (Richter, 2002). Analysts with the international financial institutions (IFIs) have seized on the utility of new institutional economics as a tool for assessing the quality and capability of state institutions. Wiesner (1998) highlight two critical aspects of this approach: 1) the recognition that within, and between, public institutions a mixture of hierarchy, cooperation, and competition are necessary for the achievement of positive social outcomes; and 2) the central emphasis on incentives as structuring behavior in the public and private sectors. With the accent on incentives, the strategy in terms of promoting institutional reform is no longer simply stating certain ideal objectives (i.e., democracy or the rule of law), but analyzing institutional restrictions to the achievement of effective governance: "What matters in effective policymaking is not so much what the objectives are but what stands in the way of their achievement" (1998, p. xii). Although Wiesner describes a "development consensus" in favor of the centrality of institutions as key determinants of economic, social, and political progress, they cite an "urgent need" to direct empirical analysis toward specific institutional and organizational factors: "If the potential of neo-institutional economics is to be realized…the challenge is to focus on micro-analytical issues such as transaction costs, property rights, incentives, public sector rent-seeking, informational constraints, and the interplay of governments and markets" (1998, p. xiii).

Others (Chhibber, 1998; Alston, 1998; Alston, Eggertsson, and North, 1996) reiterate the importance of case studies in this area. Alston specifies: "We need more micro studies over time at the country or regional level. Such studies would allow us to better control for the role of informal norms and thereby to isolate the importance of formal rules…We need more micro studies of specific institutions—both their causes and effects. This issue is especially important for policymakers, because countries' macro-institutional capability environments are less amenable to change than specific laws and policies" (1998, p. 49). These observations support the necessity of research which hones in on the trajectory of reform in institution-specific settings.

Rational Choice

In RC theory, the individual is the primary unit of analysis, and the individual is assumed to be a goal-oriented, rational creature: Faced with a variety of strategic options, she will choose an alternative that maximizes her chance of achieving her goal. Although an individual is often motivated to maximize wealth, there is no fixed RC assumption about what goals are driving choices. The goals could be institutional prestige, reelection, or promotion, just as well as money. The three RC assumptions that are common to various applications of the theory are: 1) Individuals choose means most appropriate to their ends; 2) individuals can rank order their goals; 3) their preferences are transitive or consistent (Levi, 1997; Hinich and Munger, 1997; Dixit and Nalebuff, 1991).

Barbara Geddes (1995) makes the point that RC arguments "work best" when the rules governing interactions are clear and known to all actors (p. 87). RC arguments can also make sense of situations in which full information is not available, assuming that repetition allows learning that can yield more effective decisions. Also, although typically applied to individuals, especially in political analysis, the RC approach can be applied to organizations that behave like a unitary actor due to the shared goals of its membership (Scharpf, 1997).

In RC theory, institutions enter the picture as factors shaping the strategies available to individuals (Shepsle and Bonchek, 1997). When it comes to analyzing political behavior, the RC approach is elastic enough to give a prominent role to institutions as constraints on behavior, constraints that shape outcomes (Tsebelis, 1990). Changes in formal rules and other relevant circumstances can affect the incentives facing a rational actor who will make choices based on those incentives.[19] Therefore, the RC approach is attentive to the incentive structures created by institutions.

The fundamental tenet of RC theory is appealing: The central concept is that individuals—from the Prime Minister to a street-level bureaucrat, together with voters and clients of public services—make choices that maximize their chances of achieving strategic goals. Rational individuals size up any institutional environment, than select the means (allowed by that institutional framework) with the best chance of leading them to the ends they want to achieve. There is a common-sense quality to

[19] Note how this description of rational choice could accommodate the ideas of Douglass North—despite the fact that he sometimes writes critically about the rational choice paradigm (Denzau and North, 1993), namely because he sees "strong uncertainty problems at the individual level" (1993, p. 1) that make it impossible for people to make decisions truly in their self interest, and he wants to give a more prominent role to "myths, dogmas, ideologies, and 'half-baked' theories" (Ibid).

the premises of RC. And there are unexpected results—still more appealing for being unexpected—when two or more rationale actors interact, all pursuing their strategic first choices. A common criticism of RC (Green and Shapiro, 1994) is that despite the strides made in the theoretical development of this approach, it is far less useful when applied to the real world.

What we see more and more is scholarship that assumes RC's fundamental principles but then proceeds to use language and concepts drawn from new institutional economics (NIE), transaction cost economics, agency theory, organizational theory, and so on. An excellent example of the increasingly postmodernist pastiche of knowledge comes in *Stealing the State*. Steven Solnick's micro-institutional approach (1998) employs two important assumptions about policy-making institutions: Individual actors within the institution make decisions, and their decisions are made in an environment shaped by organizational structure. Further, regarding individual actors, they make decisions based on the perceived costs and benefits of options (utility maximization), although their preferences are not fixed, and changes in institutional rules can alter individual perceptions of the cost/benefit ratio. This framework is largely an RC framework, but Solnick's empirical work is more journalistic than theoretical in its attention to documents and interviews as the basis for discerning patterns of institutional change in "linked case studies."

The research conducted for the case studies, summarized in Chapters Three through Five, is similarly based on many primary sources, field visits, and implementation reports that take me far away from intellectual journals; this research

provides an important view of transition from the ground up in an actor-centered approach that privileges the people at the center of big plans for big change—a view into the beautiful complexities of real life that, when analyzed a step removed, calls for a rich borrowing from various intellectual strains.

Cross-Country Research

The significance of the quality of a country's institutions to economic growth (or level of development) has been demonstrated in several significant cross-country studies. These studies aim to prove that institutions and governance have a quantifiable impact in economic terms. Using a panel data set of thirty years and ninety-four countries, Commander, Davoodi, and Lee (1996) demonstrate that institutional capability and policy distortion influence economic growth, but institutional capability is more important than policy distortion. An example regarding property rights makes the distinction more clear: Policy defines property rights while institutional capability reflects the enforcement of rights. Without enforcement, policy is merely words. Brunetti, Kisunko, and Weder (1997) surveyed 3,600 local firms in sixty-nine countries, creating an index of institutional capability using five measures: predictability of rule making, perception of political stability, crime against persons and property, reliability of judicial enforcement, and freedom from corruption. They conclude that high levels of institutional capability correlate with greater investment and economic growth. Because both studies represent an aggregate of indicators, the index ends up representing institutions as a black box with no distinction between rules, informal norms, choices made by decision makers,

social conditions, or growth. For the impact of institutions on performance to be properly understood, the internal aspects of institutional decision making and behavior must be deconstructed.

One of the first important early empirical studies of governance and development was executed by Knack and Keefer (1995). Using an index constructed from five International Country Risk Guide variables ("Corruption in Government," the "Rule of Law," "Expropriation Risk," "Repudiation of Contracts by Government," and "Quality of the Bureaucracy"), they concluded that the quality of governance was positively associated with investment and growth rates. In order to more precisely identify the most significant dimension of governance to growth and social welfare, Campos (2000) constructed a panel set of yearly data covering twenty-five Central and Eastern European (CEE) countries and former Soviet countries between 1989 and 1997. He found that the rule of law is the most important institutional dimension in terms of per capita income and school enrollment. The quality of the bureaucracy was most important as a determinant regarding life expectancy. Compos' research is especially valuable because he aims to map institutional change during transition. However, the weakness in Compos' quantitative work is similar to a major weakness in similar studies: The causality is concealed.

More recently, Daniel Kaufmann, Aart Kraay, and Massimo Mastruzzi constructed aggregate governance[20] indicators (covering more than 200 countries) as

[20] Governance is defined as the "traditions and institutions by which authority in a country is exercised for the common good" (Kaufmann, 2003) including the political dimension (the process by which leaders are selected and monitored) and the economic dimension (effective management of resources and implement sound policies).

part of a long term World Bank project. The indicators include six dimensions of governance: voice and accountability, political stability, government effectiveness, regulatory quality, rule of law, and control of corruption. The indicators are used to track the relationship between governance and development, and to monitor performance. Overall, the research finds a strong, positive correlation between measures of governance and per capita incomes. Increasingly, donors are more concerned with governance as a critical element in aid effectiveness.

Transition Literature

Upon the dissolution of state socialism in 1989 in CEE and in the Soviet Union in 1991, there was virtually no contestation regarding the adoption of democracy and market economics as models for political and economic organization. Certainly in the CEE, there was a spontaneous, popular assumption of these goals even as pacting among elites shaped the transfer of power in some countries. Experts, especially economists and lawyers, were quickly deployed—by Western governments, by IFIs, by private firms, and on their own—in order to guide early decision making related to the transition from a command economy to a free market. Literature on the transition is vast. Transition economics explores the process of implementing economic reform—for example, the relative merits of macroeconomic "shock" therapy (liberalizing prices, pursuing tight monetary policy and balanced budgets, and privatizing state-owned assets) versus more gradual, managed change (Marangos, 2002; Roland, 2000). Proponents of the so-called Washington consensus, such as the high-profile Harvard economist Jeffrey Sachs (1994), were ascendant in the early

1990s. They expected market forces, once unleashed, to create a positive environment for growth without explicit involvement of government or particular attention to ancillary institutions, such as contract-protecting judicial systems.

Most recent assessments of the early 1990s policy prescriptions—typically financed through a variety of foreign assistance programs—conclude that they were simplistic and inattentive to the importance of a variety of institutions that under-gird capitalist economic success. Neo-liberal assumptions that mass privatization, price liberalization, and tight monetary policy would kick-start capitalism have been replaced by more sober acknowledgment that institutions under-girding competitive markets—such as contract enforcement and property rights—are essential (Manzetti, 2003; Arrow, 2000; Roland, 2000; Zinnes, Eilat, and Sachs, 2000; Stiglitz, 1999; Olson, 2000, 1992; North, 2000, 1997; Dewatripont and Roland, 1995; Manser, 1993; Murrell, 1992).

Although this amounts to a negative assessment of the impact of the first phase of post-communist economic assistance, it is instructive in that it reinforces the institutionalist perspective: Reform efforts that are not grounded in adequate institutions are bound to fail, falter, or yield unintended consequences. The debate highlights the importance of institutional rules and institutional design in directing socially beneficial political and economic activity. Large-scale institutional change requires strategic attention to: 1) political constraints and the rules that determine which actors have access to the policy-making process, and running room within that policy regime; 2) allocative changes and how the locus of decision making regarding funding strongly influences outcomes; and 3) governance, especially the monitoring

and enforcement of compliance with legislative reform. The *lack* of consistent attention to these elements in reform schemes promoted through foreign assistance programs is detrimental to long-term reform goals. Although this literature is not precisely about foreign assistance, it is directly applicable to reform efforts financed by bilateral and multilateral donors.

Political Economy and Partial Reform

In his essay "Case Studies and Theory Development: The Method of Structured, Focused Comparison," George (1979) is keen to merge the methods and interests of historians and political scientists. Certainly, there has been extensive blurring of the lines between political science and many other disciplines, particularly economics at the level of theory. However, in reading for this dissertation, I was consistently surprised to find a certain disregard for money, and the power of financial motives, in political science literature. On the ground, in legislative bodies, electoral campaigns, and policy debates worldwide, money and the distribution of resources is the very blood of politics. It is worth considering why it is dropped from many accounts of political phenomena.

This is relevant because the most compelling research on transitions is very savvy about financial motives. Joel Hellman's work (1998; Hellman, Jones, and Kaufmann, 2000a, 2000b) on partial reform is an excellent case in point. He challenges the assumption (which became common wisdom) that short-term losers in the post-communist transition—including workers and pensioners and bureaucrats—were potentially dangerous obstacles to reform who had to be compensated and

placated in order to successfully accomplish the market transition. Instead, he concludes that short-term winners threaten reform: Short-term winners gain substantial rents from distortions in the partially reformed system then have huge incentives to resist further change. He criticizes the "voluminous literature" that argues for state autonomy in the implementation of economic reform in order to insulate the state from the pressures of short-term losers. This logic argues for a reform strategy that builds up a constituency of winners who will then become local champions of change. Just the opposite is true, explains Hellman. The costs of transition have been high; uncertainty is ubiquitous. So those who secure rents during the early rounds of reform would be irrational to let go—and, typically, they don't.

Hellman is concerned with economic rents in the quasi-private sector. His path-breaking observations are true in public sector reform as well. Most public facilities are construed as "profit centers" in one way or another by those who work there, and actors use public sector assets for private activities. For example, doctors use public hospital equipment to run tests on personal patients, entirely off the hospital books. Or state employees of the child welfare system work hand-in-hand with private adoption agencies to secure babies for—and tips from—families from the West. This can be termed corruption. But corruption is a blanket normative judgment with little power to explain phenomena. It is more instructive to see the doctors and state employees as short-term winners who secure certain rents as a function of partial reform in the healthcare and child welfare sectors. As a result, they (rationally) resist the larger reform program that would invariably undo opportunities for financial gain.

Much of the operational literature of post-communist transition is normative. With regard to foreign assistance, project design and program implementation are normative almost by definition. This normative orientation often prevents foreign assistance from identifying the most significant obstacles to the reform agenda.

Assessments of International Assistance

The World Bank and the Organization for Economic Cooperation and Development's donor coordination committee have sponsored extensive research on the impact of international assistance which informs country-specific progress reports. Most importantly, researchers for the World Bank concluded in numerous studies (Commander, Davoodi, and Lee, 1996; Dia, 1996; Brunetti, Kisunko, and Weder, 1997; World Bank, 1997; Chhibber, 1998; World Bank, 1998) that a state's governing institutions must be suitably mature, predictable, and free of corruption for international assistance to have any positive impact. The World Bank's seminal 1997 *World Development Report* analyzes the nature of state capacity and concludes that development requires an effective state.[21] The report is especially valuable because it places institutional reform at the center of the challenge for foreign assistance.

However, there is a tautological quality to the conclusions of this and a study published a year later, *Assessing Aid: What Works, What Doesn't, and Why?* (World Bank, 1998) To say that foreign aid will be effective in countries that are being run well has a certain circularity. To say, "Countries without good policies, efficient public services, or properly allocated expenditures will benefit little from financing"

[21] Two of the five core state tasks identified by the report are "Investing in basic social services and infrastructure" (health) and "protecting the vulnerable" (child welfare), the two sectors I will examine.

World Bank, 1998, p. 5) treats as a black box the entire donor-recipient dynamic that has yielded unimpressive results. To be fair, the reports offer alternative assistance strategies for countries with weak governance, for example, channeling money through non-governmental organizations (NGOs) or supporting local reform champions. But these suggestions skirt the central dilemma: understanding the dynamic of dysfunctional assistance apart from chastising weak governments.

There are surprisingly few critical academic assessments of foreign aid directed toward post-communist *political* assistance, although there are a few that are particularly strong and, in every case, grounded in close readings of programming on the ground (Carothers, 2002, 1999; Dryzek and Holmes, 2002; Cooley, 2000; Stark and Bruszt, 1998; Wedel, 1998; Verdery, 1997; Lubin and Ware, 1996). In a sharp critique of the transition paradigm that was hotly contested by the U.S. Agency for International Development and some democracy program implementers, Carothers (2002) concludes that five core assumptions underpinning assistance provided, especially by the U.S. "democracy-promotion community" (including public and private implementing organizations), have been disproved by the great number of "stalled" transitions. The five assumptions are: 1) Any country moving *away* from dictatorship is moving *toward* democracy. 2) Democracy unfolds through a sequence—opening, breakthrough, and consolidation. 3) Free elections are key to the generation of further reform. 4) Underlying conditions including history, traditions, and institutional legacies will not impede the transition. 5) Transitions modify already functioning states that require little in the way of state building. Contrary to these assumptions, Carothers considers that most of the "transitional countries" suffer from

serious democratic deficits, including poor representation of citizen interests and poor performance by state institutions. He notes, "The seemingly continual surprise and disappointment that Western political analysts express over the very frequent falling short of democracy in 'transitional countries' should be replaced with realistic expectations about the likely patterns of political life in these countries" (Carothers, 2002, p. 18). Carothers' observation is particularly apt in terms of Romania.

In an impressive thirteen-country survey of post-communist democratization, Dryzek and Holmes (2002) are particularly critical of the teleological nature of transition assistance and its supporting literature. Their book is also valuable for restoring the notion that political generalizations can be drawn about the post-communist experience, considering that the majority of regional studies since 1989 emphasize the *difference* between cases.

Globalization Critique

Another critique of foreign assistance is offered by international political economists who fear that foreign assistance undermines the sovereignty of aid recipients, especially through the imposition of conditionality that is, on occasion, contrary to local preferences or interests (Perkins, 2004; Stiglitz, 2003, 2002;). The globalization rubric includes both this negative assessment of foreign aid and neutral analysts who don't necessarily criticize assistance but observe how globalization changes the nature of inter-state relations. The aspect of this critique useful for this paper is its warning that by creating a dynamic between international lenders/donors and central

governments bargaining to gain resources, recipient governments can be discouraged from reflecting on the domestic impact of certain recommendations.

The Gap Between Academics and Policymakers

There is a noteworthy gap between assumptions among Western policymakers about the impact of foreign aid and academic conclusions: Even as some policymakers strenuously advocate for intensified efforts in transferring technical assistance, training, and grants to the developing world, many superior academic minds have concluded that this effort can not be expected to succeed. One common intellectual refrain, especially from economists functioning within an institutionalist perspective, is that change is so complex, it is impossible to impose it. In a short article that places him with the "gradualist" camp, Kenneth Arrow warns, "The readjustment of institutions is an extended process. They can not simply be imported as ready-made copies of those in the United States or Western Europe" (2000, p. 13). Similarly, Douglass North cautions, "I want to emphasize the limits of our understanding because there is a certain amount of hubris evident in the annual surveys of the World Bank and in the writing of orthodox economists who think now we have it right… [E]ven if we did have it right for one economy, it would not necessarily be right tomorrow" (2000, p. 6). In the final pages of his insightful book *Democracy and the Market*, Adam Przeworski proved to be an early skeptic: "Market-oriented economic reforms are an application of a technical economic blueprint based on theories developed inside the walls of North American universities and often forced on governments by the international lending agencies. They are based on a model of

economic efficiency that is highly technical" (1991, p. 183). Even Janos Kornai, who has advised the Hungarian government in complex reform initiatives can be found disparaging superficial reform programs, "It is naïve to imagine that the main features of the [socialist] system can be altered by applying a few ideas for reorganization" (1992, p. 376).

These individuals are major thinkers. They also range across the political spectrum, so political preferences are not driving their observations—and hesitance to assume outside pressure can engineer economic growth or improved state performance vis-à-vis policy prescriptions. Although they reflect on economic phenomenon, their fears are equally applicable to social welfare institutions and state performance vis-à-vis public service delivery.

The economist skeptics unfold their criticism from a fairly uncluttered theoretical environment.[22] Among sociologists and social anthropologists soaking up the cross-currents of change on the ground, there is also skepticism regarding the plausibility of imposing reform models through foreign assistance especially among anthropologists and sociologists whose field work is in former socialist countries. The field orientation of research by, for example, Michael Burawoy (1999), David Stark (1996; Stark and Bruszt, 1998), Katherine Verdery (1997; Burawoy and Verdery, 1999), and Janine Wedel (1998) leads them to highlight the ambiguous impact of models of change recommended from abroad. One of the few political scientists, early on, to anticipate the pernicious influence of the past on transition was Ken

[22] Kornai's quotation comes from *The Socialist System,* which is certainly *dense,* but in none of these studies are there real people with colorful complaints.

Jowitt (1992) whose prior research on communist regimes had been sufficiently empirical that he predicted the tenacity of its hold.

Stark (1996, 1998) looks at post-communist patterns of property and ownership. He sees a blurring of lines between public and private property resulting in hybrid forms of capital. He posits this as a normal situation given the persistence of routines from the past and the profound uncertainty attendant with the transition. He writes, "Thus we examine how actors in the post-socialist context… redeploy available resources in response to their immediate practical dilemmas… It is through adjusting to new uncertainties, by improvising on practiced routines, that new organizational forms emerge" (Stark, 1996, p. 995). This is an excellent way to describe the gap between teleological policy prescriptions and the social world real actors live in. It is also a nonjudgmental way to view the difficulties in implementing reform: From the perspective of recipients, foreign aid augments assets which they take advantage of in the rational effort to survive.

Janine Wedel (1998) deals directly with foreign assistance programs and describes the mixture of "collusion and collision" between donors and aid recipients that results, especially in Russia. Like Stark, she explains that external and domestic actors are functioning within dramatically different circumstances, with constraints and expectations at odds. She rightly points out that in the foreign assistance puzzle, recipient responses—their agendas and interests—influence aid administration but have been overlooked. She also asserts that Western donors ignored the central role of the state which was a powerful legacy of communism as well as the way informal relations from the communist period survived into the transition and shaped how

recipients use foreign assistance: "If donors had treated the East less as if the blackboard of communism could be wiped clean, donor efforts might have achieved more of their stated goals" (Wedel, 1998, p. 185). This is a wonderful image, as colorful as much of her book. However, the book is, fundamentally, a journalistic account of aid's foibles (with insightful observations), not an explanation of how the international and domestic actors interact or how the locals manipulate foreign assets, in a way that can be generalized.

The way in which foreign aid implementation, on the ground, can be co-opted by local agents with their own agendas or, ironically, can wind up supporting communist informal networks contrary to Western reform goals are negative accounts offered by a few analysts with field experience (Cooley, 2000; Wedel, 1998; Lubin and Ware, 1996). Most damaging to the foreign assistance project are assessments that demonstrate how foreign assistance often ignores the reality of informal norms and persistent institutional arrangements that structure experience (Carothers, 2002; Cooley, 2000; Stark and Bruszt, 1998; Verdery, 1997). Stark describes "neo-liberals" who are intent on a "project of social imitation." He writes, "In contrast to the imitationists who see in the collapse of communism an institutional void waiting to be filled with their recipes, therapies, and formulas, we look to the variation in how communism fell apart and how these partial ruins provide institutional building blocks for political, economic, and social reconstruction" (Stark, 1998). Not acknowledging the existing "building blocks" risks undermining the entire reform effort.

Corruption Research

Multilateral commitments and NIE theory have combined to surface new areas of research. The study of corruption emerged out of the growing conviction that corruption among public officials significantly inhibited economic growth and limited the impact of outside assistance. The NIE model offers an excellent framework for examining rent-seeking behavior within state institutions by considering how corrupt incentives arise in public programs (Ades and DiTella, 1997; Rose-Ackerman, 1999; Hope, 1999). Corruption is widely considered to be the misuse of public power for private gain. Looking at how institutional incentives shape individual opportunism allows researchers to recommend reform strategies that eliminate these perverse incentive sets, thereby decreasing acts of corruption.

Most of the research to date has been fairly theoretical. Rose-Ackerman recommends more detailed sector-by-sector analyses of the problem because, "only if one looks at the fine structure of political and economic systems can one go beyond a showing that corruption is harmful to an understanding of the way it operates in different contexts" (1999, p. 4). In the case studies investigated in this dissertation, there is evidence of the misuse of public power for public (institutional) prestige at work in some policy sectors, meaning that some decision makers identify personal prestige and inter-personnel commitments with institutional authority; therefore, they foil attempts to limit, or reform, the institutions in which they work without receiving outright personal pay-offs. This practice is not an example of "corruption," yet it promotes inefficiency as bad if not worse than the outright bribery schemes that donors are most concerned about.

A study of the behavior of civil servants in Bulgaria (Verheijen and Dimitrova, 1996) comes close to the situation explored later: Out of a strong sense of loyalty, civil servants were more compelled to protect colleagues in a related agency from scrutiny regarding possible corruption, even though this defense brought them no monetary rewards and, in fact, contradicted official policy. In a highly uncertain, resource-scarce environment, actors are primarily concerned with securing streams of income and influence, organizationally and personally. This is rational behavior at its finest, but it means that local actors and international donors have significantly different preferences—preferences that create outcomes unanticipated by the donors.

New Public Management

A pragmatic application of insights gained, in part, from new institutional theory as well as organizational theory is found in the new public management literature. A number of books (Frederickson and Johnston, 1999; Boudney, O'Toole, and Rainey, 2000; Kettle, 2000; Lane, 2000) review the core aspects of what is termed a new approach to the reform of public institutions. These include: focusing on ways to increase public productivity; focusing on results and outputs rather then political processes; replacing bureaucratic strategies in public service delivery with market strategies; emphasizing customer service in government's orientation toward citizen; decentralizing responsibility to "frontline" local government units; and separating government's role as a purchaser of services from its role as a service provider. Many of these ideas are drawn from private-sector strategies to gain efficiency even as firms downsize. Public-sector reforms based on these premises have been pursued around

the world—from New Zealand and Canada to the United States and South Africa—since the 1980s.

In international recommendations for reform in transitional countries such as Romania, many elements from new public management thinking are discernable. Yet, as new as the economic and political institutions are, they have not easily been able to assume the goals of productivity and service orientation described above. What has stood in the way of applying international "best practices" in public management to countries such as Romania? What human (strategic) interventions or cultural inhibitions might be at work in foiling reform ideals?

According to Pradhan (1998), the problem turns on the fact that few developing countries have strong capacity for writing and enforcing contracts or monitoring performance in order to lower transaction costs in the delivery of public services. Weak central capacity is compounded by inability to formulate strategic plans, live within hard budgets, or cost-out competing policy options. Limited accountability for inputs and lack of performance-based results hobble reform efforts. He writes, "The so-called new public management reforms in the industrial countries have sought to improve delivery primarily by using market-type mechanisms and formal contracting. New Zealand provides the most dramatic example…But what is feasible in New Zealand may be beyond the realm of possibility in many developing countries… Greater use of market mechanisms requires an effective regulatory capacity, which is not always easy to achieve" (Pradhan, 1988). Certainly, that is true in Eastern Europe, where countries such as Romania have had a major problem coordinating policy between ministries, implementing new laws, maintaining hard-

budget constraints, or executing fiscal impact analysis. This literature offers insight on reform goals, though, and is relevant for how it has guided the thinking of international donors.

Social Welfare Reform Accounts

There are some excellent studies that focus on the intense difficulty of reforming social welfare institutions in post-communist countries (Kornai, Haggard, and Kaufman, 2001; Iatridis, 2000; Boeri, 2000; Elster, Offe, and Preuss, 1998; Zamfir and Zamfir, 1996; Offe, 1993), and work that is sensitive to the balancing act between allocative mechanisms, efficiency, and fairness at the heart of any public welfare regime, in transition countries or close to home (Elster, 1992). But there are also studies that emphasize the many ingredients of Western social policy and are most concerned with stuffing those elements into the post-communist reform project (Deacon and Hulse, 1997; Fox and Gotestam, 2002)—an approach that is not particularly promising, as it ignores the real relationships and real inheritance that define living organizational and institutional interaction.

Chapter Three
Electoral Politics and Political Bargaining

When looking at post-communist Romania, political analysts frequently focus on the political tension between Ion Iliescu (who ruled for ten of the fourteen years under review) and the political parties he led (under four names) versus opposition parties and political formations including the National Peasant Party-Christian Democrat, National Liberal Party, Democratic Party, and the Civic Alliance,[23] portraying the former as bad and the latter as good. A typical political cliché of this type can be seen in the contrasting headlines from a Radio Free Europe broadcaster: "Romania's Torturous Road to Reform" (Shafir, 1992) versus "Romania's Road to Normalcy" (Shafir, 1997) lauding the election of Emil Constantinescu as president.

The Democratic Convention, an alliance of opposition parties led by President Emil Constantinescu, was elected in 1996 largely as a function of popular frustration with the lack of palatable progress in living standards or economic opportunity after six years of Ion Iliescu's presidency. But plummeting economic indicators and a ruling coalition that spent more time arguing than governing contributed to Iliescu's return to power in 2000. The most recent political turnover—in December 2004, the mayor of Bucharest, Train Basescu, defeated Iliescu's heir apparent and four-year Prime Minister, Adrian Nastase—was again marked by popular frustration regarding the ruling *nomenclatura*'s clannish inability to govern for the common good. Table 2 summarizes the transfers of power in Romania between 1989 and 2004, and related information relevant to the case studies:

[23] Table 2 summarizes presidential terms of office, party identification, and information related to the case studies.

Table 2
Presidential Terms of Office, Political Parties, and Authorities Governing Case Studies

Presidential Terms	Winner	Political Party	Child Welfare Authority	Health Ministers
Dec 22, 1989-Feb 6, 1990: President, National Salvation Front Council Feb 6, 1990-May 20, 1992: President, Provisional National Unity Council	Ion Iliescu	National Salvation Front (FSN)	1992 – Committee for the Support of the Residential Institutions for Children (coordinated by government)	Dan Enachescu Mircea Maiorescu
May 20, 1992-Nov. 17, 1996	Ion Iliescu	Democratic National Salvation Front (FDSN) Party of Social Democracy in Romania (PDSR)	1993 – National Committee for Child Protection (inter-ministerial committee)	Iulian Mincu (92-96) Daniela Bartos
Nov. 17, 1996-Dec 2000	Emil Constantinescu	Democratic Convention, a coalition of opposition formations, led by the National Peasant Party-Christian Democrat	1997 – Department for Child Protection 1999 – Agency for the Protection of Childrens Rights	Stefan Dragulescu Ion Victor Bruckner Francisc Barany Hajdu Gabor Valeriu Stoica (Justice Minister served as Minister of Health)
Dec. 20, 2000-Dec 20, 2004	Ion Iliescu	Party of Social Democracy in Romania (PDSR), renamed in June 2001 Social Democratic Party (PSD)	2001 – National Authority for Child Protection and Adoption	Daniela Bartos Mircea Beuran Ionel Blanculescu (PNA – Control Authority) Ovidiu Branzan
December 21, 2004	Train Basescu	Truth and Justice Alliance (DA) (Basescu led the Democratic Party, one of two major coalition partners)	2005 – National Authority for the Protection of Children's Rights and Romanian Adoption Office (two separate offices)	Mircea Cinteza Eugen Nicolaescu

Source: Author

Many political analysts look at Romania's post-communist political trajectory—from Iliescu to liberals back to Iliescu then to liberals again—as "exceptional" (Bunce, 2003; Ivanes, 2001) or quasi-democratic (Carothers, 2002) or ambiguous (Carey, 2004). Pegging Romania as an outlier regime gained credibility with the article "The Effects of Totalitarianism-cum-Sultanism on Democratic Transition: Romania" in *Problems of Democratic Transition and Consolidation* by renowned political scientists Juan Linz and Alfred Stephan (1996). However, the turnovers in power also qualify Romania as a consolidated democracy, following Samuel Huntington's two turn-over test" (Huntington, 1991) How closely do the turn-overs in power coincide with different attitudes toward reform and donor interventions? Is the best political explanation for the evolution of public policy in post-communist Romania the ongoing struggle between socialist forces tied to the communist regime (Tismaneanu, 2003) and democratic forces opposing the contemporary *nomenclatura*?

