SOCIAL

CASE STUDY: THE METALLURGICAL SECTOR AND THE PRIVATIZATION OF SIDEX

The Resita steel plant conflict created unrest throughout the whole metallurgical industry. Due to the forthcoming privatization of Sidex, the steel industry seems in danger to become a tension ridden sector with a high potential for conflict. The Metarom union, which represents the workers in this industry is a cohesive, quite autonomous federation, despite its formal affiliation to Cartel Alfa, which seems to increase the risk of conflict even further.

Income in the steel industry

The Romanian steel industry includes 21 units. Among the most important are Sidex Galati, now to be privatized to ISPAT, COS Resita, COS Hunedoara, COS Cãlan, Otelul Rosu, COS Târgoviste, Laminorul Focsani, Petrotub Roman, Siderca Calarasi, Industria Sirmei Cimpia Turzii, Carsiun Hirsova. Four of these - Sidex, Resita, Otelul Rosu, Siderca – are going through various phases of privatization – a process which seems plagued by controversy.

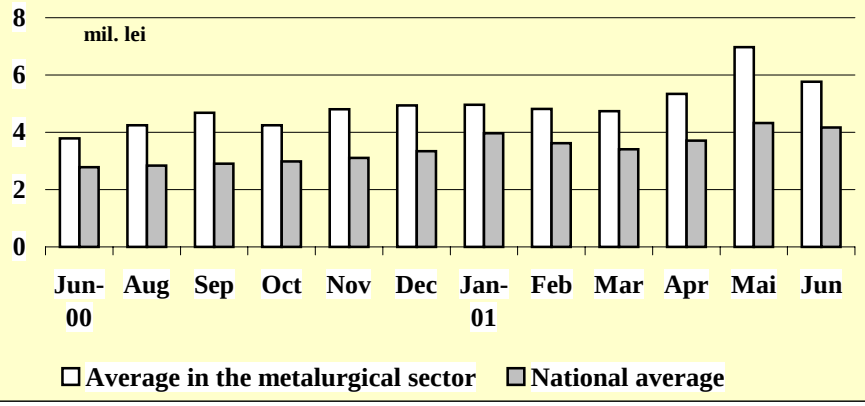
This is an industry where the gross salary level is 30% above the national average. It is true that, in the broad picture, steel industry wages (5,768,000 lei) registered a slight decrease, but this is only because one of the main units in the industry – Resita – did not pay workers' wages at all.

Labor claims

Although wages in the sector are relatively high, Metarom is one of the most active trade union organizations. Initially, trade union claims only targeted wage policy. Gradually, with the escalation of the conflict in Resita and the

passing of Pension Law 19/2000, their claims started focusing also on this latter legislation.

Fig. 1. Average monthly salary in the metallurgical sector



The first type of claims was focusing on wages, namely:

1. re-negotiating the industry collective agreement – ferrous and non-ferrous metal processing
2. increasing the minimum wage negotiated in 2000 by 75,000 lei, correlated with inflation and Law 19/2000 (Pension Law). This would lead to an increase of the minimum wage in the branch to US$ 90/month (2,700,000 lei)

During the July negotiations, employers suggested that wages only be indexed with 80% of the inflation rate and in response to the impact of Law 19/2000. Subsequent to negotiations between Metarom and the Ministry of Labor, the minimum salary in the industry has been established at 2,400,000 lei, starting with July 1 (2,500,000 starting with October 1).

The second type of claims targets important legislative changes. They were first put on the agenda by two units affiliated with Metarom – Targoviste and Galati – but were subsequently adopted by the higher echelons of the trade unions (the Metarom federation and even the Alfa confederation). These claims focus on the consequences of the new pension law. They are, according to the President of COS Târgoviste, Nicolae Coman:

1. Modifying Ordinance 79/2001 on the methodology for correlating wages and inflation rate
2. Modifying the pension law so as steel industry employees included in Group 1 can retire when reaching the age of fifty, as they did under the old pension law.

In Târgoviste, there are no tensions because there have been no lay-offs lately (on the contrary, workers were hired during the past month), so that the

union leaders blame problems in the sector mostly on the trade policies, which allegedly need revising.

