

The institutional transfer from the European Union member states to the former Soviet Union countries

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► **To cite this version:**

Rodica Plugaru. The institutional transfer from the European Union member states to the former Soviet Union countries. 2008. halshs-00345662

HAL Id: halshs-00345662

<https://halshs.archives-ouvertes.fr/halshs-00345662>

Submitted on 9 Dec 2008

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The institutional transfer from the European Union member states to the former Soviet Union countries

Working Paper

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European Centre Jean Monnet

"Europeanisation of societies: standstills and changes in the Global Age",
Summer School, September 2008

Abstract

1991 is a strategic year for former Soviet Union countries, representing the end of a system. A major historical change took place when Soviet Socialist Republics have decided to become independent states. But what happened to the institutions of these countries? Did they develop similar orientations of change or did they keep the previous models? Is it an exogenous induced change? Where did the influence originate? One of the hypotheses is that the European Union is the predominant factor in the external induced change. Another one is that the World Health Organisation had an impact in the transformation occurred. The role of the World Bank should be also emphasized. Another possibility would be that the domestic actors imported from the institutional systems of another countries like the United States or the United Kingdom or France. The studies on europeanisation provide important support for exploring the EU influences. Yet, the phenomenon is insufficient for analysing other potential actors of change. The institutional transfer approach will be adopted to complete the conceptual limits of europeanisation. This paper summarizes initial elements on the research on the institutional change in post-soviet countries. It presents the theoretical framework and the institution to be explored in Moldova, Ukraine and Georgia in order to delimitate occurred institutional change following the USSR collapse.

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1. Introduction

The present document is an initial summary of the collected information and thoughts on the research project I conduct at the Institute of political science in Grenoble¹. The PhD I prepare deals with the question of the institutional transfer from European Union (EU) member states to the former Soviet Union countries (FSUC). Since 1991, ex-USSR countries have experienced new developments. The modifications could be produced by endogenous as well as by exogenous factors. I intend to analyse institutional transformations and find origins of the change occurred.

The countries of the study are Moldova, Ukraine and Georgia. My assumption is that these states have experienced imported methods in the transformation of their health care systems. The origin and the characteristics of this external influence need to be determined. Was there an impact of international organisations such as the World Health Organisation (WHO), the World Bank or the European Union? Did countries like the United States, France or the United Kingdom influence the observed transformation and in which way? Did the international expert communities participate? Or can we observe a combination of multiple external factors?

The current research on europeanisation is of significant interest for exploring the European extensive action. Scholars in political science mainly focus on the European Union's influence on the member and candidate states (Radaelli, 2004, Schimmelfennig, Sedelmeier, 2004). However, in addition to European Union influence, other exogenous factors need to be emphasized as well. The institutional transfer is thus more appropriate for a research on the transformations in the FSUC. As there seems to be fluctuation between the europeanisation phenomenon and the institutional transfer (Saurugger, Surel, 2006), I intend to analyse the institutional change in post-soviet countries in a perspective combining the both concepts. Consequently, europeanisation and the institutional transfer are the independent variables to be considered in this research. In order to analyse the institutional change, I introduce the health care systems of Moldova, Ukraine and Georgia as dependent variables. The intervening variable is represented by the national context, as change could originate from the internal pressure of reform. Within the historical neo-institutionalism, the paradigm of path-dependency will be used to study the characteristics of the induced change following the Soviet Union's collapse.

This paper is organized in two sections. The first part develops the methodology and the theoretical approach I intend to apply during the thesis research. It explains the conceptual framework of my study, while stressing the combination of two main concepts: europeanisation and institutional transfer into analysing external influences on former Soviet Union countries. The second section deals with the empirical elements collected at the very beginning of my research. It reveals main

characteristics of the health care systems in Moldova, Ukraine and Georgia. The hospital design is chosen to be the tool to measure the institutional change within this framework.

In conclusion, I will mention the interest my subject reveals for main political science questions while leaving open room for debates.

2. Methodology and theoretical approach

In the first part of this section, I briefly present the methodology that will be used during the thesis. The second part represents an initial attempt of defining the conceptual configuration. It includes the main ideas of the concepts of institution, institutional change, europeanisation and institutional transfer within the framework of historical neo-institutionalism.

2.1 Methodology

The question of the research concerns the source of institutional change in Republic of Moldova (RM), Ukraine and Georgia. The health care system is the institution to be analysed in order to observe changes occurred after 1991. The design of medical institutions is chosen as instrument evaluating the transformation occurred.

The adopted approach of analysis starts at the domestic level and could be emphasized as a bottom-up perspective. The research focuses on the national context of post-soviet countries, on the main characteristics of adopted reforms. While revealing the institutional change occurred after 1991, various exogenous factors will be explored in order to delimitate the predominant sources. More precisely, the health care systems of Moldova, Ukraine and Georgia constitute the dependent variables, while europeanisation and the institutional transfer are the independent variables. The national context represents the intervening variable for studying the domestic pressure of reform. This mode favours a detailed insight into the specific institutional environment of Moldova, Ukraine and Georgia.

One major methodological aspect of the thesis implies the qualification of various concepts and notions that will be employed during the entire process of work. The concepts of institutional transfer, europeanisation, institutional change need a clarified definition based on the theoretical available resources. The notions of hospital as medical institution, of hospital design as well as of technical and medical norms need to be established before starting the case study analysis. This terminological clarification represents a scientific language basis for the research.

The existing theoretical background in political science will be explored for revealing the previous research in the health care systems of Moldova, Ukraine and Georgia. The thesis will investigate general orientations of reforms engaged in these countries during the transition period. A particular attention will be paid to the transformation of the health care system: what are the new trends of reform, who are the actors involved, what are the expectations? In this context, the place of the hospital, of its design and construction will be inspected: what are the methods applied, what

characteristics can be identified, what has not yet been evaluated? A brief inroad will be made into the field of architecture studies for more detailed explanations.

