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Model for public watch over healthcare spending

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In Ukraine today, the environment for a dialog between the state and citizens on public control over public healthcare spending is almost entirely lacking. The reason for this is the absence of the necessary mechanisms, institutions, procedures and practices for public participation in the decision-making process within authorities. But extending democratic principles to healthcare is one way to improve public policy in this area and raise the health of Ukrainian society in general.

The development and institution of public control over public healthcare spending should be a reform priority. This, in turn, requires a set of clear, understandable and transparent rules and procedures.

This manual presents a practical model for public control over public healthcare spending. The main requirements attached to this model are described in terms of legal and institutional arrangements for public control, the dissemination of information and the participation of NGOs in mobilizing the general public.

Jointly prepared by specialists from the Euro-Balkan Institute (Macedonia), the Public Policy Research Center (Kazakhstan), and the International Centre for Policy Studies (Ukraine), the uniqueness of this publication lies in the fact that, during its preparation, public policy tools used in the European Union, Central Europe and Central Asia were examined.

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Chapter 1

International budget watch experience at the local level

The issues of fiscal transparency and public control over public spending are of great importance to all democratic societies. They are particularly important for transition countries, since it is widely believed that they are crucial preconditions for good governance and have a broad and positive effect on fiscal performance. Efficient and workable mechanisms for citizens to influence spending decisions is extremely important for developing democracies, as it proves to the ordinary person that their opinion matters.

The quality of healthcare, as many studies confirm, remains on the list of priority issues for the majority of voters. Moreover, health policy decision-makers are grappling with increasingly complex, contentious and ethically controversial decisions around how to distribute limited resources based on real needs and requirements. Although these factors call for active public involvement in policy development and implementation, the institution of a working mechanism of public oversight in this area requires special efforts because of the complexity of this issue. Among the key factors that complicate public participation are these four:

- The lack of information about the forms and mechanisms of public participation;
- Insufficient information on public spending;
- The complexity of assessing the connection between allocated funds and achieved results;
- The risk that the most vulnerable population groups will be outside policy debates.

Since it is voters who finance a country's budget, they should benefit from public spending and should have the right to control it.

Different mechanisms of citizen participation in the policy-decision process require the active involvement of the NGO sector whether government bodies or citizens initiate the process. NGOs serve as organizational centers whose non-government specialists are in a position to provide a sufficient level of independent budget analysis—a key component of effective public engagement. This analysis can be general or thematic, but conducting it requires definite capacity and good access to information about public spending.

Although the institutionalization of different mechanisms of public involvement is not indispensable to success, it secures such mechanisms from arbitrary rule, manipulation and politicization. Special submechanisms might be necessary to enable the participation of vulnerable groups and those traditionally excluded. This can be done equally through regulations at the central and local level and through internal rule-bound procedures.

Some theory and the basics of fiscal transparency

Some research suggests that higher levels of fiscal transparency are associated with lower levels of debt, lower spending levels[1] and more moderate budget deficits.[2] Other researchers hypothesize that if the budgets were open to public and effective legislative scrutiny, there would be less scope for deviation from policy decisions and the reversal of budget allocations, i.e. the ruling elite would be less likely to manipulate the state budget, leaving less room for corruption.[3]

There are various theoretical viewpoints on the specifics of fiscal transparency. The most suitable and useful for preparing a "budget watch" model are those presented by Tsuru Kotaro, a RIETI Senior Fellow, in an article published in Economics Review.[4] Kotaro analyses the issue based on a theory by two IMF economists[5] that comprehensively takes it up from the three viewpoints of institutional transparency, accounting transparency and transparency of indicators and projections.

Kotaro indicates that, in the case of "institutional transparency," the important point is how to provide a government with effective monitoring and governance, so that the government acts as an "agent" in undertaking the planning and execution of budgets in a way that best benefits the general public, who are the "principal." He quotes Kopits and Craig, who propose that the government set forth fiscal targets and policy priorities, explain them in budget documents, ensure transparency in executing the budget, and disclose the results of performance assessments and financial audits as a specific means of realizing this. At the same time, the two economists call for the establishment of an independent monitoring body that has wide investigative authority over government activities.

Accounting transparency is a more complicated issue because normally governments submit budget documents to the legislature, so it is fair to say that the details of a state budget are fully disclosed to the public. By natural necessity, however, the budget documents of a national government are extremely complicated and far from easy to understand for the average reader. What is worse, politicians and bureaucrats may intentionally make such documents more complicated than necessary and use ambiguity to hide lax fiscal expenditures in pursuit of some private interest. Kotaro comes to the conclusion that, with regard to accounting transparency, it is important to

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[1] See *Fiscal Transparency and Fiscal Policy Outcomes in OECD Countries* by James E. Alt, David Dreyer Lassen and David Skilling, an early draft of a paper prepared for presentation at the 2001 Annual Meeting of the Midwest Political Science Association, Chicago, IL, 2002.

[2] See *Fiscal Institutions and Fiscal Performance*, edited by James Poterba and Jurgen von Hagen, NBER, University of Chicago Press, 1999.

[3] *http://www.u4.no/document/health/budgettransparencyintro.cfm/*.

[4] See *Transparency of Government (Part 2); Transparency in Fiscal and Monetary Policies (2003.7.22)* by Tsuru Kotaro, Senior RIETI Fellow, Economics Review, 2003.

[5] See "Transparency in government operations" by G. Kopits, and J. Craig, *IMF Occasional Paper* №158, 1998.

provide comprehensive information, including budget breakdowns for every entity, as well as inter-entity fund transfers, in a way that is true to reality. The general government budget, including budget breakdowns for central and local governments, should go as far as detailing off-budget funds such as social security funds, as well as the quasi-fiscal activities of public corporations.

Last, but not least, is the transparency of indicators and projections. A typical technique that government officials and politicians use to justify excessive fiscal outlays is to provide optimistic projections for economic growth and tax revenues based on optimistic predictions of the economy. This makes it extremely important to ensure transparency in projections, which can give to the public an opportunity to make a realistic assessment of how relevant the budget size is. The government should also provide information on various economic indicators in order to allow the public to adequately understand and analyze the current state of public fiscal conditions and possible alternatives.

The role of civil society in the budget monitoring process

Consistent with the movement toward more open government, citizens around the world have become increasingly concerned about obtaining access to accurate, comprehensive and timely information on their country's budget. That is why, since the 1990s, civil society organizations (CSOs) have begun to play a larger role in the budget process in some countries. Many NGOs started carrying out independent research and training with the aim of building public awareness on budget issues. NGOs are involved in budget analysis, providing comprehensive information to the public and the media, often enabling them to comment on budget proposals and to monitor expenditures. NGOs also carry out surveys to compare budget transparency across countries, thus putting pressure on governments to improve their budget systems. In recent years, many NGOs have begun to specialize in budget analysis, offering training to other CSOs.

An analysis by Warren Krafchik,[6] Director of the International Budget Project,[7] shows that the role of civil society in the budget process has been recently expanded from the so-called "applied budget groups." The majority of those groups has emerged and operates within the non-profit, NGO/CSO sectors. However, several groups have been successfully established within an academic environment and a couple of groups have been initially supported from the public sector. The leaders of these groups include activists, academics, former government leaders, business people and consultants.

The vast majority of budget groups operate independently of their country government and political parties. They work at a combination of national, state and local/municipal levels and strive to achieve timely, accessible and accurate analysis. Each group focuses on a wide variety of topics and uses several methodologies. Some groups focus on simplifying the budget for popular consumption, some develop expertise in training, while others develop analytical or advocacy expertise or some combination of these.

Most of the groups monitor every stage of the budget process, but often concentrate their interventions at a specific stage. In many countries, those interventions have enabled broader understanding and participation in the budget process and more effective oversight.

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[6] See "Can civil society add value to budget decision-making? A description of civil society budget work" by Warren Krafchik. The purpose of the paper is to examine the expanding contribution of CSOs to public budgets in developing countries. It provides examples of civil society budget activities in a variety of country contexts in order to measure the value of this work to public budgeting.

[7] The International Budget Project assists NGOs and researchers in their efforts both to analyze budget policies and to improve budget processes and institutions. The IBP is part of the Center on Budget and Policy Priorities, located in Washington, D.C. The Center is a non-profit research and policy institute that conducts research and analysis of government policies and the programs and public policy issues that affect low- and middle-income households.

Public oversight in selected countries

To build and maintain a healthcare system, responsible health sector oversight and pro-equity commitments by the state are essential. However, governments must engage with and respond to communities in a two-way relationship if they are to perform their stewardship role effectively. International experience shows both upward and downward driven patterns of public engagement in the policy-decision process. It can be initiated both by central and local governments and by citizens themselves and can be driven by a variety of motives:

- The desire of politicians to gain support from the population during an election;
- The need for state bodies to gain public support for unpopular measures;
- The desire to get clear signals as to what voters consider spending priorities;
- The dissatisfaction with healthcare users with the quality of services provided.

Regardless of what precise reason gives the initial spur to the process, effective governance and active community involvement will support each other when the right structures are in place. Matching expenditure allocations to the needs expressed by the community can produce measurable improvements in access to social services.

In most mature democracies, there is a strong concern about the ability of the existing format of democracy to ensure the voluntary support and compliance of its citizens. As a result, governments tend to launch different initiatives to engage their citizens in the decision-making process. In most cases, state bodies are obliged to support the demands of their citizens in that direction and to try to institute appropriate structures and procedures.

The situation is different in countries where community participation is only developing. Typically, government officials do not see the advantages of actively involving members of the community. As a rule, active citizens initiate this process and look for ways to influence spending decisions at the local level and to get past the reluctance of local authorities. Even in these circumstances, the organized efforts of local citizens can lead to a substantial increase in the quality of health services.

During the last decade, community participation has transformed from a narrow notion of public oversight through health committees to a wider concept based on the involvement of CSOs. This type of organization can range from management or co-management of health facilities, like the Federation of Community Health Association in Mali, promotion of self-help and self-reliance, advocacy of forgotten or excluded groups, such as people living with HIV/AIDS, or consumer protection, like Thailand's Consumer Foundation.[8]

An active NGO sector can successfully hold healthcare providers as well as governments accountable for what they do and how they do it. However, this mission of public organizations can be effectively carried out only if it is supported by accurate information about the general health of the population and the performance of the

[8] The World Health Report, 2003.

health system. The reasonable voice of CSOs can make the difference in the process of making and implementing decisions only if it is based on available evidence that fully and comprehensively reflects the actual situation and future trends. The government needs to make this information public and accessible. CSOs themselves, in their watchdog function, should also generate and share information for the purpose of accountability.

The experience of different countries is illustrated as models to help design the major components of an effective system for better public engagement in the policy-making process in Ukraine.

Canada

The Canadian healthcare system

The healthcare system in Canada, known as medicare, is publicly financed but privately run and provides universal coverage. Care is free at the point of use for clearly defined basic services.