Will Sidex become another Resita?

Union representatives of Sidex Galati are mainly unhappy with the application methodology for Pension Law 19/2000. These concerns are not specific to the situation at Sidex, but are the same in the whole industry:

- maintaining lower retirement ages for employees in categories 1 and 2
- changing the pension calculation system and their level according to OUG 79/2001

Pensions calculated under the new system are allegedly only half of those defined by the old legislation1. Consequently, if before April 1 an average worker at Sidex could retire on a 3,5 million lei pension, after that date his or her pension becomes only 1,8 mil. These claims have already made the subject of a trade union rally on July 16, showing how serious the concern of the union members is. Since the transfer of property is not yet completed, these issues could still compromise the whole process.

The events in Resita could create a dangerous precedent if the already tense situation at Sidex becomes even tenser with the approaching privatization. The change of owners, even if it does not, according to negotiations, lead to lay-offs, will bring about managerial and structural modifications triggering tensions and uncertainty. Against this background, the current claims may receive an even greater support and become reasons for conflict, specially with the external influences that promote trade union claims in order to compromise the privatization (i.e. collaborators, current partner companies etc., who benefit from the current state-owned status of Sidex).

The claims raised lately by trade unions should therefore be solved before the ownership transfer is performed. The current claims are aimed at legislative changes related to labor policy, so only indirectly connected to the future owner, and therefore should be solved beforehand. Otherwise a bizarre situation could result, same as in the Resita case, where the union from a private enterprise negotiates not with the employer but with the state.

The Sidex union's main grievance is against the pension system. The union leaders suggested that an exception could be made to the law allowing for Sidex employees to retire under the old provisions for the next five years.

How should labor negotiations be approached?

By taking into account the strategic mistakes made in the Resita case (see the last issue of our report) but also the specific elements of the privatization in

[1] Interview by the expert with Marcel Oancea, Sidex trade union leader.

the case of Sidex, the following recommendations could be made in order to relieve tension prior to the ownership transfer:

1. Closing the current labor disputes before the ownership transfer is completed.
2. The two major claims (early retirement age and a redefining of the pension calculation system) can be solved by establishing an early retirement mechanism, via a compensation system based on funds created by the new owner (to be included in the privatization contract). This is the only level at which APAPS can discuss labor-related issues.
3. The non-involvement of APAPS in post-privatization labor negotiations is desirable. The Social and Economic Council representatives are the only ones who can mediate between owners and employees. The privatization agency (APAPS) should stay within the boundary of its attributions specified by law and privatization contracts.
4. Containing the claims regarding the pension law to Sidex (especially if solutions are available) or to Metarom at most. As currently there are tensions between the leaderships of big confederations and the steel industry unions, especially those from Sidex, negotiations should take place at the lower level, with no confederation involvement.
5. APAPS should establish, immediately after the privatization takes effect, a transparent mechanism of control with clearly defined deadlines and public reports.

THE REFORM OF THE HEALTH CARE SYSTEM: KNOCKING AT THE WRONG DOOR

Defying the logic of reform, the hospital sector takes now a larger share of health care resources than before. The policy changes under consideration by the Ministry of Health will either be irrelevant or downright detrimental.

Romanian health care reform aimed to increase the overall resources allocated to health care and to shift the emphasis from in-patient to primary care. Three years after the nation-wide introduction of the new funding system – social insurance – the "pie" for the health system has substantially increased. However, hospitals consume an even larger share of this pie, due to the lack of effective cost-containment incentives in a non-competitive system dominated by hospital doctors. The situation has the risk of affecting the funds available for the primary care – an essential element of the reform

strategy -, and for subsidized drugs – a paramount social issue. The new administration has correctly identified the hospital sector as the weak link of the reform. Its key policy proposals, however, either fail to correct the problem – the new funding system based on the case mix (DRG) – or might make the situation even worse – the partial privatization of hospital clinics, that runs the risk of shifting private costs to the already over-burdened public sector.

Background

Romanian health care reform has been under consideration for most of the 1990s. The crucial piece of legislation, the Law of Social Health Insurance, was passed in 1997, and became effective in 1998. The law replaced the old funding system, based on national taxation, with a payroll-hypothecated tax (social insurance), administered by regional (county) health funds.