A hypothesis tied to electoral politics would anticipate that foreign assistance for social welfare reform progressed under the opposition parties and stagnated under the new-old guard. This is the question under investigation. Did child welfare (CW) and healthcare reform advance significantly between 1997 and 2000 while being held back or undermined during Ion Iliescu's presidencies? In fact, important reform initiatives, recommended by foreign donors, were undertaken under both Iliescu and Constantinescu—backsliding, or dysfunctional effort, characterized both administrations as well.

1990-1996: Waking from the Nightmare

Of the Central and Eastern European countries that shrugged off communist regimes in 1989, only the Romanian political transition was violent. The circumstances of this regime change are still cloaked in some mystery. What began as social resistance in the western of city of Timisoara on December 16, 1989, and spread to Bucharest on December 21, looked more like a *coup d'etat* when a clique of high-level apparatchiks used the army to overthrow and execute dictator Nicolae Ceausescu on Christmas Day.

An *ad hoc* ruling committee, the self-described National Salvation Front (FSN), appeared on live television and declared itself to be the nation's governing council.[24] Led by Ion Iliescu, a former communist party leader trained in Moscow—who had had some obscure falling out with Ceausescu in the 1970s but who had never left party circles—the FSN's ranks were sprinkled with enough dissidents and poets to give the public appearance of a broad-based ruling committee. Iliescu, heading up the Democratic National Salvation Front, was elected president with negligible opposition in May 1990 (Ratesh, 1991).

Much of the analysis of regime change in Romania emphasizes elite politics (Stefan, 2004; Tismaneanu, 2003; Tismaneanu and Kligman, 2001; Shafir, 1992; Codrescu, 1991). Among analysts who posit that leadership factions, competing for power, planned to overthrow Ceausescu long before mass demonstrations provided the perfect cover, there is less description of pacting and more evidence put forward of plotting. Undoubtedly, the demonstration effect of anti-communist momentum from the West—what Romanians witnessed in East Germany, Poland, and Hungary

[24] Table 3 summarizes presidential terms of office and related information.

in the summer and early fall of 1989—was profound, and it influenced the elite as well as the public in imagining a future without Nicolae Ceausescu.

A social movement analysis might see some of the Iliescu regimes' first moves—for example, a quick endorsement of de-collectivization, even as rural citizens were spontaneously dividing land, and a complete change of policy on abortion, illegal under Ceausescu—as evidence that anti-Ceausescu popular opinion, expressed in the December demonstrations, was acknowledged by the new regime regardless of whether it was dominated by plotters or putschniks. Because Romania under communism was starved of means through which to articulate interests, it is hardly possible to frame an explanation based on interest groups, or interest-group pressure, in considering regime change.

Iliescu has to be considered a popular leader based on his electoral success, but he had ambivalent relations with the outside world, including international donors. In June 1990 and September 1991, incidents involving rampaging miners attacking citizens in Bucharest, stained the first post-communist administration's reputation for years: Miners from the Jiu Valley, some six hours west of Bucharest took trains to the capital city where they attacked, in 1990, a student protest group occupying a prominent downtown square, and, in 1991, entered Parliament, bringing down the Prime Minister. Several people were killed and dozens injured in the 1991 clash. Many believe, including Western analysts, that Iliescu and his party leaders were complicit in agitating the miners, even encouraging them to take the fatal action they did. As a result, Western governments and donors cooled toward the Romanian government, and donors oriented assistance in child welfare away from central

government, working directly with institutions in need, and local government (Coman, 2005). How did the first and second Iliescu presidencies handle reform in child welfare and healthcare?

Reforming Child Welfare

Three phases can be discerned in reform of the child welfare system: the provision of humanitarian assistance (1990-1996), decentralization (1997-2000), and institutional reorganization (2001-2004). Superficially, these appear to coincide with presidential electoral cycles. Yet a closer examination reveals that reform both gained and lost ground under each government, regardless of political identity.

1990-1996

Between 1990 and 1996, foreign assistance was hugely uncoordinated, and much came from private entities not coordinating through their own governments (Mica, 2002; Petre, 2003; Coman, 2005). Gradually, donors began testing programs and services that served as family-oriented alternatives to the big, state-run institutions (Davis, 2005; Mica, 2002), but there was no consensus on what reform goals should be. Donors did pressure the government to sign international covenants such as the U.N. Convention on the Rights of the Child in 1990 and The Hague Convention governing inter-country adoption in 1993; the government was responsive.

The central government was extremely responsive in following donors' guidance in rewriting the rules governing inter-country adoption, generally to facilitate it (Mica, 2002). In the early 1990s, thousands of children left the country

with new families. In 1995-1996, foreign donors with local support began to insist on decentralization of the child protection system (Zamfir, 1997). The Iliescu regime supported important elements of the decentralization strategy.[25] An increase in the use of foster care as an alternative to state institutions began under Iliescu.

Although some partisans, including former president Emil Constantinescu (Constantinesu, 2003) insist that child reform only started in 1997 with Emergency Ordinances that drastically redefined the CW regime, neutral Romanian experts in the field credit the 1990-1996 period with including much, essential learning (Zamfir, 1997; Petre, 2002; Mica, 2002; Coman, 2005), an adoption regime, and the introduction of international norms.

1997-2000

The decentralization trend accelerated during the Constantinescu regime. In June 1997, the government approved an Emergency Ordinance (26/1997) to reconfigure the child welfare system. The main effect was to shift more responsibility, including financial responsibility, for managing child welfare to the county level. The major source of funding would no longer be the state budget but county council budgets and special (off-budget) funds.[26] Decentralization is generally a highly laudable goal and is essential to break communist-style organization of the economy, public services, and public finance (Hicks and Kaminski, 1994). But the state is so involved in post-

[25] See National Action Plan of 1995.

[26] Romania is divided into 41 counties (*judet*) plus Bucharest. The communist system utilized a county structure for most ministries in order to increase territorial control. As a result of public administration reforms in the mid-1990s, Romania has one of the most decentralized systems of public administration of the post-communist countries. But sub-national government units are perennially short of money in contrast to the list of mandates the central government has off-loaded over the years, beginning with the child welfare system.

communist reform that these simultaneous goals (decentralization and drastic reform of the state itself) are not always well reconciled.

Although the Constantinescu regime followed the recommendations of foreign donors (many extensively implicated in the child welfare institutions for years) between 1997 and 1999, a financial crisis emerged in 1999 when sub-national governments declared that they did not have enough money to feed children living in the state system (European Commission, 1999a). Western donors ponied up over $40 million USD to provide emergency assistance. The United States contributed $14 million. Most sources[27] consider that county and local governments were unprepared to assume management of the sprawling network, especially considering that some five national ministries or authorities continued to manage child welfare institutions.[28]

Several donor representatives involved in negotiations explained, on background, that local governments *intentionally* funded other services before attending to child welfare in 1999, knowing that international donors were far more likely to contribute to child welfare institutions in a pinch rather than to less emotionally compelling needs such as road work, garbage collection, or school maintenance. So although the Constantinescu government endorsed decentralization and child welfare reform goals supported by Western donors, it took little initiative to monitor and support local government in managing the serious, new fiscal responsibilities or to improve central-level policy coordination in order to improve governance of the high-profile sector. Willing to adopt reforms recommended from

[27] Interviews by the author with some eight people involved at the time.
[28] Ministries of Health, Education, Labor and Social Welfare; the State Secretariat for the Handicapped; and the National Committee for the Protection of Children, which was variously named a department, a committee, and an authority.

abroad, the Constantinescu government did little to anticipate the implications of change rippled through political and fiscal institutions—taking unexpected turns, such as the near financial collapse of the residential child centers in 1999.

In response to the local financial disaster, donors insisted on a reorganization of system financing and the reorganization of governing authority for the sector, which provided assurance that the national budget would compensate for any future sub-national shortfalls. In addition, donors, especially the European Union (EU) (Petre, 2003; Correll, 2002), insisted on the creation of a national agency to assume control of all children under state protection from the ministries of Education, Health, and the Secretariat for People with Handicaps. The multiple agencies controlling pieces of the child welfare problem meant an almost total lack of coordination. In a real sense, institutional reform only began in late 2000 with this initiative (Alahad, 2001).

2001-2004

Improved central government coordination was an effort picked up almost seamlessly by the new, democratic socialist government elected in December 2000, dominated once again by Iliescu and his Romanian Party of Social Democracy (PDSR). Under the PDSR government, a few months after national elections, this essential reorganization continued, although the national entity governing child welfare was renamed the National Authority for Child Protection and Adoption (*Autoritatea National pentru Protectia Copilului si Adoptii*). The government also approved the Child Emergency Ordinance 123/2001, which unified powerful district-level

commissions: the Child Protection Commission, the Commission of Medical Experts on Handicapped Children, and the Commission of Experts on Special Education.

With regard to decentralization and the consolidation of national-level authority over child protection, reform transcended electoral cycles. In the area of inter-country adoption, both Presidents Iliescu and Constantinescu strived to accommodate the many recommendations from Western governments that tended to alternate between leniency and control. Responsive to adoptive parents, Western governments lobbied for local laws that eased the rules—in some cases simply *defined* the rules—by which children could be approved for inter-country adoption. Then, when periodic media exposés revealed that poor Romanians were selling their children to foreigners, donors insisted on greater accountability from child protection institutions (Mica, 2002; Petre, 2003; Coman 2005). This vacillation continued between 1990 and 2001, until a particularly single-minded and influential Rapporteur for the European Parliament, Baroness Emma Nicholson, insisted that Romania put a moratorium on inter-country adoptions in 2001 as a virtual condition for EU membership. As had become typical, the Romanian government followed this outside advice, adopting a one-year moratorium that became permanent in 2004 (CNN, 2001; Bartos, 2002; Coman, 2005).

Electoral politics and domestic political rivalry regarding public policy do not satisfactorily explain the evolution of the child welfare or inter-country adoption regimes in Romania between 1990 and 2004. Four political administrations (1990-1992, 1992-1996, 1996-2000, 2000-2004) supported reform. Each government exhibited weak follow-through in implementing change, but they were each

responsive to donor recommendations and concerns. Donors recommended legislation throughout the period under consideration. The governments that held power 1990-1996 and 2001-2004 versus 1997-2000 had different political outlooks, but each adopted some of the most important legislative recommendations promoted by donors.

Considering the two ideologically divergent regimes, President Constantinescu was more explicitly supportive of donors' goals in child welfare and healthcare, but implementation was a problem. In sum, neither group was more receptive to outside recommendations and pressure than the other. Each government, regardless of ideology, was both responsive and indifferent to donor recommendations as a function of domestic pressures. Actually, the contrast between Iliescu's first two administrations (1990-1996) and his third (2000-2004), is the most dramatic in terms of non-cooperation versus cooperation with outside actors in child welfare. The strategic decision to cooperate, explicitly and profoundly, can be explained as a function of the EU's emphatic bargaining position that without deep, structural change to state-run institutions, Romania would lose its bid to join the EU.

Reforming the Health System

Before World War II, Romania had a limited, Bismarck-style system of insurance funds. In 1949, the communist-led government approved a State Law on Health Organization that started the country's move toward a Soviet-style Semashko health system in which central planning, state financing, universal coverage, and free access to care were the defining features (Bara, van den Heuvel, and Maarse, 2002). Post-

communist reform of the Romanian health sector got off to a later start than did child welfare reform and cannot yet demonstrate quantitative success, as judged by health outcomes, institutional efficiency, or public satisfaction. The reform phases can be divided into the following periods: overcoming status quo bias (1990-1997); implementing the social health insurance law and recentralizing (1998-2002); and digging a deeper hole (2003-2004).

A social health insurance proposal passed the Senate in September 1994 but did not gain full parliamentary approval until 1997, with full implementation on April 1, 1999. It featured a compulsory insurance system that drew money from employers and employees as a payroll tax, based on the German or "Bismarck" model as opposed to the British "Beveridge" or National Health Service model. The ostensible magnitude of this reform effort can't be understated; it represented dramatic changes, simultaneously in health financing, organization, and service delivery. It required the creation of a new National Health Insurance House (NHIH) and forty district health insurance houses (DHIHs), plus an HIH covering the city of Bucharest as well as separate health insurance systems devoted to the army and the transportation sector. It transferred significant power away from the Ministry of Health (MOH) and lodged it in the new HIH system. It also moved authority from the Ministry of Finance (MOF) to the NHIH, which was charged with negotiating an annual "framework contract" with the College of Physicians that would determine the parameters of services and payments. The MOH was supposed to concentrate on setting standards, regulating health facilities, and implementing national public health programs. These dramatic reforms were conceptualized during the 1992-1996 Iliescu presidency, initiated under

Constantinescu, and continued under Prime Minister Nastase after 2000 (Johnston, 2002).

At first blush, the reform was a success: In 1999 it brought in more resources than expected—which was always the major selling point. But from the start, the central government, uncomfortable with losing access to much-needed new revenue and unconvinced that the new health insurance funds deserved autonomy, reasserted control over the health sector. The centralizing adjustments began in late 1999 and continued into 2003. Among the most egregious violations of the law's original intent were: The Minister of Health conceded to the MOF's decision to reintroduce the health insurance budget into the consolidated state budget (1999); the MOF redirected health insurance surplus revenue to the underfinanced pension system (2001); the MOH brought the NHIH under its authority, making the House's president a ministry state secretary (2002); and the general expenditures of healthcare providers became part of the state budget law, which was redundant with the annual contracting of medical services between the NHIH and providers (2003). Thus, dramatic reforms spanned two political powers (Iliescu and Constantinescu), and the reform was undone under two political powers (Constantinescu and Iliescu). Politicians from both political formations promoted reform—and conspired to water it down during implementation.

The private sector was stifled except for in pharmacies and in dentistry. Hospitals were largely allowed to maintain budgets based on historical considerations, such as number of beds and past funding, which undermined accountability and destroyed incentives to improve performance. Meanwhile, the

population's health status continued to decline in fundamental dimensions, including life expectancy. By late 2002, the health sector was widely considered to be in crisis (Fundatia Horia Rusu, 2003; Chiritoiu, 2002, 2003; World Bank, 2002a; Radulescu, 2002; Vladescu, 2002; Vladu, 2003; Ghergina, 2005).

A strictly political or chronological narrative of the implementation of health sector reform 1990-2004 cannot make sense of whom to blame for the lack of progress in terms of health outcomes, efficiency, or public satisfaction. Nor were medical professionals or politicians from major political parties able to agree on the biggest problems (Fundatia Horia Rusu, 2003). Under-financing, excessive state control, lack of financial discipline, low salaries, and poor management were just a few of the problems identified by doctors and decision makers. In an angry video conference with county prefects[29] in March 2003, Prime Minister Nastase came close to getting the story right, blaming the "old mentality" (*mentalitatilor invechite*) and "inadequate organization" (*organizarii necorespunzatoare*) (Ziua, 2003) for dysfunction.

Although the World Bank was especially involved in efforts to help reform healthcare, beginning in 1991, international donors who were involved in numerous ways in the health reform program were not strong enough or assertive enough to force discipline on domestic actors. Outside actors were less assertive in comparison to the forceful recommendations from international donors in the child welfare field. There were no efforts to tie institutional reform goals to donor funding, and technical

[29] Central government representatives who are county-level leaders, similar to U.S. governors but appointed by the central government.

assistance was particularly inattentive to the political side of reform equations (Radulescu, 2002; Vladescu, 2002; Burduja, 2005).

Why? As reviewed in the introduction, there are at least three reasons: 1) absence of child welfare's "800-pound gorilla," the EU; 2) lack of a unified position regarding the "best" way to organize healthcare; and 3) inexistence of a coordinating mechanism to pool donor power. First, the *Acquis Communitaire*, which guides EU involvement in Romanian policy reform efforts, does not include a chapter devoted to health. Thus, healthcare was never an EU priority, despite some activities that tangentially involved the field. Second, within the EU there are a range of national solutions, with the British National Health Service and the German HIHs considered rival models with unique and respective pros and cons.

It appears there was a tacit assumption among donors that the politics of health would have to be worked out domestically. This hypothesis is intuitively plausible considering that there were bilateral health reform–related activities led by governments that had very different healthcare systems at home: For example, the Swiss (emergency medicine protocols), the Germans (healthcare contracting), the French (provision of public health), Americans (case costing in hospitals), and the British (networks of family doctors) assumed roles in the Romanian healthcare effort, although their national references were highly divergent. Finally, bilateral activities were only informally coordinated, so there was no mechanism for donors to pool their authority and exert a conditional bargaining position vis-à-vis healthcare reform requirements as they did post-1999 in child welfare.

Political Transfers of Power Did Not Drive Social Welfare Reform

For the purpose of this analysis, tracing political turnovers and the consolidation of democratic institutions through elections has weak explanatory power when it comes to the evolution of policy regimes in child welfare and the health sector.

Reform in these sectors has a strong legislative component, but the heart of the matter is in how institutions themselves are reorganized to produce—or not produce—different outcomes. From the perspective of transfers in political power, one can see the chronological course of legal change; in this regard, each successive administration built on the work of the other. Political parties did not have well-developed policy positions distinguishing one from the other, and parliamentary sessions did not typically witness opposing parties debating from core values that could be considered substantially divergent. Much public policy was approved as Emergency Ordinances designed by the government; this practice became increasingly common after 1996 and virtually routine during the Nastase government (Ionita, 2003a). However, there was ongoing bargaining between the central government and sub-national units regarding budgets and responsibilities. This domestic bargaining occurred while the central government was involved in bargaining with donors. The political balancing act that the central government has to attempt because it is simultaneously involved in these two bargaining settings can yield unanticipated results.

Romania's political turn-overs, and well contested national elections, suggest that the rules of democratic competition are respected, thus, Romania can be considered a consolidated democracy. However, Romania's mechanisms of

governance are not democratic (i.e. participatory) or particularly accountable or organized to protect the common good. So, for donors, democracy objectives and democratic governance objectives should not necessarily be considered two sides of the same coin.

Political Bargaining in an Uncertain, Resource Poor Environment

In a 1988 essay, "Diplomacy and Domestic Politics: The Logic of Two-Level Games." Robert Putnam notes that existing theories do not adequately acknowledge the link between international and domestic politics. Although he is primarily interested in how bargaining to achieve international agreements is impacted by domestic ratification contests, a subject quite different from the one explored here, the concept of a two-level game is applicable to the problem of foreign assistance.

This approach is useful in describing why reform outcomes sometimes diverge from what donors expect: Donors are typically concerned with the bargaining they are engaged in, not other dealings. Since reform often includes a legislative component, it is inevitable that donors will primarily negotiate with central political institutions. But the executive, in a democracy, must be concerned with how organized constituents are responding to government initiatives. Very often, domestic bargaining is of greater interest to post-communist executives than the donor exchange.

At the heart of the international interaction is the potential of mutually beneficial cooperation between a donor government or multilateral organization and the recipient government. The donor is motivated by an interest to influence the

policies of the recipient government. That motivation could be rooted in humanitarian concerns, economic goals, geo-political strategy, or a mixture of these, but fundamentally, there is an overriding motivation to "get inside the skin" of another nation-state.[30] Western democracies were motivated to offer assistance to Romania in the first months following the revolution for many reasons: to relieve the poverty and misery of special populations such as children in institutions, to encourage political stability in the biggest country in southeastern Europe, to encourage a market transition that would invariably represent a new market for goods and services, and even to help right an historical wrong: allied acquiescence in conceding Romania to the Soviet Union in postwar negotiations.[31] As Carol Lancaster (2000) has observed, foreign assistance's objectives have significantly widened since the end of the Cold War, especially with regard to humanitarian objectives.

A recipient government will not agree to cooperate unless it has something to gain. In Romania, with the fall of communism, there was a strong popular desire to be accepted by the West for numerous reasons that can be summarized as "access": access to travel and education opportunities, both long forbidden; access to information; access to Western goods and markets; access to the material wealth that the West enjoyed; and access to political institutions that embodied accountability and respect for individual rights. Political elites in Romania were motivated to

[30] The case of humanitarian assistance in times of natural disaster or post-conflict might appear to be different; it might seem that in cases of emergency humanitarian assistance, a donor government is not necessarily motivated by an interest in changing "policies." However, even to distribute food, a donor has to bargain with a recipient for permission and regarding the terms of distribution. Further, the number of cases in which bilateral assistance is awarded on a purely humanitarian basis is rare; international non-government organizations such as the Red Cross are different. I am interested in donors that are governments or groups of governments.

[31] All these motives are reflected in Congressional debate over the Support Eastern European Democracy (SEED) Act in 1989. The SEED Act continues to be the legislative and funding vehicle for much of the U.S. assistance that flows into the region.

cooperate particularly to gain resources that would facilitate access: technical advice and assistance; material goods, especially technology; professional training in innumerable sectors; and grants to supplement a sorely depleted national treasury.

Donors often assume that reform initiatives are a straight shot from central government agreement to achievement. Donors sometimes forget that the central government relies on its ministries, sub-national agencies, professional associations, and state-owned assets to implement reform. Central government must negotiate compliance with domestic entities for reform ideas to move off the blueprint. This is the domestic game that makes the process by which complex reform is executed more like a game of pinball than a straightforward game of horseshoes.

A review of the relationship between donors and domestic actors in post-communist Romania, first in child welfare (CW) then in healthcare, demonstrates how the notion of two-levels of simultaneous bargaining helps explain domestic outcomes considered puzzling—or corrupt—by donors.

Bargaining Between Donors, Central Government, and Local Interests in Child Welfare

Immediately following the opening of Romania to the world, a flood of donations, advice, free labor, and cash was directed at Romania's state-run residential institutions for abandoned children, their young residents, and employees. Little was required of the central government except endorsement of international protocols committing the country to a new paradigm of care for vulnerable abandoned children—commitments that cost nothing for the central government and hardly

involved local actors in the CW policy regime. This period lasted from approximately 1990 through 1993.

One of the results of the influx in foreign assistance to CW institutions was that they became more attractive: With new roofs, plumbing, and heating systems and with more food, more toys, and better furniture, the large residential facilities were consistently depicted in the Romanian media in the early 1990s as being loci of foreign interest and investment (Plotnick, 2005; Mica, 2002). Because of the acceleration of poverty in the early 1990s, the lack of prevention polices to *discourage* families in distress from abandoning their children, and the impression that state-run facilities were well endowed, the rate of child abandonment began to climb again in 1994 (United Nations Children's Fund [UNICEF], 1996; Booth et al., 1999; Greenwell, 2001; Petre, 2003).

This was not an outcome that donors desired. They began pressuring the central government to take a variety of steps to limit the growth of state-run institutions including closing them and shifting populations to small, family-style residential units on the model being implemented by numerous privately funded, non-government organizations (NGOs), often with support from foreign churches. Donors increasingly preferred to work with the NGO sector, advocating a shift in authority from the state to the NGO, or "third" sector, following the U.S. model[32] (Coman, 2005; Mica, 2002; Sauer, 2002).

[32] In the early 1990s, most observers consider that the United States was most deeply involved in CW reform initiatives; around 1997, the EU became the most powerful international actor, as its contributions to the sector increased and, especially, as the *Acquis* became the ultimate set of reform benchmarks.

However, the government was not willing to significantly change the rules of the game governing the CW sector. As a result, donors scaled back assistance offered to the Romanian government between 1993 and 1996,[33] although they continued programs directly engaged with local CW institutions, especially at the county level (Coman, 2005; Seltzer and Cromer, 1997; Cromer, 1996), and they continued significant work with NGOs implementing a variety of programs—all of which effectively took pressure off the state system. Between 1990 and 1996, the European Union (EU) expended approximately 70 million Euro on the CW problem (European Commission [EC], 1997).

From the perspective of donors, the Romanian government was a recalcitrant, stubborn interlocutor (Kessler, et. al. 1996; Cromer, 1996; Mica, 2002). However, donors gave little consideration to the related, second-level bargaining game that the central government was playing with sub-national players: county and local governments, ministry units at the county level that covered budgets for institutions and institutional staff (including sub-units from the powerful ministries of Health [MOH], Education, and Labor), and state-owned, or controlled, venders providing services to the residential institutions. From the perspective of these local actors, the influx of foreign assistance had improved the value of CW assets and strengthened the status quo. It had served to improve their employment status. It is difficult to determine CW employment totals between 1990 and 1999, but various donor reports suggest significant attention was paid to the training needs of institution staff, and there is no indication that employment *declined* during this period (Stephenson,

[33] In 1994, for example, numerous donors agreed to stop funding a UNICEF program begun in 1990 that had worked closely with the central government.

Anghelescu, Stativa, and Pasti, 1997; Ministry of Health and UNICEF, 1992; Tobis and Vitillo, 1994). Under the influence of foreign donors, the government increased the number of professionals, including psychologists and physical therapists, associated with state-run institutions. Thus, it is no surprise that local stakeholders, especially through the ministries, pressured the central government to avoid significant institutional reform in the sector.

Between 1993 and 1996, the brilliance of the central government's bargaining strategy became clear: Donor resources were pumped into the sector at the level where they were most needed, locally, and the central government expended little to no effort being tediously engaged with the donor community. The central government pursued a free-rider strategy, understood and approved by local constituencies but considered undesirable by donors.

In 1997, bargaining over foreign assistance goals changed with the addition of important new potential commitments offered by the donors. Both European and American donors offered a major "if" clause in their bargaining strategy: **If** the government cooperated in implementing reform, including more fundamental reform in the CW sector, then EU accession and North Atlantic Treaty Organization (NATO) membership would not be far behind. On April 11, 1997, EC President Jacques Santer visited Bucharest,[34] addressing the Parliament and meeting with the Prime Minister and the President about Romania's application for EU Membership (Radio Free Europe/Radio Liberty, 1997). One of the subjects was the EC's decision to include progress in CW as part of the political criteria for accession (EC, 1997). President Bill

[34] Both President Iliescu (3/10/95) and President Constantinescu (2/3/97) had already traveled to Brussels to meet with Santer to discuss accession, but Santer's April 1997 speech before Parliament represented the public launch of EU-Romania accession commitment.

Clinton and Secretary of State Madeleine Albright visited Bucharest in July 1997. Before a crowd of over 100,000, President Clinton said Romania would be the "strongest candidate" to join NATO if the country continued economic reforms and democratization (Clinton, 1997). In personal meetings with the president and political leaders, he included the importance of CW reform (Constantinescu, 2003; Albright, 2003).[35]

In response to donor pressure, the central government used Emergency Ordinances (*ordonante de urgenta,* EO) to pass two major pieces of legislation in 1997: 1) Law 26/1997 abolished the framework for the old CW system (Law 3/1970), devolving much of the authority—and financial responsibility—for CW institutions to the county level. 2) Law 25/1997 facilitated adoption with increased local responsibility as well. Donors applauded the initiatives (Saur, 2002; Mica, 2002; European Commission, 1997, 1998; Pentru Copii Nostri, 1998). State-run residential institutions that had been controlled by the MOH and Ministry of Education were transferred to the county councils. At the second-level bargaining table, the central government kept its constituents satisfied by creating new county-level entities, Departments for Child Protection (*Directia pentru Protecia Copilului,* DPCs) and Specialized Pubic Services for Child Protection (*Serviciul public specializat pentru protectia copilulu, SPSPPCi*) that were empowered to coordinate much of the significant assistance flowing from abroad. Some specialized institutions, managed by the MOH, Ministry of Education, and the State Secretariat for Persons with Handicaps, were allowed to remain under central control.

[35] Most scholarly works on the future of NATO after communism emphasize the impact of expansion on the West, not the impact of membership on the new members. See for example, Asmus, 2002 and Barany, 2003.

Therefore, the central government satisfied the donor community by accepting its vision of local control over CW institutions, while also satisfying local domestic constituents by maintaining, even increasing, the number of administrative units managing the sector, preserving the flow of international assistance to local actors, and maintaining the nexus of sub-national governing bodies that managed pieces of the sector. These concessions to local actors, but especially the persuasive promise of international acceptance into NATO and the EU, explain why the Romanian government became cooperative with international donors again in 1997.

Unfortunately, by most accounts, sub-national government was simply unprepared to shoulder technical or financial responsibility for the CW network in 1998 and 1999. A detailed World Bank study (2001a) shows that county and local government failed to comply with many of the mandates they received from the national government in 1997. In spring 1999, the central government was forced to seek emergency funds from donors when it became clear that local CW institutions were so badly managed that there was not enough food to feed the children, as has been discussed. Newspapers sensationalized the situation through headlines such as, "After 10 years of reform, the Delegation of the European Commission warns Romania: Institutionalized children have arrived at cannibalism" (Adavarul, 1999a).