Provincial governments are responsible for funding certain services—all those deemed medically necessary—for which every Canadian resident is provided with insurance by the public sector. The Canada Health Act explicitly forbids any Canadian to buy a medical service that is already covered under the public health system from the private sector. Private insurance may only cover "non-core services."[9] As a result, the role of private medical insurance in Canada is limited to supplemental care. The role of the private sector is further limited by the regulation of private medical practice and private insurance plans. Private insurance remains a small industry, contributing only 11.2% of total health expenditures. Of the plans purchased, over 85% are purchased on a group basis by an employer, a union, or an association.

Canada highly regulates all aspects of the private sector to prevent a two-tiered system. However, enterprising private clinics have found ways to provide better quality of care to patients. Meanwhile, the federal government has withdrawn much of its funding and has left the provinces to foot most of the bill. The tide may be turning now, with recent public opinion polls showing more acceptance and support of user fees and private insurance options. Future reforms may show Canadians more open to other options for funding their healthcare.

Legislative framework for public participation

The "open government" idea arose as part of a government priority-setting exercise that followed the 1974 election.[10] Driven by forces both inside Canada—rising interest in government accountability on the political agenda—and outside Canada—the Watergate scandal in Washington that broke at that time—, the country's leaders were interested in creating a mechanism that would make federal government more open and accountable to its citizens.

However, the real steps to draft Access to Information legislation were undertaken only in 1979. While political leaders and the Canadian public were ready for a bill, many logistical and national security concerns remained about how such legislation could work in practice. Although some Canadians

[9] The term "core services" has been used to describe those services covered by the provincial health plans. "Non-core services" are those that fall outside the legislative framework.

[10] See "The Exercise of Power Round Table: Open Government Institute on Governance."

were interested in making virtually all aspects of government activity public, others felt that a high level of confidentiality had to be retained.

Canada's political leaders at the time sought a less arbitrary and stringent regime than the one established in the United States. For example, any information that the US government classifies as sensitive to national security is automatically excluded from access to information requests. No test of potential injury is required, and no means of arbitration or recourse are in place. The result has been a massive growth of inaccessible, classified government information, in spite of "open government" legislation.

The real challenge for the authors of the Canadian legislation was to craft a series of tests for the classification of information that would protect not only national security interests but also the sanctity of the Westminster structure. A number of objectives were pursued, beginning with the premise that as much information as possible should be available to the public. Other objectives included:

- protecting the practices and norms which surround Ministerial responsibility and Cabinet confidentiality;
- ensuring that the system would not be abused by those seeking to profit from information or those acting as a nuisance to departments;
- creating a system that was not too "bureaucratic," that is, retaining as much informality in the system as possible;
- creating a system which would offer minimal disruption to the day-to-day activities of public servants, particularly senior civil servants;
- avoiding a potential "chill effect" which would negatively affect operational practices and norms within government;
- including the court system as an arbitrator only as a last resort.

Countries around the world are embracing the idea of open government, including many governments that have traditionally allowed virtually no access to government information. In fact, many are coming to study Canadian legislation in this area.

Ways to involve public in the policy-decision process

The Government of Canada uses a number of vehicles to study policy issues, mainly:

- Parliamentary Committees;
- Task Forces;
- Roundtables;
- Expert advisory groups;
- Advisory and Inquiry Commissions.

Commissions are set up to give what executive government cannot give: outside advice or investigation. Whether advisory or investigative, commissions are established in response to clear and widely perceived need.

Executive government establishes Commissions, sets the mandate, appoints Commissioners, and decides on their powers and procedures. Afterwards, it responds to the their reports and takes steps to implement their recommendations. Once established, Commissions function as independent bodies.

The Inquiries Act provides a legislative framework for Commissions to be set up:

- Under Part I, the Governor in Council may establish an inquiry into matters connected with "the good government

of Canada or the conduct of any part of the public business thereof." Part I Commissions fall into two broad categories: advisory and investigative.

- Under Part II, Departmental Investigations, the Governor in Council may authorize a Minister to appoint commissioners to investigate the management and business of the department.

Investigative Commissions carry out independent investigations of potentially controversial matters, such as allegations of wrongdoing, failures or accidents, which can result in findings of civil or criminal liability.

Advisory Commissions carry out the process of collecting information, analyzing, consulting and reporting on important public policy matters. Such Commissions can serve to explore alternative solutions, enhance public awareness of an issue, and help to develop consensus. Advisory Commissions help the government gauge public support for various options and prepare the ground for later government actions.

The main difference between the Canadian structure and others around the world is that most others have given Commissioners the right to view and evaluate the accessibility of Cabinet documents. In Canada, Cabinet confidentiality is strictly protected.

Public participation

There are several interesting cases of citizen involvement in the decision-making process in healthcare in Canada.

One of the best-known examples of advisory commissions is the **Commission on the Future of Healthcare in Canada**, known as the "Romanow Commission,"[11] named after one of Canada's Governors-General. It was established on April 2001 to lead a public dialog with Canadians and recommend ways to renew and modernize medicare.

The work of the Commission was built on a foundation already established by the First Ministers in a September 2000 Agreement on the renewal of the healthcare system wherein all First Ministers affirmed their support for a common vision for health, a publicly-financed health system, and the five principles of universality, accessibility, comprehensiveness, portability, and public accountability.

The work of the Commission went through four stages: education, consultation, synthesis and validation.

The first phase aimed to provide detailed information on the issue to a wider audience and form a solid background for the public discussions. The **education** phase had six stages:

- An Interim report to create a framework for consultations;
- Televised Policy Debates;
- Televised Partner Dialogs;
- Information on a website;
- A printed product for stakeholders;
- Speeches and presentations in 24 cities.

The **consultation** phase used a multifaceted approach for information-gathering:

- Written submissions for a background paper;
- Open public hearings;

[11] For more details see *http://www.hc-sc.gc.ca/english/care/romanow/index.html.*

- Website and online surveys;
- Toll-free calls.

The **synthesis** phase aimed to summarize the results of broad public discussion and elaborate consensus on the issue under discussion. The synthesis phase was based on regional sessions, that is, on four regional focus groups. Each focus group involve 12–15 participants, who were selected on the basis of region, constituency and vested interest in order to ensure the representativeness of expressed views. The results of the group discussions were presented on the website and used as input on the issues and solutions included in the Final Report.

Validation was done through discussions at a national multi-stakeholder conference. The national conference provided an opportunity to discuss the results of the preceding phases, to present the Commission's research findings, to review proposed policy directions, and to assess their implications. The goal was to move toward consensus on a coherent set of recommendations for placing the healthcare system on a more sustainable footing for the future.

Healthcare rationing in Canada and US

The government handed over to its citizens the politically-sensitive job of deciding who gets "free" healthcare services. The case-study approach to healthcare spending decision-making was tried in two Canadian provinces, Nova Scotia and Saskatchewan, and in the American state of Oregon. Citizen bodies were entrusted to prioritize the treatments that would qualify for public funding, based on technical medical criteria and community values.

In Oregon, an 11-member commission of doctors, other healthcare professionals and lay people did the work of ranking 1,600 condition treatments. In Canada, regional and community health boards had to decide what were core services, although these bodies had more broad-based citizen participation than the 11-member Oregon group. In all three cases, the government used the involvement of citizens to establish legitimate courses of healthcare reform, with varying effects. In one case, the province of Nova Scotia, participatory institutions came up against the institutional power of healthcare professionals. The community meeting process used in Oregon to help prioritize health services was an intensive one that, predictably, attracted participants from the higher socioeconomic layers of the population.

Unlike the public-participation initiatives in Oregon, the process in the regional municipality of Hamilton-Wentworth, Ontario, was not restricted to healthcare and elicited citizen views on a range of environmental, economic and social issues. This broad perspective introduced the concept of trade-offs and competing priorities, which are less apparent when healthcare is considered in isolation.

In 1989, the "Better Beginnings, Better Futures" project, a 25-year primary prevention study, was launched with funding from the Ontario government to assess the effectiveness of community-based programs in preventing emotional, behavioral, physical and cognitive problems in children from economically disadvantaged communities. An important component of this project is the meaningful involvement of parents and community residents. Programs that applied for funding under the project had to demonstrate a commitment to resident involvement by ensuring that at least half of the members of every major committee were parents or community leaders. The resulting experience with resident participation has been summarized in several publications. At all of the project sites described, residents were involved in developing programs, hiring staff and making decisions about the location of neighborhood centers and pro-

grams. Participating residents were not chosen through random selection but, rather, came forward as interested residents or unofficial community leaders. It usually took several years of concerted effort to create and sustain a full range of resident participation in the decision-making process.

Sustainable participatory process in healthcare and social services probably requires that citizens be empowered with real influence in budgetary and resource-allocation decisions. Public involvement in healthcare decision-making in Oregon has so far been consultative only. However, the participation of citizens in Rossland, BC, in local government, although not directly related to healthcare, does indicate that citizens are capable of weighing priorities and making decisions about the allocation of resources.

Hungary

The Hungarian healthcare system

The current structure of the Hungarian healthcare system represents a considerable departure from the former, highly centralized state-socialist model. Since 1989, the system has become more pluralist, with responsibilities divided among various players.

Health services in Hungary are funded primarily through health insurance from the Health Insurance Fund (HIF) for recurrent costs, and administered by the National Health Insurance Fund Administration (NHIFA). Capital costs are financed mainly through taxes.

Healthcare services are delivered predominantly by local state-owned public providers who contract with NHIFA. The national government is the dominant regulator of health services, exercising statutory supervision over HIF and controling NHIFA. In addition, it provides capital grants and delivers public health and some tertiary care services.[12]

Legislative framework for the provision of healthcare services

The Hungarian constitution clearly defines the roles of the executive, legislative and judiciary branches of government and the 1990 Act on Local Government defines the responsibilities of local governments.[13] The central government does not have direct control over local governments, which are made up of county and municipal bodies, but exercises considerable leverage through transfers and requires certain preconditions be met for local government borrowing. More than 50% of local budgetary institutions have significant revenues that they generate on their own but transfers constitute the majority of local government revenues. There are also county and regional development councils that are responsible for distributing regional development subsidies to lessen regional economic disparities.

Since the establishment of the two-tier local government system in 1990, which replaced the "council [soviet]" system of the communist regime, local governments have become key actors in the health sector.

[12] See *Health Care Systems in Transition: Hungary*, by P. Gaal, Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2004.

[13] Local governments are responsible for the delivery of utilities, education, health, and other services. Altogether, they employ 63% of public sector workers in 3,170 municipal bodies and 13,422 local budget institutions.

Although national policy determines the broad framework for local policy, the Constitution guarantees the discretion of local governments in local affairs and this cannot be overruled by national authorities.

Act LXV of 1990 on Local Governments defined the basic structure, rights and duties, sources of funds and properties of local governments. Municipal and county governments share responsibilities on the principle of subsidiarity. This means that county governments take over only public services that municipal governments cannot undertake and are willing to transfer to the county level. The 1990 Local Government Act assigned responsibility for local health services to local governments, implying that they should plan health services for local needs. Responsibility for primary care rests with municipalities and secondary care with counties, but they are allowed to contract out service delivery to private providers. Under a scheme of "functional privatization," a large proportion of primary care has been contracted out to entrepreneur family doctors and a smaller segment of secondary care mainly to a few church-owned hospitals. These providers have two types of contracts: one with the local government, in which they take over service provision, and the other with the county offices of the NHIFA, to become eligible for HIF funding.