The method of analysing the changes of the hospital design of post-soviet countries is based on three case studies. In Moldova, the Republican Clinical Hospital of Chisinau will be analyzed. According to the Ministry of Health, this is at the moment the only medical institution of the country to have entered a process of reconstruction based on foreign practices. The second case study is the project of Mother and children Hospital of the Future in Kiev, Ukraine. In Georgia, the Hospital of Tbilisi is taken as a case study as well. The last two projects are designed by the English-French architecture consortium bdpgrupe6. I have the opportunity to bring my support as coordinator of international projects in this firm, which gives me the possibility of observing directly the processes of design of two case-study hospitals. This position, as well as the knowing of Russian language, allows collecting and analysing necessary data such as technical and medical norms of the hospital architecture.

As the medical institutions are subject of political and public expectations, the national Ministries of Health have more or less impact on their design and construction. This implies that the architects in charge need to respect the national requirements. But do the foreign architects conform to the domestic disposals or do they change the national orientation in terms of hospital design? What are the main characteristic of the adopted practices? Is there any foreign influence? From this point of view, the role of the domestic actors, as decision-making representatives and of international actors, as agents of transfer will benefit of detailed consideration.

After analysing all necessary documents adopted for designing the medical institutions, I will conduct interviews with concerned specialists and thus confront the theoretical collected information.

A comparative perspective will analyse the situation during the soviet period as well as after its collapse. The path-dependency phenomenon will underline the radical or incremental character of the change. The results of the three countries will allow to compare the differences and similarities in systems having had experienced the same historical and institutional environment. The comparative method in analysing three case studies in three different countries should be useful in adding each national specific puzzle to the global picture of the institutional change in former Soviet Union countries.

2.2 Theoretical approach

2.2.1 The new institutionalism: which one?

In order to find a way to answer the question of institutional change in FSUC, historical neo-institutionalism is chosen as theoretical framework. Accordingly to this theory, the institution has a central role in analysing a society. It presents several characteristics that will be very briefly further explained.

The new institutionalism implies that an older one has existed before (Peters, 2005). The old institutionalism focused on the study of institutions. But after 1945, this theory was rejected in favour of behavioralism and rational choice approaches which explained individual action by socio-psychological aspects or “rational calculation of their personal utility” (Peters, 2005). In 1984, March and Olsen advocated the return to the important role of institutions and called this orientation the new institutionalism. At the difference of the older version, this one enriched political science with new tools, while using the behavioural and rational choice as background (Peters, 2005). While evolving, this approach transformed itself to a variety of forms. Today, we can mainly specify four of them: historical, rational choice, sociological and more recently discursive institutionalism (Schmidt, 2008).

What matters for my thesis in the new institutionalism is the concern to history. This very significant aspect is convenient for explain the institutional changes occurred in countries with similar historical background such as Moldova, Ukraine and Georgia. As the scholars of this category, I think that the path-dependency phenomenon plays a crucial role in further developments of a system. The decisions took in the past have an influence on the one that are taken today and the ones will be taken tomorrow. The questions to raise here are: at what extent the paths from the Soviet Union period influenced the measures taken after 1991? Did new reforms cut all old path or only old inconvenient path? How difficult is to delete these paths and under what conditions? I intend to present the inherited soviet patterns of the health care system of Moldova, Ukraine and Georgia, the ones that disappeared and the ones are still present after 1991. One of the goals of choosing the historical neo-institutionalism is to see how the path-dependency issue has an impact on further developments of FSUC.

Another concern is the character of the observed change. The historical new institutionalists stress the fact that the institutional change in a system is an incremental process (North, 1990). Still, the hypothesis I make concerning the change in the health care system of analysed post-communist countries is that the character of it is radical rather than incremental. Does historical neo-institutionalism give a complete explanation in these cases? North accepts the radical change in a context of crisis (as revolution for example). Does the radical aspect of development in countries that

have experienced communism subscribe to a period of crisis? The observations during my thesis should complete the view on this point.

2.2.2 Institution and institutional change

In terms of concepts, this research will employ very often the term of institution, the heart of the study. Almost all the actions, actors and phenomenon of the thesis imply aspects of institutions.

First of all, institution is used as a general concept for analyzing the institutional change. I adopt the definition presented by Douglass North: “Institutions are the rules of the game in a society or more formally, are the humanly devised constraints that shape human interaction”. They can be formal (laws, constitutions, contracts) as well as informal (custom, traditions, ways of conduct). The main role of an institution is “to reduce uncertainty by establishing a stable structure to human interaction” (North, 1990). In my research, the health care system will be observed under this sight.

Secondly, as I intend to analyse the changes that occurred in the institution of health care after 1991, I need to choose one characteristic tool. The system of health care is characterized by different items: the insurance system, the medical institution, the medical training etc. I choose the medical institution. The evolution of the hospital design after 1991 will be the instrument employed to measure the change in the health care system. In terms of methodology, I take this concept as developed by Pierre Lascoumes and Patrick Le Galès in their work “Governing by instruments”. The authors advise to adopt a new angle of analysis which gives a central role to the tools in the public action. In their view, the instrument can be used as institution or become an institution once established, as it might develop different effects from the original ones. Lascoumes and Le Galès suggest dividing the scale of the analysis on several levels: instrument, technique and tool. Even if the context of the idea concerns public action studies, I intend to apply the scheme to my thesis. At the heart of the subject, the health care system is the institution through which the institutional change will be observed. The instrument of observation is the process of hospital design, as essential part of the health care system. And finally, the technique concerns the documents containing all medical regulation that need to be adopted for the design and the construction of a medical institution.