In 1999, the EU insisted that the multiple authorities managing parts of the CW system be united, and that the central government contribute more funding to local CW institutions. By 2001, the EU, World Bank, and the U.S. Agency for International Development introduced strong conditionality into grants and loans to reform the CW system: The government was expected to close large residential

institutions in exchange for financial and technical assistance. This conditionality was considered essential in order to accomplish what the Romanians most resisted: closing institutions with large employment despite the fact that most child protection alternatives were less expensive than the big institutions (Petre, 2002; Wulczyn, et. al, 2000). The funding at stake was sizable: The World Bank loan, supported by the Council of Europe Development Bank, represented $30 million USD in financing alone. Again, the promise of external, long-term rewards is a major reason why this reform was finally undertaken. Moreover, the government realized that it could convert some of the large residential institutions into smaller units without losing staff (Correll, 2005; Coman, 2005).

During this period, it was possible for the central government to make concession which risked offending sub-national units and public employees in the sector, because Romanian local actors had already come up with a remarkably effective scheme for bringing new discretionary money into the child protection network: the so-called point system. The local funding crisis in 1999 had revealed a serious lack of sub-national funds for CW programming and institutions. In response, the government in cooperation with its local agencies and CW stakeholders, agreed on a scheme for raising more money for local CW services through a point system. Based on contributions (cash and in-kind donations, but mostly cash) made to CW institutions, international adoption brokers received points. These points could eventually be redeemed for babies (Davis, 2005, Coburn, 2005, Coman, 2005, Ambrose and Coburn, 2001).

The point system relied on coordination between the national-level Romanian Adoption Committee and the DPCs created in 1997; it proved to be remarkably effective in bringing hard currency into the CW system by making babies available to the adoption agencies that contributed the most money.[36] Since the law required that international adoption agencies employ local partners, these local agents typically were the runners between international agencies and the Romanian public institutions, steering resources and identifying available children. Because families were willing to spend up to $30,000 per child, the international agencies were eager to buy advantage through contributions to local CW institutions. Unfortunately, procedures guiding the point system—from what contributions equaled how many points to how often points were converted into children—were not well specified, and there was no institutional accountability to verify that the scheme put the child's interests at the heart of each transaction (Ambrose and Coburn, 2001).

While the point system held sway from 1999 into 2001, besides the move to consolidate CW authority, the central government was more engaged in strategy vis-à-vis local actors than in strategy vis-à-vis international donors. The donors noticed. Concerned with what they termed rampant corruption in the sector, the donors rebelled. Led by representatives from the EU, the Romanian government was told that if it did not end inter-country adoption and accept aid conditionality regarding the closing of state-run institutions, then Romania could forget the dream of joining the EU. (Micklewright and Stewart, 2000; European Commission, 1999a) Although it

[36] The issue of corruption in inter-country adoption is considered remarkably sensitive by donors and GOR authorities alike. There are few written accounts of how the point system functioned. The report that comes closest to specifying the mechanisms of exchange is Ambrose and Coburn (2001), a document paid for by the USG, but not widely circulated. My information was almost entirely derived through interviews.

felt less passionately, the U.S. Government conceded that the adoption system was characterized by irregularities that required putting an end to the point system (Correll, 2003; Ambrose, 2005; Guest, 2005).

Following a moratorium announced in June 2001, inter-country adoption never resumed. New legislation making it virtually impossible for a non-relative living abroad to adopt a Romanian baby was approved in 2004 (Wheeler, 2004). The U.S. Government protested strongly, since the Romanians had promised many times that inter-country adoption would eventually resume (Guest, 2005). But the EU was the dominant donor; by 2004, its contributions dwarfed those of any other bilateral donor (OECD, 2005b). Romania caved to the dominant donor: Inter-country adoption ended for good. However, other programs of assistance to the CW sector, conditioned on the closure of state-run institutions, continued, which kept local actors quiet if not happy.

In sum, at important junctures, when donors were promoting specific CW reform strategies, the central government's response—in 1993 (institutional reform rejected), 1997 (decentralization accepted), 2000 (consolidation of authority accepted), and 2001 (moratorium on inter-country adoption accepted)—can be explained in terms of the strategic goals of domestic actors with whom the central government was also bargaining and in terms of the credible promises or threats asserted by international donors.

Bargaining Between Donors, Central Government, and Local Pressure in Health Sector Reform

Less storming—but also less *norming*—characterizes the game played between international donors and Romanian actors in the health sector. Like the two-level game described in the CW sector, in healthcare, a game is played between donors and the central government, including the MOH. This is related to bargaining within a game played between central-level organizations (namely the central government, MOH, and Ministry of Finance [MOF]) and local-level players including doctors, hospitals, pharmacies, the health-seeking public, and the National Health Insurance House.[37] The local game was largely characterized by cooperation between 1990 and 1994 but became significantly more contentious regarding the implementation of a major law to reform health service delivery and financing. Local actors were consistently the strongest advocates for change, especially if it would yield more resources, both financial and capital, and more professional independence.

In the discussion of CW, we saw that the first post-communist government was supportive of reform in that it approved new international covenants related to the rights of the child and established rules to guide international adoption, but it did not confront the most important obstacle to deep reform: the way in which state-run institutions absorbed most of the resources in the sector while poorly serving the best interests of the vulnerable children it was supposed to serve. Simply put: Central government was allowed to ignore the profound inefficiency of the state-run residential system.

[37] Although technically a national level institution, the National Health Insurance House (NHIH, created by law in 1997 and in force in April 1999) consistently played on the side of local actors because it was originally designed as an autonomous entity, independent of central government control. Repeated attempts by central government to limit the NHIH and usurp its authorities pushed it to identify with players bargaining against the central government.

In the health sector, in the early post-communist years, the central government barely acknowledged donors, although the Romanian healthcare system benefited from donor assistance in tangible ways. The government signed an agreement with the World Bank in 1991 for an ambitious $150 million USD loan to study reform, introduce computers, rehabilitate rural dispensaries (420 in all), establish schools of health management, and outline future options; however, this agreement required little of the Romanians in terms of deep, structural reform. The national government also allowed numerous donor-sponsored training programs paid for by the Swiss, Canadian, Japanese, German, Australian, Dutch, Swedish, and U.S. governments benefiting local actors, especially local doctors and nurses. The segments of the MOH responsible for managing facilities and care for abandoned children aged 0-3 years certainly benefited from the extensive humanitarian assistance provided by NGOs such as the French *Medicin sans Frontier*, the United Kingdom's *Children's Trust*, and UNICEF. Yet little significant change was required on the part of the central government, much as little was required of the government in the CW policy regime. Donors were obviously not offended, since they kept coming back to Romania. In fact, the central government allowed direct donor access to local actors in ways that benefited those constituencies without significantly touching the institutional structure governing health. Between 1990 and about 1994, in terms of institutional reform, nothing serious was accomplished.

The central government used donor programming to help satisfy demands from local actors for more technical knowledge, training, and better equipment. Thus, the government was a free rider, benefiting from contributions from abroad, without

significantly participating, besides opening the door. In addition, the central government had quickly satisfied a significant preference asserted by local actors just after the revolution and, thus, was not under much pressure to introduce further reforms. Without input from donors, as a reaction to medical (and perhaps public) preference, one of the first laws enacted by the provisional government in December 1989 was legalized abortion. The high rates of maternal mortality and child abandonment, both of which were linked to illegal abortion,[38] were the rationale offered for legalization. But abortion also became an immediate source of income for doctors nationwide: Hardly regulated and in an environment where there was no supply of contraception (because it had been forbidden), the number of abortions shot up to approximately one million in 1990.[39] In one donor document, the author observes, "Because the current generation of OB/GYNS depend on abortion for income, they may be a 'lost cause' as far as providing contraceptives and counseling are concerned." (Cromer, 1996)

Other laws advocated by doctors were approved: The requirement that doctors had to spend at least three years in rural areas was dropped, and a new specialization, general practice, was approved in 1992. But these laws were passed in response to local constituents, not donor pressure. The Romanian central government was comfortable deflecting donors' recommendations regarding reform because, at the same time, it allowed donor resources to be steered to local actors, thereby satisfying local preference for cooperation that was perceived as leading doctors and medical personnel out of their resource rut.

[38] About 10,000 women died between 1966 and 1989 due to illegal abortion, according to the Centers for Disease Control and Prevention (CDC) and Institute for Mother and Child Health Care (1995, p. 2).
[39] Ibid.

In fact, central government was mainly preserving the status quo (i.e., maximum resource control at the center), although the MOH could see that the revenue available to health through the state budget was paltry and getting smaller. In 1994, Dr. Iulian Mincu, former doctor to Nicolae Ceausescu and Minister of Health, gained Senate approval[40] for a major overhaul of the Semashko system: He favored a Bismarck-style social health insurance system of mandatory contributions from employers and employees.

Two major influences on this preference were his daughter, a practicing doctor in Germany, and a team of German doctors advising the Ministry between 1993 and 1995 (Mincu, 2003; Erhan, 2003; Gherghina, 2005). As well, he valued the system because he considered it to have the greatest potential to significantly increase the revenue available to the healthcare system. Doctors were the most supportive of this major overhaul because they were convinced it would generate more money.[41]

Many agree the breakthrough agreement that paved the way for health system reform was a World Bank–sponsored pilot program initiated in 1994 that road-tested the Bismarck system: Eight counties (covering four million people) were selected for trial implementation of a system that gave citizens free choice to select a primary care doctor and paid health providers, especially general practitioners, on the basis of a combination of capitation (per head) and fee for service. The pilot required prior approval and financial commitment from the MOH,[42] which, besides the Minister himself, was not enthusiastic. The ministry was forced to accept it by Parliament, responding to local constituents, especially doctors who were keen to test whether the

[40] It was an unusual case of Parliament, not the government, proposing a law.
[41] Dan Enachescu, 1998, p. 69.
[42] Approved by Government Decision 370/1994. The pilot continued to operate through 1996.

public would participate and whether the financial benefits would accrue under a health insurance financial scheme. Doctors and hospital directors lobbied the Parliament and Ministry (Enachescu, 1998; Erhan, 2003; Mincu, 2003). Minister Mincu was very supportive in order to demonstrate the intelligence of his endorsement of this plan already. Since he was also in Parliament, he was able to help engineer parliamentary approval for the pilot project. Parliament passed an unusual law approving the World Bank pilot project and directing the MOH to cooperate with the Bank in implementing the pilot (World Bank, 2002c).

The pilot project proved several important things: A mandatory insurance system raised new money, the public was eager to participate (84% of the eligible population registered in the first year), and competition led to increased productivity.[43] Evaluation of the pilot project concluded that the output of family doctors improved: They provided more consultations and increased the number of home visits. Because the doctors in the pilot districts had established contracts with district health authorities, the doctors were no longer state employees; they clearly became more client-oriented. On average, the income of these doctors increased 15% (World Bank, 2002c). Pilot projects can contribute to essential learning, allowing players to recalculate their positions in negotiating change while reducing the uncertainty of change.

Outside the pilot districts, doctors continued to pressure central institutions to approve the social health insurance law. Doctors, the most active constituency in the health constellation, did achieve some victories in this period: For example, Parliament established the College of Physicians in 1995, with official recognition

[43] Institute for Health Sector Development, 1995, pp. 36-40.

and standing to negotiate with the state on behalf of doctors. However, between mid-1994 and 1997, the central government remained ambivalent regarding the health insurance scheme largely due to two opponents: The MOF feared that the health tax, by increasing overall taxes on employers, would inhibit much needed economic growth. The Ministry of Labor feared that it would lose certain authorities, such as the authority to administer sick leave, to the new Health Insurance House (Radulescu, 2002; Vladescu, 2003).

With the election of Emil Constantinescu in late 1996 came a new Minister of Health, Stefan Iosif Dragulescu, who had served in the Senate and was familiar with the reform debate. He became a champion of the health insurance law and says he first approached the Romanian Party of Social Democracy (Iliescu's party) to support the reform, *then* went to his own coalition for support (Fundatia Horia Rusu, 2003). Meanwhile, the MOH made a concession to the Ministry of Labor regarding control of sick leave administration, and the MOH made a concession to the MOF regarding the first-year employer tax rate. Despite the lack of any impact analysis of the law (Radulescu, 2003) or a strong strategy besides the raw facts of reorganization (Enachescu, 2003), the MOH got the central government on board and the new Social Health Insurance Law 145/1997 was approved by Parliament in August 1997. Notably, healthcare expenditures in 1997 had sunk to a level below that of 1994-1996, putting significant pressure on the government to come up with a scheme that would bring new resources into the system (World Bank, 2002b).

Although some donors, especially the World Bank, had advocated for the health insurance reform as early as 1993, its passage was only secured when key

central government actors were convinced that it would raise new money: in the midst of a deepening budget crisis, they concluded that it would raise money without disrupting existing institutional relations too much. Thus, approval in 1997 of the health insurance reform came when cooperation at the local bargaining game triggered cooperation in international bargaining. In health reform, local bargaining drove the issue, while in CW, international bargaining dominated.

Between 1997 and 2000, the central government and international donors were not engaged in strong bargaining over healthcare because the locus of power was much more contested on the domestic level. But donors opened a new reform front in 2000 with the idea of introducing Diagnostic Related Groups (DRGs), or case-based financing, when it was clear that soaring hospital costs were preventing fundamental reform of Romania's healthcare system. One approach to introducing greater transparency into hospital spending is by implementing reimbursements based on DRGs; this has the added benefit of putting more rationality into hospital decision making and, it is assumed, reducing costs. Basically, every service available at a hospital is coded and assigned a price. With DRGs, hospitals are like big stores. By tracking patients through DRGs, managers can compare levels of activity, hospital performance, and costs across hospitals. The three main problems with the DRG system are: 1) It is a technologically intensive system. 2) It is a tool that doesn't *in itself* manage anything. 3) It takes time to implement (Bubenek, 2005; Fundatia Horia Rusu, 2003; Enachescu, 2003; Vladescu, 2003).

Nevertheless, health sector decision makers at the central level decided to endorse this reform solution as a way to get hospital costs under control (Bartos,

2002; Cocora, 2002). The U.S. government took the lead in working with the Romanian government to develop DRGs in 2000[44] with support from the World Bank and EU. By 2003, the Romanians had taken over the program itself. Thus, in order to push reform more deeply into hospitals, the government began a new round of cooperation with donors. In the domestic context, local doctors, convinced that hospitals were stealing money from the primary care level, pushed the central government (including the MOH) to agree to the DRG solution (Burduja, 2005; Lazarescu, 2003; Vladescu, 2002).

Since it began as a pilot, hospitals were curious but not threatened at the outset, especially since the initiative included a significant budget for information technology–related equipment and training, about which hospitals were enthusiastic. However, by 2003, there were complaints that it was taking too long to implement the DRG system; meanwhile, hospitals continued to dominate annual budget resources, pharmaceutical costs were skyrocketing, and the public was unhappy with both access and quality of care (Fundatia Horia Rusu, 2003; Chiritoiu, 2003; Bubenek, 2005).

In sum, at important junctures, when donors were promoting specific healthcare reform strategies, the central government's response—in 1995 (World Bank pilot program giving primacy to general physicians accepted), 1997 (social health insurance scheme recommended by Germans approved), and 2002 (DRG case-based financing for hospitals, promoted by the U.S., used as pilot financing for twenty-three hospitals)—can be explained in terms of the strategic goals of domestic actors with whom the central government was also bargaining. What is critically

[44] The DRG project is another example of a program that began in one administration and was continued by the next. It was adopted by the Constantinescu government in spring 2000, but program implementation got under way in 2001.

different in healthcare as opposed to CW is that international donors offered few credible promises or threats related to the reform agenda. Donors offered concepts and technical assistance, but there was no "fear factor" to enforce compliance or cajole follow-through.

By 2001, as the CW sector finally began to adopt reforms that changed the way services were delivered, and even worked against the status quo, in healthcare there was a systematic trend away from reform toward recentralization, as well as an inability to maintain a clear vision of change in the face of skyrocketing pharmaceutical costs and hospitals chronically incapable of living within agreed-upon budget limits. Analyzed in terms of bargaining, in CW reform the donors used considerable bargaining power to force local organizations (with an interest in preserving partial reform) to produce outcomes the donors wanted. In the case of healthcare reform, key domestic organizations had veto power over moving forward, and no actor had the power—or the will—to coerce the outcome.

By tracing the government's pattern of cooperation and defiance vis-à-vis foreign donors as a function of its relationship with domestic actors in the CW and health sectors, respectively, I am able to depict the fundamental rationality of the government's positions. Other observers see central government ambivalence without considering the larger context of its choices. For example, Barbara Nunberg, an international financial institution analyst who studies administrative reform, wrote about the Romanian government: "Despite some promising initial efforts, this…transition has been more halting and *ad hoc*… than elsewhere in the region" (1999, p. 53). The World Bank's Country Assistance Evaluation covering 1990-2004

leads with a description of the perceived unevenness in Romania's reform commitments: "Vacillating government commitment became a major trait of Romania's reform efforts," characterizing the 1990s as witnessing "many half-hearted reform attempts" (2005b, p. *v*). Halting, half-hearted, vacillating, perhaps, in light of donors' teleological drive toward certain reform ends, but it is logical in light of the central government's primary concern to maximize resources, especially financial resources, available to public institutions without limiting its authority.

Viewing the reform trajectory through the bargaining lens is limited in that it does not link outcomes to the procedural rules governing interactions between institutional actors. In Chapters Four and Five, I attempt to penetrate the conditions for success and failure in social welfare reform promoted by foreign actors by tying performance outcomes back to institutional rules and procedures, especially procedures governing budget allocation—an approach that supplements the two-level bargaining explication without displacing its insights.

In Chapters Four through Six, the aim is to deepen the analysis of strategic interaction among donors, central government, and domestic stakeholders in order to explore how institutional change—and institutional continuity—can be explained through the RC and institutionalist paradigms. These chapters delve into the case studies in greater detail.

Chapter Four
Interests and Institutions in Child Welfare Reform

As earlier descriptions of the child welfare (CW) system and residential, state-run institutions suggest, this network of warehouses (large and small) for abandoned children, and the people working there and running them (all state employees), represent a set of political interests. Between 1990 and 1997, these interests became more powerful as facilities were physically improved through contributions from foreign donors and staffed up as a result of donor-driven initiatives to bring more professional staff into caregiving roles.

However, political interests are only powerful to the extent that there are institutional mechanisms through which they can express—and impress—their will. Between 1999 and 2001, the county and local-level CW organizations nearly overran central-level authority by creating decentralized methods of fund-raising based on new procedures for inter-country adoption. By 2001, foreign donors had exerted themselves, forcing the Romanian central government to make commitments that embraced reductions in institutionalized children in exchange for access to Western multilateral organizations—an agreement so strictly enforced that local and county interests lost their ability to participate in CW decision making, thereby losing their ability to steer outcomes.

In terms of the political institutions governing the sector, between 1990 and 2001, there was a certain "everyone and no one" quality to governance. A series of national entities were contrived by the central government (typically recommended by donors) to serve as a steering committee/advisory board, but until the late 1990s, none of these had substantial authority. Once CW was decentralized in 1997, county

council secretaries, then county council presidents, had important authority. But this diffusion of political responsibility only made policy coordination less likely.

Under the Nastase government, in 2001, governance of the sector was recentralized in that the National Authority gained Cabinet-level status, reporting directly to the Secretary of the Cabinet. Considering that most CW legislation was approved by the Cabinet as Emergency Ordinances, the Cabinet was, in a real sense, the political authority most implicated in the governance of CW—which signifies the strategic importance this sector had vis-à-vis Romania's post-communist political aspirations to be accepted by the West and is one of the reasons institutional reform was, ultimately, successful.

1990-1996: Humanitarian Assistance

A 1996 United Nations Children's Fund assessment of six years' worth of foreign assistance to Romania's CW sector summarizes the sense among donors that hundreds of millions of dollars in aid[45] had not had a deep impact on the CW regime:

> Systems changes are not evident yet. Adequate budget allocations for child welfare reforms are not widely available, and systemic family and community supports are not in place. In the past year, the number of children in state institutions has actually increased, presumably due to the declining economic conditions for large segments of the Romanian population. There is widespread frustration among many donors and NGOs [non-governmental organizations] that little progress is being made despite substantial inputs and local changes. A National Plan of Action (NPA) for child welfare and protection has been adopted, but mechanisms for its implementation and

[45] It is impossible to estimate the total expenditures from foreign entities, 1990-2004, because so much of the assistance flowed through private entities, especially church organizations. One U.S. document estimates that private contributions were twice as large as bilateral aid (Cromer, 1996). Guesstimates by EU and U.S. government officials regarding total amounts of foreign aid to Romanian child welfare entities during this period range from $800 million to1.5 billion USD, the later figure includes an estimated value of goods and services donated by private groups.

> budgetary allocations have not been established. Lack of inter-ministerial collaboration remains a problem and responsibility for protection of children continues to be fragmented. (Kessler et. al., 1996. p. 3)

As a result, the authors recommend, "In the present political climate, local-level actions appear to offer the greatest opportunity for achieving changes. The burgeoning civil society is highly receptive to technical assistance, practical demonstrations, and new ideas and methods" (Ibid).

Shifting attention to local and civil society–oriented development strategies when central government lacks "political will," or commitment, is a common approach among both bilateral and multilateral donors all over the world. The obvious problem is that this reorientation takes the focus away from more profound institutional reform constraints identified just a few sentences before: the process of budget allocation, the existence of institutional interests that do not want to forgo assets, fragmented responsibility, and resistance to a new service mix—regardless of potential cost savings.

Without a doubt, unemployment and the loss of purchasing power as a result of the transition from a command to a market economy caused increased poverty in Romania. But poverty is not a sufficient cause for the increase in children abandoned to state-managed residential facilities in the mid-1990s. Strong financial incentives existed, spurring ministries to defend the status quo, especially between 1990 and 1996 when ministry budgets were directly tied to the number of children receiving care under their authority (Davis, 2005; Sheele, 2002; Correll, 2002; Sauer, 2002; Mica, 2002).

The Romanian CW regime between 1990 and 1996 benefited from an unusual parallelism: The state system existed alongside CW services paid for by private and public external donors. As a free rider, the central government had no reason to increase its own budget resources on CW. The strategic genius of the Romanian strategy was to create a flexible policy environment that accommodated, even welcomed, outside assistance while encouraging sub-national institutions to utilize the technical assistance being offered. Meanwhile, the government maintained a state system dependent on its existing base (abandoned children). This was an achievement in the rational self-interest of state employees, state institutions, and elected officials, if not in the long-term interest of abandoned children already cared for by the state or heading for that fate.

Therefore, it is not surprising that although eight *leagane* (state-run institutions caring for infants and children aged 0-3 years) were closed between 1990 and 1996, approximately the same number of babies and toddlers entered the system each year (Greenwell, 2001) despite the fact that the birth rate *declined* during this period. Abandonment rates for children aged 0-3 years went from 600/100,000 in 1990 to just over 800/100,000 in 1998. One important institutional explanation for this phenomenon has hardly been noted in the vast number of reports on the subject: Through 1996, it remained extremely easy to institutionalize a child. Local child protection commissions were charged, by law, with deciding the fate of an abandoned or at-risk child. Most members of these commissions were also directors of residential institutions. They had a clear financial incentive to keep institutions full since budgets were directly tied to the number of beds occupied.

According to one of the most comprehensive studies of the first ten years of reform in CW, foreign assistance simply did not impact the CW institution itself: "Despite much foreign assistance between 1990 and 1996, the complex institutional structure maintained in Romania continued to reflect the great handicap of a totalitarian, centrally coordinated system in which local structures played either no role, or merely a cosmetic one."[46] It is true that foreign assistance did not have a deep impact on the CW institution in this period, but I strongly disagree with the authors that local structures played no role; on the contrary, local players, especially the directors of child placement centers, and the staff of all units, played a significant role in stalling structural reform. For example, as a UNICEF-funded study highlights, local decision makers have *no* incentive to reorganize the CW regime. Their *rational* interest is in maintaining the multiple income streams that preserve their raison d'etre:

> "The institutional infrastructure for child protective services, as it exists today in Romania, is a self-sustaining system and will remain so as long as it is maintained. Putting the onus of responsibility for deinstitutionalization [be it family reunification, foster care, or adoptive placement] on the directors of institutions has not had a significant impact on the numbers of children in care. Doctors' main concern is the everyday administration of the institution, and their jobs depend on keeping the census of the institution high enough to avoid budgetary and staffing cut backs. Likewise, tutelary authorities can do little to prevent children from going into institutions since they have few alternatives to offer families in trouble." (Stephenson, Anghelescu, Stativa, and Pasti, 1997, p. 6)

In CW, partial reform existed during this period as a function of heavy outside financing supporting service alternatives and organizational maintenance, without significant impact on reorganizing and downsizing the CW institution (in the

[46] Booth et al., 1999, p. 11. The EU, for example, donated over $80 million USD to child welfare in 1990-1999 between two programs alone: PHARE Child Protection and PHARE Bridging Facility for Children.

Northian sense) itself. In this scenario, CW sub-national leadership and employees were the short-term winners who gained rents from distortions in the partially reformed system, namely, the donor funding that underwrote reform and the inter-country adoptions that brought in cash. These CW bureaucrats had clear incentives to resist change—certainly, to resist reorienting the institution away from institutions.

1997-2000: Decentralization

With the 1997 CW decentralization reforms, the CW budget picture became more complex. In addition to the state budget, funds for CW were supposed to come from the budgets of the county councils and non-budgetary funds, also known as off-budget "special funds" (Polishchuk, 2002). As discussed earlier, the county and local governments proved to be unprepared to assume significant responsibility for the vaguely defined local mandate, which led to a financial crisis in 1999. However, with changes in financing (namely, a significant decrease in resources transmitted from the state budget to local coffers, although the state continued to pay approximately 50% of the cost of CW services) came the *start* of a decrease in abandoned children.

One significant aspect of the CW reform story is the absence of strong professional associations functioning as organized interests. Besides the interests that formed around inter-country adoption (1999-2001), the chief concern of Romanians associated with CW has been to protect their employment. By most accounts, employment in the CW sector was static or increased between 1990 and 1999 as a function of donor pressure to improve staff/child ratios (which averaged 1:1 by 1999) although a review of employment data maintained by the National Institute of

Statistics demonstrates that employment is not disaggravated in a way that makes it useful to see this trend. One newspaper account (Adevarul, 1999) clearly blames the organized interests of CW employees for the dismal conditions in certain residential institutions:

> "As a result of hunger, in Nicoresti-Galati, an infant bit and swallowed the flesh from the upper arm of his neighbor in bed. Ten days after the incident, other children at the Nicoresti-Galati special residential hospital for children (*camin spital*) were in the same situation: starving and unsupervised. Today, the only improvement brought to their lives is that they were moved to a children's hospital in Galati. New patients were brought to Nicoresti-Galati…adults. 'It was more important to maintain (*pastrarea*) the staff than to change the situation,' a community source told the paper recently."[47]

The most vocal associations in the sector were groups of social workers who worked with donors on various programs. This profession was banned under the Ceausescu regime; donor support in 1991 helped restore it to university curriculums nationwide. Donors insisted on the importance of involving social workers in every aspect of child protection, from counseling families at risk of abandoning children to training institutionalized teens in essential life skills. Perhaps because the profession evolved with strong donor support and because an ongoing shortage of trained professionals meant that members did not have to worry about job security, they consistently supported donor initiatives.

The most consistent, organized interests prodding the national government regarding CW reform were, and continue to be, associations of bilateral and private donors. In 1997, a directory of organizations active in the sector in Romania listed about 1,500 organizations, with between 350 and 400 active (Mica, 2002). At the official level, the so-called High-Level Donors meeting, which met roughly three

[47] *Ziua*, 2003. Translated by the author.

times a year between 1997 and 2003, brought together the major bilateral and multilateral players including the European Union (EU), United Nations Development Programme, and governments of Australia, Canada, Germany, Italy, Japan, the Netherlands, Norway, Sweden, Switzerland, United Kingdom, United States (with some annual variance). Among private, church-based, and independent activists in the sector, most non-Romanians, about 20 groups created the Pro-Child Federation in 1999. Pro-Child is an Internet-networked group of individuals and independent NGOs, most with funding from abroad, which lobbies vocally at the national and county levels, and at embassies in Bucharest, about policy issues and trends in the sector. Therefore, there were mechanisms to coordinate both official and non-governmental assistance in CW reform.

2001-2004: Institutional Reorganization

As discussed in Chapter Three, donors were deeply perturbed that inter-country adoption had devolved into a virtual baby auction by 2001. There is little doubt that the man who designed the point system, Cristian Tabacaru, who headed the National Authority for Child Protection and Adoption (*Atoritatea National pentru Protectia Copii si Adoptia*, ANPCA), sincerely believed that his was a creative solution to the chronic need for more financial resources at the local level (Ambrose, 2005; Coburn, 2005; Coman, 2005; Correll, 2002, Petre, 2003). It was so creative that the local stakeholders *cum* financial beneficiaries—including adoption agents, Department for Child Protection (*Directia pentru Protecia Copilului*, DPC) directors, directors of the residential institutions, directors of the special services for the protection of children,

and members of the Romanian Adoption Committee (RAC)—had every incentive to maintain the scheme for as long as they could.

According to American analysts who spent several months in Romania interviewing stakeholders about the system, there was no domestic accountability mechanism that could or would undo the point system because it satisfied all parties: Foreign families received children, children went to the highest bidders, and local agents received tips at every transaction point—from the residential institution, to the DPC, to local courts, to the RAC (Ambrose, 2005; Coburn, 2005; Sauer, 2002). The system satisfied local players and took pressure off the central government by bringing new resources into a resource poor country. Only one factor upset this equilibrium: a powerful donor with a highly motivated champion, Baroness Emma Nicholson.