The same Act transferred the ownership of the bulk of primary care facilities, clinics and hospitals from national to local government. As a result, local governments have become the main healthcare providers in the Hungarian healthcare system. Municipalities usually own primary care facilities and, depending on the size of the municipality, may own and run out-patient clinics and city hospitals. County governments usually own large county hospitals that provide secondary and tertiary care. Local government-provided health services are financed from HIF. Capital investments are supposed to be provided by the local governments, as they are the owners of the healthcare facilities. Since capital costs are usually higher than the revenue capacity of local governments, the national government provides conditional and matching capital grants through a system of earmarked and targeted subsidies.

Legal basis for fiscal transparency

According to an IMF report on fiscal transparency,[14] in recent years, Hungary has made significant progress in increasing the transparency and accountability of government, and in some areas has established high standards of practice relative to the IMF fiscal transparency code.

The activities of fiscal authorities are clearly spelled out in the Act on Public Finances (APF), which conforms to EU requirements for regulating budget management and provides for comprehensive coverage of central budgetary institutions, extra-budgetary funds, local budgets, and the social security funds the health insurance and pension fund.[15] The APF was put in place in 1992 as one of the first measures to modernize the Hungarian budget process. Thanks to these reforms, Hungary already has a modern and well-working budget process that has comprehensive coverage and is developed within a well-articulated medium-term economic framework. The number of extra-budgetary funds has been reduced significantly, comprehensive fiscal data are reported, and there are effective internal and independent external audit controls.

[14] See the *Report on the Observance of Standards and Codes – Hungary*, Fiscal Transparency, IMF Fiscal Affairs Department, April 2001.

[15] As of the 2001–2002 fiscal years, the budgets of the social security funds have become an integral part of the parliamentary budget process, and are included as separate attachments to the annual budget law.

According to the Public Availability of Information section of the IMF report, "Budget documents provide comprehensive coverage of general government with the biennial budget providing detailed information on the general government and each of its subcomponents (with both a functional and economic classification) for the two preceding years, the two budget years, and an indicative projection for the following, third year. In the case of local governments, only the subsidies transferred by the central government budget are subject to parliamentary approval, but complete information on local budgets and outcomes is presented for information. The final report contains an analysis detailing any deviation between the budgets and the actual out-turn and identifying the effect of changes in the macroeconomic environment, forecast errors, and policy changes during the budget year. Budget details are available through the finance ministry website at *http://www.meh.hu*."

The Hungarian government has recently put in place a system of two-year budgeting and multi-year planning which are intended to be a permanent feature of fiscal management. These two-year plans apply to the central government, social security funds, and the two extra-budgetary funds. In addition the government is encouraging local governments to prepare two-year budgets.

The authorities comply with the requirements of the APF to present the final accounts—for the central government, social security funds, extra-budgetary funds, and local budgets—to Parliament within eight months of year-end, which requires presentation to the State Audit Office within 6 months. During the year, the Ministry of Finance publishes monthly budget monitoring reports covering the central government, social security, and extra-budgetary funds within one week of month-end and sends these reports to the State Audit Office (SAO), the Government Control Office (GCO), and various parliamentary committees. From 1992 to 1998, the government was required under the APF to present a mid-year report to Parliament. This obligation was withdrawn in 1998 since detailed monthly reports are readily available. Under the biennial budget the requirement for annual reports will be retained.

Internal management and controls have been greatly enhanced in recent years by the creation of the Hungarian State Treasury (HST), which controls all disbursements against authorization by the central budget, the extra-budgetary funds, and the social security funds. The HST is responsible for *ex ante* control and overall supervision of the process of appropriation control. The GCO, which operates under the direction of the prime minister's office, is responsible for internal audit and control. The GCO investigates the impact of expenditure or revenue collection, financial controls, and the management of budgetary institutions and the extra-budgetary funds, including the use and management of public funds given through public foundations, county and regional development councils, and NGOs. It also reviews the effectiveness of controls at any level, including ministerial internal control units and the systems and methodologies of the HST. Each budgetary organization has its own internal control unit responsible for ensuring effective control (mainly *ex post*) and monitoring of the effectiveness of control systems.

Slovenia

The Slovenian healthcare system

The Slovenian healthcare system is financed by the state budget, local budgets and mandatory health insurance contributions. Similar to most systems in Europe, the Slovenian healthcare system has characteristics of both the integrated and the contract model of healthcare provision. While the services performed are paid by the Health

Insurance Institute of Slovenia (HIIS) based on a contract between HIIS and the healthcare institution, capital investments in healthcare facilities are covered by the central or local government budgets.

The state budget covers the capital investments for all secondary and tertiary healthcare facilities. It also covers expenditures for the national public health program, which includes traditional national prevention programs as well as some new health promotion programs, medical education and training, research, the national health information system, cooperation between sectors, the national health sector management project and healthcare coverage for specific groups such as soldiers, prisoners and refugees. In the year 2002, the Slovenian Parliament endorsed the introduction of excise "sin" taxes on tobacco and alcohol, part of which has been allocated to preventing non-communicable diseases and health promotion.

Capital investments into primary healthcare facilities are covered by local community budgets. The law obliges self-governing communities to provide for all public services at local level and gives them the right to decide locally how much to actually invest in health.

Existing mechanisms for public participation

There are mechanisms for direct and indirect public participation in healthcare issues in Slovenia. Individuals can participate directly in public debates on the healthcare plan held in the Parliament and in regional-level committees of insured people, which have been established to provide an opportunity for the public to participate actively in planning and managing the health insurance system. Ordinary citizens can also participate indirectly through their representatives in the Parliament, in the Economic and Social Council of the Parliament, in the HIIS assembly and council, in the Councils of Healthcare Institutions, and in health-related associations and NGOs.[16]

Legislative framework for public participation

All requirements for central government budgets, local budgets and the budget of the Health Insurance Institute of Slovenia are stipulated in one act, the Public Finance Act (PFA).

The PFA regulates the composition, preparation and implementation of central and local government budgets, the management of state and municipal property, borrowing on the part of central and local governments, debt management, and accounting and budgetary oversight. It also covers extra-budgetary funds, including the two larger social security funds—the Health Insurance Institute of Slovenia and the Retirement and Disability Pension Insurance Institute—, and the activities of the indirect budget users. It stipulated the rules for drawing up and submitting financial plans, cash management, borrowing, issuing guarantees, accounting, submitting annual reports, and budgetary oversight.

The main focus of the PFA is on financial compliance, but it also includes provisions for the efficiency and cost-effectiveness of budget expenditures. All laws and regulations must be accompanied by cost estimates and all major budget proposals must include cost-benefit analyses. The PFA includes provisions for budget proposals and financial statements from central and local governments, but there are no specific legal require-

[16] See *Health Care Systems in Transition–Slovenia* by Tit Albreht, Marjan Cesen, Don Hindle, Elke Jakubowski, Boris Kramberger, Vesna Kerstin Petric, Marjan Premik, and Martin Toth, Vol. 4, №3, 2002, European Observatory on Health Care Systems, 2002.

ments for transparency in budget management and reporting.

The transparency of extra-budgetary funds is provided by the *Law on Public Funds*, adopted in February 2000, which creates a consistent framework for the management of and reporting on public funds.

Fiscal reporting to the public and the legislature in Slovenia is done on a monthly basis. The Ministry of Finance prepares a monthly bulletin, which covers the cash flows of the central budget, local communities and social security funds. According to the results from the *Open Budget Questionnaire Survey*[17] Slovenia is one country that has developed an open budget system in a relatively short period of time. The Slovenian institutions responsible for budget matters issue both timely and detailed in-year reports and a mid-year review of the budget. Similarly, the executive's year-end reports are timely—within six months after the end of the fiscal year—and provide detailed comparisons of actual outcomes and enacted levels. Audit reports are released within 12 months of the fiscal YE. Furthermore, reports that track implementation of audit recommendations are issued as well.

According to the same survey, Slovenia engages in practices that encourage both public and legislative involvement. It provides information that highlights policy and performance goals, including performance indicators and, for some programs, performance targets. Moreover, it provides supplementary materials, such as a non-technical "citizens' budget" and a pre-budget statement, that can help facilitate a better understanding of the budget and its policies.

Budget documents[18] are available to the public in the *Official Gazette* of the Slovenian Parliament and most of them are available on the internet as well. According to an IMF report on the state of fiscal transparency in Slovenia,[19] these budget documents provide a fairly comprehensive and detailed coverage of all fiscal activities.

The Slovenian *Act on the Access to Information of Public Character* establishes the conditions for transparency of public information, including budget spending, which, combined with the openness of the budget process, create good preconditions for exercising public control and monitoring budget spending. According to the PFA provisions, local governments are to set up suitable forms of internal budget control in accordance with the detailed instructions laid down by the minister responsible for finance.

[17] The *Open Budget Questionnaire* is a measurement tool to evaluate public access to budget information from the perspective of CSOs. It also covers other budget process issues in order to explore ways of improving public understanding and involvement in the budget. The questionnaire was developed by the *International Budget Project*, which is part of the Center on Budget and Policy Priorities, Washington, D.C.

[18] Budget documents include the budget memorandum; the proposed central government budget with explanations; planned sales of state assets for the next year; proposed financial plans for the Health Insurance Institute, Retirement and Disability Pension Insurance Institute, Public funds and agencies established by the central government.

[19] See *Republic of Slovenia: Report on the Observance of Standards and Codes – Fiscal Transparency Module*, IMF Country Report №02/115, June 2002.

Lessons to learn

Each dimension of community involvement, including participation, ownership and power to make decisions, is necessary to promote accountability and effectiveness in the healthcare system. However, the concept of public participation is not easy to put into practice. Too often, it turns into a mere formality, which does not provide any value-added to the provision of healthcare services to the public. Developing genuine community involvement means overcoming numerous obstacles. Among the most constraining issues are:

- Ordinary citizens are not always aware of the different forms and mechanisms of public participation.
- Better-organized or relatively more influential groups of citizens may dominate the political process. As a result, the voices of some groups, more often, the most vulnerable ones, are excluded from the policy debate.[20]
- Insufficient or distorted information can negatively affected people's choice of policy options.

An analysis of different cases of public initiatives related to healthcare can provide broad lessons to help guide the development of public watch model for healthcare spending that are relevant to SEE and CEE countries and Central Asia. The main conclusions include:

- Successful public participation in the process of setting spending priorities, implementing recommendations, and monitoring and evaluating results often involves representatives of different interest groups. Joint efforts by actors with different backgrounds and skills, including NGOs, researchers, parliamentarians, members of political parties, and members of various social groups, help to create a new level of relationship within the policy process, and bring in actors who were previously excluded from the policy debate.
- The readiness of citizens to be active players in the budget process often leads to positive results, if it is included in a broader context, such as a political movement, and supported by other actions.
- Public participation in the budget process is stronger where governments have a particularly strong framework of policy goals, or some other framework for accountability, such as constitutional provisions related to economic and social rights.
- Many successful budget watch initiatives have benefited from donor support. This can be through support to CSOs or through capacity-building within the governments themselves.