The two most important objectives of the reform process were:

- To increase the overall resources for health, and
- To shift the emphasis from in-patient care, to primary care

For example, Fig. 1. summarizes the major problems to be resolved, in the view of consultants who helped draft the reforms. Low funding and emphasis on specialist care figured prominently.

Fig. 1. Pre-reform strategy. Bottlenecks and problems in Romanian health care

*Insufficient funding
⇒ specially low incentives for professionals
*Poor health indicators
*Inefficiencies:
⇒ Emphasis on specialist care
⇒ High hospitalization rates
⇒ Surplus of hospital beds and high occupancy rates (but no staff surplus)
* Insufficient quality assurance
* Poor performance of certain prevention programs
* Existence of parallel health care systems
* Decreased access in rural areas
* Unclear ownership of facilities

Source: BASYS, 1997

The reform process moved further in primary care, which was effectively privatized through the introduction of family doctors and the change of the funding system to one based mainly upon capitation. There was much less progress in the hospital sector. The ownership of facilities is still unclear, and

funding is still based on traditional budgetary distribution. **Health funds, which theoretically belong to the purchasers of health services, and have to enter into contracts with the providers, failed to act selectively and had little impact upon the behavior of providers.**

Healthcare Funding

Romania used to spend 2-3% of the GDP for health care. This was one of the lowest shares of GDP devoted to health among CEE countries (even if, according to the World Bank, it was consistent with the development level of the country). The health status of the Romanian population also looked worse than in neighboring countries. In this context, policy makers considered the level of spending insufficient; therefore social insurance was introduced to mitigate the situation.

Fig. 2. shows that since its introduction in 1998, social insurance has reached this goal. Public expenditure on health care increased to 4% of the GDP. When private expenditure is added, the total amounts to almost 5%. While this is still low by European Union standards, and even by the statistics of other CEE countries, it is a considerable increase in relative terms from the early 1990's.

Fig. 2. Evolution of health expenditure – relative terms

Funding sources	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Total public health expenditure out of the GDP (%)	2.7	2.8	3.1	3.0	3.1	3.1	3	2.8	3.2	4.0	4.0
Total health expenditure out of the GDP (%)	3.5	3.5					3.7	3.5	4.1	4.9	-

The increase is substantial, as also shown in Fig. 3, which presents the evolution of health expenditures calculated in US dollars.

Fig. 3. Evolution of health expenditure – absolute terms

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Total public health expenditure (bil. USD)	1.09	0.81	0.6	0.78	0.93	1.09	1.05	0.98	1.3	1.37	1.34

Social insurance has now become the main source of funding for the health care sector. Fig. 4 presents the evolution of the sources of funding. Currently, social insurance accounts for over 80% of health care finance.