Hounded by Baroness Nicholson, a particularly vociferous Special Rapporteur for the European Parliament, Romania was explicitly threatened with the loss of EU accession if the country did not put a moratorium on inter-country adoption. Other conditions were soon added: The EU insisted on the deinstitutionalization of children still living in big state institutions as well as the closure of the institutions themselves.

Other donors let the EU take the lead in making foreign assistance conditional, but the EU was not just an agent of tough love; it provided significant direct resources to underwrite the CW budget. For example, in 2001, at the height of acrimony in EU pronouncements and reports regarding the adoption situation and CW compliance, the EU and multilateral donors provided over 20% of total expenditures on CW: 38% was transferred to the counties from the state (central)

budget; 35% came from county and local revenues; 6% from off-budget National Interest Programs; 17% from the EU's PHARE (*Pologne, Hongrie Assistance à la Reconstruction Economique*) program; and 4% from the multilateral development banks (European Commission, 2001).

The effect of conditionality was felt immediately. The number of children living in state-run institutions decreased by 24% in the two years between January 2001 and December 2002. At the same time, the number of institutions housing over 100 children decreased from 205 to 131, a decrease of 36%.[48]

By the end of 2004, the number was down to 32,679[49] children protected in state or private institutions (out of a national population of some five million minors) and 50,239 children under age 18 protected in substitute families, of which 34,405 where living with their extended family or other individuals/families and 15,834 were in foster care—a form of child protection that did not exist in 1990. Table 3 depicts the dramatic trends of decreasing numbers of children in institutions while more and more children were protected in families.

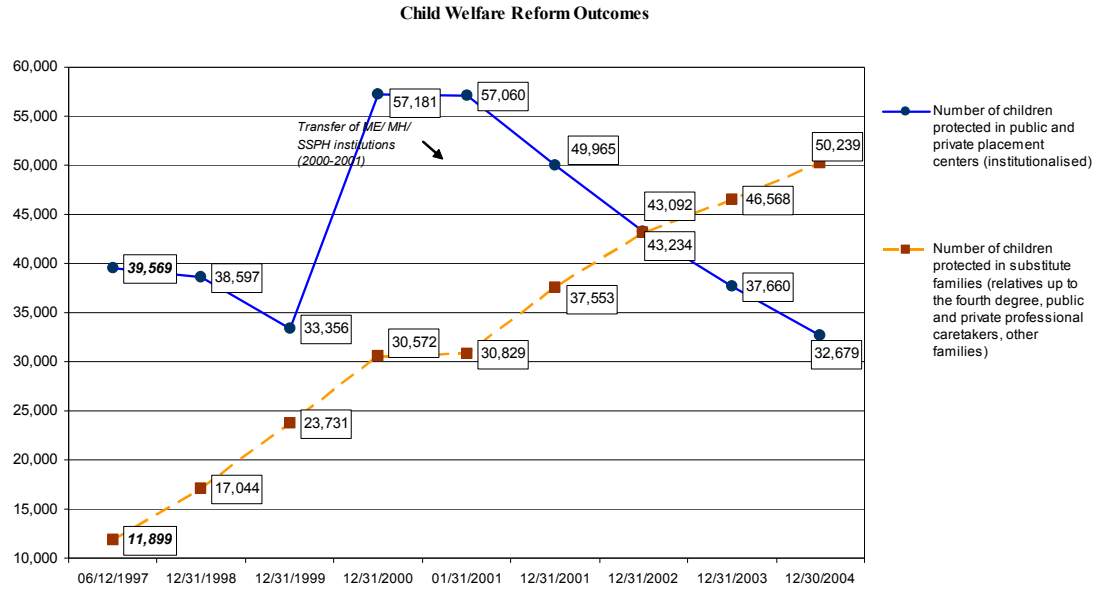
Significant evidence of the positive impact of donors and conditionality on the Romanian CW system can be seen in contrasting the mix of services utilized between 2001 and 2004. In May 2001, of the total number of children residing in substitute families or in institutions, 63% were protected in institutions while 37% were protected in substitute families (professional foster care both public and private, subsidized families, or extended families). Just a little over two years later, the percentages were reversed: Of the total number of children residing in substitute

[48] Statistics are on the National Authority's Web site at www.copii.ro including archived data.
[49] All statistics: National Authority for the Protection of Children's Rights (ANPDC, 2004) confirmed by European Commission, 2004.

families or in institutions, 39% were protected in institutions while 61% were protected in substitute families. The number of domestic adoptions increased slightly during the period: From an average of 95 adoptions/month in 2001 to an average of 106 per month in 2004, while inter-country adoption fell sharply, from 179/month in 2001 to 30/month in 2004.

One data set for the period 2000-2004 is not invoked by donors: sector employment trends. As Table 4 demonstrates, in exchange for closing the old-style institutions as donors insisted, central government, which engineered the overall CW reorganization, has been careful not to disturb sector employees. Many of the former state institution staff became service providers of another sort—in the day care centers or shelters) (Coman, 2005; Correll, 2005), and some became maternal assistants under the foster care program captured statistically in Table 3. Note in Table 4 how institutional staff shrinks as foster care and community-based employment increases.

Table 3
Child Welfare Outcomes, Per Child Placement, 1997-2004



Source: National Authority for Child Protection and Adoption

Table 4
Employment in Romanian Child Welfare System, 2000-2004

Child Welfare Employment Category	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**
Local staff: Division for Child Protection (DPC)	No Data	3,398 (11%)	3,372 (10%)	3,801 (11%)	3,801 (11%)	4,926 (12%)
Institutional Staff	No Data	24,241 (76%)	22,954 (65%)	19,498 (54%)	19,497 (54%)	12,979 (31%)
Foster care/ professional caregivers	No Data	3,494 (11%)	7,436 (21%)	9,536 (26%)	9,536 (26%)	15,828 (38%)
Non-institutional community-based services	No Data	852 (3%)	1,378 (4%)	3,377 (9%)	3,376 (9%)	8,012 (19%)
TOTAL	**20,598**	**21,984**	**35,138**	**36,211**	**36,211**	**41,745**

Source: National Authority for the Protection of Children's Rights

So, although the sector employment mix changed drastically in a short amount of time—with 76% of CW personnel working in institutions in 2000 but only 31% still there four years later—no one lost their jobs, since overall employment increased! By all accounts, in the context of uncertainty and poverty that characterized post-communist Romania, job security was a major concern; the socialist governments were particularly sensitive to the implications of lay-offs and job loss. The central government was willing to cooperate with international donors after 2000 not only because donors strong-armed change with threats that Romania would be excluded from Western alliances, but also because local constituencies, tied through employment to the CW network, could stay employed *as a function of* the type of reform being promoted—namely, *more* diversified services.

Highly Complicated Financing

Reform is also hard to disagree with when you're getting so much to do it. The Romanian government only began to compile donor contributions in 2000 at the insistence of donors. Since 2000, data maintained by the Romanian government reflects approximately $70 million USD and 85 million Euro. Foreign aid is fungible, or interchangeable, meaning that the recipient government can spend its own-source dollars in other areas as a result of receiving assistance. It is a long standing critique of foreign aid that it actually causes governments to weaken their commitment to certain activities—public health, for example—by taking over the responsibility. Donors have become savvy to this problem and typically sign memos of understanding or make aid conditional on cooperative programming (Collier, 2002;

Gwin and Nelson, 1997; Nelson and Eglinton, 1993; Packenham, 1973). The central government demonstrates its commitment to CW reform through so-called Programs of National Interest (PIN) funded by the state budget. They supported goals upheld by the EU and Unites States: closing institutions, creating new services, and campaigning to prevent child abandonment.

But could Romania, on its own, support the comprehensive range of community-based options being developed by donors? Is this system of child protection sustainable in a post-donor world? It's basically impossible to say, especially because sector financing is complex, with numerous income streams supporting CW: extra-budgetary funding from the state budget, funding from county budgets, funding from local budgets, and funding from international donors. Neither local nor county government could maintain these services on their own (Ghise, 2003; Funar, 2002), despite the fact that the reform law is premised on decentralization. Romanian reform in CW appears dangerously donor dependent, unless the reform effort not only focuses on reorienting the system away from state-run institutions, but also addresses the informal norms that rationalize abandoning children in the first place, and improves financial procedures in a way that allows county and local government to be able to prioritize services, and assume the burden of a manageable mix.

Implications of Narrative and Data Analysis

The political context is an institutional context. Foreign donors were intent on strongly influencing—in fact, transforming—the CW regime in Romania. But until

1997, when they became more deeply engaged in reforming the rules governing CW, donors had no impact on the performance of the sector despite a massive infusion of cash, goods and services, and technical assistance. Even after donors became savvy to the significance of the institutional configuration, they could not prevent the internal dynamic between central and local level actors from producing, in succession, a disastrous financial crisis in 1999, then a brilliant, but ethically dubious, financial boom between 1999 and 2001. Because of the necessary, two-level process by which externally recommended reform initiatives in social welfare are communicated and implemented, there is hardly any way for donors to determine the outcome at the second-level bargaining table, short of strong-arm techniques (i.e., credible threats tied to promises of long-term gain if conditionality is satisfied).

Between 2001 and 2004, donors were able to effectively influence the outcome of the domestic reform game in Romania for five significant reasons: 1) Major donors had credible leverage over the central government as a function of the link created between CW and larger geo-political goals, namely North Atlantic Treaty Oganisation membership and EU accession. 2) Despite decentralizing reforms in 1997, the institutional configuration of CW was still dominated by a powerful center, maintaining control over money (directly contributing over 40% of the CW budget and indirectly controlling donor contributions totaling 21%) and employment much as it had under state socialism. 3) There were few organized domestic interests with access to CW decision making to capture assets or subvert change. 4) The nature of the reform reorganized the CW regime in a way that expanded it, thereby protecting employment and allowing the central government to satisfy its main constituency in

the sector. 5) Donors put their money where their mouths were, investing heavily in the changes they required.

Ironically, although most donors point to the success of CW reform as being a function of its change to a paradigm oriented toward local service provision and the unique needs of each child, reform was only possible because the Romanian central government continues to be the strongest interest in the constellation of domestic actors.

A strong central government is the institutional "default" in post-communist Romania with regard to governance and finance. Political and budgetary procedures gave no veto power—and little voice—to sub-national interests, despite their purported stake as being central to reform objectives. This reality has been ignored by foreign donors who aggressively promote teleological reform plans dependent on existing Western norms and institutional relationships, especially decentralization and local public accountability.

Chapter Five
Interests and Institutions in Healthcare Reform

Associations of professionals—in the health sector, doctors are the example *par excellence*—are important stakeholders with powerful *potential* to influence political outcomes. The extent to which interests *do* influence outcomes depends on institutional procedures that determine who gives input to decision making, whether veto points exist (and who gets to use them), and whether the central government implements deep institutional reform to match and secure sweeping legislative change.

As we saw in the child welfare case, after 2001, foreign donors were able to compel structural reform—and trump domestic stakeholders who were benefiting from partial reform—as a result of credible threats related to membership in the European Union (EU). Was there any compelling political interest, external or internal, able to enforce discipline on the health system reform program? The short answer is no. Were there domestic stakeholders, with access to the decision making process and/or veto points, who benefited from partial reform and were able to capture resources in a way that subverted the common good (i.e., subverted long-term healthcare reform goals that aimed at improving population health outcomes and efficiency of the system) in ways that were perfectly rational from the perspective of their interests, both organizational and financial? The short answer is yes.

This chapter elaborates on these short answers in order to describe the rational failure of healthcare reform in Romania. What we will see is this: Within the political framework, heavily controlled by the institutions of executive authority, the healthcare budget-making and allocation decision points allowed little access to

organized interests besides elite doctors associated with the hospital sector—who were often simultaneously political decision makers. The hospital-based constituency made strategic choices *within the political economy of healthcare* in the first years of reform implementation that maximized the freedom of doctors (to treat, to prescribe, to spend), then used the national budgetary system to confirm the legitimacy of hospital profligacy, a rational set of behaviors that directly contradicted the original goals of health reform. Once sanctified, the cycle of hospital overspending and pharmaceutical inflation was virtually impossible to break. Donor programs first emphasized humanitarian aid, which was seized by recipients but had negligible impact on the institutions governing healthcare, then offered well-considered, but highly technical, policy recommendations that tended to be out of sync with the politics of reform.

Baseline – Misery

In one of the earliest assessments of the post-communist Romanian healthcare system, on assignment from the World Health Organization to the Ministry of Health (MOH), Julia Plotnick described the "catastrophic state of the health sector" (1991) in terms of the health of the population—highlighting the fact that Romania had the highest maternal mortality rate in Europe, the highest mortality rate in Europe for children in the 1- to 4-year-old age group, one of the highest infant mortality rates, and one of the lowest average lifespans in Europe, 69.56 years—as well as the general inadequate condition of health facilities, equipment, and stocks of medicine.

Plotnick (1991) described a highly centralized system, coordinated by the MOH and reaching deep into the countryside through a well-defined vertical structure organized to provide everyone free medical care—in theory. The network of health units had three levels: general practice through dispensaries at the primary level, hospitals and policlinics at the regional level, and specialized medical institutions on top. At the local level, four types of medical dispensaries (urban, enterprise, school, and rural) were on the frontline of care provision, manned by approximately 20,000 of over 41,500 practicing doctors. They were supervised by a county-level department representing the MOH. In total,[50] this far-flung health network represented over 9,290 health units, of which the most numerous were the most starved for resources: medical dispensaries (5,500), pharmacies (1,925), and orphanages/homes for abandoned infants (912).

Plotnick (1991) found "essentially no equipment in the dispensary." Typically, dispensaries had a scale, an examining table, a metal tongue depressor, some old-fashioned syringes, and a small amount of emergency medicine. With no otoscopes to perform ear exams for children, speculums to perform vaginal exams, or slides or microscopes to do simple lab tests, the dispensaries could serve few functions. Patients were supposed to see doctors in the dispensaries where they would receive referrals to hospitals if necessary. But in reality, patients bypassed dispensaries (Plotnick, 1991; World Bank, 1992). Care in the policlinics was not always better. In 1980, specialized training for doctors was discontinued, which had a terrible impact on medical training and knowledge. Some specialties were declared

[50] Julia Plotnick has the most comprehensive breakdown, but her numbers are confirmed by other reports.

unnecessary, such as social work, occupational health, and physiotherapy. Formal education for nursing was terminated in 1978, although there were special nursing high schools.

Money, supplies, pharmaceuticals, and staff assignments were tightly controlled by the MOH at the center of the centralized system. Yet there was weak central enforcement of medical protocols, care norms, or professional standards. Instead, medical accountability to patients was almost nonexistent, and subjective decision making was common. For example, disabled infants and toddlers aged 0-3 years were automatically placed in special institutions managed by the MOH. At age 3, the children were tested to determine whether they should be transferred to institutions managed by the Ministry of Education or to so-called homes for the "irrecoverables" managed by the Ministry of Labor. There was no standard test used to make this life-changing determination. And there was no uniform age when children were retested. At any time, children could be transferred from one institution to another based on beds or staff whims. This often made it impossible for families to maintain ties with children, although the system was supposed to encourage ongoing familial relationships (Stephenson et al., 1997; MOH, 1991).

Besides the 41,500 doctors, there were many others employed by the health sector including medium-trained personnel (135,200), especially in hospitals; so-called auxiliary personnel (61,100) covering abandoned children and the mentally and physically disabled; dentists (7,200); and pharmacists (6,500)—for a total of some

251,600 people tied to this impoverished sector.[51] Between 1980 and 1988, in the MOF's list of health expenditures by category, the only line item that increased was "Salaries" and "Salary Tax and Contributions" under Personnel. Salaries increased from 44.2% of total health sector expenditures in 1980 to 52.5% in 1990. Related expenditures for personnel "Tax and Contributions" increased from 13.6% to 16.9%. Thus, in 1990, almost 70% of healthcare expenditures went to salary-related expenses. During the same period, funding for "Drugs and Service Supply" plummeted from 18.1% of total expenditures in 1980 to 5.7% in 1990! "Other Expenditures" (where capital investments including technology were counted) fell from 4.6% to 0.6% in 1990. Finally, expenditures for all the normal supplies used by medical facilities, from tape and gauze to ammonia and oxygen, were held constant at a paltry 3.0% in 1980 and 3.4% in 1990 (Ministry of Finance [MOF], 1991). This detail provides a context for greater understanding of healthcare reform's baseline in 1990: resource poor but employment rich.

Compared to regional neighbors, Romania spent less on health. In 1989, Romanian health expenditures constituted 4.2% of total government expenditure and 2.4% of Gross Domestic Product (GDP)—keeping in mind that Romania had one of the lowest GDPs in the region. Poland, in comparison, spent 11% of total government expenditures and 3.7% of GDP in 1988 (World Bank, 1992). Between 1980 and 1988, Romania was one of the few countries in the region *not* to increase spending on healthcare. In comparison, healthcare expenditures as a percentage of GNP increased by 40% in Hungary during the same period. As reflected in the MOF data, the

[51] Semashko healthcare systems generally have more doctors, more medical staff, and more beds than Western health systems in order to compensate for the shortage of supplies and low quality of the facilities themselves (Marrée and Groenewegen, 1997).

Romanian central government controlled costs in three brute ways: not supplying drugs to the network of dispensaries, forgoing staff training, and not investing in new technology (World Bank, 1992). These policies bred massive dissatisfaction among doctors, medical staff, and the population.

Although Romania had thousands of medical dispensaries and doctors, the majority of health funding went to policlinics and hospitals. Of all funding spent on case-related healthcare in 1989, 64% went to policlinics and hospitals. And although 45% of the population lived in rural areas of the country, where theoretically there was decent dispensary coverage, MOH finance data indicate that only 13% of healthcare expenditures was expended by rural healthcare units (World Bank, 1992). This service mix is worth highlighting because fourteen years later, hospitals continued to receive approximately the same percentage of health-sector funding. In terms of general practitioners (GPs) and primary care, this frontline of preventative care was so neglected and underfinanced that most primary care was provided by medical specialists in the policlinics or rural health centers. There were not many practicing GPs. In fact, patients under communism relied on ambulance service to provide primary care after normal business hours; over 90% of ambulance usage was for primary care (World Bank, 2002c).

Another aspect of the communist healthcare system that constituted a fundamental baseline weakness was the method of distributing medicines and supplies. The MOH managed the procurement and distribution of drugs nationwide. Under communism, a special trading company served as a procurement agent, obtaining drugs that the MOH ordered based on the amount of foreign exchange

made available by the MOF. Imported drugs were kept in a central warehouse in Bucharest. From Bucharest, they were sent monthly to seventeen regional distributors for further division between 450 hospital pharmacies and some 1,500 retail pharmacies owned by the MOH. Domestic drugs were brought to Bucharest or distributed directly to the pharmaceutical network. Hospital pharmacies generally got first dibs on medical supplies, further undermining the value of dispensaries, since often nothing was left after the hospital pharmacy network took its supplies. The practice of providing medications free of charge in hospitals, which encouraged overuse of hospitals, also meant that the hospitals represented a big demand for pharmaceuticals when they were distributed by the central warehouse. Because the overall amount allocated for pharmaceuticals by the central government was so low, and because medicines were ostensibly free to patients in hospitals, the hospitals tended to run through pharmaceutical supplies quickly, well before the end of the month, so shortage characterized the pharmaceutical distribution network at every level.

1990-1997: Overcoming the Status Quo

The politics of healthcare reform involved, from the start, two major interests: the central government power structure dominated by the MOF and MOH[52] and, on the other side, doctors. This is a classic tension: For over 150 years, redefining national

[52] Although the MOF and MOH were occasionally, even publicly, at odds with regard to annual budgets for health, with the MOH consistently petitioning for more central resources and higher allocations in certain functional budget categories (e.g., for capital equipment), the two institutions consistently sided with each other in matters of health system governance, financial norms, and, eventually, a shared distrust of decentralization. Therefore, while there was episodic conflict between the ministries, their interests were typically in sync, which represents a shared central government perspective—generally adverse to significant or deep institutional reform.

healthcare programs pits the state (concerned to regulate providers) against doctors (concerned to protect professional autonomy) (Marreé and Groenewegen, 1997; Immergut, 1992). There was virtually no pressure from the public for significant health reform (Enachescu, 1998).

Doctors

From the first days of post-communist Romania, doctors pressured the Romanian government for changes that would increase their independence, reassert their professional autonomy, and allow them to make more money. In Chapter Three, I discussed the legalization of abortion in response to medical and, possibly, public pressure. This liberalization generated immediate income and new clients for doctors practicing in hospitals and those who had been performing illegal abortions at home for years. Another concession made by central authorities was awarding greater self-determination to new doctors: Before the revolution, doctors and other healthcare personnel were assigned places to work by the MOH. For the first three years after medical school, doctors were required to practice in rural areas. These compulsory assignments were dropped at the behest of doctors beginning in 1990. The change amounted to granting more professional freedom to doctors, but it increased the disparity in medical care between urban and rural areas. To encourage rural doctors to stay put, the MOH declared that they no longer had to work weekends, a rule that placed pressure on hospital emergency facilities.[53] Liberal leasing arrangements to allow doctors to take possession of their offices was another government response to

[53] It should be noted that this was part of an initiative taken by the Romanian government that benefited all public servants who had worked six-day weeks under communism.

GPs' demands for more autonomy. But since doctors still did not own their offices, there was no incentive to invest in facilities or make extensive improvements (Bara, van den Heuvel, and Maarse, 2002).

Besides these "one-shot" reforms, medical personnel were eager to endorse more comprehensive reform. As the country's first Minister of Health, Dan Enachescu, writes:

> The first reaction generated by the violent political change of December 1989 was to reject the structures of a totalitarian state and, with respect to the health system, the principals and organization of a socialist, Semashko-type health system. Doctors were the strongest pressure force, fighting for the adoption of a Bismarck-type model and the development of private practice or private practice within public services. (1998, p. 69; confirmed by Bara, van den Heuvel, and Maarse, 2002)

Enachescu describes "near total consensus" regarding the need to radically change the healthcare system. Most doctors favored transition to a Bismarck-type model because they considered it to offer a combination of freedom and financial reward.[54] He summarizes, simply, "The system of health insurance was seen as bringing wealth" (Enachescu, 1998, p. 67). This was the model being adopted across the region including in the Czech Republic, Estonia, Hungary, Slovak Republic, Poland, and Bulgaria.

In the 1970s through late 1980s, the trend in Europe was to adopt the so-called "Beveridge" system, or National Health Service system, based on the British model, as did Italy, Portugal, Greece, and Spain. The social-insurance health system—the "Bismarck" system used in Germany, France, Austria, Switzerland, the Netherlands, and Belgium—was not making new converts. But aversion to state-centralized

[54] However, Enachescu himself favored a national health service funded from general taxes, as in the British healthcare model (2002).

systems encouraged post-communist Central and Eastern European countries to adopt the Bismarck system, although they generally combined it with a new emphasis on the GP as the "gatekeeper" for care, which is central to the Beveridge model (Marrée and Groenewegen, 1997).

In 1994, a doctor (playing many roles) led passage by the Romanian Senate of a mandatory health insurance law. Dr. Iulian Mincu, a high-profile medical specialist in nutrition who had served as Nicolae Ceausescu's personal physician, was Minister of Health. He was also a Romanian Party of Social Democracy (PDSR) member of the Senate and Chair of the Senate's Committee on Health. Mincu was convinced that the Bismarck system of healthcare financing held the key to increasing resources available to the health system. He worked with the German medical team and his own staff (Erhan, 2003) to develop a draft law to implement national health insurance. But Mincu claimed that the effort pitted him against his political party's leadership, which cautioned a go-slow approach to health reform. He was not able to convince the Parliament's lower chamber, the House of Deputies, to follow his lead and buck the Cabinet. As a result, health reform died in Parliament during the 1992-1996 session; when the PDSR put together its parliamentary lists for the 1996 elections, Mincu was dropped.

So, despite enthusiasm for the Bismarck social health insurance by virtually all doctors—from rural generalists to surgeons in the elite teaching hospitals, represented by the College of Physicians (COP)—it wasn't adopted as law until 1997. Why? There is one major explanation: Political decision making was dominated by the central government, which didn't yield on health reform until 1997.

The medical profession did achieve official professional recognition and a governing role in 1995 with parliamentary approval in July of a law creating the COP.[55] The law empowered the COP to draw up rules for accrediting medical schools and licensing doctors together with the MOH, as well as the authority to define and enforce rules for medical ethics. Arguments between existing medical associations and the new COP prevented the organization from becoming viable for several years.

Central Government

Transforming social welfare systems—including health, pensions, and unemployment policy—is a complicated set of reforms involving complex administrative changes, politically charged questions of resource distribution, and a high degree of inter-agency coordination. It takes time to design and implement these reform programs. In the transition literature, this is sometimes termed "second generation reform" (Kornai, Haggard, and Kaufman, 2001; Nelson, 2001; Elster, Offe, and Preuss, 1998; Diamond and Plattner, 1995). The Romanian government was more preoccupied with "first generation" macro-economic stabilization goals—including opening the economy to the world, liberalizing prices, and, hesitantly, privatization—and consolidating authority than anything politically or administratively demanding. As discussed in Chapter Three, central government managed to placate most doctors by allowing donor programs a wide berth, which offered medical personnel the kinds of access they so strongly desired.

The Romanian government was a particularly strong executive system between 1990 and 1996. Although there was some churning at the level of the Prime

[55] Law 74/1995.

Minister, with three men serving this capacity during the period,[56] President Ion Iliescu was an assertive character who dominated the political landscape. Parliament was not disposed to serve as a counterweight to executive power. Decision making flowed through the Cabinet with the vast majority of new laws starting as drafts emanating from the Cabinet, sent to Parliament for approval, or after being issued as Emergency Ordinances (EOs). The Cabinet's style of adjudicating policy options was chaotic, with few policy choices presented as a function of cost/benefit or efficiency gains, and the status quo typically persevered since there was little consultation with stakeholders and few opportunities for public input (Ionita, 2004, 2003b). As Romanian analyst Sorin Ionita explains in *Governing By Default: Failures of Policy Process in Romania* (2004), Romania maintained a large number of Cabinet-level portfolios (twenty-four to twenty-five between 1990 and 2003 as opposed to seventeen at most for all other EU members or candidate countries), which functions to inhibit change. Ionita writes:

> Romania continued with an expanded Soviet-style arrangement [in terms of central government structure] that tends to preserve the status quo, where narrow issues are assigned to a series of central agencies expected to execute diligently pre-defined budgetary items, while effectiveness is measured in terms of inputs. Reallocations are difficult to operate, both because of the opposition of administrative staff and the lack of information about actual performance, while the policy agenda is strongly influenced by the pressures to continue existing programs. (Ionita, 2004, p. 7)

This is an apt description of the state of central government decision making through 1997—and beyond.

Coordinating closely with the International Monetary Fund (IMF), the MOF was considered the most powerful ministry and, thus, the most powerful Cabinet-

[56] Petre Roman (1990); Teodor Stolojan (1991-1992); Nicolae Vacaroiu, (1992-1996).

level player in the central government. The MOF was unconvinced that Romania was ready for mandatory health insurance until 1997 (Gherghina, 2005). The MOH and MOF were often at odds, with the MOH assuming that its major problems stemmed from lack of funding (World Bank, 1993), but in the course of healthcare reform, the MOH and MOF eventually became allies—against change.

Romania's strong executive model of decision making did not facilitate access to decision making for doctors or other stakeholders. Although a reading of the 1991 constitution suggests that Parliament should have had a more active role to play, it was dominated by the PDSR, the governing political party; party discipline was strong enough that Parliament was extremely deferential to party leaders, especially President Iliescu. However, Minister Mincu's incomplete victory in the Senate foreshadows the future role that Parliament's health committees would play in 1997 and after, acting as a kind of veto point for legislation and budgets that might have inhibited the autonomy of Romania's powerful hospitals.

Donors

Foreign donors were a weaker factor in health reform in the first post-communist years than in child welfare reform.[57] There were numerous donors (including United Nations Children's Fund, bilateral development organizations, and private groups) contributing equipment, supplies, and medicines as an emergency response to the health aspect of the child welfare crisis. To address the weak *system* of maternal, prenatal, and infant care, donor interventions (including programs implemented by

[57] In child welfare, donors count as a disorganized but vocal interest from 1990 on, even though I argue that they did not gain a strong voice until after 1997.

the World Bank, French, Dutch, Canadians, and Americans) addressed reproductive health issues including the provision of contraceptives, which had been illegal under Ceausescu. The Swiss government took on the problem of emergency medical response as a special concern and provided equipment, training, and technical assistance to emergency personnel. But the major player in terms of critiquing the overall healthcare scheme—including organization and service delivery, finance, human resources, technology, and accountability—was the World Bank.

In 1991, the World Bank and the Romanian government signed an ambitious "mega-project": the Health Services Rehabilitation Project worth $150 million. In terms of size and complexity, it was one of the Bank's first such loans—and one of its last.[58] The objectives were numerous and diffuse: developing an overarching health reform strategy ($2.8 million) including a health management information system ($2.8 million); upgrading dispensaries in rural areas to improve provision of general practice medicine ($16.7 million); improving reproductive health services ($32.1 million); improving the emergency medical system ($3.6 million); providing training programs to doctor and nurses ($0.9 million); developing a health services management institute ($2.9 million); buying consumables, drugs, blood, and vaccines, as well as preparing a restructuring plan for the pharmaceutical industry ($83.2 million); and promoting public health through preventative medicine ($4.5 million). Although the program was supposed to be completed in four years, by mid-1994, the

[58] The Bank's first health loans in Eastern Europe went to Poland ($130 million) and Romania ($150 million) in 1991. There was another mega loan, in 1993, to Hungary for $91 million. After that, between 1994 and 2004, most health sector loans were much smaller, $10-60 million, except one mega-loan for $270 million for medical equipment to Russia in 1996. The need to have more focused objectives in healthcare was the stated reason.