The practical dimension of establishing effective public control in healthcare raises several questions:

- Which group or groups of citizens should form the representative decision-making body for effective supervision of healthcare spending?
- What information is necessary for that body to make well-grounded decisions?
- Can a participatory process that is only consultative be sustainable, or must the decision-making body be given responsibility for the allocation of resources?

[20] The World Health Report, 2003.

- What types of decisions should citizen groups make, and will these decisions involve trade-offs between competing priorities?

A study conducted by Julia Abelson and Pierre-Gerlier Forest[21] stated that randomly selected citizens and interested citizens tended to prefer a consultative role, whereas a majority of elected officials, appointees to district health councils and experts were willing to accept responsibility for one or more of the specific types of decision-making examined.

All groups ranked the requirement for information about community needs first and the requirement for information about community preferences last.

Most study participants expressed a strong preference for some sort of mixed body for making all local healthcare and social services decisions, one that includes members with different backgrounds, such as specialists, interested individuals, the provincial government, and elected officials. The suitability of the provincial government and district health council appointees as sole decision-making groups was rated more highly after the complexities of the decision-making process had been discussed. However, the most suitable decision-making body appears to be a mix of lay people and experts.

The experience of many public watch initiatives demonstrates that self-selected citizens who are members of advisory or decision-making bodies represent a better choice than a random sample of community members. However, the Better Futures project indicates that lay people in such a group may need several years to acquire the self-confidence and skills necessary to fully participate in allocation decisions. Many of the details of participation will likely be worked out only after such a process is put in place.

[21] *Towards More Meaningful, Informed and Effective Public Consultation*, the Final Report to the Canadian Health Services Research Foundation (RC1-0628-06), February 2004.

Chapter 2

Institutional and legal frameworks for public oversight of budget spending in Kazakhstan, Macedonia and Ukraine

Budget transparency and public control over healthcare spending in Macedonia

The Macedonian healthcare system: sources of financing and division of responsibilities

According to official World Bank data from 2004, public expenditures on health in Macedonia were in the range of 5.5–5.6% of GDP for the previous three years. This was higher than the average spending for both lower middle-income countries—2.3%—and the ECA Region—4%. Government spending on health, as a percentage of total spending, is also high compared to other lower middle-income countries. In 1999, private expenditures on health accounted for 3.3% of GDP, which is also high compared to lower middle-income countries. And yet, the quality of services continues to be a problem despite these high spending levels.

Compared to countries in Central and Eastern Europe, Macedonia has an average number of doctors and nurses, lower hospital capacity, and a higher number of dentists. At 8.95/100 compared to 18.2 for the EU, Macedonia's in-patient admission rate is much lower than the EU average, and the average length of stay is slightly higher than the EU average, 11.8 days versus 10.05. However, the occupancy rate in hospitals has steadily worsened and is currently only 53%. Allocative efficiency is a concern and a large proportion of spending (more than 50%) goes to secondary and tertiary in-patient care. Low levels of investment in primary care have resulted in a primary care system that provides very poor quality care, especially in rural areas. It is no surprise that patients tend to by-pass primary care in favor of treatment at highly specialized healthcare facilities. The average number of out-patient visits in public health organizations per capita/per year in Macedonia is only around 3, compared with an EU average of 8.[22]

Healthcare in Macedonia is almost entirely a national function. The country has a single payer system of national health insurance, primarily financed through the public Health Insurance Fund (HIF), which collects earmarked payroll contributions and receives certain central budget transfers. The share of payroll contributions has steadily fallen, however, from 75% in 1992 to 59% in 2004. A combination of factors such as shortfalls on the revenue side and poor expenditure management has contributed to persistent cash deficits, resulting in debts to suppliers estimated at $32.5 million or 13% of annual expenditures.

Health services in Macedonia are delivered through a network of public and private healthcare facilities that have contracts with HIF. The number of private providers, especially in primary care and dental practices is steadily growing and the long-term government intention is to completely privatize healthcare service provision, including some primary healthcare services.

[22] *FYR Macedonia: Health Sector Management Project; Project Appraisal Document, R2004-0064/1 April 26, 2004;* The World Bank, 2004. See *http://www-wds.worldbank.org/servlet/WDSContentServer/WDSP/IB/2004/04/27/000160016_20040427163501/Rendered/PDF/277600MK.pdf.*

Although negotiated in the *Ohrid Framework Agreement*, the intended real decentralization of the healthcare functions in Macedonia did not take place.

Art. 3 of the Framework Agreement explicitly includes healthcare in the list of services for which the powers of elected local governments were to be reinforced and their competencies substantially enlarged. Healthcare decentralization is also included in Constitutional amendments and is obliquely referred to in the legislative annex to the Framework Agreement.

In the spirit of the Framework Agreement, the initial draft of the Law on Local Government (LLG) proposed an ambitious decentralization of healthcare functions, which raised considerable concern among sector experts. In their opinion, such a broad decentralization would complicate ongoing reform within the sector. Shifting facilities to local governments would make privatization more difficult and might also lead to a highly inefficient use of facilities, as many municipalities were too small to permit all but the most rudimentary forms of primary care to be provided on an efficient scale. The municipalities could, of course, address this problem by sharing facilities through a referral system, but this would be rather difficult to organize under the existing political conditions and interethnic relations. These were the main reasons why the provisions regarding the role of municipalities in the healthcare sector were considerably amended prior to the final vote by Parliament.

Under the adopted version, the municipal role in the management of healthcare facilities was limited to representation on the local boards of public healthcare organizations. Under the final draft of the LLG, municipalities, nevertheless, are given responsibility for public health education, health improvement, contagious disease control, and occupational health. The law also decentralizes responsibility for assistance to special needs groups: the mentally ill, victims of child abuse, and so on. This provision has little immediate significance since, with the exception of a few pilot programs financed by the World Health Organization and NGOs, there are only a few Government programs for people with special needs, and these could be decentralized.[23]

Legal basis for a transparent budget process at the central and local levels

Budget process transparency at the central government level

According to the provisions of the Macedonian Constitution, the state budget and the balance of payments of the Republic are to be prepared by the Government and adopted by the Parliament. Since Parliamentary sessions are open to the public, such a requirement should represent a precondition for the transparency of budget processes at the central government level. The Constitution, however, allows the Parliament to decide whether to work in open or closed session, which means that transparency is not fully guaranteed.[24]

The transparency of budget spending is further provided for by the *Law on Budgets*, which introduces specific requirements of the Minister of Finance. According to the provisions of this law, in the second half of

[23] *FYR Macedonia Decentralization Status Report*, World Bank Report №24305, September 2003.

[24] Neither the Constitution nor the Rules of Procedures of the Parliament specify cases when the public may be excluded.

July every year, the Finance Minister is supposed to present the Government with an overview of budget implementation and the country's debt for the current fiscal year. The overview is supposed to contain comparative figures for actual and budgeted levels of revenues and expenditures, and the budget deficit and debts. Any deviations from the budget are supposed to be accompanied by an explanation. In actual fact, the Macedonian Finance Minister provides monthly updates on budget implementation that are publicly available on the ministry's official website.

Budget implementation is subject to internal and external audit. According to the provisions of the Law on Budgets all central and local budget units and extra-budgetary funds are required to set up an internal auditing body. If they do not establish such a body, internal audits are to be done by the Ministry of Finance auditors. In all cases, the Ministry of Finance is the body responsible for conducting a central internal audit of budget implementation in all central and local budget units, as well as in extra-budgetary funds.

The external budget audit is done by the State Audit Office[25] (SAO). According to the *Law on State Audits*, the SAO is responsible for assessing budget implementation according to two particular aspects: a) conformity with the law; b) economy, effectiveness and efficiency of expenditures.[26] SAO makes at least one audit per year of all central and local public spending, as well as of the expenditures covered by funds from the EU and other international institutions.

SAO reports are presented to the Parliament. Within 14 days after the presentation, they are supposed to be posted on the SAO website as well. The Chief State Auditor (CSA) is responsible for the transparency of the SAO's work. The CSA is the person responsible for posting the SAO reports on the Web and for keeping the public informed about SAO audit results through press conferences or other means of communication with the media. The CSA and their deputy are directly appointed by the Parliament for a 10-year term, which is expected make them independent and resistant to political pressure. Under the present political model in Macedonia, however, where the executive power has great influence over the parliamentary decisions, such resistance is not entirely guaranteed. As mentioned in the 2003 Nations in Transit report, the real distribution of power in Macedonia is not determined according to the Constitution but according to party membership. "Parliament passes legislation, elects the head of the government (prime minister), and appoints judges. When the ruling party has a parliamentary majority, it has effective control over all three branches of government."[27]

The transparency of budget spending is partly provided for in the Law on Public Procurement (LPP) as well. LPP requirements are mandatory for:

- all central and local government bodies;
- legal entities of public interest that do not have an economic or profitable character, are largely financed by cen-

[25] Drzhaven Zavod za Revizija.

[26] In terms of that law, "economy" means conducting the activity with minimized expenditures; "efficiency" means achieving maximum effect at minimum possible cost; "effectiveness" means achieving maximum program objetives.

[27] See *Nations in Transit 2003–Civil Society, Democracy, and Markets in East Central Europe and the Newly Independent States*, Freedom House Foundation, 2004.

tral or local government bodies, or are subject to having their operations supervised by central or local government bodies, or have more than half of their managing, supervisory or other bodies appointed by central or local government bodies;

- public enterprises, joint stock companies and limited liability companies in which the state or local government have dominant direct or indirect influence through ownership, that is, if they hold the largest equity share in the company, have a majority of the shareholder vote and appoint more than half of the members of the managing or supervisory board of the enterprise;

- civic associations and foundations whom the law grants public powers.

LPP also regulates the special manner and procedure for legal entities engaged in one or more activities in areas such as water supply, energy, transport, telecommunications, utilities or public enterprises. Such entities are to fulfill public procurement contracts on the basis of special or exclusive rights granted by central or local government bodies authorized by law.

According to LPP provisions, all the entities mentioned here are obliged to have a public procurement record containing:

- number and date of the procurement decision;

- item and value of procurement;

- type of procurement procedure;

- number of submitted bids and their value;

- number of acceptable bids;

- lowest and highest bids;

- criteria applied for the selection;

- decision for selection of the most favorable bidder;

- price of selected bid;

- name, surname and address of selected bidder;

- complaints submitted by bidders;

- outcome of the complaints;

- number, date and value of the concluded contract and Annex to the contract.