The institution being selected, I can then move forward and explore the notion of institutional change. A change “consists of marginal adjustments to the complex of rules, norms, and enforcement that constitute the institutional framework” (North, 1990). Following this definition, the study on the health care systems of Moldova, Ukraine and Georgia imply the analysis of the medical norm corpus currently in law as well as of the norms implemented in the hospital projects after 1991. If the latter

are different of the institutional framework, then a change can be observed. This change needs to be deeply analysed in terms of characteristics, favourable conditions and decisive actors.

As North explains, “institutional change shapes the way societies evolve through time and hence is the key to understanding historical change”. Although this definition presents the scope rather than the explanation, it follows the ideas of historical neo-institutionalists. It points out the significance of history in human development. My thesis is part of these concerns. It will account of changes occurred in the health care system after 1991, while comparing with the situation of previous years.

2.2.3 Europeanisation

Analyzing how the reforms of Ukraine, Moldova and Georgia could be shaped by actions coming from the European space is of particular interest nowadays. These questions integrate the field of europeanisation, a phenomenon largely studied and debated in political science. I will briefly introduce the definition of the concept through the literature in political science and then explain the interest for my research.

A lot of literature can be found on europeanisation. Yet, the quantity of information does not imply that the phenomenon is explicit. Even if considerable efforts on defining the concept have been made (Radaelli, 2000 and 2004), several questions still persist (Saurugger, Surel, 2007). In addition, emphasize europeanisation as a process, linked to evolving objects as the European Union and states, lets an open window for eventual variations. If a few years ago, scholars concentrated on European integration, then on europeanisation of European Union members, then on candidate countries (Radaelli 2004, Schimmelfennig, Sedelmeier, 2004), we can recently observe suggestions of extending the development of europeanisation to countries outside the EU (Sedelmeier, 2006). I include my research in this particular area.

Europeanisation is a current subject in political science since the end of the 1990's. Scholars extracted the notion to the literature on the European integration. The questions of the European influence and impact on national systems was a European integration concern. This explains in part why the first attempts to define europeanisation focused mainly on this aspect. From one effort to another, it can be observed how the notion of europeanisation expands, includes new terms, draws boundaries and becomes a distinct concept. I will mention here only several of the scholars that revealed significant ideas for my thesis.

The majority of works I have read on europeanisation mention Caporaso, Green-Cowles and Risse as one of the first definition suggestions. They express europeanisation "as the emergence and

development at the European level of distinct structures of governance, that is, of political, legal, and social institutions associated with political problem-solving that formalize interactions among the actors, and of policy networks specializing in the creation of authoritative rules" (Caporaso et al. 2001). As Radaelli specifies, this definition is more concerned by the European level and less by the effects on domestic systems (Radaelli 2004). It seems that there is not a very clear delimitation between the European integration and what should be characteristics of europeanisation (Saurugger, Surel, 2007).

Tanja A. Börzel and Thomas Risse in the article "When Europe hits home..." adopt the top-down perspective of the europeanisation. The authors specify in the introduction that the "bottom-up perspective, in which the dynamics and the outcome of the European institution-building process are the main dependent variable" was largely adopted in European studies. At the same time, more recently, there is a literature analyzing the top-down dimension. This process studies "the impact of European integration and Europeanization on domestic political and social processes of the member states and beyond". The authors consider the top-down dimension "a process desperately needed in order to fully capture how Europe and the European Union matter". Hence, they focus on effects of Europeanisation on domestic factors of "member states and beyond".

In addition, Börzel and Risse develop the concept of "misfit" characterizing the degree of difference between the European and the national levels. The authors point that a misfit should be noticed for "expecting any change". At the same time, veto points and mediating factors should also be considered as "adaptational pressures alone are insufficient". During the study on the change in the health care system of FSUC, I intend to analyse the veto points and the internal sources that might encourage the adoption of foreign institutions. The adaptational pressure will be a main aspect in explaining how external practices were implemented into national health care systems.

One of the conceptual definitions of europeanisation was established in political science literature by Claudio Radaelli. In an article published in 2000, the author explores the debate around the europeanisation and stresses the importance of a well-defined concept. Radaelli concentrates its paper on the "impact of Europeanization on member states although there is evidence outside the current domain of the EU". The definition he gives can be applied to a large amount of studies, including the post-soviet countries. Hence, europeanisation is defined as " a process of (a) construction, (b) diffusion and (c) institutionalisation of formal and informal rules, procedures, policy paradigms, styles, 'ways of doing things' and shared beliefs and norms which are first defined and consolidated in the making of European Union decision and then incorporated in the logic of domestic discourse, identities, political structures and public policies". As it specifies the institutionalisation of formal and informal rules as

well as of norms, the definition is relevant for research on the links between europeanisation and the reforms in post-communist countries.

It seems that boundary of the phenomenon are not specified. At the same time, Radaelli writes further that europeanisation can "affect members but also the wider world, as there is undoubtedly Europeanization of policy in countries applying for EU membership". He argues that "without boundaries, it is impossible to define Europeanization" and that by trying to find a degree of europeanisation everywhere, there is a "risk of conceptual degreeism". Even if agreeing with the argument, I should insist on the necessity to enlarge europeanisation to countries where empirical finding can prove the phenomenon, be they excluded as potentially EU candidates. Therefore, a research on ex-USSR might enlarge the area of application of the definition as well as of the boundaries of europeanisation phenomenon.