Bank had only dispersed $34 million, mostly to import drugs and buy contraceptives (World Bank, 2002a).

In a mid-term review in January 1994, the project was rated as "unsatisfactory." In 1997, the World Bank came close to canceling two major procurement packages, for ambulances and the management information system, based on evidence that the Romanian MOH had not followed Bank procurement rules (World Bank, 2000). By its own admission, the Bank had trouble achieving its objectives between 1990 and 1997. Although most country-specific assessments of the World Bank project do not single out an entity or institution to blame for the disappointing results during this period, a regional assessment completed in 2002 is more candid: Analyst Timothy Johnston from the Bank's Operations Evaluation Department writes:

> Until the change of government in 1996, the [Romanian] Ministry of Health demonstrated either indifference or resistance to reform activities, but persistent pressure from the Bank, together with support from stakeholders outside the MOH, permitted some progress in reform components including a 1993 sector study, district decentralization pilots, and the successful establishment of a health management institute. (World Bank, 2002c, p. 7)

Deconstructing One Donor Document as a Trope for Others

In fact, based on my research, only the county-level pilot project strongly influenced the course of reform between 1990 and 1997. The 400+ page study (World Bank/Government of Romania, 1993) hardly represents "progress" in reform components since the government never responded to the study; furthermore, most health sector participants claim that the extensive research that went into it, carried out with little Romanian participation, wasn't used by stakeholders. The massive set

of studies makes at least three core recommendations that were eventually incorporated into the Romanian reform plan: It calls for a national health insurance fund, a stronger system of GPs, and greater hospital autonomy. But the fact that these three core suggestions were eventually adopted in the 1997 law just demonstrates that the value of these ideas was apparent in 1993, not that this report in particular was instrumental in shaping reform. The health management institute that the World Bank helped support has been influential because it has trained some of the best health policy analysts in the country. But its impact is indirect and long-term. The county pilot project, however, was indeed a major contribution to reform, as discussed in Chapter Three and confirmed through participant interviews (Burduja, 2005; Vladescu, 2002; Enachescu, 2002; Mincu, 2003; Erhan, 2003).

One of the overall conclusions of the World Bank's 2002 regional health sector assessment is a refrain often heard in development assessments: Local politics is blamed for the mixed results in achieving program objectives. Johnston writes, "Experience in Estonia, Hungary, and Romania also shows… [the] Bank's ability to influence the development of national health insurance has been limited, largely because the decision to implement social insurance has usually been driven by domestic political considerations."[59] A related cautionary reminder is that "The Bank has only a peripheral role in domestic political bargaining and coalition building around health reforms."[60] What is somewhat humorous about these caveats is that they are typically a function of retrospective accounts of assistance efforts. When it comes to planning ahead, evaluation documents often assume an expansive, virtually

[59] Ibid., p. vi.
[60] Ibid., p. v.

omnipotent, political role for the donor. Johnston's assessment is no different from so many others. Having modestly circumscribed the World Bank's empirical role in health reform to "catalyzing wider reforms"[61] in the future-oriented chapter on "Determinants of Successful Support for Reform," the author wishes for a more schematic approach in technical assistance. He observes:

> The Hungary and Romania projects were both complex but lacked coherence, and taxed the implementation and coordination capacity of the borrower. The projects therefore often seemed to be a series of disparate, uncoordinated activities, and proved difficult to supervise and implement. Similarly, some structural reforms—such as establishing national health insurance—place significant demands on government implementation and regulatory capacity. **The design and sequencing of reforms should be adapted to the institutional context, together with sustained efforts to build capacity.**[62]

The problem is, it is simply never possible to "design and sequence" reform in a meta-historical way—not because politics is inaccessible but because politics is lived, institutions function in real places, nothing ever stands still, and people and institutions with stakes in reform programs will rationally maximize their utility in ways that typically disturb pre-planned, optimal "sequencing."

Without burdening this single short document with too much analysis, in reviewing the specific aspects of the World Bank's $150 million Romania program as the assessment does, it is ironic to see how thoroughly involved the Bank was in *enabling* the MOH to *avoid* exactly the kind of reform decisions that the Bank ostensibly wanted the central government to make, especially regarding mandatory health insurance in order to increase resources available to the health system and to improve system performance and efficiency. Johnston's assessment explicitly reveals

[61] Ibid.
[62] Ibid., p. 21, emphasis added.

what is also suggested in other World Bank reports—namely, that most of the money expended between 1990 and 1997 was wasted (in terms of achieving macro-system reform goals) because the MOH, ambivalent about transforming the system itself, drove decision making on the Bank loan and steered expenditures to facility improvements, commodity purchases, and high-tech capital investments. These loan expenditures amounted to over $80 million, or over half of the loan. For example, over $60 million was expended on pharmaceutical purchases, but there was no progress at all in adopting a cost-efficient pharmaceutical procurement or distribution plan. Almost $17 million was spent on upgrading rural facilities, yet much of the investment was underutilized because of the weak incentives for GPs to practice in rural areas. Furthermore, there was extensive confusion regarding the ownership of these upgraded facilities, and GPs were unwilling to spend money maintaining the new equipment while the MOH insisted that it remained the owner/manager of all health facilities. One final example of a loan expenditure that did not advance reform: In light of the extensive needs in the health sector, was it really necessary to equip an in-vitro fertilization laboratory in Romania at the Giulesti Maternity Hospital? The MOH wanted it, elite doctors, including a former PDSR Minister of Health Bogdan Marinescu, wanted it (who practices at Giulesti), and the World Bank went along with it; one could argue that this was irresponsible, as it neither advanced health outcomes for the population nor improved the efficiency of the Romanian healthcare system overall.

These World Bank–approved loan expenditures allowed the central government to appease local stakeholders including doctors. And they allowed the

MOH to act as a free rider at a time when own-source revenue was unsatisfactory. Yet these line items did not *touch* the need for institutional reform, let alone improve health financing, hospital efficiency, public participation, professional standards, or performance accountability. Not only that, but by the World Bank's own admission, several of these big-ticket expenditures were boondoggles. Although almost $36 million was spent to establish 230 family planning local centers, provide equipment, and supplies including a "wide range of contraceptive supplies in sufficient quantities and at affordable prices" (World Bank, 2000), many of these family planning centers shut down in 1999 and 2000 because, under contracting rules developed by the COP and the National Health Insurance House (NHIH), GPs could not be reimbursed for contraception services. Worse, one of the original loan components was for $3.1 million to design, implement, and procure a health information system. Although the line item ballooned to nearly $20 million, it was never fully implemented because, according to Johnston, the software and systems selected were inappropriate for Romanian health units, consultants rushed the project component with little input from end-users, and, ultimately, the system didn't work. One factor that is extremely valuable in any reform effort (more specifically, any effort to improve system performance) is improved information. The opportunity to introduce a healthcare information system was, simply, squandered. The MOH was not keen to improve sector transparency through greater information tracking, and the World Bank pushed through the capital acquisitions and software development phases with little attention to the implementation stage, particularly with regard to changes in corporate culture required for any computer-based tool to succeed. The absence of improved

information capability made it harder to track the impact of healthcare legislative changes after 1997 (Burduja, 2005).

These small reform tragedies underscore that, considering how discrete project components can go badly awry, it is foolish to imagine that improved "sequencing" is the holy grail of reform implementation. These examples demonstrate that all donor projects—the good, the bad, and the ugly—interact with the domestic politics of reform and are eventually irrelevant (1993 study), beneficial (eight-county pilot), or destructive (health information system), which is largely dependent on how well they coincide with and advance the dispositions of local stakeholders and whether they manage to be relevant to living political decision making processes.

The Budget Process and Resource Allocation

In the section above on the central government, we reviewed how the central government, acting through a Cabinet strongly influenced by presidential preferences and the MOF, drove political and policy decision making. In Chapter Three, we discussed how Romanian institutional players and medical personnel were motivated in large part by concerns with scarce resources. In assessing options regarding when and how to cooperate with foreign donors, the central government rationally allowed donors to contribute to the healthcare system but hesitated from initiating changes that would significantly upend the status quo. Doctors and medical staff, eager for access to training, equipment, and more autonomy, were generally willing to participate in donor-funded activities. What about the financing of healthcare during

the period under consideration? What do the budgeting process and methods of allocating resources tell us about the relative power of various stakeholders? Which stakeholders, if any, had particular access to financial decision making for the healthcare system? This examination will help, looking back, to determine what did and did not change after the major institutional reform of 1997 and beyond.

Funding for healthcare between 1990 and 1997 was drawn from general taxes, specifically, taxes on profits, turnover (i.e., sales), and a payroll tax. Over 70% of health expenditures came from these taxes in 1991 (World Bank/Government of Romania, 1993). That year, to supplement these funding sources, a special fund was created for health, drawn from wages and transferred from the Ministry of Labor directly to the MOH. It was approved by the government especially to cope with inflation in the price of drugs. In the first year alone, this special fund contributed almost 10% to the overall financing of the health system. So the major source of post-communist health finance was a combination of profit and wage taxes. Some user fees were charged especially at the policlinics. In addition, under-the-table payments made by health consumers directly to doctors and medical personnel were ubiquitous throughout the system (Lewis, 2000). Public expenditure on health increased from 1989 to 1990 by approximately 20%, even before the special fund was added in. With the special fund and accounting for inflation, the 1991 increase was approximately 15% over the previous year. As a proportion of GDP, healthcare spending also rose significantly between 1989 and 1991: from 4.2% to 11% (World Bank/Government of Romania, 1993). These increases help explain the lack of strong dissatisfaction

regarding the health system, especially among doctors and medical personnel, in the first post-communist years.

The *method* of budgeting for healthcare expenses between 1991 and 1997, although premised on a new law governing public finance,[63] included important aspects of budgeting inherited from the communist period. Health units assembled annual budgets into three functional classifications: personnel, materials, and capital. Materials included food and utilities as well as medical supplies, while capital included both equipment and buildings. The unit budgets were submitted to the MOH's county-level divisions and forwarded to the MOH. These budget requests were based on historical inputs: prior-year expenditures on staff, average number of patients, and, for hospitals, the number of beds. The MOH assembled district-level budgets plus funding for national institutes and its own expenses, submitting the package to the MOF. The MOF assigned funding to the MOH via a consolidated state budget that was sent to the Cabinet for approval, than submitted to Parliament by the end of each year. Parliament, as was typical, rubber-stamped the state budget. The MOF assigned funding to the three input categories, and funding was distributed to the ministries every quarter. Ministries were allowed to shift money between counties and between health units, but by the end of each year funding totals had to conform to the amounts assigned to each functional category. Neither county offices of the ministry nor health units were allowed to shift funding between these categories

[63] Law 10/1991.

without permission from the ministry.[64] In fact, ministry approval was required even to replace a low-level member of a medical staff.

Therefore, since health budgets were built on the basis of existing conditions, and since health funding in the late communist period largely went to personnel, this budget mix was quickly locked in for the post-communist period as a function of unchanged budgeting norms. Indeed, in 1991, 64% of funding went to personnel, much as the majority of communist-era healthcare financing was absorbed by personnel expenses. However, the functional spending categories were so broad that there was little transparency in the allocation of resources and little opportunity to improve performance from one year to another (World Bank, 1992).

The annual budget assigned by the MOF to the MOH was not adjusted in 1990 or 1991, much as annual budgets were technically set just once a year during the communist period. Following passage of a new finance law of 1991, the budget process allowed a second annual opportunity to examine the budget: Mid-summer budget "rectification" introduced a new opportunity to revisit healthcare funding and became a veto point exploited in the late 1990s and early 2000s as a way to cover chronic hospital debt.

With regard to the way resources were allocated, hospitals were particularly well positioned. Funding for health was distributed from the MOF through the MOH to the county divisions and on to the hospitals. Then each *hospital* was allowed to decide what resources would be passed on to the policlinics and dispensaries, including control over the assignment of resources for capital expenditures! It is no

[64] Monthly reporting to a county finance ministry division was required in order to enforce this regulation.

wonder that a disproportionate share of resources was designated for inpatient care in hospitals as opposed to primary care in dispensaries or ambulatory care in policlinics—58% of the MOH's 1991 funding went to hospitals as opposed to 23% for dispensaries and policlinics.[65] This mix was largely maintained five years later: In 1996, dispensaries (i.e., primary care) received 17.9% of recurrent healthcare spending, while policlinics received 4.2% of spending for a total of 22.1% for first-line healthcare (Australian Health Insurance Commission, 1998). The methodology for distributing healthcare dollars was largely the way funding was distributed in the communist period—leaving the dispensaries at the end of the line with few resources, and leaving much funding discretion to county representatives of the ministry and to hospitals. Since healthcare financing was driven by historic norms and current capacity, there was little incentive to adjust treatment protocols so that healthcare was delivered more efficiently or in a cost-effective way; there was also no incentive to shift the healthcare service delivery away from hospitals to primary care. To reform the communist healthcare system, which overemphasized inpatient care, it would be essential to reduce the average patient length of stay (LOS) and, therefore, the number of beds. But with funding tied to number of staff, patients, and beds (LOS), there was no incentive to reduce beds, as that would mean a reduction in overall resources. Input budgeting enabled ongoing incentives to defend the status quo in terms of the overall service mix, locus of care, and (high) personnel expenditures. Therefore, the institutional reality of healthcare budgeting, combined with low overall

[65] Health data for the early 1990s didn't break out funding for dispensaries versus policlinics, so it is not possible to distinguish.

spending in this sector, has strong explanatory power regarding the difficulty of overcoming the status quo in healthcare reform in 1990-1997.

An essential, separate topic under the heading of resource allocation is pharmaceuticals. Resources for pharmaceuticals were counted under "materials," a particularly pinched category. In 1991, 25% of drug products were imported. Under communism, the procurement of all drugs was made by an autonomous state agency called UNIFARM, but in 1990, medical units were allowed to purchase from private importers or directly from foreign suppliers in addition to state-owned entities. This new freedom, in the name of competition, introduced both confusion and inflation into the drug picture early on in the post-communist period (World Bank/Government of Romania, 1993). International drug companies were excellent marketers and appealed to doctors on many levels, including offering all-expense-paid trips for conferences in exchange for promotion of their products. Considering the wide discretion doctors had to prescribe whatever drug they wanted, international drug marketing paid off—for the doctors and the importers!

The cost of drugs provided to patients in hospitals was 100% compensated by the MOH. This was an important incentive for patients to bypass lower levels of care and seek hospital admission straight away. The lack of equipment or supplies at the dispensary level—a situation the hospitals themselves were able to maintain—further undermined the attractiveness of primary care in the eyes of patients.

Overall, the medical profession did not have particular influence over the healthcare budget process *per se*, except insofar as hospitals, dominated by medical doctors *cum* decision makers, had significant authority in the distribution of resources

at the local level. One institution where one might expect doctors to have influence was the MOH. Indeed, medical doctors occupied senior decision-making positions in the MOH, but they were a small minority next to MOH bureaucrats who had occupied positions virtually for life. In the budget office, for example, there were no medical doctors involved in the compilation or processing of budget documents between 1990 and 1997 (Erhan, 2003).

Passage of the Social Health Insurance Law of 1997

We saw in Chapter Three how central government acquiescence (specifically, the acquiescence of the Ministry of Labor and MOF) was essential to secure approval of the Social Health Insurance Law of 1997 (145/1997) and how a notable drop in national resources available for the health system was a further impetus for the central government to finally agree to a reform long championed by most in the medical field. Although there were other alternatives available for funding healthcare besides social insurance, especially the option of funding health out of general taxes—a method that has the advantage of being relatively inexpensive to administer—Romanian decision makers spent little time considering this possibility.

In the analysis of the rational motivations of political actors, I did not discuss what the 1997 reform entailed. The Law on Social Health Insurance represented a huge undertaking, a radical redirection. The law adopted by the Romanian Parliament was consistent with major elements in health sector reform schemes adopted in neighboring countries, including Hungary, Poland, Slovakia, Estonia, the Czech Republic, and Bulgaria, often with help from the World Bank (International Labour

Organization, 2002). The new scheme initiated change in the financing, organization, and delivery of heath care. Financing would largely shift from the state to NHIH and district-level entities, the district health insurance houses (HIHs) being fed by mandatory contributions from employees and their employers (5% payroll tax from each in 1998, raised to 7% from each in 1999); general practitioners and primary care medicine would assume a more pivotal role; and hospitals, resource-sucking monoliths that they were, were supposed to shrink as a result of care shifting to the primary care level.

Most important, the state's role was supposed to transform from being both the payer and provider of healthcare services to being the policy-setter, regulator, and guardian of public health. The payer role would be assumed by an entirely new actor: the NHIH and district HIHs. The providers would be doctors and hospitals, negotiating with the HIHs based on a government-approved framework contract worked out by the NHIH, the COP, and the MOH at the beginning of each year—until 2004 when the COP was demoted to a consultative role, contrary to Law 145.

Law 145 describes a generous system. Under Chapter III, "The Health Insurance Holders' Rights," Article 12, participants are assured that coverage includes medical services, "from the first day of sickness or the date of accident, until they are fully recovered" including:

a) preventive health care services, early diagnosis included
b) ambulatory health care services
c) hospital health care services
d) dentistry services
e) medical emergency services
f) complimentary medical rehabilitation services
g) pre-, intra-, and post-birth medical assistance

h) home-care nursing
i) medicine, health care materials, prosthesis and orthesis

Exactly what package of services within these broad parameters would be included, the terms for healthcare services, payment criteria and procedures, as well as allowable costs and justification and length of hospital stay—these were all put off on the annual framework contract described in Article 11. While the status of primary care doctors is described in some detail—the insured are entitled to chose their family doctor, can switch after three months, and GPs are paid on the basis of a combination of tariff per insured person (capitation) and fee-for-service—the payment method for hospitals is more vague: Hospital service providers are paid on the basis of the annual framework contract and "by tariff per hospitalized person, by tariff per hospitalization day, tariff per medical service, and negotiated tariffs for certain services" (Article 45, para. b). This is quite wide open and supposedly regulated in more detail every year in the Application Norms issued by MOH and NHIH together.

The law describes non-contributors eligible for insurance including the unemployed, the imprisoned, children and youth under age 26 if they attend school, the handicapped, those persecuted for political reasons under the communists, those wounded during the events of 1989, and family members of the insured. According to participants who were at the MOH and World Bank at the time of the bill's passage (Vladescu, 2003; Radulescu, 2002; Erhan, 2003), there was no strong sense of how much income would be raised by the new system, nor was there a good accounting of what carrying the non-insured would cost the state. The World Bank had helped arrange a financial assessment of the law's impact by a group of Australian consultants, intended to be completed before the law was considered in order to

inform its final form, but Law 145/1997 was approved before the assessment was completed.[66]

Other aspects of note in Law 145 are its infrequent references to a private sector in health, its designation of a special role for the COP, and an acknowledgment that drug cost control would have to be part of the reform program. In 1997, only dentistry and pharmacies could be described as including an active private sector. Besides a handful of small private clinics in major cities, there was no active private sector in the provision of medical services. In 1999, there were only three hospitals in the country with private majority ownership (Bara, van den Heuvel, and Maarse, 2002). The role described for the COP pertains to negotiating the annual framework contract with the MOH, monitoring emergency medical services, and establishing special commissions endorsed by the MOH to monitor service quality, including one designated to oversee "fertility rehabilitation in couples" (Article 32). Regarding pharmaceuticals, Law 145 refers to a drug list of compensated pharmaceuticals to be included in a Drug Catalogue to be drawn up by the MOH and NHIH as a function of the framework contract also published yearly as Application Norms, MOH and NHIH Common Order.

One thing is clear from contemporary accounts of debate around the law and a reading of the law itself: Far more attention was paid to creating new institutions for managing funds and describing services to be provided than to the (more contentious) question of defining and allocating resources. The hard decisions were largely

[66] The Australian Health Insurance Commission's 1998 report on the *Romania Health Financing Project* did provide a positive contribution that wound up being approved as an amendment to Law 145: The report concluded that due to inequities in country-level wealth, the NHIH would need to redistribute up to 25% of national health contributions. The original law set the percentage allowed for redistribution at 7%. This percentage was increased to 25% following the Australian recommendation.

postponed. One of Law 145's eight chapters is devoted to a detailed description of HIH organization, including extensive autonomy for the district houses governed by managerial boards of elected members. These boards were never created; before the law was even implemented, it was concluded that the elections would be too expensive, and the district houses should be less autonomous than originally envisioned (Burduja, 2005; Gherghina, 2005).[67] It is worth remembering that, as the product of politics, institutions can also bring about confusion and upend the public good (Soltan, 1998). But even subversive outcomes are shaped by intentional actors. However, during this period, the major hope for the new insurance scheme—that it would raise new and more revenue for health—proved to be a legitimate expectation. And this was the aspect of the law that all stakeholders were most keenly anticipating.

1998-2002: Recentralization

In choosing to look at this period, the aim is to examine the implications of the healthcare reform of 1997,[68] especially to note if change unfolded according to plan—or if, instead, I can detect (to use Joel Hellman's terminology) short-term winners who achieve benefits from partial reform and are thus positioned to work against full implementation of the law as it was supposed to evolve. In the five years following passage of Law 145, most of the reform elements that decentralized

[67] The health sector was the only area of social services in which local government had *less* responsibility upon adoption of the major reform initiative: With establishment of the new health insurance funds, local political entities were left managing healthcare units owned by local councils, as well as funding health services through crèches for abandoned infants, but were no longer obligated to contribute much money.

[68] In the health sector, the health insurance law was the foundation for all other change, but other important legislation was passed after 1997; such as a new law on Public Health (Law 100/1998); an Emergency Ordinance on pharmaceutical products used by humans (EO 152/1999); and a law clarifying the status and financing of hospitals (Law 146/1999).

decision making away from central government and envisioned autonomy for the HIHs were undone. Why? Two major goals for reform were: 1) increasing overall net sources available to healthcare, and 2) shifting medical care away from expensive, inpatient care toward preventative care at the primary level. Both of these goals aimed to achieve the overarching reform objective: improving the health status of the population. To judge the success of the 1997 healthcare reform legislation, one must consider outcomes in terms of increased financial resources, the relative strengthening of primary care as opposed to hospital care, and improved health status.

Based on Law 145, starting in 1998, revenue for public health finance came from two main sources: mandatory contributions to the new health insurance funds (approximately 70% of financing) and the state budget. State budget funds covered investments for healthcare facilities; spending on high-tech medical equipment; and costs associated with national programs of disease prevention, public health, and "curative and rehabilitation activities of national importance" (Article 57, para. C). The MOH was charged with managing public health and programs of national importance, but the clear intention of Law 145 was to vest the HIHs with the task of collecting funds, managing money destined for healthcare expenditures, and carrying over surplus funds from year to year. This is such an important point that it is worth quoting a few articles from the legislation itself:

> Article 43 – The health insurance houses and medical service providers conclude annual contracts for medical services and their payment, in order that financial balance is reached.
>
> Article 51 – NHIH funds, county and Bucharest health insurance house funds are built up by: a) equal shares of the natural persons' and legal entities contributions; b) state and local budget subsidies; c) other income sources.

Article 60 – The health insurance funds are used:

a) To pay for granted medicine and medical services
b) For HIHs (national and locals) administrative and operations/capital expenses up to a maximum of 5%
c) For redistribution – 7%[69]
d) For the reserve fund – 5%

Article 61 – The sums that were not spent at the end of the year are carried forward to the following year, with the destination stipulated in art. 60.

Article 62 – Health insurance houses are public, ***autonomous***,[70] non-lucrative entities occupied with health care activities

Article 82 – The financial oversight of NHIH and county health insurance houses shall be conducted by the Romanian National Audit Office on an annual basis.

The scheme envisions an autonomous HIH system that is: 1) raising and managing healthcare funds; 2) paying out healthcare providers as a function of a framework contract elaborated through negotiation with the COP; and 3) accountable to the National Audit Office. No ongoing role was ascribed to the MOF, although during the transition year of 1998, the MOH and MOF performed revenue collection functions that would eventually be assumed by the NHIH and district HIHs.

Increased Revenue

The new health insurance law went into full effect on April 1, 1999, but contributions from employers and employees were collected during the transition year of 1998 by the MOH and MOF. Table 5 compares resources and the resource mix between 1996

[69] The percentage of funds set aside for redistribution among districts was amended to 25% by Emergency Ordinance 125/1998 as a result of the recommendation from the Australian Health Insurance Commission in a study funded by the World Bank.
[70] Emphasis added.

and 1999[71] demonstrating that health funding had dropped in 1997, one of the motives for passing the Social Health Insurance Law, and that it increased immediately in 1998 as a function of the new financing scheme.[72] Keep in mind that between 1993 and 1997, local government was responsible for funding utilities, maintenance, and some non-drug medical supplies for dispensaries from local budgets. Service providers were especially dissatisfied with contributions from local government, which were considered to be inadequate and haphazard World Bank, 2001a.

As Table 5 demonstrates, by 1999, national spending on healthcare had increased 29.6% over 1997. Healthcare expenditures in 1999 (1.309 billion lei) were higher than in any year since the fall of communism, suggesting that doctors, especially, had been right on the money in championing the health insurance law. As well, healthcare expenditures in 1999 amounted to 3.9% of GDP, the equivalent of $60 USD per person—still lower than neighboring countries but at least trending upward, especially considering that GDP had *decreased* during this period.

Table 5
Health Spending Summary Data, 1996-1999

Health Spending in Real Terms	1996	1997	1998	1999
Total Health Spending (1996=100%)	100	87.5	100.6	113.4
Local Govt Health Spending (1996=100%)	100	86.1	3.1	3.0
Health Spending as %				
Total Health Spending as % GDP	3.0	2.8	3.2	3.9

[71] Adapted from a chart in World Bank, 2001a, p. 68.
[72] As part of the phase in plan, in 1998, 5% of wages was collected from employers and employees, a percentage that increased to 7% in 1999.

Total Health Spending as a % of Govt Spending	8.8	8.2	8.8	10.5
Local Govt Spending on Healthcare as a % of Total Health Spending	19.1	18.8	0.6	0.5

Source: Adapted from World Bank, 2001a

Calculated in terms of USD, despite overall weak economic indicators on every dimension between 1995 and 2000, the budget assigned to healthcare increased from $985 million in 1997 to $1.34 billion in 2000 (Bara, van den Heuvel, and Maarse, 2002). The budget increased by 36% in just four years. Thus, in terms of finance, more was available, as hoped. This was the rational objective of doctors, medical personnel at lower levels of the healthcare system, and healthcare decision makers in public institutions. However, as we shall see, although Law 145 represented a significant paradigm shift in theory, describing a new financing mechanism and a new set of institutions charged with managing the relationship between payers and healthcare providers, in practice, established institutional norms in the management of money undermined this new system. Despite increased revenue, resource allocation did not become more efficient, primary healthcare did not become the locus of most treatment, population health outcomes did not improve, and public disgust with Romania's healthcare system only increased.

Service Mix and the New Political Division of Doctor: General Practitioners versus Hospital Staff

With implementation of Law 145, doctors were suddenly divided into two groups with interests at some variance: GPs providing primary care around the country

versus doctors based in hospitals—traditionally the doctors with more status. Before 1997, hospitals administered and funded primary care facilities. This important element of control was removed under Law 145, which assigned responsibility for overseeing primary healthcare to the District Public Health Directorates and gave GPs autonomy to manage their own practices. GPs were no longer considered civil servants but independent practitioners, or "budget holders," who contracted with district HIHs but operated offices privately. GP salaries were determined mainly on the number of clients they signed up to their lists (weighted capitation, about 70% of total reimbursement) and fee-for-service payments. GPs now had to compete for the allegiance of patients who, under the law, were awarded free choice in the selection of family doctors. Hospital-based doctors, on the other hand, were salaried civil servants still, with few incentives to increase productivity since they weren't compensated as a function of any new type of competition, nor were there any new incentives for increased productivity, especially in 1998 and 1999. Although GPs were supposed to serve as "gatekeepers," granting referrals for specialized services at higher levels, these referrals were rarely enforced, as hospitals routinely allowed patients to bypass GPs.

The power of hospitals—dominated by the country's most elite doctors, including surgeons and other specialists—is apparent in Law 145/1997 in that the legislation is quite vague on the basis for reimbursement:

> Article 45 – (1) Medical service providers shall be paid by health insurance houses in terms of the framework insurance contract, which can be:…
>
> b) In hospitals and other inpatient medical units – by tariff per hospitalized person, by tariff per hospitalization day, tariff per medical service, and negotiated tariffs for certain services.

According to staff active at the MOH in 1997 (Vladescu, 2002; Erhan, 2003), the World Bank (Radulescu, 2002), and an early leader of the NHIH (Bubenek, 2005), hospital financing was intentionally vague in order to maintain commitment from influential doctors associated with hospitals, including most of the members of Parliament active on the health committees in the Senate and Chamber of Deputies. Although there was agreement in principle that the role of primary GPs should increase in order to improve preventative healthcare strategies and to decrease the flow of patients into hospitals, Law 145 does not specifically indicate any new limits on hospital practice. These decisions were postponed. As already discussed, doctors are normally keen to protect their autonomy in decision making; to maintain their support for the reform legislation, the MOH minimized any language that could be interpreted as reining in the doctors—although the explicit strategy for gaining efficiency was to squeeze hospital expenditures down from 50% to about 35% of total funding while increasing primary healthcare from approximately 20% of resources to 35%. The remaining 30% was to be secured for secondary, ambulatory care (Chiritoiu, 2003; World Health Organization, 2000; World Bank, 1999).