This data should be entered into the state register within 10 days after the contract signing. Within 30 days after the contract signing, this information should be sent to the Public Procurement Bureau (PPB) and published on the PPB website.[28]

PPB is the public administrative body under the Ministry of Finance that is responsible for the development of the public procurement system in terms of securing legality, rationality, efficiency and transparency in public procurement. It is also expected to stimulate competition and equality of conditions for bidders in the public procurement process. PPB maintains a consolidated procurements register and specific sub-registers for all users of public funding. The registers establish conditions for transparency and at least *ex post* public control over budget spending.

[28] See *http://javni-nabavki.finance.gov.mk*.

Transparency in the budget process at the local level

The Macedonian Constitution guarantees the right of citizens to local government. Units of local government, municipalities, are financed from their own revenues, as determined by law, and by funds from the Republic.

In addition to the laws already mentioned, the transparency of local government budget processes is also governed by the Law on Local Government and the Law on Financing Local Government.

According to the provisions of the Law on Local Government, local government budgets and balances of payments are to be prepared by the mayor and adopted by the City Council. City Council sessions are public. A City Council has the right to exclude the public in certain cases but never when the session concerns budget issues, balance of payments or urban planning.

The Law on Financing the Local Government lays out the specific requirements regarding local government budget procedures: preparation, implementation, auditing, reporting, and so on. According to this law, in addition to an annual budget report, the Mayor is supposed to present the Ministry of Finance quarterly budget updates, which are public and should be published after being approved.

Transparency in the Macedonian Health Insurance Fund

Along with the Macedonian Pension Fund, the Macedonian Health Insurance Fund (HIF) is one of the largest extra-budgetary funds in Macedonia and the transparency of its expenditures is facilitated by the same laws that govern central budget transparency.

However, the transparency of HIF spending is an issue that has raised great concern in Macedonia. According to an IMF report from 2004,[29] "While there is some evidence of progress in fighting corruption in the public sector, governance at HIF remains weak and has contributed to non-transparency, high costs and mismanagement." According to the same IMF report, "...inefficiency and corruption in the state Health Insurance Fund (HIF) and state-owned healthcare institutions are the major source of poor performance in the health system." According to the World Bank's FYR Macedonia Decentralization Status Report, "The healthcare system is plagued by financial problems, mismanagement (in both HIF and healthcare institutions), and questionable spending priorities."[30]

The World Bank and the IMF are currently assisting the Macedonian Government in improving HIF management and reducing opportunities for corruption and mismanagement. The World Bank is also supporting the Government in its commitment to audit the Health Insurance Fund and to implement cost-saving measures, which will include new tenders for pharmaceuticals and other efficiency gains.

Meanwhile, with the aim of improving the tracking of financial flows, the Ministry of Finance has taken steps to transfer HIF's account balances to the Treasury Single Account. Another step toward bettering the transparency of HIV operations and spending was to publish the findings of the SAO's financial audit, which included critical remarks on inefficiency and fraud.

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[29] See *Second Review under the Stand-By Arrangement and Ex Post Assessment of Performance under Fund-Supported Programs in R.M.*, IMF staff report, July 2004.

[30] S*ee FYR Macedonia Decentralization Status Report*, World Bank Report №24305, September 2003.

Access to information in Macedonia

Budget-related legislation in Macedonia establishes preconditions for transparency of budget information. However, clear legislative procedures for providing free access to that information have not yet been developed. Although the phrase "ensuring maximal transparency" is one of the most frequently used in all government documents and strategies, the Republic of Macedonia continue to be one of the two SEE countries where a *Law on Free Access to Public Information* has not yet been adopted. The first draft of such a law was initiated and prepared by experts from the NGO sector back in 2002.[31] During the last three years, however, it has only been submitted the Parliament, without any further progress.

Free access to information is a constitutionally guaranteed right in Macedonia. In contrast to other basic human rights, however, for Macedonian citizens to exercise the right to free access to public information, certain actions are needed on the part of the state. The procedure for accessing public information and related restrictions need to be defined by law. The Macedonian Law on Free Access to Public Information has not been adopted yet, but sooner or later it will be. This is why there is reason to pay some attention to its draft provisions.

The Law on Free Access to Public Information will regulate the procedure for exercising the right to free access to public information in the possession of central and local government bodies, public institutions and services, public enterprises, and those legal entities and individuals with public powers granted by law, in short, information holders.

According to the law, free access to information will be available to all legal and physical entities in Macedonia. Access to public information from information holders will be on the basis of a request.

However, the current bill includes 13 exceptions, instances where free access to public information may be restricted. This means that information holders will be able to reject a request for access to information, if the information refers to:

- data that, based on the law that regulates classified information, is defined as secret for the purpose of safeguarding national defence and security;
- personal data the revelation of which would violate the law that regulates the protection of personal data;
- data that refers to the individual data of physical and legal entities and has been collected, processed and provided for statistical purposes;
- data that, in accordance with the law that regulates archival work, is defined as confidential;
- data whose release could violate the confidentiality of tax procedures, according to law;
- data acquired or assembled for an investigation as a part of criminal or penal procedures, the release of which could result in harmful consequences during the process, according to law;
- data acquired or assembled for the purpose of implementing administrative procedures, the release of which could jeopardize the process;

[31] The law was drafted within the framework of the project "Accountability in Western Balkans," financed by the Finnish Government and implemented by Transparency International Macedonia.

- data acquired or assembled for a court process, the release of which could jeopardize the process;
- data that refers to commercial or other economic interests, including monetary policy;
- data from document that is being prepared and is still subject to the approval of the information holder and therefore whose release could result in misunderstanding of the content;
- environmental protection data that, in compliance with the law that regulates environmental protection, is not accessible to the public in order to protect human health or the state of the environment;
- data that jeopardizes rights to industrial property (patent, model, goods or service brand, mark of goods' origin), in accordance with the law;
- data from a document that has been acquired in conjunction with copyright in compliance with the law.

Since budget information is not explicitly mentioned as an exception, where access to information is restricted, it is presumed that it will be freely accessible. Moreover, the information holders cannot categorically refuse to provide information even in the cases quoted above, if the good for the public interest in publishing is greater than the consequences for the protected interest. With regard to budget information, indisputably, the transparency of budget spending is a matter of public interest. The open question here is, how the judgment is made, whether the public interest is greater?

The law places special obligations on the information holders, who are obliged to make information of public interest available to the public, including allowing free access to information about the organization, its powers and cost of its work.

According to the law, access to public information may be requested orally or in writing. Moreover, the information should be submitted in the requested form, except when: the requested information already exists in a previously prescribed form; it is already accessible to the public; or it is more appropriate to submit the information in a form different than the one requested, regarding which the information holder should explain the reason. The latter formulation could present serious difficulties in obtaining requested budget information in the most appropriate form, that is, the one allowing public control.

Should the Law on Free Access to Public Information be adopted, it will establish additional mechanisms for public control over budget spending. It will also set more favorable conditions for the emergence of "budget watch" groups whose main goal will be achieving better transparency in the budget process and exercising public control over public spending. At present, such groups would be unlikely to receive the information needed for analysis, because there are no legal grounds or procedures for requesting such data. Some information on budget issues, including budget spending, can be found on the websites of various bodies. However, the information is too aggregated and does not allow in-depth analyses. Thus, the eventual adoption and implementation of the Law on Free Access to Public Information will be crucial for the functioning of an efficient budget watch model. Practice will show if and what legal amendments will be needed in order to assure maximal transparency and public control over the budget process.

The experience of other SEE countries suggests that getting an administration used to releasing information will be a long process in which all players in the society have a clear role. In the first place, state authorities will

have to forget the current centralist style of administration, where having information is considered as the prerogative of state officials alone. In the second place, voters, the media and civil society as a whole will have to start requesting information and exercising their constitutional right to know.

Practice from the region shows that the state will continue to be reluctant to release information to the general public for a long while if civil society and the court system do not force it to comply with the law. That makes a strong and active civil society and a properly functioning court system crucial players in the process. Unfortunately, in Republic of Macedonia today, both of these players are quite weak and are likely to find it fairly difficult to play their parts in the process properly.

Public participation and public oversight in public spending in Macedonia

Legislative framework for public participation

In Macedonia, public participation in and public oversight of budget spending can be exercised in different ways.

At the central government level, public participation and public oversight of budget spending is supposed to be guaranteed by the mechanisms of representative democracy. Voters can participate in the decision-making process through their legally-elected representatives in the Parliament. In limited instances, voters can directly influence the work of the Parliament and its ancillary bodies. According to the provisions of the parliamentary Rules and Procedures, for example, every citizen, group of citizens, institution and association has the right to initiate the inclusion of certain issues on the draft agenda of a parliamentary working session or even to submit an initiative to pass a law, using the power of an authorized representative.

The Macedonian Constitution and the Rules and Procedures of the Parliament also allow citizens and media representatives to attend parliamentary sessions and the meetings of ancillary bodies, except in those instances when the Parliament or working body has decided to work behind closed doors. Neither the Constitution nor the Rules and Procedures define specific cases when the exclusion of the public is justifiable, which means that nothing prevents the Parliament from working behind closed doors whenever it so chooses.

Thus, the transparency required of Parliament is not particularly effective. Parliamentary sessions are open to the public, but attendance is not encouraged.

At the local level, the legal mechanisms for public participation and public control over budget spending are provided by the Constitution and the Law on Local Government.

Art. 115 of the Constitution says, "In local governments, citizens participate directly and through their representatives in the decision-making process on issues of local relevance, especially in the areas of urban planning, community activities, culture, sport, social security and childcare, preschool education, primary education, basic healthcare and other areas stipulated by law."

The Law on Local Government indicates specific forms of public participation and public control in the work of local governments. According to the provisions of this law, the Town Council sessions are public. In certain cases, the public may be excluded, but never when the sessions concern budget issues, balance of payments or urban planning.

The law contains a whole Chapter entitled "The Direct Participation of Citizens in the Decision-Making Process in Municipalities." According to this chapter, local citizens may participate directly in the decision-making process on issues of local importance through civil initiatives, town meetings and referenda. The costs of such direct participation in the decision-making process are to be covered from the municipal budget.

Civic initiatives

Local citizens have the right to propose to their town council to pass certain laws or to decide upon certain issues within its authority, except for personnel and financial matters. If the proposal is supported by at least 10% of the voters in the municipality, that is, in the neighborhood government to which a certain issue relates, the council is obliged to raise the issue not latter than 90 days after the initiative was submitted and local citizens are to be informed of its decision.

The fact that financial issues are an exception to this right of civil initiatives could create difficulties in exercising effective public participation and public control over the local public spending.

Town Hall meetings

Town meetings can be convened by local mayors on their own initiative, at the request of the local council or at the request of at least 10% of the voters in the area, that is, in the neighborhood government to which a certain issue relates. Town meetings can be convened for the entire municipality or for a neighborhood government. The law makes it mandatory for municipal organs to review the conclusions of this meeting and to take them into account when making decisions and determining measures on related issues within 90 days after the town meeting.

Referenda

Macedonia's citizens are also allowed by law to decide issues of local importance through referenda. A referendum may be initiated by at least 20% of the voters in the municipality. The decision of a referendum is binding on the local council.