The work of Radaelli on europeanisation is of significant importance for my thesis. As expressed in the upper lines, it provides necessary conceptual framework. In addition, it perfectly explains the bottom-up dimension which will be applied to the research on Moldova, Ukraine and Georgia. Under this facet, europeanisation is analyzed as a process starting and finishing at the local level. The research on the FSUC does not start from the European level but from the changes observed in the national health care system. The notion of 'impact' from Europe that could be emphasized should be viewed as going "beyond the 'reaction' to Europe" and more as an active action of local actors. Radaelli gives some directions to the question of the origin of the observed change. How are we sure that change is caused by European integration and not some other variables? National actors, i.e. political leaders, could integrate in their discourse domestic politics or globalisation under the image of europeanisation. Europe would be then used to legitimize internal choices. This is one main aspect of the analysis to be studied.

If the beginning of the research on europeanisation explored particularly the EU influence on the members, rather rapidly scholars started to question the impact on candidate states. This orientation was following the enlargement process (Sedelmeier, 2006). The author expands this understanding to the applicant states: "what the literature usually considers as 'Europeanisation' is not confined to the member states" of the European Union. At the same time, he mentions that the concept should be more broadly applied, to other international organisations or other countries than the candidate ones. Sedelmeier notifies a key issue for the research on "Europeanisation beyond the EU" by raising the question of the "ability of the EU" in influencing countries with no potential membership. An empirical research on former Soviet Union states is part of this context.

2.2.4 Institutional transfer

The research on the health care system of Moldova, Ukraine and Georgia will raise the question of the source of the institutional change. The concept of europeanisation will be helpful in analysing European Union action in the ex-USSR. But this concept is insufficient for discussing other potential origins of the change, like international organisations such as the World Health Organisation (WHO), the World Bank or states. Here, the concept of institutional transfer would be more appropriate. As Saurugger and Surel suggest in their article on "Europeanisation as process of public policy transfer", the concepts of europeanisation and institutional transfer can be crossed in order to analyse the change in a comparative perspective (Saurugger, Surel, 2006). The authors complete the initial scheme on europeanisation of Börzel, Risse, Caporaso and Green Cowles by adding the notion of institutional transfer. The latter is linked to the formulation of Dolowitz and Marsh in his work on public policy. A series of questions can be raised, particularly concerning the sources, the origins and the actors managing the process of change. Despite the fact that europeanisation and institutional transfer have many points in common and are delicate to distinguish, the combination of the two concepts presents the advantage of identifying precisely the origin of the change by comparing different sources.

The institutional transfer is a main concept in political science, yet little literature was developed on the subject. Most of the explored sources refer to the approach of transfer in public policy studies. In this area, the framework of Dolowitz and Marsh is preferred. The authors define "policy transfer" as "the process by which knowledge about policies, administrative arrangements, institutions and ideas in one political system (past or present) is used in the development of policies, administrative arrangements, institutions and ideas in another political system" (Dolowitz, Marsh, 2000). The notion is mostly utilized in works on public policies. As the background of my thesis is larger than the public action, the notion of institutional transfer is more appropriate. However, the Dolowitz and Marsh framework presents key questions that could be addressed during the analysis: why do actors enter a process of transfer, which actors are implied and what are the sources? These problems are important more generally in the study of the process of transfer and could suggest an initial framework on this question.

From the literature reviewed until presently, it can be mentioned that the institutional transfer is applied to the study of de-colonisation phenomenon and of the role of international organisations in spreading the "good-governance" in developing countries (Larmour, 2005). After the Soviet Union collapse in 1991, scholars became interested in the institutional transfer from European Union to the Central and Eastern European Countries (CEEC). The initial works focused on the case of German reunification and the transfer from West to East Länder (Lehmbruch, 1996, Jacoby, 2005, Lozac'h,

2006). Lately, the concept is used as a complementary source for understanding the EU enlargement process (Saurugger, Surel, 2006).

The expression of 'institutional transfer' was firstly used by David Apter in a study on Ghana in the 1950's, in the context of transfer of British parliamentary democratic model to the African systems (Larmour, 2005). In his book "Foreign flowers", Larmour presents different examples of institutional transfer over history such as the police force adopted by Japan from France or the spread of the Roman civil law through the West of Europe or the reproduction of Ombudsman institution from Sweden to other European states. It can be added that the idea of "countries often copy from each other and look for examples of best practice abroad" is still current nowadays. These considerations are subject of increasing interest with the development of europeanisation and globalisation phenomena.

The case of the German reunification presents notable interest for the study of institutional transfer. Gerhard Lehbruch introduced the definition for characterising the export of the political, socio-economical and juridical West-German model to the East regions (Lozac'h, 2006). Still, little attention is paid to this example of transfer in understanding the East-European transformations. The West Germany is considered to be the main actor leading the process of transfer to the East, an element which is absent in the other post-communist countries (Bafoil, 2006). Nevertheless, empirical researches show that the process of institutional transfer in East Germany was not exactly "top-down" and met several resistances (Lozac'h, 2006). The transfer can not be simply emphasized as a "past and paste" process (Bafoil, 2006). It is necessary to explore more deeply the role of the actors during transformation and observe if some resistance and path-dependencies can be noticed.

The concept of institutional transfer is also used in the context of the European Union's enlargement of 2004 to the CEEC. In a serial number of International Review of Comparative Politics of 2006, Sabine Sarugger and Yves Surel adopt the combined approach of europeanisation and policy transfer for analysing the process of EU's enlargement. The authors are inspired by current research observations on external influences of domestic reforms. The transformations of policies are often the result of a transfer of methods or techniques of another policy system (Saurugger, Surel, 2006). The several articles of the review explore the question of the institutional transfer in the context of enlargement, going beyond the limits that europeanisation can present in terms of explanation of CEEC adjustments.