A law specifically devoted to hospitals did not bring much more clarity to the issue of hospital financing in 1999.[73] Law 146/1999, *Law on Hospital Organization, Functioning, and Financing*, reasserts that both public and private hospital financing is based on contracts concluded with district HIHs and that contract terms for services and tariffs are given in the framework contract negotiated between the NHIH and the

[73] Almost half of the language of the law pertains to organization of hospital staff for emergency services, demonstrating that the central government still considered it to be a government prerogative to get deeply involved in the details of service provision, despite the vague treatment of hospital management and financing issues.

COP. The law explains that the system of salary payment for public hospital staff is set by government ordinance. In fact, Law 146 reasserts the vague treatment of hospitals that began in Law 145. There are no incentives in the law that would inspire hospital management to improve performance in service delivery or to take responsibility for cost savings. Not only are hospital salaries fixed, but hiring and firing of medical staff is subject to MOH approval, as is the ratio between number of staff and the number of beds—a situation that was still true in late 2004.

Hospitals and district HIHs negotiated hospital budgets for the first time in 1999. Between 1999 and 2003, hospitals were allowed to continue receiving input-oriented budgets—first, a tariff for each hospitalization day by type of hospitals (1999-2000), then by type of department (2001), then by type of department capped with a maximum LOS by specialty (2002-2003)—but all of these tariffs were calculated based on previous-year spending, so the methodology locked in prior-year "bads." Patient admission was the main indicator for service contracts, although by 2000, per diem tariffs were increasingly differentiated by department and type of hospital,[74] with a cut-off in per diem tariffs (i.e., reimbursable days) beyond the average LOS for the most common medical treatments. However, the cap on LOS simply reinforced the strong incentive for hospitals to freely admit new patients—an old habit that secured income for hospitals but also served to lock in the service mix that prioritized expensive inpatient care over primary care. A review of the income and expenses of the NHIH between 1999 and 2002 clearly underscores that although

[74] Romanian hospitals are categorized into four types: rural hospitals with at least 120 beds; town and municipal hospitals (250 and 400 beds, respectively) providing surgery, OB-GYN services, and pediatrics; district hospitals in cities with a range of specialties from intensive care to orthopedics; and specialized units such as the Institute of Oncology and the Neuro-surgery Hospital.

new revenue came into the healthcare system as a result of financing reform, and despite new institutions to collect and disburse healthcare funding, overall resource allocation was unaffected by reform. Not only did hospitals continue to absorb most revenue, but they also increased their take over pre-reform years!

With the first negotiated budgets, hospitals seized the day and captured the vast majority of available healthcare dollars. At first glance, it appears that hospitals gained a very significant share in 1999 (63.9%), which was somewhat restrained in 2000 and 2001 when its portion of total funding fell to 57.1%, subsequently inching up in 2002 to 58.5%. In fact, by doing a more comprehensive analysis of inpatient dollars, as seen in Table 6, it is evident that hospitals captured almost two-thirds of all healthcare dollars in 1999, then maintained and even increased this exorbitant level between 2000 and 2002:

Table 6
Percentage of Health Spending: Hospital-Based, In-Patient Care

Inpatient Dollars	1999	2000	2001	2002
Hospital healthcare services	63.9%	57.1%	57.1%	58.5%
Drugs and medical supplies (nat'l programs)	5.2%	8.4%	9.2%	9.4%
Free of charge and compensated drugs in ambulatory care	8.1% x 50% **4.1%**	13.0% x 50% **6.5%**	14.4% x 50% **7.2%**	14.1% x 50% **7.1%**
Medical devises	0.3%	0.3%	0.5%	0.5%
TOTAL:	**73.5%**	**74.3%**	**74.0%**	**75.5%**

Source: Personal calculation based on National Health Insurance House data tables.

In considering how much money flowed to inpatient care, besides the obvious

category "hospital healthcare services," over 90% of the money described as "drugs and medical supplies (National Programs)" went to hospitals (Burduja, 2005), as did funding for "medical devices." Moreover, the "free-of-charge" drugs part of the category "Free of charge and compensated drugs in ambulatory care" and much of the "ambulatory care" portion were distributed at hospitals. Therefore, the percentage of national healthcare funding supporting inpatient care is more accurately described as absorbing approximately three-fourths of healthcare funding—an overwhelming amount of national health dollars, as summarized in Table 6.

During this same four-year period, funding *decreased* in every category of healthcare spending outside of hospitals, from primary care and dental care to pre-hospital emergency treatment and rehabilitation services.[75] Hospitals secured an exceptional level of funding upon the introduction of the health insurance scheme; this prevented the anticipated shift, let alone increase, in resources to primary healthcare or to other non-hospital, ambulatory service providers. This result is especially astonishing considering the pre-reform strategy summarized in Table 7.

Table 7
1997 Reform Objectives in Reallocating Healthcare Services

Type of medical assistance	**1997 Allocation of funds**	**Estimated allocation of resources**
Hospital	50%	35%
Secondary (outpatient) medical assistance	30%	30%
Primary medical assistance	20%	35%

Source: European Union, 2002

[75] Para-clinical specialties are a difficult category to classify because there were no constant year-to-year criteria for what specialists were funded—some based in hospitals, some in institutes—but the category is too inconsistently defined to be assigned as hospital- or non-hospital–related funding.

The resource allocation tables do not explain the politics of the hospital sector's success. What combination of stakeholder rational interest and political procedures allowed this outcome? In terms of stakeholders, the most important development that emerged with the implementation of Law 145 was the political division of physicians between doctors associated with hospitals and family doctors, or GPs, now functioning as independent agents. Although they lobbied together for adoption of the social insurance system, this alliance fractured after 1997. At every level of political decision making regarding healthcare—from the governing boards of the COP and NHIH to the Prime Minister's advisors and the Members of Parliament sitting on the health committees (see Table 8) in the respective chambers—senior hospital doctors dominated the process (Burduja, 2005; Rebeleanu, 2004; EU and OECD, 2002).

Table 8
Medical Doctors who were Members of Key Parliamentary Committees

Senate	**Chamber of Deputies**
1996-2000	
1. Avram Gheorghe 2. Ion Circiumaru 3. Ioan Cretu 4. Iosif Stefan Dragulescu 5. Bogdan Marinescu 6. Alexandru Ioan Mortun 7. Nicolai Marin 8. Alexandru Pop Stelian 9. Elena Preda [Out of 13]	1. Ion Berciu 2. Daniela Bartos 3. Liviu Iuliu Dragos 4. Barany Francisc 5. Vasile Cindea (from 9//97) 6. Florian Udrea (through 9/ 1/97) 7. Bazil Dumitrean 8. Nicu Ionita 9. Constantin Remus Opris 10. Cristian Radulescu [Out of 25]
2000-2004	
1 Serban Alexandru Bradisteanu 2. Ion Circiumaru 3. Ion Iliescu	1. Mircea Ifrim 2. Daniela Bartos 3. Liviu Iuliu Dragos

4. Constantin Gaucan 5. Sorin Mircea Oprescu 6. Ioan Pop de Popa 7. Mircea Laurentiu Popescu 8. Corin Penciuc [Out of 13]	4. Ion Burnei 5. Ana Florea 6. Ludovic Abitei 7. Ovidiu Branzan 8. Ion Luchian 9. Constantin Florentin Moraru 10. Ioan Mihai Nastase [Out of 25]

Without a framework for the development of a private sector in healthcare, all of the elite medical specialties—from cardiology and neurology to plastic surgery and orthopedics—were still hospital based. These doctors used their positions of influence to assure maximum resources for hospitals and to protect maximum autonomy for hospitals. Since the vast majority of medical staff was associated with hospitals, this group was an indomitable force.

One might imagine that the most powerful, authoritative organization of doctors, the COP, would be neutral regarding preferences of hospital doctors versus GPs. By law, through 2003, the COP strongly influenced: what is included in the healthcare benefits package, what drugs are compensated, the kind of reimbursement mechanisms to be utilized, what training is required for medical staff, which hospitals are accredited, and so on. It is comprised of district-level branches, a domineering Bucharest branch, and a national governing body. All doctors are required to be members, but the COP has been dominated by specialists affiliated with hospitals. Thus, the COP was unwilling to serve as an enforcer of the reform strategy vis-à-vis shifting resources away from inpatient care to more cost-effective preventive care at the primary level when the COP and the NHIH determined the initial framework contracts. Another organization of GPs had to emerge before their interests were

fairly represented in the media or in political settings. The Federative Chamber of Physicians is a sort of trade union that represents GP interests; a GP professional association also exists. Yet by the time these smaller, new groups made themselves known, the hospital sector had already laid claim to the national healthcare budget and worked the political system to its advantage. The next section explores the legal and normative environment that locked primary care out of the budget picture.

Central Government, the Budget Process, and Resource Allocation

Despite the picture painted in Law 145 of an autonomous HIH system, a series of decisions and legislative modifications made between 1998 and 2001 effectively undermined the independence of the health insurance regime. Before the law was even fully in effect, the central government issued EO 125/1998, amending Law 145. Among the articles added to the law, one was designed to clarify the chain of command between the NHIH, district HIHs, and Parliament: "the centralized Health Insurance budget shall be approved by Parliament, following proposition by the NHIH. The county health insurance budgets shall be approved by NHIH." In the original law, there were few suggestions that the health insurance system would be embedded in political institutions. Further limiting the autonomy of district HIHs, in the same amendment the amount of local funding that had to be sent to the national HIH for reallocation was increased from 7% to 25%. As well, governance of the HIHs was assigned to appointed boards of administration rather than to elected

managerial bodies, as described in some detail in Law 145, in order assure local stakeholder participation.[76]

As explained by Gheorghe Gherghina, the most influential MOF policymaker covering health budgeting between 1991 and 2004, Romania intended to transplant the German health insurance, including the principle of autonomy for NHIH and local-level HIHs, but on the verge of implementation, the government saw the need to make two "big changes" that, admittedly, moved the Romanian scheme away from the German model. First, explained Gherghina, "we"[77] realized that the ideal of holding elections for the district HIHs was too expensive, "so we could not do that." This initiative might have been a cost savings, but it also short-circuited the prospect of greater public participation in district HIH accountability.

The second "big change" discussed by Gherghina had even more profound implications for the management—and outcomes—of healthcare reform. According to Gherghina and confirmed by others (Monaghan, 2003; Burduja, 2005), the IMF strongly recommended that the money raised by the HIHs be considered part of the general consolidated budget. The Romanian constitution supports the fact that preparing the consolidated budget is the prerogative of the government, said Gherghina. Therefore, "Since we had to follow the IMF's advice and bring the HIH budget into the consolidated budget, the *de facto* decision was made to give the government responsibility for overseeing the HIH budget implementation despite trying to give larger autonomy to the house" (Gherghina, 2005). Although he seemed almost apologetic about this result, acknowledging that this budgetary arrangement

[76] Codified in Law 145, Chapter VI. Section 2.
[77] Ghergina used the plural pronoun in this interview. I assumed he was speaking for the MOF, but when I reviewed my notes, I realized that his "we" included the Cabinet.

was not the original vision, he also rationalized the inevitability of embracing the healthcare financial system within a larger process of financial control. He said, "We thought it was necessary to fortify the discipline and control of the funds, to manage closely the way they were spent and dispersed" (Gherghina, 2005).

Thus, the MOF quickly asserted control over the financial parameters of healthcare. Rather than being maintained as a separate, autonomous fund with the launch of the new insurance house system in 1999, health revenue was declared a "special fund" annexed to the national consolidated budget. At first, the district HIHs were allowed to collect the money from employers. The NHIH oversaw collection and managed the reallocation of funds. By 2002, the central government used an EO to formalize MOF control over healthcare revenue collection and management, awarding collection responsibility to an agency of the MOF. EO 150/2002 is considered by many doctors and analysts (Fundatia Horia Rusu, 2003) to represent the legislative death of the health insurance reform enshrined in Law 145/1997.

Through the state budget process, the MOF sets limits on how much of the collections can be expended on health. According to the one of the earliest presidents of the NHIH, Serban Bubenek, his team was able to cajole the MOF into approving basically all of the money collected in 1999, besides the required reserve fund, for healthcare expenditures. But it was very clear that the MOF held all the cards in their negotiations, remembers Bubenek (2005). The MOH was enthusiastic about pulling the HIH revenues within the state budget framework for two reasons: 1) Each Ministry has strong influence in elaborating elements of the state budget, and as happened, the MOH was assured a more determinative role in shaping health

allocations if health revenues were managed as a "special fund" ultimately overseen by the MOF. 2) Law 145 attributes to the MOH responsibility for national health programs that are funded in the state budget. Certainly, the MOH had a rational, institutional motive for wanting to see the maximum amount of revenue transmitted to medical service providers—it was the very purpose of adopting the social health insurance system. Yet, from the beginning, the MOH budget office was leery about losing so much financial authority to the NHIH and the district HIHs, so the decision to locate health revenue within the state budget offered an opportunity for the MOH to restore some of the clout it lost in Law 145.

To understand how political actors, or stakeholders, could influence healthcare resource allocation once the decision was made to govern healthcare revenue within the state budget process, it is necessary to review Romania's national budget process, especially the decision points for budget design and execution. The Romanian budget is prepared annually by the MOF. It includes detailed annexes broken down by Ministry as well as numerous off-budget items organized as so-called "special funds" including health insurance. During the period 1998-2002, budget requests were "narrow-based" requests for the coming year with no references to the previous or upcoming year and no reference to programmatic impact. Following the Public Finance Law, the MOF and Prime Minister are supposed to meet in mid-summer to establish expenditure ceilings for the next budget year. By September 25, the Cabinet is supposed to consider the MOF's draft; by October 10, the draft is supposed to move to the Parliament for consideration. In fact, that calendar is rarely met. In 1999, for example, Parliament received the state budget for

consideration on December 31—the earliest in five years.[78] The layers of the Romanian Parliament, consisting of the lower house, the Chamber of Deputies (341 members), and the Senate (143 members), are functionally but not highly differentiated. Both chambers have responsibility for reviewing the budget. The standing committees divide the consolidated budget by subject area and distribute it to the standing committees for review. The budget is ultimately approved in a joint session. The Romanian Parliament has the authority, by law, to increase or decrease the government's proposals and when done; the standing committees tend to influence these decisions.

During this period, the MOF was motivated by the IMF to pursue an austerity program keeping the deficit at or below 2% of GDP in order to qualify for debt financing. (Guess, 1999). So the MOF was more obsessed with maintaining overall expenditure ceilings than in how money was exactly spent within sectors. In the case of healthcare funding, the most important time in the budget process has been July, when the budget is reconciled against actual revenues and expenditures, giving both government and Parliament a second chance to adjust the funding figures. Despite the fact that by that month Parliament would have already approved a framework contract for medical services, including spending targets for every service sector, the July budget rectification process was used as an opportunity to endorse increased funding for hospitals or reimbursed drugs and decreased funding for primary care.

The World Bank staff (2002b) adapted NHIH data to derive Table 9 comparing: 1) framework contract targets, 2) revised budget, and 3) actual

[78] If the budget has not been approved at the start of a fiscal (calendar) year, the law provides that public institutions spend under the previous year's spending limits, or 8% of the last year's expenditure/month.

expenditures between 1998 and 2000. Although these numbers are slightly different than figures I obtained from the NHIH (see Table 7), the data demonstrate that hospital services consistently spent more money than was allocated in the framework contract *and* the revised budget. For example, in 1999, the framework contract assigned 40% of revenue to hospitals, which was revised to 61.2% by the summer budget rectification and wound up as 64.2% of actual 1999 expenditures. In 2000, hospital services absorbed 65.5% of all health insurance fund expenditures.

Table 9
Budget Trends in Healthcare Financing 1998-2000

Type of Service	**1998 Actual %**	**1999 Frmwrk Contract**	**1999 Rectified Budget**	**1999 Actual %**	**2000 Frmwrk Contract**	**2000 Rectified Budget**	**2000 Actual %**	**2001 Frmwk Contract**
Primary care	9.0%	15.5%	9.5%	9.1%	14.5-15.0%	9.8%	9.5%	14.5-15%
Out-patient specialists (ambulatory care)	5.9%	11.8%	6.6%	6.1%	8.8%	7.9%	7.2%	8.5%
Hospitals	67.3%	**40.0%**	61.2%	64.2%	**59-61%**	64.0%	65.5%	**50-53%**
Subsidized drugs	6.8%	20%	9.3%	8.0%	10-11%	12.8%	12.4%	10%

Source: World Bank, 2002b.

1999 was the critical first year of health insurance fund implementation on the basis of a framework contract and through the HIH system. The lessons learned during this year had a strong influence on strategies pursued by relevant institutional actors.[79] Having asserted its intention to manage the process through the consolidated state budget, the MOF changed the rules of the game in an important way: suddenly,

[79] Douglass North terms this phenomenon "path dependence" and contends that it is difficult to change institutions once this state has been achieved.

the framework contract represented, in a sense, policy targets that could be overridden by aggressive spending by the hospital sector. As already discussed, Law 145 allowed hospitals to maintain global budgets that were not transparent; there were few administrative mechanisms—let alone incentives—for hospital directors to maintain strict control on spending.

Although the framework contract was devised by stakeholders largely committed to the strategy of shifting healthcare to the primary care level, especially principals at the NHIH, the central government's preference for financial control, and specifically the mid-year budget rectification opportunity, allowed the budget process to trump the HIH process described in Law 145. It also gave a different group of stakeholders access to decision making about health financing: members of Parliament serving on the health committees, most of whom were medical doctors with positions at the elite hospitals. This parliamentary veto point allowed hospital doctors to reward profligate hospitals, which served to stall the shift in resources from hospitals to primary care; it represents the effective defeat of one of the major reform objectives: reorienting health delivery to GPs. One can read how fast institutional actors learned from the 1999 experience (and how fast the hospital spending strategy became dominant) in the difference between the 1999 and 2000 framework contract targets for hospital spending: The 2000 framework contract target is 20% higher than the year before! By 2000, hospital overspending and drug costs had undercut reform objectives and had become the norm around which politics adjusted.

One might expect the MOF to have tried to prevent hospital spending from skyrocketing, but again, its primary objective was to hold healthcare to expenditure

ceilings, which it did. Budget norms allowed the mid-year adjustments that were beneficial to hospitals, even if what the MOF and Parliament were doing was giving a political "seal of approval" to hospitals that ignored limits set out in a framework contract the hospitals were supposed to respect. As already suggested, elite doctors, thoroughly sympathetic to hospitals and their "desperate need for more funding" (Bubenek, 2005), dominated the policy discussion at every level, tacitly or overtly; in their view, the end (increased revenue for hospitals) justified the means (increasing funding assigned to hospitals through the budget rectification process and, later, by covering hospital arrears). One example of a prototypical doctor at the heart of decision making helps exemplify how advocates for hospitals functioned at every decision point. Senator Sorin Oprescu, a member of Iliescu's PSD sat on the Senate's health committee between 2000 and 2004; he was deputy chair of the committee. His primary cause was maintaining the independence of hospitals, and he had numerous positions through which to work to achieve this goal. He served as President of the Bucharest branch of the COP and as President of one of Bucharest's biggest hospitals, University Hospital. He was appointed general manager of the elite hospital of the Romanian Academy, which had been the hospital of the communist elite, "Elias." He also practiced at another major hospital, Emergency Hospital. Through his various functions, Senator Oprescu was associated with every stage of healthcare decision making: establishing the medical terms of service (COP), approving the framework contract (Senator), providing service (doctor), overseeing service performance (hospital manager), and approving healthcare funding (Senator). While there were few medical doctors as multi-faceted as Senator Oprescu, there were many others

who played several stakeholder roles at once. Ministers of Health, for example, were typically associated with specific hospitals. In the view of the MOF, allowing powerful doctors in Parliament access to health financing decisions was just a trade-off related to the overall gain of being able to manage health funding through the state budget.

The MOF had no incentive to speak out against hospital spending trends because it had no real institutional prerogative to do so. The public institutions immediately overseeing hospital spending were the district HIHs. One might expect the district HIHs, representing the interests of healthcare payers, to exert some expenditure control over local hospitals. But as one of the best analysts of the Romanian hospital sector points out (Chiritoiu, 2002, 2003),[80] the district HIHs function as regional monopolies—no competitions exists as, for example, in Germany where the population can chose from several houses in every region—so in the end, "The lack of competition between health funds… creates an institutional set-up where there is no incentive for the health fund to take on these powerful interest groups [hospital doctors]… The dominant strategy is an alliance of the purchaser and provider to pass the costs to the [state] budget."[81] As well, something Chiritoiu does not flag, managers of district HIHs were also powerful doctors from the county/university hospitals! Their financial and social ties were strongly skewed toward the hospitals.

On the national level, within the expenditures approved by the MOF and Parliament, the NHIH sends "recommended budgets" to district HIH for the units it

[80] Although in these two papers, he mistakenly uncouples escalating hospital costs and drug costs in my view.
[81] Chiritoiu, 2002, p. 5.

pays, including hospitals. In theory, the NHIH could have narrowed the funding "allowed" to hospitals—to the dissatisfaction of healthcare decision makers (Blight, 2003). But the NHIH had little incentive to flaunt the politics of the situation. For one thing, the reform position that the HIH should have been championing (as described in reform documents and even the law)—that of reducing hospital spending and limiting coverage of services and drugs in order to live within budget limits—wasn't popular. Newspapers were quick to report the fact that hospitals were *under-funded*, not that they were sucking up all the cash in the system. Populated by doctors, technocrats, and bureaucrats, it was not possible for the NHIH or district HIHs to become the reform champions at this point.

Did the MOH have a role to play in terms of constraining the hospitals? Not according to Law 145. Contemporary observers agree that the MOH never acculturated itself to the HIH system, and rivalry was apparent between the NHIH and the MOH. Not only did the MOH do little to encourage financial efficiency where it could, but it also allowed the vast majority of its discretionary programs, the so-called National Program, to be used for hospital supplies and medicine, giving slight attention to public health programs, preventative medicine, or social messaging on healthy lifestyles described as essential in several reform planning documents (World Bank/Government of Romania, 1993).

The HIH system proved to be an efficient revenue collector, showing surplus between 1999 and 2002. But in the words of the first NHIH General Director, Iulian Popescu, "The fact that the HIH was successful made it the prey" (2005) of resource-sucking central-level institutions.

Medical Response

In a severely resource-poor environment, it was a rational response for medical doctors based in hospitals to exceed spending limits. It is important to keep in mind the daily, crisis-oriented decision making faced by hospital doctors. Their treatment decisions can be aggregated as trends in service costs, but these decisions are experienced day-to-day as demand from patients for hospital services and the professionally requisite response to patients' needs—not just patients with injuries or illnesses but patients with no place else to go. As one well-known Bucharest medical specialist explained, "If I'm treating an old person, with no money for drugs, with no one to care for him, with no heat or hot water, sure I'll write him up so he can stay in the hospital as long as possible. It's my ethical duty. It's not my fault that there is no other place for social cases, so I'll do what I need to do to help him" (Florescu, 2005). By some estimates, at least 20% of the cases in Romanian hospitals are so-called social cases (the old, the destitute, the depressed). (EU and OECD, 2002).

Increasingly, in talking to doctors throughout this period, it was clear that the medical elite became less, not more, committed to the idea that hospitals needed to live within certain hard-budget limits. Not only was the practice of ignoring spending limits not penalized, it was actually sanctified and enshrined in the annual state budget at the mid-year mark, then in the practice of covering arrears out of the state budget. Further, increasing evidence of the MOF's exploitation of healthcare revenue bred a certain distain for all the rules. The MOF boldly exploited its authority over health finance when, in 2001, it began using surplus revenue from the health fund to

satisfy deficits generated by the under-financed pension fund (Constantinescu, 2003; World Bank, 2002b). This practice was obviously considered expedient by the government at the time, but it is the kind of interference typical of chronically *weak* public administration, paradoxically, and invites actors within public institutions to cannibalize the national budget since restraint has no reward. As Polishchuk (2002) writes in a study of the excessive use of special funds in post-communist Romania, "While special funds were often established in response to the poor state of public finance, they in turn contributed to chronic fiscal crises by eroding overall fiscal management" (Polishchuk, 2002, p. 9). At the time Polishchuk completed his study, Romania had over twenty national special funds.

In interviewing doctors, I am most struck by the fact that they perceive the problem in a very pragmatic way: immense demand for treatment and no protocols for deciding when, and when *not*, to respond. So they generally provide services, leaving it to others to worry about payment. Isn't this an idealistic response? Ironically, even elite doctors involved in conceptualizing reform, including the expanded GP role, did not make the connection between hospital overspending and the inability for reform to succeed in reorienting the service mix. Angry at the MOF's cynical treatment of healthcare surplus, convinced that the sector was under-funded, not penalized for overspending, medical professionals based in hospitals made daily decisions that optimized their professional autonomy but jeopardized the financial stability of the entire national health system.

There are specific factors that contributed to hospital financial overruns: 1) failure to define a limited package of benefits, especially considering limited

available funds per person; 2) failure to control hospital admissions, for example, by insisting on GP references and by ending hospital-based incentives that attract patients, such as providing free medicines in hospitals; and 3) failure to give hospital management significant incentive to cut costs, for example, by allowing them to invest savings in high-tech equipment or to invest in the facilities. All of these factors contribute to the rational behavior of individual doctors who chose to offer treatment, with few controls on their discretionary decision making—thereby driving up spending.

Robbing Peter to Pay Paul and Hospital Arrears

Escalating hospital costs (due to the unlimited benefits package, weak controls on hospital admissions, few incentives for hospital management to control costs, and soaring drug costs) contributed to debts being accumulated at most hospitals in 2002. By the end of 2002, hospitals had racked up debt of approximately 200 million Euros.

Ironically, although the NHIH data table reflects an overall revenue surplus in 2002 of $176 million USD, this is deceptive. In 2001, the MOF had begun using healthcare's so-called surplus funds to cover deficits in other sectors of the state budget, especially the pension fund. This practice made sense from the perspective of the MOF since all funds over which it had control were fungible, and the greatest fiscal urgency was in the pension fund deficit. As well, the IMF allegedly encouraged the MOF to commingle health and pension funds because the IMF was philosophically opposed to extra-budgetary funds such as the health fund (Monaghan, 2003; Radulescu, 2002). However, it was well known in the medical profession—and

deeply resented—that the central government was robbing Peter to pay Paul. Considering the way hospital unit budgets were compiled, there was never strong transparency in the sector. But the problem of weak financial management became ubiquitous as soon as the MOF was allowed to collect health insurance revenue, move money between state accounts, set overall expenditure ceilings for health, and then, as a perverse *mea culpa*, agree to cover hospital deficits from the state budget. We see this massive deficit reflected in the NHIH figures, amounting to some $247,391,000 USD in arrears in 2003. Keep in mind that Romania's per capita allocation to healthcare was, and is, low: In 2004, the country's per capita spending on health services was under $200.

Run-Away Pharmaceutical Spending

Alongside, and related to, the explosion of costs tied to hospitals was a dramatic increase in spending on drugs. It is hard to know exactly how much of overall healthcare funding is spent on drugs each year because pharmaceuticals are counted in several NHIH funding categories. Consider expenditures under the two main funding categories shown in Table 7: Under "Drugs and medical supplies," managed by the MOH, and "Free of charge and compensated drugs in ambulatory care," the majority of which flows through hospital settings, funding increased by 81% and 74%, respectively. The economics of pharmaceuticals is a fairly complex subject, but the politics of pharmaceuticals in Romania between 1998 and 2002 can be summarized with a few key observations: The fact that drugs were provided free-of-charge to hospital patients created a strong incentive for people to seek hospital

admission; with negligible cost-control incentives in hospitals, drug costs were simply allowed to escalate. Although Law 145 called on the MOH and NHIH to draw up a Drug Catalogue of subsidized and free-of-charge drugs in order to guide doctors, the Catalogue was extremely long, with few controls on which drugs were allowed on the list. Further, the mark-up allowed to imported drugs was significant, totaling about 30%, while cheaper, domestic drug production shrank throughout this period. Big international drug companies moved aggressively to place their products, offering doctors incentives to prescribe their (more expensive) products. Since doctors had wide discretion to prescribe medicines, the enticements offered by foreign producers were converted into prescriptions according to observers. According to Petre Panculescu, President of the Romanian Pharmaceuticals Producers Association, "The period 1998-2002 was Heaven for drug importers. There was a long list of foreign drugs on the subsidized list, doctors had discretion to prescribe, and foreign companies were better at marketing than us" (Panculescu, 2005).Thus, there were weak controls on commodities susceptible to excess demand due to subsidization.

Emergency Ordinance 150/2002

The factors driving up medical costs cannot be analyzed apart from the politics of decision making and budgeting for healthcare. The politics and procedures of budgeting drove decision making in a critical way. Because the MOF, with central government support, asserted its right to manage the health insurance revenue as a special fund in the national budget, health monies became interchangeable with money raised from any other source. The NHIH's fiduciary responsibility for

managing health revenue on behalf of health consumers (in constructive tension with the COP, charged with negotiating on behalf of doctors) was entirely undercut. Every institution and individual in the system experienced under-funding so each did what he, she, or it could to maximize resources. This strategy was rational within a paternalistic system in which there was little "local" accountability, or even *information* regarding how much services cost, how much units were spending overall, and how to control costs in order to prioritize services. Hospitals, which had long been privileged, exerted their preferences through a network of well-connected doctors who were simultaneously political decision makers. Although these decision makers opposed the controlling role assumed by the MOF, they found ways to use the budget process to influence spending on behalf of hospitals—at the expense of general practitioners. The politics of healthcare decision making was captured by the state through central institutions: first by the MOF, then through the MOH, which took over the HIH system in 2002, upon approval of Emergency Ordinance 150.