According to the provisions of the Law on Local Government, every citizen has the right, individually or together with others, to submit appeals and proposals regarding the work of their municipal administration and its organs. In terms of exercising this right, the law obliges the mayor to: establish procedures for the submission of appeals and proposals; provide a detailed reply to the appellant at the latest within 60 days of the receipt of the appeal or proposal; submit appeals and proposals that refer to the powers of municipal organs to the relevant bodies and inform the appellant of this.

In the course of preparing local government regulations, the municipal council or mayor may first organize public hearings or call for proposals from the public. However, since this is not mandatory, it is not likely to happen.

A *Consumer Protection Council* can be established to review issues and determine proposals regarding the quality of municipal services. This council can include representatives of larger groups of public service users. Once established, such a council can play a crucial role in ensuring public participation in and oversight of local public spending.

Civil society in the public participation and budget watch processes

Despite the existence of all these legal mechanisms for public participation in and control over the decision-making process,

lack of transparency continues to be a feature of Macedonia's political and business environment.

Largely because of a passive and weak civil society, mechanisms for public participation and oversight are not yet being used effectively. Despite the existence of more than 5,500 registered CSOs in Macedonia, only a very few of them deal with public policy issues and not one carries out consistent and in-depth budget monitoring and oversight. It is true that access to the data needed for such analyses is quite restricted, but it is also true that only a few ever request access to such data. There are no procedures or "beaten paths" for receiving budget information and exercising control over budget spending in Macedonia, which makes a budget watch model a much-needed instrument. The budget watch model, along with the upcoming adoption of the Law on Free Access to Public Information, should support the emergence and work of budget watch groups in Macedonia.

The media in the budget watch process

In the absence of active NGO groups dealing with budget issues, the media remain the main source of information in this area. Macedonian law gives special access to information to media representatives. According to the provisions of the parliamentary Rules and Procedures, media representatives can attend sessions of the Parliament and ancillary bodies and "shall have at their disposal the acts reviewed and adopted by the Parliament, information and documentation regarding the issues reviewed in the Parliament and such working bodies, reports on the operations of these working bodies and official minutes from the sessions, unless the Parliament or working body decides that certain issue will be reviewed without the presence of the media." Of course, it is not clear why only the media should have such rights and why, say, NGOs should not have the same right to receive the documents mentioned here.

Although there is better access to information, the lack of capacity and the nature of daily media work do not allow for in-depth, high quality analysis. Journalists are usually only able to present figures, ask questions and report on ongoing budget-related "scandals." The media alone cannot ensure transparency and public control over public spending, but it can disseminate available information, keeping voters informed about ongoing processes. If the media starts cooperating with budget watch groups, together they might establish the conditions for better public control over public spending.

A review of the Ukrainian context

The healthcare system in Ukraine

Since independence, Ukraine has made no drastic changes in the structure and organization of its healthcare system. It remains the same integrated, command-administrative system it always was. With this system, both medical professionals and the general public have virtually no influence on the development and institution of political and administrative decisions.

A complex healthcare reform plan was promoted in 2000. In line with reforms elsewhere in Eastern Europe, the Government program proposed strengthening primary healthcare on the basis of family medical practice, developing a health insurance system, and establishing the conditions for private medical practice. But throughout the transition period there was no overall national strategy for co-ordinated restructurization. As a result, the main feature of this early process was the effort to preserve existing standards and facilities in the face of a drastically declining economic situation.

The next attempt to optimise healthcare came with budget reform,[32] which introduced new approaches to interbudget relations in Ukraine. Healthcare was classified as a responsibility delegated to local governments, so budget reform had a direct impact on the system. Among other measures, the principle underlying healthcare financing was changed from facilities-based to more needs-oriented. To that end, the Finance Ministry began to use population numbers instead of hospital numbers as a basis for budget formulation.

Although it was a step forward in terms of increasing efficiency and transparency in the allocation of resources, more reforms were needed. Thus, the methodology used to calculate healthcare spending for local budgets mostly takes into account population numbers or the numbers of consumers of specific services, rather than estimating real needs for public services. For example, in Odesa oblast, the number of AIDS and TB-infected people is much higher than the national average. But calculating the amount of healthcare spending for Odesa oblast using this formula does not reflect this reality.

The situation becomes even more complicated with the unclear question of the scope of fiscal responsibility at the local level. Although the Budget Code defines which level of government provides services at which level of healthcare,[33] it is not clearly defined which specific unit belongs to which level. Moreover, the status of a given healthcare institution can be changed from year to year, making attempts to rationalize existing medical facilities quite difficult.

Public spending on healthcare is nearly 3.5% of GDP in Ukraine, much less than the 7–10% level recommended by ROE WHO to member countries as the level that is "feasible" and acceptable to provide effective and competent assistance. Lack of budget funds

[32] The State Budget and local budgets are the main official source of healthcare funding in Ukraine.

[33] According to the Budget Code, the State Budget funds national hospitals. Primary healthcare is financed from city and village budgets. District budgets fund general hospitals, maternity hospitals, ambulance and first aid departments, and medical-sanitary education programs. The oblast is responsible for oblast hospitals, specialized ambulatory and clinic assistance, TB sanatoriums, sanatoria for children and teenagers, and medical rehabilitation sanatoria.

has resulted in free medicine gradually being replaced by paid treatment. Every year, the share of personal expenses on healthcare has been rising for the average Ukrainian as the relative weight of unofficial—under-the-table—payments has grown.

The country has made some attempts to improve the funding of medicine through the introduction of a medical insurance system, but the legislation for this is still incomplete. The various bills that have been submitted to the Verkhovna Rada all had serious flaws. In particular, they did not detail the organizational and legal bases for providers of medical services to operate, starting with the proper procedure for interacting with insurers and policy holders. The proper procedure for determining insurance fees is also not specified. In addition, the various alternatives for introducing universal medical insurance required additional payments to the insurance fund without any change to the existing tax rates, which could cause some wages to return to the shadow economy.

Access to information

Free public access to information is a sticking point in public oversight of Government activities in any area, including oversight of State Budget spending. Indeed, only full, objective and timely information can give the public an opportunity to evaluate how effective Government activities are and how appropriately the Government spends taxpayers' money.

Ukraine has been paying attention to providing free access to information practically since it became independent, back in 1991. Today, numerous regulations guarantee the public the right to information. Indeed, Ukrainian law offers a solid foundation for providing free public access to information, which makes it possible to say that there is an environment to build an effective public watch system in Ukraine.

Nevertheless, the practical implementation of public oversight of government activities is hampered for two main reasons:

- evident barriers to access to information in government bodies;
- "procedural" obstacles in legislation that complicate public access to information.

A guaranteed right to information is the basis for public scrutiny

The right to information is viewed as one of the fundamental human rights in Ukraine. The Basic Law of Ukraine[34] contains several articles that secure the right of the country's citizens to any information they need.

The basic piece of legislation that regulates information relations in Ukraine is the 2 October 1992 Law №2657-XII "On information." According to this law, key principles with regard to information in Ukraine are:[35]

- the guaranteed right to information;
- open and accessible information and free excahnge of information;
- full and precise information.

The right to information presumes the opportunity to freely obtain, use, disseminate, and save data as needed by participants in the exchange of information, so that they can exercise their rights, freedoms and legal interests.

[34] This refers to the Constitution of Ukraine.

[35] See Art. 5 of the Law on information.

Constitutional rights to information

1. *Every citizen shall have the right to freely collect, save, use and disseminate information in oral, written or any other form at their discretion (Art. 34 of the Constitution of Ukraine).*
2. *Ukrainian citizens shall have the right to submit individual or collective written inquiries or personally address central and local government bodies, as well as elected and appointed officials of these bodies (Art. 40 of the Constitution of Ukraine).*
3. *Every citizen shall be guaranteed the right to have free access to information on the state of environment, the quality of food products and household items, as well as the right to disseminate such information. Such information cannot be classified as secret (Art. 50 of the Constitution of Ukraine).*

The right to information is equally guaranteed to all Ukrainian citizens, legal entities and government bodies. Discrimination in any form is not allowed.

To guarantee the public the opportunity to exercise their right to information, the Law on information:[36]

- binds central and local government bodies to inform the public about their activities and decisions;
- envisages the establishment of special information services or systems within government bodies in order to provide access to information according to the established procedure;
- defines mechanisms for exercising the right to information.

For people to exercise the right to information, the government has instituted appropriate mechanisms and procedures. However, there are still many barriers that make it difficult to agree that Ukrainian citizens really have free access to any information they need, in particular to information on budget expenditures.

Mechanisms for accessing information

There are several mechanisms that help the public obtain information from central and local government bodies. The most suitable instruments for public oversight are:

- requests for information from the public;
- public dissemination of information on activities and decisions by central and local government bodies;
- accountability of central and local government bodies.

Information request

The right of citizens to information can be implemented by submitting requests for information to central and local government bodies.[37] There are two types of information requests:

- requests for access to official documents;
- requests for the provision of specific information orally or in writing.

[36] See Art. 10 of the Law on information.

[37] Issues related to the submission of, the consideration of and replies to requests for information are governed by Art. 32–36 of the Law on information.

Requests for access to official documents can be both individual and group. They may submitted only in writing. Ukrainians have the right to submit such requests in order to demand any official document, including those not actually related to the inquirer. Such requests for access to official documents can be rejected only if access to such documents is specifically restricted (see p. 37).

Requests for the provision of information orally or in writing are defined as applications with a request to provide oral or written information on specific activities of legislative, executive or judicial bodies of Ukraine or their officials.[38] Inquiries on the provision of information can be submitted both by specific individuals and associations of citizens.

Ukrainian legislation establishes a simple procedure for submitting requests for information that is not burdened with excessive red tape. Specifically, inquirers need not:

- explain the reason for a request;
- indicate how this information will be used;
- provide identifying documents.

Furthermore, to ensure greater openness of government bodies, the president of Ukraine has assigned the Government to introduce a system for providing assistance to citizens in formulating requests for information, appealing against refusals to provide information, and settling possible disputes on such issues.[39]

Although this task has not been completed, the Government has taken certain positive steps to facilitate public access to information. For example, today, the official websites of some government bodies provide samples and templates for information requests and explanations of the submission procedure. The Government is also introducing the practice of submitting inquiries in electronic format.

According to the Law on information, requests are supposed to be satisfied within 30 days.[40] In practice, this deadline is mostly breached, an example of shortcomings of the Law (see pp. 37–38).

Public dissemination of information

In general, publicly announced information is information disseminated by government bodies on their own initiative or to fulfill the requirements of the law. Such dissemination is an important mechanism to provide the public with access to information on government activities, as it makes it possible to deliver the most important information to the broadest base of voters at a minimum cost.

The Law on information makes it imperative to systematically publish:

1. statistical information, except for statistical data that is confidential;[41]

[38] For obscure reasons, Ukrainian legislation does provide for the opportunity to submit such requests to local government bodies.