In one of the articles, Maxime Forest analyses the institutional transfer of gender equality policies in new EU member states, while stressing the influence of socialist heritage in the process of transformation. The concept of institutional transfer is more appropriate than europeanisation as changes were noticed before the possibility of entering the EU. Other international organisations, as the United Nations have to be considered as well in the study of gender equality objectives. The

enlargement represented an opportunity for the domestic actors to stress the gender equality policy points that still needed enforcement. Thus, europeanisation is regarded as a context of interpretation of the institutional transfer phenomenon (Forest, 2006). The author mentions the interest of employing historical neo-institutionalism and the path-dependency paradigm into analysing the national context of the post-communist countries. Not only the top-down perspective of europeanisation is insufficient (we need to have a detailed look on the domestic context of a system), but this is not the only concept to be considered. The institutional transfer is supposed to successfully complete the information on the observed change.

In an article on the Europeanised asylum policy, based on empirical research, Laure Neumayer confirms that the international organisations have played a significant role together with the European norms in modelling the asylum policy of CEEC. The author presents the idea of use of European "political and social capital" in the context of post-communist changes. Certainly, the role of the actors transferring foreign capital into the national systems will be studied during the analysis on the health care of Moldova, Ukraine and Georgia.

From the institutional transfer concept, as studied until now, I retain several elements for my thesis. First of all, it could be applied to the developments observed in the former Soviet Union countries after the 1990's. The question to ask is what paths were kept from the soviet period and what evolutions can be observed? The health care system institution will serve as object to be experienced in this context. I argue that some mechanisms were inherited from the past while some others were borrowed from foreign systems (Larmour, 2005). The research should distinguish which instruments correspond to each category and what are the origins of their transformation? The actors involved in this process are of particular importance as well. Are they Government or administration representatives or economical actors? What are their motivations and their role as veto points? Secondly, the nature of the transfer is a significant question as well. In case of colonisation, it can be supposed that the type of transfer was coercive. I argue that in the case of the health care system transformation of Moldova, Ukraine and Georgia, the transfer is voluntary. The aspects to be developed are the reasons for adopting institutions from another system as well as the reason of choosing a special foreign system. Finally, I employ the institutional transfer perspective in order to delimitate the source of the observed change. Are international organisations, as the World Bank, the World Health Organisation or the European Union the key actors? If yes, what are the main characteristics of influence of the post-soviet health care system? Who are the exogenous and endogenous transfer agents involved in this process? While analyzing the possible influence of the European Union, the europeanisation phenomenon should be emphasized. The major challenge of this

research will consist in articulate the two distinct concepts of both europeanisation and institutional transfer.

3. Initial research elements

This section is divided in two parts. Firstly, it presents an overview of the health care system situation in Moldova, Ukraine and Georgia before and after the crucial year 1991. Secondly, it introduces the hospital design as instrument of the evolution of the health care institution.

3.1 The health care system of Moldova, Ukraine and Georgia

Historically, Moldova, Ukraine and Georgia have tempestuous past, with the soviet period in common. Nowadays, these countries have various political and economical problems. The latest internationally discussed conflict is the Abkhazia region in Georgia (August - September 2008). The Moldova has problematic Transnistria, a separatist territory, outside of the central government control since the civil war in 1991. And Ukraine experiences permanent conflict situation between its West and East part after the Orange revolution in 2004 (the third early parliamentary election was called in October 2008). From the point of view of territory and population, Ukraine is the biggest from the three states: 46 millions of people (in 2007) for an area of 600.000 km². Georgia and Moldova are much smaller countries with 4.6 millions (in 2008) for 70.000 km² and 4.3 millions (in 2007) for 33.000 km².

In order to present the situation of the health care system in Moldova, Ukraine and Georgia, the literature of the European Observatory on Health Systems and Policies² is used as theoretical basis. Some scholars from Moldova, Ukraine and Georgia are roughly cited as well. For a comparative perspective, the Health care systems in Transition (HiT³) summary publications per country have been examined. The most recent is the HiT summary on Ukraine, dated from 2005. The HiT summary on Republic of Moldova dates from 2004 and the latest I could find on Georgia dates from 2002. These documents explicitly and briefly explain the main lines of development of health care reform in post-soviet countries. Detailed information from the WHO country reports was also explored. The following thoughts are presented in an historical perspective. The main lines of health care systems of Moldova, Ukraine and Georgia are briefly studied in the context of the Soviet Union, as well as after its end. The countries are presented rather separately, even if similar aspects can be found.

3.1.1 Before 1991

Until the 18th century, Moldova had no formal health care institutions as such and no structured provision of health assistance or services. By early 19th, an increasing number of hospitals began to

open, largely based in the capital Chisinau or in municipalities. The secondary or in-patient care has continued to be central in Moldova until the most recent reforms (Figueras and al., 1996). The specificity of Moldova is that historically, it was a part of Romanian state. From 1812 until 1918, Moldova was under Tsarist Russia and has become a "gubernia" (province) more commonly known under the name of Bessarabia. In the middle of the 19th, during the Russian period of reform under Alexander the Second, a district council called "zemstvo" was established in the province. Health care delivery became more organized and public health was provided to rural areas as well (Figueras et al., 1996). The number of hospital remained very low as only 3 Zemstvo hospitals were accounted in 1870. The number of it increased very rapidly as in 1914 there were already 115 hospitals in the country.

In 1918, Bessarabia unified with Romania and stayed within it until 1940. During this period, an elementary Bismarckian insurance system developed. It was a difficult period, although the number of medical institutions and staffing increased. By 1940, in Moldova there were 446 health institutions, 1055 physicians and 2400 nurses and midwives. The health care delivery was divided into a three-tier system related to the ability to pay and the private provision became dominant (Figueras et al., 1996). After German-Russian Ribbentrop-Molotov pact in 1939, Romania was asked under an ultimatum to give up Bessarabia to Stalin's regime. In 1940, Moldova became the Soviet Socialist Republic (SSRM). During the war, 82% of all health care institutions were destroyed (Figueras et al., 1996).