The *coup de grace* against Law 145, EO 150/2002, introduced a fatal confusion regarding the roles and responsibilities of institutional actors in healthcare. It made the president of the NHIH a new state secretary of the MOH, reporting to the Minister. Health insurance collections were to be made by an agency subordinated to the MOF. The NHIH was dependent on the Ministry, yet it still had attributes assigned in Law 145, including negotiating a framework contract with the COP. But while the existence of the framework contract was preserved, it was approved by a government ordinance while the budget for medical services was provided within the national budget—so the framework contract wasn't a contract between independent

parties at all. As one Senator, a National Liberal Party (PNL) member, said at a 2003 PNL-sponsored roundtable discussion (among doctors for the most part) on the health crisis:

> By putting the Houses [HIHs] under the command of the Ministry of Health as was done in Ordinance 150, any element that makes a health insurance house system disappeared. It is a classic budget system through which financial norms are flagrantly violated by government entities, especially the Ministry of Finance which uses its discretion to decide how to use the [health] money. (Fundatia Horia Rusu, 2003, Translated by the author)

Most doctors expressed anger with the central government for undermining the HIHs through EO 150. Dan Peretianu, president of an association associated with GPs said, "We no longer have Law 145, we have Ordinance 150. Who brings this Ordinance? An old idiot and a child as idiotic" (Fundatia Horia Rusu, 2003, Translated by the author). Peretianu was referring to President Ion Iliescu and Prime Minister Adrian Nastase in this insult. The president of the Chamber of Deputies' health committee, Mircea Ifrim, explained, "Ordinance 150 was rejected by the Health Committee and the Labor Committee in the Senate, as an ordinance making the biggest nationalization from June 11, 1948 until today" (Fundatia Horia Rusu, 2003).

EO 150 reduced contributions from employees (from 7% to 6.5%) while stipulating that a wide range of services be available to large categories of people not paying in: veterans, students up to age 26, refugees, political prisoners under the old regime, children, pregnant women, and pensioners. In a move to take pressure off the state budget, pensioners were removed from the list of contributors; the Ministry of Labor and Social Solidarity no longer made contributions to the Health Fund on behalf of pensioners beginning in December 2002 as a result of EO 150. This meant a

loss of approximately 13 billion ROL per year (almost $4 million USD). With the decision to remove pensioners from the list of contributors, there remained only 6.5 million Romanians—in a country of 23 million people—contributing to the mainline Romanian health insurance system (Jitea, 2005). Under Law 145, services for non-contributors went to several important categories such as veterans and students, but the intention was not to provide essentially free service to more than two-thirds of the country. And still there were few protocols or criteria by which doctors could determine which patients to serve or what treatments should be given priority.

Donors

Despite the profound nature of this sector's reform, and despite the extent of learning needed to get the new HIH system up and running, develop contract protocols, and design accountability systems, donors were largely marginalized between 1998 and 2000 in terms of structural reform. Donors were welcome to tinker at the edges—delivering training and technical assistance, spending out loans—around the country. Evidence of the World Bank's frustration with its inability to help steer the major reform initiative can be read in a document published in 1999 *Romania Health Sector Support Strategy.* According to participants (Farcasanu, 2003;Vladescu, 2002; Radulescu, 2002), the purpose of compiling the document was to put on paper the advice Bank advisors had been trying to convey to the government since the push for decentralization in 1997. The report does not mince words. It announces, "Current conditions imply serious risks of failure in several parts of the reform" emphasizing that neither the MOH nor the NHIH was prepared for its new role. In terms of

regulating, monitoring, and evaluating the health system, "The Ministry is not prepared to carry out these functions effectively" and the HIH "is charged with far more organizational and management responsibilities than it can handle in the near term" (World Bank, 2002a, pp. v-xi). But the central government was not eager to hear the technical advice coming from the World Bank between 1998 and 2000 except for the advice on increasing the percentage of funds to be used for redistribution (Burduja, 2005).

By 2001, Romanian decision makers and donors were aware of the toll that run-away hospital spending was taking on the sustainability of reform as well as the solvency of the healthcare system. Despite the fact that plenty of specific factors established or allowed to continue by the central government *and* the HIH network contributed to the hospital spending profile—factors pointed out by donor documents such as the 1999 strategic report quoted above—the decision makers were shopping for a new fix in 2000. With encouragement from the U.S. Agency for International Development (USAID) and support from the World Bank staff, the Ministry of Health began to consider introducing a case-based methodology for hospital payments, termed DRG (Diagnostic Related Groups) in the United States where it is the standard way to assign prices to services delivered in hospitals. As mentioned in Chapter Three, there were influential voices (generally outside the political and medical elite circles) supporting this approach as a way to fulfill the reform promise that more resources would shift to the primary care level. Since the program was begun as a pilot, it was not immediately threatening to hospital discretion. To achieve wide buy-in from hospital directors as well as politicians, USAID sponsored a three-

day summit in the Czech Republic in 2000. The purpose was to get all of the primary decision makers away from their institutions and into a setting where they could focus on their shared need to control spending (Monaghan, 2003). As a result of the summit, all of the principles endorsed the technique, and a team of young Romanian doctors was established to introduce the system. An inspiring but cautionary aspect of the plan to introduce DRGs was the fact that neighboring Hungary had introduced DRGs with World Bank support in the early 1990s and, ten years later, was still struggling to make the system work. In 2002, DRGs were introduced in the first twenty-three Romanian hospitals.

2003-2004: Digging a Deeper Hole

In 2003-2004, the healthcare regime dug itself into a deeper hole, a hole first dug in 1998-1999 when the hospital sector took advantage of loopholes and vagaries in Law 145 to spend, treat, and prescribe with little attention to budget restraints. The MOF's decision to exert budgetary control over the sector in 1999 could be seen as a smart response to the risk of profligate spending by hospitals and in subsidized prescriptions. But this heavy hand, unanticipated by legislatively mandated healthcare reform, helped rationalize a free-for-all in institutional opportunism on the part of the NHIH, district HIHs, MOH, hospital sector, and the panoply of drug companies and medical materials suppliers who used confusion over rules as an excuse to abandon reform objectives.

What is most remarkable about the period 2002-2004 is the inability of the healthcare system to reform itself, which proves the thesis animating Chapters Four

and Five: Short-term winners of partial reform have no incentive to let go of their gains—unless a compelling threat exists, such as the potential loss of EU membership if certain institutionally self-serving behaviors are allowed to persist. In the healthcare sector, there were no such threats to compel movement off the equilibrium of run-away hospital and pharmaceutical spending on one hand, and complicity from the Ministries of Finance and Health.

This wasn't supposed to happen: As Gheorghe Gherghina, former State Secretary of the MOF (2001-2004) and director of the division managing health finance (1991-2001) throughout the adoption of the reform remembers:

> When we conceived this in 1996-7, we thought that the insurance house would succeed in elaborating medical contracts according to the population's needs, and that suppliers of medical services, including doctors, hospitals, and the ancillary service providers, would reorganize and function following the principles of competition. In this way, services would improve, costs would decrease, and health would improve. Unfortunately, this did not happen. (Gherghina, 2005)

The assumptions Gherghina alludes to were especially mistaken because: 1) There were no mechanisms to generate competition in the health insurance scheme described in Law 145, so, not surprisingly, competition did not develop organically.[82] 2) There were few opportunities to register the "population's needs" besides the population's ability to select GPs as family doctors. 3) He ignores the politics of reform that gave greater weight to the voice of elite hospital officials who succeeded in enshrining hospital overspending in budget decisions.

[82] Although national procurement rules governing acquisition of supplies and services in hospitals, as in other public facilities, should have introduced an element of true competition to the system (thereby driving costs down), these came into force in 2002. There were numerous accusations that favoritism tainted hospital procurements between 1998 and 2002. Since these reports were generally newspaper accounts, it is hard to judge their veracity.

Doctors

The frustration of most GPs and hospital-based doctors increased throughout 2003-2004 as they experienced the tension between professional judgment about treatment and the resources available to them. Newspapers were full of accounts of nearly bankrupt hospital facilities with twenty-year bed linen and drug supplies that would last, at best, a few more months. Meanwhile, so many hospitals were behind in payments to medical suppliers that these vendors refused to sell to hospitals without immediate payment. The paradox was confounding: On paper, hospitals were soaking up all the money in the sector, while practically, hospital to hospital, the experience was one of shortage. A 2003 detailed account of a symposium of doctors (Fundatia Horia Rusu, 2003) reveals the general confusion regarding the causes of healthcare's instability—and the conviction shared by most doctors that more money was the solution.

Average salaries did not increase significantly between 1997 and 2004. I talked to nearly fifty doctors at every level of the system: In 1997, they received an average of 150 Euros/month USD, which had increased to 200 Euros by 2004 USD. The average national salary was between 100 and 150 Euros for the same period. To supplement these unimpressive salaries, doctors take under-the-table payments from patients. These side payments can be considered a form of co-payment, although they become particularly steep for surgeries and major injuries and illnesses. A senior surgeon reportedly makes about 1,500 Euros/month USD through under-the-table payments. Most everyone in the Romanian healthcare system, including well-

connected doctors, agrees that one of the most important explanations for resistance to reform, or, put more accurately, a reason to maintain the atmosphere of confusion and fluidity that characterizes the sector, is that this environment allows the continuation of tips and side payments, although, as explored in the next chapter, most Romanians were not deeply disturbed by the practice of tipping doctors for services rendered.

Central Government

Like Nero fiddling while Rome burned, the central government allowed the detrimental pattern to continue—namely, using health fund surplus to cover pension shortfalls, then covering health sector arrears with current-year funding, thereby depleting the money available for health overall. The 2003 NHIH deficit was almost $250 million USD. In 2004 it was officially 175 million Euros.

When criticism became particularly intense regarding the healthcare crisis in spring 2003, the Prime Minister fired the Minister of Health, Daniela Bartos, who was, by most accounts, a dedicated, committed professional. Her successors, Mircea Beuran and Ovidiu Branzan, were criticized as hacks or worse in an accelerating media campaign regarding the state of crisis and confusion in health. By summer 2003, there was some evidence that public dissatisfaction with health might impact the standing of the ruling party (Open Society Foundation, 2003). Any casual observer of the Romanian healthcare system could see that the lack of competition, and the very limited private sector, constrained efficiency. In 2004, the Parliament responded to this much-perceived problem by passing Law 212/2004 allowing private

health insurance. However, one year later, implementation norms were still not promulgated by the MOH, thereby freezing implementation of the law. One reason the MOH was ignoring the law was the perception that they would have to describe, by law, a minimum package of services (MPS) to be provided under the standard Romanian health insurance in order to assign a role for the private insurance market. (Popescu, 2005; Burduja, 2005), Yet it was considered politically risky to demarcate an MPS when, almost any service was free to anyone in the healthcare free-for-all that continued into 2005.

Donors

A variety of health-related donor programs continued in 2003-2004, but the fundamental capture and subversion of reform by the hospital sector skewed the contributions that could be offered by donors. EU programs emphasized public health, and a second World Bank loan of $40 M was approved in 2004 to continue reform objectives. A World Bank–funded hospital rationalization strategy (Blight, 2003) was completed in 2003, but its recommendations—including an elaborate new scheme of regional health networks and a National Hospital Rationalization Council of Cabinet—were basically ignored by the central government and were not incorporated into short- or medium-term agendas by the new government inaugurated in early 2005 (Burduja, 2005).

One of the few quiet successes was the transfer of the USAID DRG effort to the Romanian government, with 185 hospitals financed on the DRG system in 2004 and 276 (all acute care) in 2005. But considering the confusion governing hospital

budgets—namely, the simultaneous application of the framework contract and the national consolidated budget—the overall problems at work in the sector undermined the contributions that technical improvements such as DRGs offered.

A weird conflict arose in June 2004 between the U.S. Ambassador and the MOH, which symbolizes the distrust that had developed between donors and government with regard to healthcare reform. Ambassador Michael Guest offered $400,000 on behalf of the U.S. Government to the MOH—as long as the money went to corruption-related programs. According to the Ambassador (Guest, 2005), despite numerous attempts to contact and discuss grant options with the MOH, no one ever responded to describe how the money would be spent. After giving the MOH an ultimatum, which, in Guest's view MOH officials ignored, the Ambassador let the press know that the funding would be retracted. In his view, this attitude proved that the MOH was clueless regarding the deep problems besetting healthcare. In my view, and in light of the material reviewed since Chapter Two, the MOH was well aware that the U.S. Embassy expected a response, but it was unwilling to accept conditional grants. In a press release issued at the time and in news accounts (Sava, 2004), the MOH explained that it intended to spend the U.S. funding on psychiatric hospitals, which had been severely criticized in spring 2004 by Amnesty International. In the MOH's view, donor funding should be allocated to a sector of indisputable need, not to an impossibly vague target such as corruption. The dispute resulted in real casualties. Iulian Popescu, the first General Director of the NHIH, who was also the first Secretary of State at the MOH when the NHIH was brought under the MOH, was blamed for not responding fast enough to Ambassador Guest's proposal. Popescu

remembers, "I had nothing to do with this project. I was out of the country and got a call that I would have to resign when I got back. After all the congratulations I received from Americans on my work, to be blamed for not responding to Ambassador Guest really hurt. I was just a scapegoat" (Popescu, 2005).

But donors were marginal to the primary, domestic game in healthcare, which centered, as it had for several years, on the tension between central government authority and the inability to enforce fiscal discipline on major healthcare actors. James Q. Wilson, in his masterful classic *Bureaucracy* (1989) makes the point that administrative confusion contributes to increased powers for the State. The example of healthcare reform in Romania reminds us that administrative confusion allows rent seekers to carry on, with little reason to worry that their actions will be reprimanded—in fact, in this example, considering the pose taken by most hospital doctors, they don't seem to realize that individual choices have critically undermined healthcare reform, especially the introduction of a viable primary healthcare sector!

In August 2005, Prime Minister Tariceanu replaced the Minister of Health, Dr. Mircea Cinteza. For the first time since 1990, a non-doctor was appointed: economist and Liberal Party activist Eugen Nicolaescu. His status as coming from outside the health sector was offered as an advantage, but *The Economist's* Intelligence Unit called his assignment a "poisoned chalice," noting "the system is in acute crisis" (Economist Intelligence Unit, EIU Viewswire, August 24, 2005).

Chapter Six
The Legacy of State Socialism and Soft Budget Constraints

The reform programs in child welfare and healthcare unfolded differently after 2001 and had radically different outcomes: A strong executive, together with assertive donor involvement, ultimately facilitated reform in child welfare, while a disinterested executive combined with strong self-interested central government ministries and weak donor input confused and upended reform in healthcare. Nevertheless, there are some notable similarities in the two cases: 1) Despite reforms that envisioned transferring significant authority and financial decision making away from the central government to the local level, there was a centripetal tendency to recentralize power. 2) There was an ongoing problem in maintaining budget agreements or targets—although in child welfare, there was so much money floating around in the sector that the lack of financial discipline did not become evident until the 1999 financial crisis. 3) Numerous reorganizations and a confusing array of policy directives created an ongoing atmosphere of uncertainty that worked against reform goals. Central-level decision making was notably *ad hoc*, with Emergency Ordinances utilized by the Cabinet in order to bypass Parliament, laws promulgated with minimal impact analysis, and changes announced without consultation with important stakeholders.

Is there a satisfying theoretical framework that can help explain these trends? Political economist Janos Kornai, one of the most astute analysts of state socialism,[83]

[83] Kornai uses the term "socialist system" to refer to the political economy of twenty-six countries run by the communist party. As he explains (1992, pp. 9-11), adherents of the communist party never referred to their own system as communist, but as socialist, reserving "communist" for an unattained utopia. Since Kornai's goal is to describe the system from "the inside," he prefers to use the term that the system used for itself. Following Kornai, I refer to state socialism to describe the political economy

provides several valuable keys to help understand the centripetal trend in power relations in post-communist Romania as well as the detrimental habits of ignoring spending limits and constantly revising policy as it is implemented.

Shortage and Soft-Budget Constraints

In his 1980 classic, *Economics of Shortage*, Kornai highlights institutional relationships that explain why the socialist system is characterized by chronic shortage and how this shortage drives so many other behaviors in the socialist system. He elaborates a theory of the shortage phenomenon that can be used to help understand the nature of post-communist power and development.

Kornai describes hospitals, schools, and research institutes as nonprofit institutions much like units of the central government and local administration with a separate budget and financial accounting. In certain important ways, these nonprofits behave much like firms within the socialist system: They function as "claimants" competing to gain investment from the central "allocator." All of these claimants exhibit a permanent "investment hunger"[84] because prestige, power, and loyalty are tied to constantly growing operations. Once gained, investment is automatically justified because budget constraints are soft: The claimants don't experience financial risk, so there is no "internal power of restraint."[85] For nonprofits such as hospitals, decision makers are motivated to attract as many patients as possible, a "quantity

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of communist party-dominated states, but I also find the term "post-communist" useful, as it refers to the period following communist party rule.

[84] Kornai, 1980, p. 191. In fact, all of Chapter 9 is relevant to this summary.

[85] Ibid., p. 210.

drive," as well as to demand financial resources, the "expansion drive."[86] Since services are provided free of charge or at highly subsidized rates, it is not difficult for nonprofits to stimulate the client demand that is transmitted as investment hunger to the central allocator.

To try to adjudicate between simultaneous demands, the central government develops a convenient rule: Each claimant should get the same amount as was received the year before. But this practice helps enshrine the constant demand for investment. Kornai summarizes: "Irresistibility of growth is a permanent feature of the socialist economy but momentum that makes growth unending leads to permanent reproduction of shortage,"[87] a process he also describes as having a "suction effect"[88] on a nation's wealth.

Describing every decision maker in the system as having a pump, Kornai graphically describes why it is insufficient to simply admonish directors to use self-restraint in pumping out resources from the general pool. He draws a scenario in which a "foolish decision maker" reduces the amount of siphoning he engages in with his unit's pump. The foolish director watches as other nonprofits, firms, and government units absorb everything he renounced. There is no reward for his modesty. Next time, he will pump with vengeance on behalf of the unit he controls.[89] The result of all these independent decision makers making similar calculations is general and chronic shortage—general because no sector is free of the tendency; chronic because the system continually reverts to this position. Kornai concludes that

[86] Ibid., p. 550.
[87] Ibid., p. 202.
[88] Ibid., p. 209.
[89] Ibid., p. 552.

chronic shortage can be explained by the institutions of state socialism and the behavior these institutions provoke among lower-level decision makers.[90] He writes:

> The explanation of chronic shortage, of suction, and of the functioning of a resource-constrained system is to be found not in the financial sphere, or in special features of price information, but at a deeper level, in institutional relationships and in behavioral regularities which these institutional regularities foster in decision makers.[91]

Returning in the final chapter to the concept he is arguably best known for, the concept of soft-budget constraints (SBCs), Kornai draws out the link between institutional relations and the presence of chronic shortage. He describes relations between the state and micro-organizations (firms as well as nonprofit organizations) as being marked by degrees of paternalism in both capitalist and socialist states. Where there is a Degree 0 of paternalism, the budget constraint is hard: The state does not intervene if a firm goes bankrupt; it collects taxes and leaves the firm to largely manage its affairs. Degrees 1-3 of paternalism can be found in socialist systems. In Degree 3, for example, central authorities allocate inputs among firms through rationing schemes without much role for money, but bargaining can occur between the central authorities and unit decision makers regarding specific allocations. Kornai posits that excessive paternalism, embedded in relations between the central authority and lower-level subordinates, generates SBCs and thereby engenders the related phenomenon of chronic shortage.[92]

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[90] Ibid., p. 556. More specifically, he gives primacy to the following four institutional relationships: a high degree of centralization, multi-level control by the central allocator, administrative rationing, and the subordinate role of money and prices; for my purposes, I keep the focus on his larger conclusion here.
[91] Ibid., p. 559.
[92] Ibid., pp. 561-569.

Finally, in a section titled, "The possibilities for and limits on conscious action," Kornai explains that since the institutional conditions he describes were not initiated by edict or plan, "no government decision or state plan can eliminate them as long as the conditions exist that maintain these phenomena."[93] Although he puts the accent on paternalism in his final chapter, Kornai is in fact describing the risk of relaxing financial constraints—a risk that has truly plagued the Romanian healthcare system at least since 2001.

We find persistent conditions of paternalism, SBCs, and chronic shortage in both the child welfare and healthcare systems of post-communist Romania. In fact, SBCs and inter-enterprise arrears take numerous forms in Romania. As noted by the International Monetary Fund (IMF) in a report that reviewed policy developments between 1990 and 2000, financial "indiscipline" characterized sectors ranging from agriculture to utilities. Inter-enterprise arrears amounted to a full 42% of Gross Domestic Product by the end of 1999 (IMF, 2001, p. 14). Therefore, soft-credit constraints and SBCs were the norm in public financial relationships more than ten years after the defeat of state socialism, just as they characterized exchange before.

Kornai's more recent insights contribute as well to a deeper understanding of the legacies that constrain social welfare reform in post-communist Romania—despite the naïve faith of Western donors that change can be organized through "decisions of the state."[94] Building on his path-breaking research in 1980, Kornai in 1992 produced an "anatomy" of the socialist system designed to describe characteristics of the system that are system specific and causally related to each

[93] Ibid., p. 569.
[94] Ibid.

other. He said the key to understanding the socialist system is to understand its political structure, especially the fact that the one-party system dominates the state through the mechanism of bureaucratic coordination.

The Institutional Legacy of Socialism

Kornai argues that specific features of the socialist system are intrinsically related to each other such that the undivided power of the party and influence of the communist ideology of control caused, or required, the dominance of central-state institutions, which required the emergence of bureaucratic coordination, which leads to the chronic shortage economy characterized by SBCs, among other adverse economic effects.[95] As Kornai demonstrates in the diagram, entitled the "Main Line of Causality"[96], there is neither opportunity for feedback nor learning in this system. The notion of a coordinating mechanism is important here. To Kornai, a coordinating mechanism not only coordinates people and organizations through both written and unwritten rules, but it also includes the idea of allocation.[97] The essential factors of bureaucratic coordination are: 1) centralization of information and decision making, 2) elimination of competition or autonomous actors, 3) dominance of hierarchical dependence, and 4) vertical power relations over horizontal ones.[98] The elite dominating bureaucratic coordination tend to be suspicious of those below them and

[95] Ibid., p. 361.
[96] Ibid.
[97] Besides the bureaucratic coordinating mechanism, Kornai discusses four others: market, self-governing, ethical, and family CMs. Although there is no room to unfold the argument here, I believe the only effective countervailing CM under communism was the family coordinating mechanism, which proved to be most resistant to ideology and even created zones of liberty during that highly repressive period.
[98] Kornai, 1992, p. 363.

of their peers, so there is a "multiplicity of regulation and control which seems dysfunctional," Kornai explains.[99]

This overregulation is also a function of paternalism. As we reviewed in his earlier work, Kornai sees the concept of SBC as a manifestation of paternalism that is particularly pernicious: "The softness of the budget constraint does not simply arise because the higher organizations of control fail to keep tight financial discipline, or the tax authority, banking sector, or price office are overly tolerant. Its appearance is a strong regularity, deeply rooted in the basic traits of classical socialism."[100] In other words, it would be particularly difficult to prevent SBCs from characterizing relations between post-communist institutions, especially where the bureaucratic coordination mechanism was still in place—for example, in child welfare and healthcare.

Hierarchical relations under state socialism, stretching from the center to the periphery, involved everything from shoe or textbook production to theatres and warehouses for abandoned children. In all these hierarchical relations, there was a terrific problem with regard to information. The central bureaucracy required a lot of it for planning purposes and to monitor sub-units, yet the only power lower-level entities often had was information; so it was manipulated, hoarded, and hidden.[101]

Implications for Romanian Reform in Healthcare and Child Welfare

Kornai's ideas and concepts provide a theoretical framework for the case studies analyzed in this paper: Although political structures and the ideology of state

[99] Ibid., p. 91.
[100] Ibid., p. 144.
[101] The essential problem of information circulation in a planned economy was highlighted early on by Frederich Hayek.

socialism were defeated in Romania in 1989, post-communist reforms left bureaucratic coordination in place,[102] especially with regard to the provision of public services by the state, including healthcare and child welfare services. The bureaucratic method of coordination and other socialist norms, such as relying on the SBCs, ultimately subverted mere attempts to reorganize services, as was tried in both healthcare and child welfare reform between 1990 and 2000. Although the dominant ideology of communism was clearly repudiated in December 1989, the mechanism of bureaucratic coordination was left in place as an enduring legacy of the communist period—a legacy with implications for the traction reform can gain, especially in sectors involving numerous administrative entities.

Much of Kornai's description of political economic relations under state socialism characterize the political and administrative relations in Romania today in ways that function to undo reform programs promoted by donors. Looking at healthcare first, the centripetal tendency that undermined the autonomy of national health insurance, creating a divergence between stated legislative goals of reform and the operational reality of central control, can be explained as a manifestation of the bureaucratic coordination mechanism that was still in place. So too, the thorough elimination of competition from the healthcare scheme is a manifestation of the bureaucratic coordination mechanism. Although a role for competing regional insurance houses was alluded to in Law 145, no implementing norms ever allowed such a development. Similarly, although planning documents mention the importance of allowing a private sector to grow in ambulatory care as well as in hospitals, the

[102] Besides the continuation of the bureaucratic *mechanism*, the *people* managing post-communist ministry finances and budgets were often the same people who had performed these tasks under state socialism.

private sector remained anemic because there were no procedures for establishing such facilities as legal entities that could bargain for contracts.

Between 1998 and 2004, there was a power struggle between the insurance-financing regime envisioned by Law 145 (by which the NHIH and the College of Physicians negotiate a framework contract, which the houses then use to negotiate with health service providers) and the use of the national budget to finance healthcare. Fundamentally, the tension is between a system with strong elements of horizontal bargaining and a hierarchically dependent method of financing services. In light of the insights gained from Kornai, it is not surprising that the vertical approach trumped the method with more horizontal elements. Similarly, the way the Ministries of Finance and Health gradually reasserted themselves over the Health Insurance House (HIH) system represented the assertion of a vertical power relation over horizontal ones: The HIH system is less strictly vertical since the district HIHs establish relations and contracts with service providers in their area, and the National HIH was supposed to have significant autonomy, certainly in power relations with the central government.

A particularly satisfying aspect of applying Kornai's work to the Romanian scene is the power of the shortage economy and SBCs to explain the reoccurring problem of hospital arrears since 2002. Not only was there *no* stigma attached to exceeding budget limits among hospital administrators, but those who respected limits in 2002 soon saw themselves as "foolish decision makers" and began overspending (Burduja, 2005). Individual doctors and management staff make discrete treatment decisions driven by a conviction that other institutions are pumping

more out of hospital funding than they have a right to, so they pump harder. The paternalist central government eventually rewards the unruly children,[103] the naughty hospitals, with debt repayment since the central government appreciates that it has, in fact, been robbing the health fund in order to cover pension shortfalls. In addition, in a system such as healthcare, in which the state's bureaucratic coordination mechanism continues to dominate and order decision making, the state can't escape responsibility when sub-units appeal that they can't function within hard-budget constraints—the central government officials are tolerant because it is a common, accepted practice that has been in place for decades.

In the child welfare sector, decision making was centralized—even after it was ostensibly decentralized. Although we noted that this reality allowed the Romanian government to impose reform at the behest of international donors, it is certainly symptomatic of both paternalism and bureaucratic coordination. The multitude of non-governmental organizations (NGOs) devoted to working in Romania, often supported by donors, made it impossible to eliminate autonomous actors in this sector—which benefited the reform effort. But the structure of power in the sector was emphatically vertical and strictly hierarchical: Between 2001 and 2004, for example, the General Secretary of the Cabinet directed a Cabinet-level authority devoted to child welfare, the National Authority for Child Protection and Adoption (*Autoritatea National pentru Protectia Copilului si Adoptii*), that dictated to county council presidents who controlled the residential facilities and county services. This was a structure of power that allowed little room for local determination of services or service mix. Finally, Kornai's observation that bureaucratic coordination tends to

[103] Kornai himself uses the parental analogy in explaining the psychology of socialist paternalism.

overproduce regulations, often with dysfunctional outcomes, is certainly true in the field of child welfare. Every year produced a flurry of legislative edits, especially Emergency Ordinances, pertaining to child welfare. This created extensive confusion, especially at the local and county levels where real services were struggling to establish themselves (Petre, 2003).

With regard to information in both healthcare and child welfare, donors were consistently puzzled to note that a variety of information tracking systems consistently failed. The World Bank underwrote management information systems in both healthcare and child welfare that either weren't implemented (healthcare) or were implemented partially and differently in different counties (child welfare) (Correll, 2002). From the perspective of Kornai's characterization of the unwillingness of local actors to introduce transparency to information flows between local and county entities and the central government, it becomes more clear why the donor programs for information management failed or had trouble achieving full implementation: Claimants in a shortage economy are loath to provide information that will create opportunities for accountability or greater control.

Although *The Socialist Economy* was largely completed before the transformative events of 1989, Kornai writes about the reform agenda in the closing pages of the book. Not surprisingly, he considers the institutional legacy of state socialism to be a significant constraint. He writes, "A change of government is not a change of system, merely one of the political preconditions for it. The change of system is a historical process that seems likely to require a long period of time. Its point of departure is the legacy received by the new system from the old… The old

institutions may hamper the development of the new system for a long time."[104] This is what we witness in the evolution of Romanian reform.

Mental Models, Ideology, and the Power of Informal Constraints

But in what way does the old hamper the new? And where do external recommendations, formal constraints like the ones implemented through donor technical assistance, fit in? Let's call on Douglass North. After publishing his seminal 1990 work on institutional change and economic performance, North turned more and more toward the function of informal norms—belief systems and cognitive processes—that constrain the human psyche and strengthen this aspect of his theory of institutional change (North, 1996, 1994b, 1993b; Denzau and North, 1993).