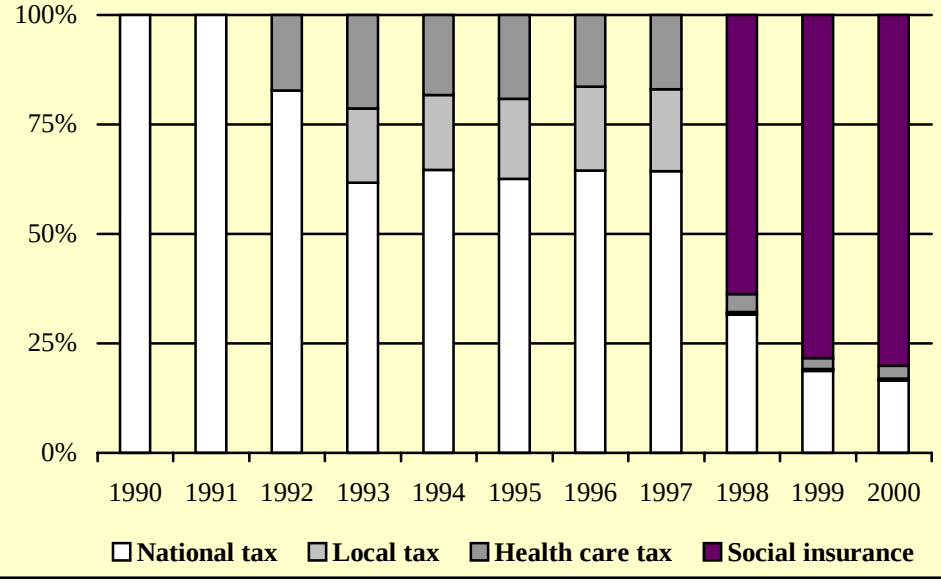
Hospital sector

Romania entered the reforms with an over-bloated hospital sector – not unlike most CEE and even EU countries however. The main indicators used to assess efficiency in the hospital sector are:

- Number of beds,
- Occupancy rate
- Number of admissions, and
- Length of stay

The latest statistics available present Romania's figures at the higher end, but within the expected range, in reference to all the indicators. The rate of admissions (about 20/100 people), and the length of stay (about 10 days) are in the higher numbers in WHO Europe region as a whole, and average for CEE countries. The occupancy rate (about 75%) is in the lower half, while the number of beds (over 7/1000 people) is in the higher one.

Fig. 4. Main public funding sources



In assessing this performance we have to take into account that all the countries we benchmark with have a dire situation in the hospital sector: they all attempt to reduce the number of beds, admissions and length of stay, and to increase the occupancy rate. A situation which is slightly worse than their average is, therefore, still problematic.

However, it is important that over the 1990's these indicators moved in the right direction. The number of beds declined sharply by about 20%, while the admission rate remained nearly the same. This boosted the occupancy rate. The length of stay declined by about 15%.

The most important conclusion from the point of view of funding is that the utilization indicators have not worsened. This shows that the pressure for increased spending does not come from a larger number of cases.

Hospital funding

Fig. 5 lists once again the reformers' expectations concerning the allocation of resources within the health care sector. We can clearly see the intended shift of resources away from the hospital sector, and into primary care.

Fig. 5. Wishful thinking: 1997 pre-reform strategy.

Kind of health care	Current (1997) financial allocation of resources, %	Estimated financial allocation of resources, %
1. Hospitals	50	35
2.Secondary care	30	30
3. Primary health care	20	35

Source: BASYS, 1997

Fig. 6 presents the resource allocation breakdown within the health care sector. Presented are the provisions of the framework contract (drafted at the beginning of the year), and of the "summer budget" – the mid-year correction of the budget.

Each year, the share allocated by the summer budget for hospitals was over-shot by actual expenditures. The reverse is true for primary care and drug expenditures. This data suggests the inability of the budgetary sector to respect budget constrains. We have to bear in mind that, as fig. 7 proves, the resources actually collected have always been smaller than the estimated. This resulted in lower than expected expenditures. As a consequence, a higher than expected share for hospital expenditures means lower than expected real resources for primary care and prescription drugs. **From the champion of reforms, primary care has become the Cinderella of budget allocations.**

The fact is that Romania spends, in relative terms, more on hospitals, and less on primary care and prescription drugs than most OECD countries. **In addition, we have to bear in mind that this breakdown is based on the expenditures of health care funds. The share of hospital expenditures would be even higher if the 20% of public expenditures were to be taken into consideration.**

Fig. 6. Health care expenditures: a comparison between actual expenses and the amount provided by the National Framework Contract (NFC), and the revised mid-term budget (MTB)

Type of service, %	1998 Actual	1999 NFC	1999 MTB	1999 Actual	2000 NFC	2000 MTB	2000 Actual
Primary care	9	15.5	9.5	9	14.5-15	9.8	9.5
Out-patient (specialists)	5.8	11.7	6.6	6.1	8.7	7.8	7.2
Hospitals	67.2	40	61.2	64.1	59-61	64	65.5
Subsidised drugs	6.8	20	9.3	8	10-11	12.8	12.4
Dentistry	2.7	4.2	2.8	2.4	2.5-3	1.6	1.4
Rehabilitation services	0.8	1	1.2	1.1	1	0.6	0.6
Prosthesis	3.2	3	0.6	0.3	1	0.3	0.3
Ambulance services	4.3	4.5	3.8	3.7	3-4	3	3
Health programes	0.1	0	5	5.2	0.1-1	0	0
Total	100	100	100	100	100	100	100