Ukraine had a rather different past, even if similar characteristics with Moldova can be noticed during the Russian rule in the 19th century. Before the Soviet Union period, the borders of the country varied a lot over time. Documented references to the land of Ukraine date back to the era of Kievan Rus, from the 9th to the 13th century, when it became under Mongol control. After the destruction of Kiev (1240), Ukraine was divided in different parts of different influences (Mongol and Cossacks, Polish-Lithuanian). At the same time, Moscow has gradually extended its influence on the Ukrainian territory since 1654. By the end of the 18th century, main parts of Ukraine had become under Russian's influence, while western territory came under Austro-Hungarian rule (Lekhan, Rudiy, Nolte, 2004). This period was particularly difficult for the population. The mortality levels were higher than in other countries in Europe. Health care and other social services have developed under Tsarist Russia by 1864. As in the case of Moldova, these services run under the local governments called zemstvos. The social health insurance, based on Bismarckian model, was introduced in 1912 and covered about 20% of industrial workers. In 1917-1918, there was an attempt to create the independent Ukrainian state, but with the Russian October Revolution, the territory became part of the Soviet Union. The Ukrainian Soviet Socialist Republic was established in 1922. Ukraine suffered a lot during all the first 20th

century events: the World War I, the October revolution and the Civil War. The World War II again destroyed many health care infrastructures. The health care system was formulated as centralized under the Soviet Union and several public health measures were to be put in place.

In the case of the Georgian history previous to the Soviet Union, it can be said that it is very rich in links with the European and the Asian cultures. Ionian Greeks colonized the Georgian land in the 6th century before Christ (BC). In the 4th century BC, Georgia was united into a single kingdom. In the 4th century Anno Domini (AD), the Christianity was introduced. The Persian and Byzantine empires were present until the 7th century. In the 11th century, the territory became under the Turks domination (Gamkrelidze et al., 2002). A very brief period of unification and independence can be noticed in the 12th century, although the Turco-Mongols invaded in the 13th. Until the 18th century, Georgia was controlled either by Persians, either by Ottomans. The country knew a very short kingdom in the middle of the 18th before being annexed by the Russian Empire in 1801. Georgia became independent very shortly once again after the Russian Revolution in 1917. In 1921 it was included in the Soviet Union and became an USSR republic.

As it can be observed from the description above, the three countries of the study experienced very significant historical moments. Before the Soviet Union inclusion, Moldova, Ukraine and Georgia have had different developments. Although, a similar trend of the Russian influence on their systems should be noticed during the Tsarist period in the 18th century. It can be concluded that Moldova, Ukraine and Georgia, despite more or less different location and historical elements, have a common background related to the Russian influence on their territory. This can be argued for the period following their inclusion in the Soviet Union, as well as largely before that time.

3.1.2 After 1991

Moldova, Ukraine and Georgia became independent states in 1991, after the Soviet Union's collapse. During the soviet period, the three countries experienced similar developments of the health care systems. Based on the Semashko model, it had a centralized planning and administration, with high numbers of doctors and hospital beds (HiT summary Moldova, 2004). The immediate consequence after 1991 was the absence of funding for health in a context of a difficult economical situation, which threaten the provision of the most basic health services for the population. The previous system, very complex, proved to be inefficient in terms of structure of health services. These considerations, linked to the difficulties in economy, led to a deregulation of supply of medicine, of

technical materials and to increasing prices. The health care system passed through a period of crisis (Rusu, Volevei, 1995). This crisis was due not only to the absence of financial resources as to the inefficient distribution and use of these resources in the medical institutions. The situation led to the decrease of the quality of the health care services. It became obvious that in these conditions, the State had to enterprise some actions. Moldova, Ukraine and Georgia were confronted to more or less similar crisis problems. But did they develop similar solutions? This section develops a few lines of the main aspects of the health care systems of the three countries after 1991 and some trends of the beginning reforms.

In the Republic of Moldova, the reform of the health system was rather slow (HiT summary, 2004). A Health Policy Note of the Government of Moldova and the World Bank published in 2006 makes statement of a starting health sector reform at the end of 1990. The report specifies that "in 2000, health sector indicators were deteriorating", which makes clear that no effective development was realized in the period immediately after 1991. Moldavian scholars as Rusu and Volevei in the book "Reforms and medical insurances in the health care system" write in 1995 that the "current health care system, based on the centralised rule and financing do not assure the necessary level of medical assistance to the population". Still, some efforts in legislation have been made. In 1992, the Parliament of the RM adopted the Law on "Health Assistance through Health Insurance" which has been ratified only in 1996. In 1995, the Parliament adopted the basic Law of Health Care which confirmed the health care system decentralization and financial reform. Also in 1995, the Government adopted the State Programme for Health Care System which presented new orientations. The new health legislation envisaged introduction of health insurance, private sector development and reorganisation of health service administration and improvement of medical education (Figueras et al. 1996). Since 1997, the institution of family doctors has been set up in primary care (HiT summary Moldova, 2004). In 1998 and 1999 there were reforms of the hospital institution by reducing the number of beds and personnel, while in 2001 a new financial tool was applied, based on the number of patients and not on the number of beds. In conclusion, after 1991, RM developed a health care reform based on strengthening primary health care and restructuring the hospital sector (World Bank Health Policy Note, 2006).