Remember that North calls the process of change "overwhelmingly incremental" (1994b, p. 6) because the institutional matrix of formal rules, informal constraints, and enforcement attributes bias change in favor of: 1) existing organizations (such as hospital doctors), especially those with existing bargaining strength; and 2) the subjective perceptions (also called mental models) of agents who assess costs and benefits in favor of choices consistent with the *existing* framework. North terms this bias "path dependence."

For actors making choices in post-communist Romania, the existing framework had more attributes of the socialist political economy described by Kornai than of a competitive market governed by strong rule enforcement and negative consequences for discretionary behavior, especially because the so-called transition period was characterized by pervasive uncertainty.

[104] Ibid., pp. 577-578.

In “Shared Mental Models: Ideologies and Institutions” (Denzau and North, 1993), the authors explain how, in conditions of uncertainty, individuals are especially likely to act on the basis of “the learning they have undergone,” even if these perceptions are based on “myths, dogmas, ideologies, or ‘half-baked’ theories” (p. 1). In the authors’ scheme, mental models are internal representations created by individual cognitive systems that, when shared by a community, become “ideologies,” while institutions are the external (i.e., outside cognitive systems) mechanisms created by individuals to structure the environment. Ideologies and institutions are, essentially, two kinds of mental models. Shared mental models, or ideologies, guide choices made by individuals and organizations, thereby shaping the evolution of politics and economics in a society.

In a sense, North and his colleague are widening the lens on institutions in order to give a more significant role to belief systems in this essay and related work. Institutions are now more firmly embedded in history. In the paper’s concluding paragraph, they write:

> The performance of economies is a consequence of the incentive structures put into place; that is, the institutional framework of the polity and economy. These are in turn a function of the shared mental models and ideologies of the actors…[S]ystems of mental models exhibit path-dependence such that history matters, and…suboptimal performance can persist for substantial amounts of time. (Denzau and North, 1993, p. 15)

The mental models that evolved in the forty-year course of state socialism in Romania included behavior that rationalized, even required, persistent aggrandizement of one’s own organization or institutional sub-unit; disregard for budget limits; hoarding of information and goods; a tendency to revise and rework rules in a way that increases uncertainty; the use of public and work-related networks

to increase personal/family "stability" (or "gain," in the view of analysts not experiencing profound shortage); and a complicated attitude toward the state of both dependence and rejection: A deep expectation that the state should provide employment and services for free, such as health and child care, coexists with a distain for ubiquitous state property, such that hospitals or state-run institutions for children are fair targets for rent seeking. This belief system informed how organizations and individuals adapted to, and adapted, formal post-communist reform initiatives.

In light of this thinking, it's not a surprise that North is skeptical about the prospect of recipient countries absorbing formal rules *qua* institutional models from Western donors. In "The New Institutional Economics and Development," he writes, "[S]ocieties that adopt the formal rules of another society…will have very different performance characteristics than the original country because both the informal norms and the enforcement characteristics will be different" (North, 1993b, p. 7). Too true.

Implications of the Socialist Legacy

Corruption

In light of this discussion on legacies and institutional change, let's look at an issue area that is virtually synonymous with contemporary Romania: corruption. By the late 1990s and into the next century, the most common explanation for Romania's slow economic growth, judicial sluggishness, unexpected results in development programs,

lack of foreign direct investment, and various political machinations[105] was corruption. Just about everything in politics or economics that could not be readily explained by donors was vaguely categorized as a function of corruption.

A variety of well-respected international surveys confirmed negative assessments regarding corruption in Romania. Berlin-based NGO Transparency International (TI)[106] added Romania to its annual, global Corruption Perceptions Index (CPI) in 1997. TI defines corruption as the "abuse of public office for private gain," a common definition in donor circles. The CPI is a composite index drawn from eighteen surveys conducted by twelve independent groups. Scores range from zero (very corrupt: Bangladesh and Haiti tied in 2004 with 1.5) to 10 (most clean: Finland scored highest in 2004 with a 9.7). Romania's scores are anemic for the period 1997-2004: Debuting with a 3.44 in 1997, it was down to 2.9 in 2000 and sank to 2.6 in 2002 (placing the country at #77 of 102 countries listed). By 2004, Romania had edged up slightly to 2.9, tied with Gambia and India.

The European Commission's (EC) annual reports on progress toward accession[107] offer a narrative critique of the corruption complaint. The first overarching report, "Opinion on Romania's Application for Membership," compiled in 1997, notes, "Much still needs to be done in rooting out corruption" (EC, 1997, p.

[105] For example, so-called political tourism, whereby many local mayors elected as opposition party candidates in the 2000 local elections, converted to the PSD between 2000 and 2003 was often deemed proof of political corruption, rather than simply rational opportunism. Local government remained highly dependent on a variety of resources from the national budget, and mayors saw it as being in their localities interest to be in the good graces of central PSD party leaders who controlled government (Ghise, 2003).

[106] Founded in 1993 by Peter Eigen, a former World Bank official with Africa and Latin America experience, TI was the first transnational NGO devoted to fighting corruption. It is organized through highly autonomous country chapters around the world.

[107] Romania submitted its application for EU membership in 1995. A response took two years to prepare. Regular EC reports on progress toward implementation of the *Acquis* were initiated in 1998.

18). A year later, analysts point to corruption and suggest a legal reform: "The fight against corruption needs to be further strengthened. Without the adoption of the *Law on the Prevention and Fight Against Corruption*, unclear institutional responsibilities and the lack of specialized bodies dealing with the problem will continue to affect any efforts in this field" (EC, 1998, p. 10). Two years later, the 2000 Regular Report observes, "Corruption continues to be a widespread and systematic problem. It undermines not only the functioning of the legal system but also has detrimental effects on the economy…" (EC, 2000, p. 18), although it notes that a new anti-corruption law had taken effect in May 2000.

In 2001 we learn, "Despite a general recognition of this problem by the government, there has been no noticeable reduction in levels of corruption and measures taken to tackle corruption have been limited" (EC, 2001, p. 21). The report recommends to the central government a set of actions including approving secondary legislation to support the 2000 anti-corruption law; granting more resources to the anti-corruption unit of the General Prosecutor's office; finalizing and adopting a national anti-corruption strategy; introducing the concept of criminal liability to legal persons in the criminal code; and revising rules governing political party financing.[108] But the 2002 Regular Report remains dissatisfied:

> Surveys indicate that corruption remains a widespread and systematic problem that is largely unresolved. Despite a legal framework that is reasonably comprehensive, and which has been expanded over the last year, law enforcement remains weak. New institutional structures have been created but are not fully operational… Corruption remains a common aspect of commercial operations, but is also widely reported in dealings with public bodies as well as at the political level. Such high levels of corruption

[108] Most of these recommendations were accepted by the GOR within the next two years, as the 2003 report acknowledges.

> undermine economic development and erode popular trust in state institutions. (EC, 2002, p. 26)

Similarly, the 2003 report acknowledges a "relatively well developed" legal framework after bemoaning, "[C]orruption in Romania continues to be widespread and affects all aspects of society" (EC, 2003, p. 20). Virtually the same words are used in the EC's 2004 report: "[C]orruption remains a serious and widespread problem in Romania which affects almost all aspects of society. There has been no reduction in perceived levels of corruption" (EC, 2004, p. 31). The purpose of quoting extensively from these documents is to demonstrate that in the view of the European Union (EU) (by all accounts the most influential donor operating in Romania), the pervasive practice of corruption persisted *despite* the government's acceptance of specific reforms recommended by the international community. Therefore, the very *persistence* of the behaviors termed "corrupt" should be examined.

The Europeans are certainly not the only donors disturbed about corruption in Romania. The U.S. Government[109] includes references to Romania's corruption problem in State Department, Central Intelligence Agency (CIA, 2005), U.S. Trade Representative (2004), and U.S. Agency for International Development (USAID) reports (2004). USAID's 2004 Congressional Budget Justification submission calls corruption "endemic" and specifically flags corruption in the healthcare and social welfare sectors (2004). This year's CIA Fact Book uses the term "rampant" to describe corruption in Romania.

[109] In 2000, the U.S. Congress added a new section on corruption to the Foreign Assistance Act of 1961 as part of the "Micro-Enterprise Self Reliance and International Anti-Corruption and Good Governance Act of 2000."

As suggested by the regular reports, like other donors, the EU seems most concerned with the ethics of public officials and the matter of bribery. Its recommendations for solving this perceived problem is a set of stand-alone programs that center on signing international conventions, approving a national strategy, increasing law enforcement attention to white-collar crime, and punitively controlling rogue behavior. The U.S. Government's central anti-corruption program in 2001-2002, for example, provided financial and technical support to a new National Anti-Corruption Prosecutor's Office staffed with prosecutors and police (Department of State, 2005b). In the same document, the U.S. Government lauds Romania for passing anti–money laundering legislation and setting up an office devoted to combating money laundering.

The point is not to take issue with the legitimacy of donor concern in this regard. Corruption has been widely identified as a major post-communist problem (World Bank, 2000; Hellman, Jones, and Kaufman, 2000); the evidence that corruption, specifically state capture, undermines democracy while administrative corruption and the high transaction costs associated with persistent bribery undermine economic development is convincing (Open Society Institute, 2002; Center for Institutional Reform and the Informal Sector, 2001; USAID, 2001).

However, the current, legalistic approach toward corruption among donors appears to breed a certain distain for the recipient country, an attitude that "corruption," being illegal and bad, is practiced by contemptuous people. The legalistic approach also encourages a simplistic assignment of causality between poverty and corruption. The focus on bribery leads, inevitably, to proposals to

increase civil servants' wage rates—a solution that has been touted by the EU. Without a doubt, public salaries could be doubled and the EU would still have to complain about corruption a year later: What donors are calling "corruption" can also be read as a rational response to an environment of chronic shortage and uncertainty, a response that is supported by the "mental models" of people who experienced the political economy of state socialism.

Let's look at a specific example of perceptions regarding corruption being at odds between donors and local residents. Donors refer to the healthcare system as "the most corrupt institution" (Open Society Institute, 2002) and bemoan the toll under-the-table payments take on the population (Lewis, 2000). Indeed, polling data confirm that the Romanian public is dissatisfied with *government* activity in the field of healthcare (Metro Media Transilvania, Gallup Organization Romania, *Fundatia pentru o Societate Deschisa*, 2004). But an extensive 2003 survey of public opinion on health (1,192 respondents) also found that people were *very satisfied* with their experience with doctors, both family physicians and hospital doctors, and the medical care they received (Centrul Pentru Politici si Servicii de Sanatate si Metro Media Transilvania, 2002-2003).

On the following dimensions, over 70% of respondents gave their family doctors a score of over 8 out of 10 (10 being excellent): professional preparation, advice, prescribed treatment, and attention. Grades given to hospital doctors and medical assistants were also high: 75% of respondents considered the professional knowledge and technical ability of hospital doctors to rate an 8 (13%), 9 (17%), or 10 (45%). The speed with which hospital staff resolved patients' problems received

grades of 8 (15%), 9 (15%), and 10 (34%), with only 7% of respondents rating this important dimension with a grade of 6 or less. Asked whether they had complained about any aspect of hospitalization, patients responded overwhelmingly (86%) that there was nothing negative or that they had not complained about anything. Other answers reflect overall satisfaction with personnel and care.

Respondents are dissatisfied regarding the lack of compensated or free medicines (8%), the lack of funding for healthcare (22%), and the absence of modern equipment. Only 1% of respondents considered the following to be a problem: "money, gifts, bribes taken by doctors" (*banii, cadourile, mita primita de medici*). However, 14% of respondents said they had given money for medical services—an average of 1,787,086 lei ($52 USD)—and 8% said they had given a gift.[110] Gifts averaged in value of 765,277 lei ($23 USD). Interestingly, the payments and gifts do not appear to inspire negative impressions of medical personnel; on the contrary, the side payments and gifts might reflect the appreciation for treatment and service that is also reported in the survey.

Healthcare in Romania is not in crisis because of petty "corruption." It has been overwhelmed by weak budget constraints; poor financial management at the level of the Ministry of Finance and individual hospitals; lack of competition; lack of procedural enforcement especially related to the framework contract; a high level of confusion regarding institutional roles and responsibilities, which shrinks the planning horizon for all actors; and professional collusion between decision makers

[110] It is possible that this figure underreports the number of people who gave side payments to doctors. Romanians do not necessarily trust pollsters and generally know that sidepayments are frowned upon by Westerners.

and a well-organized professional sector. In this scenario, there is no one for the new Anti-Corruption Prosecutor's Office to arrest.

Where there are examples of administrative corruption in the cases studies—for instance, the use of hospital and clinic resources to perform medical services that are off the books, or staff siphoning goods and food away from the state-run institutions for personal use—it must be recognized that using public assets for private gain has been sanctioned in Romania both by the simple, commonly understood need for resources (by any means) and the deep, accepted informal norms that helped people survive under communism.

It is the legacy of communism, especially the soft budget constraint characterizing relations between central institutions and sub-national units, that explains patterns of behavior that donors see as perverse, defiant, incompetent, and/or corrupt. What we see in the domestic, micro-institutional case studies of child welfare and healthcare reform is a consistent pattern of extra-budget flagrancy (i.e., a tendency to ignore budget constraints, even to exceed budgets with impunity), an unwillingness to trim bureaucracy, and a tendency to grow institutions while hording resources. These habits have strong roots in the communist past. Much of Kornai's account of the shortage economy applies to ongoing relations in the post-communist state. In light of his insights, reform programs and Emergency Ordinances (the legislative vehicle of choice in Romanian between 1997 and 2004) were insufficient to revise default forms of institutional problem solving—namely, SBCs, central control, and bureaucratic coordination. These attributes represent informal norms that

decision makers in Romania (within their institutional relations) fall back on, especially in the context of gross uncertainty.

These findings, supported by Kornai's explication, offer specificity to the observation made by North in the final pages of *Institutions, Institutional Change, and Economic Performance* (1990): When change is dramatic and conclusive, such as the revolutionary actions that ended communism, North refers to "discontinuous institutional change." He cautions that radical change is rarely as dramatic as it first appears, because although formal rules can change overnight, informal constraints never do. Thus, informal constraints will reassert themselves to structure "basic exchange problems among the participants be they social, political, or economic. The result over time tends to be a restructuring of the overall constraints… to produce a new equilibrium that is far less revolutionary" (North, 1990, p. 91). The partial equilibrium of rent-seeking winners identified by Joel Hellman, broadly termed "corruption" by outsiders, comprises the "less revolutionary" reality anticipated by North.

Kornai has written many instructive books and articles since the classics referenced above. Interestingly, he was hired by the Hungarian government to help shape healthcare reform in the mid-1990s.[111] His description of the sector at that time has similarities with the Romanian system a little later: Limited autonomy for hospital management, excessive intervention from the central government, ambiguous property rights for health facilities, a tiny private sector, and SBCs.[112] He describes it as exhibiting characteristics of market socialism, especially because most facilities

[111] Kornai, 2001. p. 260.
[112] Ibid., p. 255.

are state owned. In a set of recommendations for Hungarian health reform published in 1998, Kornai declares, "The central problem in health care is scarcity," and that there is a dangerous "fiscal illusion that health care is free"[113]—both problems at roughly the same time in Romania. In zoning in on the primary problems inhibiting sector reform, Kornai identifies healthcare financing as problematic: "[T]he financing of the sphere is opaque. The average citizen in uncertain what is going on…[s]tate financing must become transparent."[114] Again, this same problem inhibited, and inhibits, change in Romania.

It seems that Kornai clashed with some Western advisors during his efforts on behalf of post-communist reform. In appropriately sarcastic lines, he complains about reformers with unrealistic expectations regarding change: "All those controlling the classic socialist system, from the tip to the base of the bureaucratic pyramid, are not stupid at all. They are quite capable of asserting their interests and objectives. The system evolved in the way it did precisely because this is the structure that can perform the functions expected of it. *It is naïve to imagine that the main features of the system can be altered by applying a few ideas for reorganization.*"[115] Especially in the Romanian healthcare story, this is exactly what we discovered.

Decision Making

Especially when we look at reform implementation in healthcare, we find excessive interference from the state in policy sectors that were supposed to be autonomous.

[113] Kornai, 1998, p. 192. NOTE: The Word Bank played a role in Hungarian healthcare reform in the early 1990s but felt that reform was not going well; in 1996,the Bank took a health reform component out of a PSAL (structural adjustment loan).
[114] Ibid., p. 191.
[115] Ibid., p. 371-372. Emphasis added.

The Ministry of Finance had a pivotal role that was completely unanticipated by the reform legislation approved in 1997. This pattern of central involvement, especially interference from the Ministry of Finance which proved to be highly destabilizing for newly created institutions such as the NHIH, is a strong legacy from state socialism. As Gerard Roland writes in a description of the initial situation before post-communist transition, "[E]conomic ministries…were thus the spinal column of the economy and played a key role in coordinating production and adjusting to unexpected disequilibria…Ministries not only played a crucial role in planning the yearly outputs and inputs of t heir enterprises, but also interfered constantly in enterprise activities. In general, these interventions were responses to perceived shortages by enterprises" (Roland, 2000, p. 8-9). This description of economic ministries under state socialism is a fitting description of the Romanian Ministry of Finance's (MOF) role in reallocating resources from the health funds to the pension funds in order to cover social welfare shortfalls. Despite the absence of a formal role for the MOF in the new health regime, it had the ongoing power and authority carried over from the political economy of state socialism to interfere in health reform implementation. As a result, organizations of interest, especially doctors in the hospital system, made choices that maximized their organizational standing and professional independence—a decision set that was inefficient and financially detrimental, but rational.

In a perceptive, albeit unsigned, introduction to *Institutional Design in Post-communist Societies: Rebuilding the Ship at Sea*, Jon Elster, Claus Offe, and Ulrich Preuss (1998) observe that post-communist decision makers are often loath to allow

"institutional pluralism," meaning, the development of autonomous, functionally specific units of governance because, "State socialism is an institutional order that systematically obstructs horizontal differentiation and maximizes inter-domain convertibility of resources, thereby creating a pattern of 'tight coupling' of domains…[T]ight coupling nurtures irresponsible behavior as it provides ample opportunity, as well as incentives, to either blame others if things go wrong, or to exploit others (as in the case of 'soft budget constraints')" (p. 31). This general description aptly fits the health reform story as well. It helps explain the legacy of control that makes the behavior of: 1) the MOF, as discussed above, rational; and 2) the Ministry of Health (MOH), in bringing the Health Insurance House system back under its authority despite the legislative vision of an autonomous health insurance fund, rational. With the pressure of inadequate financial resources, in a decision making environment characterized by crisis not strategic planning, with insecurity regarding new rules and their potential impact, and cynicism regarding enforcement of the new rules, the administrative hierarchies that survived the breakdown of communism, as seen in the MOF and MOH, were true to form in spending power to maximize control, not investing power in new, untried, untethered organizations.

Another adverse legacy inherited from the communist period is a tradition of *ad hoc* policymaking that characterizes decision making to this day. The public agenda is determined by a small coterie of individuals around the government power who do not document deliberations, let alone engage in consultation with stakeholders. In considering public policy options, rudimentary exercises such as cost/benefit analysis or impact analysis are rarely done, both because civil servants

don't know how and because decision makers don't expect them to. Public participation is discouraged and ordinances often emerge from Cabinet as surprises, even to interests that will be immediately impacted (Ionita, 2004, 2003a, 2003b; Sandor, 2000). These are all aspects of policymaking that characterized healthcare reform as well as child welfare. As political scientist Sorin Ionita observed, even after a piece of legislation or ordinance is approved, "Formal policy is the basis for perpetual negotiations, vertical and horizontal, in the political system and in public administration during the implementation stage."[116] Under the communist system, decisions were the subject of constant negotiation regarding how to implement a decision—or not. In the midst of post-communist reform, this decision making model creates a paralyzing level of uncertainty. To this day, decisions rarely seem settled, and policy is endlessly revisited as though every law was just a draft. Yet, as has been discussed, this environment of uncertainty allows maximum discretion for organizations that have benefited from partial reform.

[116] Ionita, 2004, p. 14. In the same article, he memorably describes the governing reality in Romania as "an uneasy alliance between old-time communist bureaucrats and foreign donors" (p. 8).

Chapter Seven
Conclusions and Lessons for Donors

Interests and Institutions; Money and Incentives

In some ways the Romanian child welfare (CW) story is unusual: Rarely are donor-supported reform projects acted out so publicly, under international media scrutiny; rarely are the carrots and sticks so enticing, so threatening, as they were in the CW bargaining situation, with membership in two powerful geo-political alliances at stake. Yet, despite the money from abroad, the attention, and the drama, fundamental fiscal reform, sustainable by the Romanian government itself, still eludes the CW institution: public expenditure management in child welfare is chaotic, *ad hoc*, and short term. While the central government has completed strategic planning for policy (for example, Government of Romania, 1993, 1995, 2001), it is hardly capable of multi-year budget planning, or budgeting by program result. Especially considering that on and off budget resources are flowing through so many pipes into Romania's child welfare sector, sub-national government, charged by law with governance of the sector, can hardly *know* the real costs of services being provided to their citizens, let alone make strategic, fiscally-sound decisions about the best service mix.

To make CW reform lasting, donors will have to confront fiscal sustainability, although the inherent free rider problem attached to foreign aid, and the fungibility of assistance, makes it virtually impossible to enforce hard budget constraints for the sector while significant aid is flowing in. This is the paradox of curative politics. To overcome this paradox, donors must focus on institutional relationships and political and administrative procedures governing money, and "beneficiaries" in order to

uncover perverse incentives—keeping a wary eye on organized interests that benefit from early phases of reform and insisting that donor investments be tied to measurable goals.

In healthcare reform, donors advanced technical solutions—albeit smart and theoretically beneficial—concocted and recommended with virtually no attention to the politics of healthcare reform. Of some 50 donor prepared or finance reform-related documents I read pertaining to healthcare reform (1991-2004), not one discussed the role of the medical elite as decision makers, and the multiple incentives that existed in the original law for hospitals, led by these elite, to flaunt the reform initiatives. Only among a handful of Romanian academic observers and donor representatives, was this widely, albeit quietly, acknowledged.

Organized interests, with access to political decision making, the resources to use political opportunities advantageously, the rational incentive to flaunt rules, and the conviction that rules are not being enforced anyway—will logically break any agreements regarding institutional reform, regardless of the social value these agreements represented on paper, or in law. Elite doctors, based in hospitals (as well as Parliament and other privileged decision making positions) rationally elected to assert their preference for professional freedom against central control—but inadvertently brought the healthcare system to the brink of disaster as a paradoxical result. Child welfare interests organized around inter-country adoption temporarily pumped tremendous resources from a brand new private sector (foreign adopting families), a rational and predictable response, but one that turned babies into commodities, an ethically abhorrent result. In each case, the organized interest was

not a sufficient source of power to subvert reform: a necessary condition was the existence of institutional procedures and politico-legislative lacunae that gave organized interests a way in, the consolidated state budget process in healthcare and the inter-country adoption scheme in child welfare, for example. Only as a function of higher level bargaining, and credible threats exerted by international donors, was the child welfare "veto point" closed. And *still* the sector's financing can not be called efficient or sustainable.

In considering the politics of reform the following dynamic was identified in both case studies: Organized interests (i.e. actors) and institutions interact as a function of instititutionally-codified incentives, which inspire the actors to make certain choices, which lead to efficient—or inefficient—outcomes. When the incentives change, the choices can change. In child welfare, when donors changed incentives facing the central government in 2001 (by tying accession to child welfare reform), the Romanian government began moving quickly to shut down state-run warehouses and move abandoned children to family settings as a result. In the other case, after new legislation governing healthcare financing and service delivery was implemented, doctors remained with maximum professional latitude including a lack of professional protocols regarding treatment decisions, or limits on prescription discretion, or enforcement of rules against side-payments. Elite doctors confronted few if any incentives to control costs so, rationally making their own daily decisions, their choices contributed to a massively inefficient hospital sector. Despite some legislative tinkering, few changes had presented new incentives for hospital-based doctors to adjust their behavior in socially beneficial ways by the end of 2004.

Meanwhile, as mentioned in the opening chapter, foreign assistance is a growth industry. More countries are putting more money into more ambitious bilateral and multilateral programs. Yet, influential public policy advisors appear not to have learned from rational choice and institutionalist insights, since it is still common to hear calls for, "More development dollars!" not "Better rules and incentives!" For example, writing about his latest book, *The End of Poverty* (2005a), in *The Washington Post* (2005b), economist Jeffrey Sachs argues that the United States should increase contributions to Africa to around $15 billion by 2010. Sachs acknowledges the importance of measurable program goals, but he argues as though more money alone can solve the poverty problem, a point underscored by David Brooks on the same editorial page.[117]

More Lessons From the Case Studies

This research exercise was initiated with a rather open-ended "*how*" question and looked for patterns to explain variance between two reform outcomes. It concludes with a strong sense that although the circumstances of every reform effort is unique, as every real world situation is, there are critical, routine ways that donors should assess potential interventions in order to assure that donor dollars have impact. Recommendations based on the case studies follow:

1) In Romanian healthcare and child welfare reform between 1990 and 2004, donors promoted, and the recipient governments adopted, reform programs

[117] Brooks' op ed piece includes this revealing critique, "One of the striking features of his book is the absence of individual Africans. There is just the undifferentiated mass of the suffering poor, trapped in systems, and Sachs traveling around the globe prescribing treatments." (Brooks, 2005)

that emphasized reorganization and legislative change, rather than rewards and positive incentives. Legislative reform is a necessary but not sufficient condition for social welfare change.

2) Donors tend to focus on technical goals without giving sufficient attention to the political bargaining occurring among domestic actors over reform implementation—and the importance of political processes of allocative decision making that help determine outcomes.

3) The greatest incentive for domestic stakeholders is revenue generation and employment security, and the central government accommodates this rational drive in the process of bargaining, especially since the same needs motivate central institutions. Reform initiatives should be scrutinized with this reality in mind.

4) The multi-stage nature of complex reform initiatives creates opportunities for resource-starved actors to achieve rents, thereby creating a partial-reform equilibrium that they are not keen to leave. Donors should expect this outcome, as logical and rational. Therefore, donors should think backward from this inevitability and address the opportunities for short-term winners to hijack the reform process—in a rational way.

5) It is essential that institutional reforms start from an empirical analysis. This sounds commonsensical, but it is not. In an analysis of commercial cases in Romanian courts, Peter Murrell (2001) shows how businesses used elements of the justice system to file cases where they faced less delay, thereby creating competition between two courts (*Judecatororii* and *Tribunale*). But a reform of commercial court procedures, premised on the *theory* of the system's organization, was promulgated by the Romanian government in 2000, which worsened commercial justice by removing the element of choice (*ergo*, competition) that benefited business. Institutional design that borrows from Western models—or proceeds from theory to reform—without considering empirical relationships, the combination of formal constraints (especially those governing budgeting and public expenditure management), informal norms, and institutional enforcement is courting failure. Similarly, policy prescriptions must be keyed to the empirical conditions and institutional relationships specific to a country or policy regime (Zinnes, Eilat, and Sachs, 2000).

6) Instead of selecting from a virtual menu of program options, donors committed to institutional reform need to assess each sector with this perspective:

    a) What *incentives* or *pressures* can be mobilized to motivate actors to change behavior?

b) What *incentives* and *pressures* are driving behavior in the institution under review?

Donors have a lot of check lists, but more analytical capacity needs to be applied in designing assistance programs. The thought process that donors go through has to shift. Donors need to think in terms of identifying opportunities; assessing organized interests around the opportunity; considering how to develop points of leverage; all through the eyes of recipient.[118]

7) "Corruption" is widely considered a core problem in post-communist regimes such as Romania. This is a normative judgment that misses an extraordinary lesson from the transition trajectory—namely, that rational actors maximize utility, and in the highly uncertain environments of institutions in flux, they will utilize resources at hand to enhance financial, organizational, and psychological security. Administrative corruption is a reasonable response to messy situations. "Corruption" is unfortunate but unsurprising considering the rational motivations and lack of serious criminal enforcement of laws against white-collar crime.

8) The past is a heavy mantle. Legacies continue to influence the way organizations interact with institutions, and vise versa.

[118] Of course there are excellent implementing organizations that do this already, including the University of Maryland's Center for Institutional Reform and the Informal Sector, but it is not the norm in development programming.

9) To understand the deeper significance of incomplete reform and the way institutional decision makers accommodate the need to secure revenue, we must consider political and economic legacies especially the legacies of political economy. Budgetary rules shape political contests for resource allocation and these are sometimes embedded, for example, in the old centralized system that privileges the Ministry of Finance as the main controller in Romania.

10) Evidence of consolidated democracy in terms of electoral competition and the alteration of power does not necessarily imply accountable governance. Citizens want both.

Foreign assistance is beneficial as a source of emergency aid, technical assistance in structuring reform projects, and credible international commitments that can spur difficult, complex change. However, by fixing on teleological end-states and normative goals, donors ignore: 1) the powerful impact of inherited institutions and slow-changing informal norms; 2) the overwhelming utility for domestic actors of raising revenue in an environment of scarcity; and 3) the free-rider problem created by donor intervention and the very fungibility of assistance. These factors can overwhelm donors' good intentions—especially at the domestic level of play where the interaction between central government actors (who are cooperating with donors) and domestic policy implementers (who are strongly motivated to secure resources) determine performance outcomes.

Although political structures and the ideology of state socialism were defeated in 1989 in Romania, post-communist reforms left bureaucratic coordination largely in place, especially in the provision of public services by the state. With norms such as the reliance on soft-budget constraints maintained and without the introduction of competition—or outside monitoring to enforce accountability—outside attempts to help reorganize health services failed. Performance-based conditionality tied to credible international threats led child welfare reform beyond stalemate, although deep changes in the form of employment cuts and financial decentralization are still resisted.

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