Fig. 7. Income and expenses of Health Care Funds 1998-2000

	1998			1999			2000	
Bil. ROL ,000	Budget law	(*)	Actual	Budget law	(*)	Actual	Budget law	(*)
Income	10.3	9.5	8.4	11.9	20.4	18.4	26.7	29
Total expenses	7.6	7.6	7.4	11.4	17	15.9	23.9	25.2
Reserve funds	-	-	-	0.6	0.96	0.8	1.3	1.4
Balance	2.7	1.9	0.9	0	2.5	1.6	2.3	2.3

(*) Mid-term budget adjustment

To put things into context, Fig. 8 presents the break down of resources by sector in health care for OECD countries.

Fig. 8. Public health care expenditure broken down by sector in OECD countries

Public expenditures by health care sector out of total public health care expenditures, %	Average	Max	Min
Hospitals	54	78	30
Prescription Drugs	13	27	6
Out-patient services	21	40	8

This is even more surprising when taking into account that in the early 1990's Romania and the Czech Republic were the champions for prescription drug spending. The expectations for a country like Romania is to spend a greater percentage on prescription drugs compared with western countries, because the prices of tradable goods such as prescription drugs vary less among countries than the price of labour. Therefore, one would expect the labour intensive sectors to take a lower share from the overall resources in Romania, as compared with Western Europe.

An institutional explanation

The root of the problem is the lack of adequate institutional incentives for cost-containment at the hospital level. The hospital sector is very powerful politically, as it is comprised of the medical elites. The problem is made worse by the fact that the members of this elite are the decision-makers at all levels of the health care system.

The lack of competition between health care funds (that are regional monopolies, and therefore do not have to compete for clients) creates an institutional framework where there is no incentive for the health care fund to confront these powerful interest groups and enforce hard budget constrains upon hospitals. The dominant strategy is an alliance of the purchaser with the provider to pass the costs on to the budget.

In addition, the autonomy of hospital managers is limited, which precludes even the restructuring measures intended by public-spirited managers.

Reform plans of the government

The previous administration had come to terms with the profligacy of the hospital sector, and accommodated their increased expenditure. The new leadership in the Ministry of Health and Family has identified hospital sector reform as its priority. However, it is less clear whether the new decision-makers understand the mechanisms that led to the current situation, and - if they do - how are the policies that have been announced going to mitigate the situation.

The main initiatives consist of changing the funding system to DRG (diagnosis groups), and partial privatization. Theoretically, basing the funding on the case-mix rather than on actual costs would encourage hospitals to be more efficient. The problems is that DRG *per se* could lead to more efficient interventions, but not necessarily result in overall cost reductions. More important, the full implementation of DRG is a very complicated process, which is going to take years, as proven by the Hungarian experience (the first CEE country to use this method). Therefore, whatever benefits it will bring, DRG is not going to be a solution for the short term.

Privatization is a tricky matter. Whether this means the outsourcing of some services, or even the privatization of hotel services, it will improve efficiency. Partial privatization of hotel facilities**,** however, bears the risk that a part of the private facilities costs will be passed to the public section of the hospital.

A much better alternative would be the outright privatization of hospital sector (or creating new private hospitals).

While both policies have things to be commended for, they fail to address the cost containment of hospital expenditures and the looming crises in the primary care and pharmaceuticals.

Conclusions

In spite of improved overall funding for health care and no increase in utilization rates, hospitals consume an even greater share of health care resources. Romania, despite its low wages, is in the paradoxical situation of allocating larger shares of public health care resources to hospitals than other OECD countries. This situation presents obvious social and political risks. In addition, it undermines the role of primary care as the champion of reform.

The initiatives of the new administration concerning the hospital sector fail to address the cost-containment problem. While the shift to case-mix funding and the privatization are commendable, their effects will not be seen for years to come. Moreover, partial privatization of hospital clinics might worsen the financial problem in the public sector, resources from the latter being detoured by managers to private patients.