[39] See Item 3 of the 1 August 2002 Presidential Decree №683/2002 "On additional measures to ensure openness in the activities of government bodies."

[40] See Art. 33 of the Law on information.

[41] Statistical data that contains confidential information is identified in Art. 21 of the Law on state statistics.

2. legal information if the sources are legislation, regulations and by-laws, standards and principles of international law, and other piece of legislation, announcements in the media, and public statements by government officials that include information on legal matters;

3. other information from central and local government bodies in those situations anticipated by legislation that regulates the activities of those bodies. Specifically, all government bodies must provide ongoing updates of official information on the implementation of programs and plans, current and no longer valid regulations, formats and samples of documents, and draft regulations on their websites.[42]

Publicly announced information also includes information about the State Budget: planned areas and volumes of spending, real budget expenditures, and so on. The procedure for publicizing such information and the amounts that should be disseminated thus are identified in the Budget Code of Ukraine.[43] According to this piece of legislation, the Ministry of Finance must make two items available for publication:

1. Draft State Budget Law. This draft is subject to mandatory publication in *Uriadoviy Kurier* [The Government Courier] newspaper within seven days after being submitted to the Verkhovna Rada of Ukraine;

2. Information on the fulfillment of the State Budget and local budgets. Such information is subject to mandatory publication prior to 1 March of the year following the reporting fiscal year.

In addition, the Ministry of Finance must publish the four kinds of fiscal information:[44]

- statistical booklets called "The Budget of Ukraine;"
- updates and analyses of the fulfillment of the current year's Consolidated State Budget;
- updates on the servicing of Ukraine's domestic and external debts and its domestic and international borrowings;
- financing for manufacturing and non-manufacturing sectors.

Recently, some managers of State Budget funds have undertook an additional commitment to report to the public. For instance, the Ministry of Health made a decision[45] to post three key reports on its website:

- the progress of targeted programs and plans;
- government procurements of goods, works and services;
- the list of services and conditions for providing services to the public.

As a rule, though, this kind of information is largely summarized and generalized, which reduces its value for public oversight of budget spending in various areas.

[42] See Item 3 of Art. 2 of Presidential Decree №683/2002.

[43] See Art. 28.

[44] Publication of such information is required by the 24 August 2004 Ministry of Finance Decree №536 "On organizing activities to supply information and run the official website of the Ministry of Finance of Ukraine."

[45] See the 25 April 2003 Ministry of Finance Decree №185.

Accountability of central and local governments for budget spending

The Budget Code of Ukraine calls for a public presentation of reports on the fulfillment of the State Budget, in the form of economic classifications by type of expenditure, and the spending of State Budget funds. Such presentations are supposed to be made by:

- by March 20: the Ministry of Finance jointly with the Verkhovna Rada Budget Committee and the Accounting Chamber;
- by April 15: the top managers of State Budget funds must make a detailed disclosure of expenditures for items worth over UAH 5mn, except for salaries, payroll taxes and utility payments;
- by March 20: the Verkhovna Rada of the Autonomous Republic of Crimea and its Council of Ministers, local state administrations and local government bodies, on the fulfillment of local budgets, except for the budgets of villages and settlements. These reports must include detailed disclosure of expenditures for items, except for salaries, payroll taxes and utility payments, worth over: UAH 2mn for the Kyiv Municipal Budget, UAH 1mn for the Budget of Crimea, oblast budgets and the Sevastopol Municipal Budget, and UAH 0.5mn for budgets of other cities and districts.

Restricted access to information

The Law on information allows for public access to certain information to be restricted by setting different access levels.[46] In terms of access levels, all information is divided into:

- open information;
- restricted information.

Any individual has the right to obtain open information. No restrictions on this right are allowed.

The situation is quite different with restricted information. In terms of its legal procedure, such information is divided into confidential and secret information. The Law on information, states that not everybody has the right to obtain such information. Access to confidential and secret information is given only to those individuals who have been granted the necessary permission of the owner of this information or have a special permit for access to state secrets.

In addition, the Law on information places restrictions[47] on providing the public with:

- documents that constitute intradepartmental service correspondence: staff reports, correspondence among departments, and so on;
- information from financial institutions that has been prepared for oversight and financial registers.

According to the logic of the Law on information, such restrictions should apply only in exceptional cases. However, government bodies have their own understanding of this logic and, in practice, restrict access to a broad base of information–first of all, to information on decisions related to volumes of and areas of spending State Budget funds.

[46] Information access levels refer to the procedure for obtaining, using, disseminating, and saving information as established by law.

[47] See Art. 37 of the Law on information.

In theory, if government bodies impose unjustified restrictions on access to information, such information can be disseminated without their permission. Art. 30 of the Law on information provides for such a possibility, if:

- this information is important to society, that is, it affects the public interest;
- the right of the public to know this information outweighs the right of its owner to protect it.

However, the Government has not developed a mechanism for exercising this option. Today, the only way to make this option in the Law on information apply is to sue.[48]

It is clear that there is a need for different information access levels. Indeed, this is one way to protect private data, the interests of the state, and other owners of information. The problem of unjustified restrictions on public access to information finds its roots, not in the fact that the Law on information offers the possibility of restricting access, but in the fact that neither this law, nor any other legislation clearly determines the criteria for classifying information as confidential.[49]

Currently, government bodies make their own decisions on classifying information that is at their disposal as confidential. Such a decision is made on the basis of criteria approved by the Cabinet of Ministers.[50] However, these criteria are very vague and leave room for interpretation.

An analysis of these criteria makes it clear that any information produced as a result of any activities undertaken by government bodies can be classified as confidential.[51] Thus, it is no wonder that the public does not always have an opportunity to obtain information on certain government activities—especially on decisions related to the handling of State Budget funds.

The situation is complicated by the fact that lists of restricted data are, as a rule, approved by internal, that is, departmental regulations and instructions, which, in reality, deprives the public of an opportunity to evaluate whether the refusal to provide access to certain information is justified or legitimate.

This problem has, apparently, been recognized by the government. Back in 2002, the president instructed the Cabinet of Ministers to prepare a **comprehensive list** of all types of information whose free collection, saving, use, and dissemination might be restricted in any manner and to improve the procedure for overseeing the provision of such information.[52] However, this has not been done to date.

In light of this, it becomes clear that Ukrainian legislation does not contain enough guarantees of free access to infor-

[48] Given the dependence of the judiciary on the executive, such lawsuits have little chance of succeeding.

[49] The situation is much better with secret information. A list of data classified as state secret is clearly identified by the 21 January 1994 Law №3855-XII "On state secrets."

[50] See Appendix 13 to the 27 November 1998 Cabinet of Ministers Resolution №1893.

[51] At the least because all such information is produced at public cost and, therefore, matches the first criterion.

[52] See Item 3 of Art. 2 of the 1 August 2002 Presidential Decree №683/2002 "On additional measures to ensure openness in the activities of government bodies."

Criteria for classifying information as confidential

1) *The information is produced at public cost or is owned, used or managed by a state organization;*[53]
2) *The information is used to secure national interests;*
3) *The information is not classified as a state secret;*
4) *The dissemination of such information might lead to:*
   - *the violation of constitutional human and civil rights and freedoms;*
   - *negative consequences for domestic or foreign policy; the economy; the military; social, humanitarian, scientific and technological, environmental, and information spheres; or for national security and the security of the state border;*
   - *obstacles to the activities of government bodies.*

mation on public spending in various areas.

Legislative shortcomings that complicate public access to information

Lack of clear deadlines for providing information

In practice, government bodies frequently do not reply to requests for information by citizens within the deadlines established by the Law on information. The reason for this can be found directly in the law itself, which offers an opportunity to postpone replies without a clear indication of:

- appropriate reasons;
- the maximum extension on the deadline;
- penalties for unjustified refusal to reply or to reply in a timely manner.

These drawbacks substantially reduce the effectiveness of requests for information as an instrument for gaining access to the information necessary to exercise public oversight of government decisions.

Lack of effective procedures to appeal against illegal actions by government bodies

In certain cases, a government body can refuse to satisfy a request for information from the public. From the viewpoint of the Law on information, such a refusal is legitimate only if restricted access was established for the requested documents and information. In reality, government bodies and their officials often refuse to provide information without justification because they realize that the average citizen is unlikely to appeal such a refusal. Indeed, Ukraine does not have simple and effective mechanisms to appeal against government actions that violate the right to information.

Certainly, a person or organization can sue in court when there is such a violation. However, given the current shortcomings of the Ukrainian court system, such a suit could easly drage on for more than a month and lead to significant expenses.

[53] In fact, this criterion alone makes it possible to classify all information produced as a result of activities by government bodies—that is, at a cost to budget funds—as confidential.

Lack of transparency in collecting payments for access to information

Existing legislation requires inquirers ti fully or partly compensate costs related to the satisfaction of their requests for access to official documents and the provision of information in writing.[54] According to the Law on information, such fees shall be determined by the Cabinet of Ministers or other government bodies that provide information upon a request from the public.

However, at this time, there is no unified approach to paying for such access to information. So far, the Cabinet of Ministers has not regulated the procedure for paying for the provision of information, although the president assigned this task back in 2002.[55] Specifically, the Cabinet of Ministers has not identified:

- cases of free or discounted provision of information;
- the rate of payment;
- payment procedure.

Given such unclear conditions, central and local government bodies independently determine the procedure for paying for the costs associated with replying to requests for access to information. In addition, these fees are frequently overstated without any justification, which gets in the way of exercising the right to information.

Public involvement in decision-making in Ukraine

Public involvement in the process of making decisions related to financing various public needs is one of the most important components of a public watch system. Participation in the regulatory process allows stakeholders to ensure that decisions adopted by government bodies meet public interests.

Ukrainian law not only allows government bodies to organize public consultations but, in many instances, it requires them to do so.

The right of the public to participate in the regulatory process was enshrined in law back in early 1990s. Specifically, the Basic Health Law adopted by the Verkhovna Rada on 19 November 1992 declares that the right of citizens to proper healthcare includes the right to:[56]

- participate in discussions of draft regulations and submit proposals on health policy;
- get involved in the healthcare financing and public participation in healthcare issues.

The most widespread instruments of public consultations in Ukraine are:

- advisory/consultative bodies that are set up and function under central and local government bodies;
- mechanisms that involve the public in the regulatory process;
- public hearings;
- open sessions of local governments.

[54] See Art. 36 of the Law on information.

[55] See Item 3 of Art. 2 of the Presidential Decree №683/2002.

[56] See Art. 6 of the Basic Health Law.

Advisory/consultative bodies

Ukrainian legislation provides for the possibility of setting up advisory, consultative or supervisory bodies under government agencies. Specifically, the Basic Health Law states that community-based consultative or supervisory bodies can be set up under healthcare agencies or facilities to:

- facilitate the activity of government agencies;
- inform the public;
- organize a public health watch;
- participate in identifying the focus of and mechanisms for instituting universal state and local health programs.

Consultative bodies can also be established under other executive bodies, as well as under legislative and judicial bodies.