Ukraine engaged in a process of reform of the health care system immediately after declaring its independence in 1991. This target was placed on the national agenda of the country. The necessity of reform was largely inspired by the economical problems and the recognition of the inefficiency of the previous soviet model (Lekhan, Rudiy, Nolte, 2004). In 1992, the Parliament adopted the

Principles of Legislation on Health Care in Ukraine which put in place the main legislation acts of the health care system. The aims of change concerned the improvement of financial procedures for the health care system, the reduction of hospital number, the development of primary care and the decentralization of management. Despite the initial motivation, the process of reform was slowed down until 2000, due to the lack of clearly defined priorities and mechanism of implementation of the legislative framework (Lekhan, Rudyi, Nolte, 2004). The relative economic stability accelerated the process of reform. In 2000, a presidential decree formulated the Concept of the Development of Health Care in Ukraine. The goals of the document were to maintain and promote the health of the population, to ensure a guaranteed level of high quality health care free of charge, to establish a regulated market for health services etc. Finally, through these range of disposals, Ukraine managed to put in place a solid legal framework for the health care system. The political instability, the economical problems and the inefficient use of the new mechanisms led sometimes to a delay in the institutional change (Lekhan, Rudyi, Nolte, 2004). However, real attempts of reform can be observed, especially related to the reorganization of the primary health care and of the hospital sector, even if examples of decentralization need more practical effectiveness.

After declaring its independence in 1991, the health care system of Georgia proved to be inefficient for the new market relations. The model was too expensive and had a very complex structure for the new needs of the population. Georgia was the country with the highest number of doctors to population in the world (Gamkrelidze et al., 2002). As for Moldova and Ukraine, there was a too important capacity of secondary and tertiary care beds. The health care budget line suffered a significant financial shortage which led to a generalised crisis (HiT summary Georgia, 2002). This situation pushed the Government to initiate rather rapidly a reform. The orientation of change began in 1993. The first main legislation is the decree No. 400 which asserted a decentralized funding for health care. Another significant measure was adopted in 1995 – the first Georgian Health Care Reform package. The program included basic services designed for the population lacking of resources. The initial changes of the health care system introduced by the Government aimed at the introduction of the health insurance system, the basic health benefits package and the "establishment of new provider payment mechanisms" (HiT summary Georgia, 2002). The objectives of the reform extended to a larger concept by 1999, when the Georgian National Health Policy was formulated. The point of reference concerned equity, accessibility and affordability in a health system financed by a semi-public social insurance, with an advanced primary care system, a health promotion and disease prevention (Gamkrelidze et al., 2002). More detailed priorities for implementing previous objectives were published in the Strategic Health Plan for Georgia 2000-2009. This new phase of reform seems

very promising and proves the determination of the State to perform the health care system. Still, these adjustments have to bring the expected health benefits to the population.

As it can be seen from the above lines, Moldova, Ukraine and Georgia had a series of similar problems after declaring their independence in 1991. The health care system of these countries suffered major financial shortages and proved to be extremely complex and expensive to the new demands. The economical difficulties aggravated the situation and led to a crisis of the health care institution. In this particular context, the State had to enterprise imperative reforms. All Moldova and Ukraine, and Georgia adopted changes in the period following the Soviet Union collapse. These reforms took place at more or less different degrees. Ukraine and Georgia embarked almost immediately for institutional change, while Moldova did it in a more slowly manner. The three countries had to respond to similar problems and thus focused on the development of the primary care, the reduction of the hospital sector capacity and the decentralization of the system. The process of reform continues nowadays, as many problems subsist. Policy decision makers look for solutions internally, but also at the level of international experience. This is precisely the point of a research on an institutional transfer in the health care systems of Moldova, Ukraine and Georgia: which institutions from other systems were borrowed to the national specific context of these post-soviet countries?

3.2 The Hospital Design process: a key to the reform?

While exploring various literature in the area of development of Georgia, Moldova and Ukraine (reports, articles in medical science, books on the health care reform), I observed that main changes in the health care systems have occurred since the year 2000. In order to measure what transformation, of what importance and under which conditions took place, the medical institution is employed as a tool. Its evolution after 1991 is expected to show a concrete example of change. This choice is made upon the significance of the hospital in the health care system and more broadly, its place in the society.

The hospital has a central position in the health care system. It represents an important subject of reform in European Union countries as well as in former Soviet Union states. Yet, as institution, hospital has received little attention from policy-makers and researchers (McKee, Healy, 2002). Most of the found literature is produced by the European Observatory on Health Care System. Scholars as Martin McKee, Judith Healy, Josep Figueras etc. have provided precious information on the role of the

hospital in the health care system, the process of hospital reform in West European countries and other linked subjects.

The significance of hospitals relies on the financial account they represent in the health care budget (50% in many west European states and around 70% in former Soviet countries), but also on the policies they adopt, the service access they provide, the professional specialists they employ and the technological developments (McKee, Healy, 2002). The organisation and efficiency of hospitals influence positively the development of the health care having a major impact on the system. In this context, I employ the hospital as a tool for measuring the change occurred in the health care institution of Moldova, Ukraine and Georgia.

Before being analyzed, the hospital as an institution needs to be defined. McKee and Healy consider the hospital as "an institution which provides beds, meals, and constant nursing care for its patients while they undergo medical therapy at the hands of professional physicians. In carrying out these services, the hospital is striving to restore its patients to health". In another article of 2002, authors mention that the hospital is not only a place where ill people are treated. It also participates at the training of professionals in the health sector and realizes necessary research for the development of the medicine field. Paraphrasing these expressions, the hospital can be envisaged as a medical institution which provides care and/or therapy for its patients in the aim of restoring their health and participates at the advance of research in medical science (McKee, Healy, 2002).

The role of the hospital is mainly to provide care to the patients. Maurice Le Mandat, who wrote the "Bible" of the hospital architecture in France, suggests five functions of this institution: welcome and accomodation of patients, technical-medical function, medical training and research. The author stresses the significance of the hospital which represents an expression of time, related to the economy and the architectural tendency of the moment (Le Mandat, 1989). This suggests the idea of the hospital evolution over time. At different historical periods, hospital represented different configurations. At the beginning, hospitals in Western Europe emerged in the monasteries. As services were little developed, much of the care was provided by the family and the local communities (McKee, Healy, 2000). The industrial revolution induced several changes. Hospital remodelled its image in the context of the rapid urbanisation and of the increasing needs in health care. By the end of the 19th century, the medical science developed knowledge on many popular diseases, thus enlarging the care procedures at the hospital. Since the 20th century, the institution has integrated the role of cure, in addition to the care providing. Main evolutions took place after the World War II, as well as in the 1970s. New disease treatments, new technologies and specialities emerged, thus establishing the role and the major place of the hospital in the health care system. The image of the hospital changed as well. In the past it represented a building concentrating the illness and sometimes infectious disease.

Today the hospital is “a modern complex in which seriously ill patients are treated at high speed with highly technical equipment and by skilled specialist staff” (McKee, Healy, 2000). In addition, the institution is subject of advanced design, perfectly integrating the urban paysage. More generally, its transparent image is transmitted to the public by several American or European television programmes.

As it can be seen, the hospital as institution is an integrated part of the health care system, related to the evolution of the society. This reflection implies that it responds both to the needs of the population and to the economical possibilities of a country. The material and human resources have a significant importance in the realization and the functioning of a hospital. At the same time, these items have a cost and thus influence the configuration of the institution. Policy-makers are concerned about these issues. They need to estimate the health care policy objectives the hospital are expected to cover, in terms of current and possible disease, in terms of staffing (reflecting the demographic situation) and of technology developments for new treatments. As the design can be rather long and the expected life time of the structure is of around 50 years, the construction of a hospital is an elaborated process that needs definition and programming. The realities of each country shape the nature and the characteristics of the hospital in different ways, both in terms of demands and available resources. The former Soviet Union countries face with inherited hospitals of inconvenient size, position and functions. These institutions need to be either restructured, either completely rebuilt. This process implies particular consideration and benefits of special attention from the national policy-makers.

As the second part of this paper mentions, the three post-soviet countries were challenging several problems of the health care systems after declaring their independence in 1991. The hospital sector counted important capacity of structures and personnel. The number of beds was extremely high and did not correspond to new economical situation. The line of the health care system needed reform. Further research will focus on this aspect of changes in Moldova, Ukraine and Georgia. A comparative perspective will be used in order to stress the similar or different adjustments. In a paper for the Medical Revue of the Medical Insurance, Martin McKee and Judith Healy argue that hospitals are able to change, but they can not do this very rapidly – "hospital mutations are slow", as their structures and cultures can be hardly transformed. During the study on the hospital reform in post-communist countries, the character of the transformation will be analysed. The questions to be raised would be under what favourable conditions the change took place? In another words, I will study the procedure of transformation of former soviet hospitals, outline the main current characteristics and measure the foreign adopted influences after 1991.

4. Conclusion

After Soviet Union's collapse, a series of transformation in economical and political system of Moldova, Ukraine and Georgia took place. The purpose of the thesis is to analyse the origin of the change observed in the health care system. Did the European Union, the World Health Organisation, the World Bank or other actors induce institutional transformations in the post-soviet countries? The main issues of the research concern the characteristics of the transfer, the involved actors and the reasons of acceptance of foreign experience.

In order to analyse the institutional transfer in the health care system of former soviet countries, the medical institution is used as instrument. Its evolution over time will establish the institutional change. The reconfiguration of hospitals is one of the main subjects on the national agenda of post-soviet countries thus placing the issue at the heart of the reform. The hospital can face various changes over history. Its design have to respond to new population demands, patterns of disease, new technological methods, public and political expectations. More precisely, these expectations could have been influenced, thus raising the question of the institutional change source.

The hospital institution will be analysed in the framework of the historical neo-institutionalism. The study of the inherited USSR patterns in Moldova, Ukraine and Georgia will point out the incremental or radical character of the reform. The concepts of institution and institutional change bring necessary definitions for elucidate the observed phenomenon. The ideas explored by the institutional transfer will serve of theoretical base for understanding the main actors influencing the institutional change in the three countries. The phenomenon of europeanisation, largely explored by scholars in political science especially during the last decade, presents necessary tools for confronting the hypothesis of the European Union's involvement.

The research on the institutional transfer from the European Union to Moldova, Ukraine and Georgia will enlarge the discussion on the institutional change in post-soviet systems, will explain the trends of the new health care reform in these countries and will present an original articulation between institutional transfer and europeanisation phenomena.

Notes and References

¹ The paper presented follows my participation at the summer school "The Europeanisation of societies: standstills and changes in the Global Age" organized by the European Centre Jean Monnet, Universities of Trento and Innsbruck, during September 2008. Having had the opportunity to discuss questions of europeanisation with students and professors of political science, as well as to present a poster on my thesis, I have been inspired to write a paper summarizing the main points of my beginning research.

² The European Observatory on Health Systems and Policies represents a partnership between the World Health Organization Regional Office for Europe, the Government of Greece, the Government of Norway, the Government of Spain, the European Investment Bank, the Open Society Institute, the World Bank, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine (<http://www.euro.who.int>).

³ The Health Care Systems in Transition (HiT) profiles are country-based reports that provide an analytical description of a health care system and of reform initiatives in progress or under development. The HiTs are a key element of the work of the European Observatory on Health Care Systems. The documents are produced by country experts in collaboration with the research directors and staff of the European Observatory on Health Care Systems (<http://www.euro.who.int>).

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