Although consultative bodies have a rather long history in Ukraine, they have not managed to fulfill their potential. Today, they have little real impact on the decision-making process and are unable to exercise effective oversight of how policies are implemented. The reason for this is that government bodies are reluctant to cooperate with the public, which can be seen in the way that the recommendations of consultative bodies are ignored and important information, in particular on State Budget spending, is concealed.

Public watch through participation in the regulatory process

Public watch over budget spending should start at a stage when government bodies make decisions on the areas and volumes of expenditures. It can be organized through mechanisms for public participation in the regulatory process that allow stakeholders to affect decisions and to ensure that they meet public needs as much as possible.

There are such mechanisms in Ukraine today. The most effective of them were introduced by the 11 September 2003 Law №1160-IV "On the principles of business regulation policy." According to this law, the key principles of regulatory policy are transparency and the consideration of public opinion. To ensure that these principles are adhered to, the Law on business regulation makes it mandatory for central and local governments to publicize regulations at the draft stage, along with impact analysis that specifies:

- Which problem needs solution?
- What are the regulatory goals?
- What results are anticipated from adopting the proposed regulation?
- What are the options and why was the proposed one chosen?
- Performance indicators for a given regulation that can be used to track the effectiveness of that regulation if it is adopted.

This kind of information makes it possible to consider whether the proposed decision will be effective and meets public needs at a stage where the regulation is only being developed. In addition, stakeholders have an opportunity to influence policy by providing comments and proposals that government must take into consideration. The authors of the proposed regulation must either reflect the feedback and proposals or justify their rejection of this input.[57]

[57] See Art. 9 of the Law on business regulation.

To ensure that these requirements are heeded, especially regulatory policy body has been given sufficient powers to block, or at least substantially complicate, the adoption of any proposed policy, if stakeholder input has been ignored.[58] All this makes the mechanism a fairly effective instrument to assist the public in having input into policies being made by central and local governments, including decisions on spending State Budget funds.

In addition, according to the Law on business regulation, the public is supposed to be involved in the regulatory process through the right to track the implementation of government policies, evaluate their effectiveness, and initiate their cancellation or revision if they fail to reach the identified goal.

Local governments and public watch

Local governments are essentially a particular way to implement "people power," allowing communities to independently resolve local issues. Local government not only allows communities to made key decisions independently, but also offers the opportunity for these communities to carry out public oversight in areas that concern the interests of local residents, especially public oversight of local budget spending.

This is the conclusion that was drawn after analyzing the impact of the 12 May 1997 Law №280/97-VR "On local government in Ukraine," which defines the principles for local governments to operate in Ukraine. This law offers local communities a number of mechanisms to carry out public oversight.

Public hearings. These must be organized at least once a year. During public hearings, communities have the right to hear out the reports of local government bodies and to submit motions and proposals related to local issues that must be considered.

Open sessions of local governments. According to the law, local councils make decisions at open sessions.[59] Local citizens have the right to participate in such sessions and, thus, to oversee the decision-making process.

Civic associations as a public watch instrument

Ukrainian law views civic associations as one instrument to enable citizens to exercise their rights and protect their interests, including through public watch. The 16 June 1992 Law №2460-XII "On civic associations" grants such organizations the right to:

- receive information from central and local governments that is necessary for implementing their goals and tasks;
- submit proposals to government bodies;
- disseminate information and popularize their ideas and goals.

By exercising these rights, civic associations can obtain needed information from government bodies, analyze and summarize it, disseminate it among stakeholders, and prepare and submit proposals to relevant gov-

[58] If violations of regulatory policy principles are evident, a specially authorized body is supposed to refuse to accept the draft regulation (Art. 21 of the Law). Without its approval, the regulation cannot be registered with the Ministry of Justice (Art. 25 of the Law).

[59] Closed plenary sessions can be held in special cases.

ernment bodies on improving the effectiveness of government policies.

Apparently, only civic associations are considered capable of ensuring effective and systematic public watch and a powerful lobby for the interests of various social groups. But, so far, such organizations have not become a powerful instrument of public oversight, the result, primarily, of a number of drawbacks in existing laws:

- the lack of effective mechanisms for communicating with the government;
- overly complicated registration procedure for civic organizations;
- a tax system that provides disincentives for civic associations by closing access to many sources of financing;
- the lack of legislative guarantees for the independence of civic associations—first of all, from the governmental bodies—, that makes their evaluation of the government actions not always objective.

Media—the key source of information for the public

The mass media are the main source for the public to satisfy its need for information. Given this, it is no wonder that the press plays an important role in ensuring public access to information on the activities of government bodies, including State Budget spending.

The media's role in public watch is important because it:

- facilitates overall access to information;
- provides information in a form suitable for the general public;
- helps evaluate government policies and activities;[60]
- disseminates information among broad groups of the population.

Guarantees of full and objective information

The 23 September 1997 Law №539/97-VR "On the proper procedure for media coverage of the activities of central and local government bodies in Ukraine" contains a number of regulations that guarantee that the general public will receive full and objective information on government activities in different areas through media. These:[61]

- give media the right to cover all aspects of the activities of central and local government bodies;
- make oblige central and local governments to provide media with complete information on their activities and to provide journalists with free access to

[60] According to the 23 September 1997 Law №539/97-VR "On the proper procedure for media coverage of the activities of central and local government bodies in Ukraine," media have the right to carry out their own research into and analysis of the activities of central and local government bodies, central and local government officials, evaluate their activities, and provide comments.

[61] See Art. 2 of the Law on media coverage.

such information, except for instances envisaged by the Law "On state secrets."

According to this law, the media can have free access even to confidential information, which is very important. As already indicated in other sections of this study, Ukrainian citizens do not have this right. Confidential information contains important data from the viewpoint of the society, such as information on how governments spend public funds.

The media as communication link between the government and the public

The media play a key role as communication link between citizens and their governments. They inform the public about the activities of central and local governments, usually on the basis of information services provided by the government bodies themselves. According to the Law on media coverage, this kind of information can be delivered through the media by:

- publishing and disseminating bulletins, press releases, surveys, information booklets, information updates, and so on;
- holding press conferences, briefings, organizing interviews with top officials from central and local government bodies for domestic and foreign consumption;
- providing publications or statements from top officials or other authorized employees from central and local government bodies in the press;
- transmitting television and radio broadcasts.

The institutional and legal basis for public oversight of budget spending in Kazakhstan

The healthcare system in Kazakhstan

A number of reforms have taken place in the healthcare sector in Kazakhstan. Some of these reforms were successful; others were not taken to their logical conclusion. The latter include setting up a system of universal medical insurance in order to switch to the family health model. Still, a number of positive changes are worth noting: the passing of basic health legislation, a major increase in healthcare funding that has made it possible to build a number of modern clinics, major repairs and upgrades of the healthcare facilities and equipment, and the introduction of new medical technologies in the diagnostic and treatment processes. Better healthcare and greater access have resulted in some positive trends in overall health statistics in terms of infectious and other diseases. But most indicators for health among the population of the Republic remain unsatisfactory.

Today, the Kazakh healthcare system consists of 886 hospitals and 3,463 ambulatories and clinics. In the regions, the delivery of healthcare services differs according to various indicators, such as: level of financial functions and administrative consolidation; volumes of resources available to fund a guaranteed quantity of free healthcare per person; sources and approaches to funding; primary healthcare structure; organization of medical facilities; and quality control of delivery. This situation makes it very hard to implement State policy in this area and to ensure of equal guarantees to all members of the population.

Since 2001, the number of hospitals has increased, going from 845 in 2001 to 860 in 2002. Today there are 76.8 hospital beds per 10,000 residents, for a total of 114,782 beds. This is nearly 5% higher than the European average, which is 73.3 per 10,000, according to WHO. Of course, this indicator varies significantly even among developed countries like Germany, France and Japan, and high indicators tend to reflect a larger portion of elderly people—the main consumers of health services. The number of doctors in Kazakhstan is 54,600, the number of nurses 115,000. Adequate indicators are 36.5/10,000 for doctors and 76.9/10,000 for nurses.

Despite these high indicators for the availability of healthcare professionals and hospital beds, the healthcare system in the Republic of Kazakhstan is ineffective, especially at PHC level. Important steps were taken in terms of funding healthcare over 2002–2004, with functions and responsibilities distributed among levels of government.

In recent years, the volume of State spending on healthcare, including health education, has increased not only in absolute terms, but in percent of GDP as well, which is very important, especially since the overall economy has grown significantly:

According to WHO recommendations, the minimal level of State expenditures on healthcare should be not less than 4% of GDP. Per capita expenditures have also grown steadily. Unfortunately, increased financing in 2002–2003 was not effective, as the number of patients treated in hospitals has grown 5–7% per year. Despite several increases in salaries for healthcare staff—in

2004 alone, by 20%—, official average wages in this branch are two times lower than overall wages in the Republic. The problem remains that the State's commitment to guarantee free healthcare for its citizenship is not being adequately funded. In some instances, free services are being replaced by services for which fees are charged.

Table 1. Healthcare in Kazakhstan

Year	Spending	% of GDP	Per capita
2001	TEN 63.9bn	1.97	TEN 4,308 (US $29.00)
2002	TEN 73.0bn	1.93	TEN 4,911 (US $32.00)
2003	TEN 92.4bn	2.08	TEN 6,201 (US $41.00)
2004	TEN 133.7bn	2.63	TEN 8,797 (US $63.60)

The lowest share of GDP was in 2002, 1.93%.

For lack of clear differentiation between guaranteed volumes of free healthcare and payable health services, there continues to be a fairly high level of informal payments to healthcare providers. The fact that the calculation of the consumption of guaranteed free care is not properly established promotes the unofficial economy. Nor is there any comprehensive approach to economizing on resources in the healthcare sector. In the regions, healthcare development is not a priority in social or economic policy.

Sanitary conditions and poor environmental factors are having an impact on the general health of the population, primarily due to infectious, occupational and somatic diseases.

Preventive, hygienic and anti-epidemic measures have resulted in the reduction of infectious diseases. Sanitation services have been subdivided for the purpose of preventing the spread of dangerous infections from abroad. Over the last few years, quarantine points have been established on the main trunk roads at state border crossings.

As a result, infectious diseases have declined over the last 5 years: measles (58.2 times), tetanus (5.0 times), whooping cough (4.7 times) and diphtheria (3.6 times). Kazakhstan is also recognized by the World Health Organization as a territory free of poliomyelitis. With regard to intestinal infections, the incidence of typhoid has declined by 3.5 times, bacterial dysentery 3.1 times, salmonella 1.7 times, acute intestinal infections and acute viral hepatitis A 1.6 times. Especially dangerous infections are registered in individual cases. One of the most effective measures for the prevention and reduction of the rate of infectious diseases is planned immunization.

The birth rate in Kazakhstan

In Kazakhstan, the birth rate has been growing steadily. In 2003, it was 17.2 per 1,000. The mortality rate is also increasing: it was 6.7 per 1,000 in 2003. The main causes of death are cardiovascular and oncologic diseases and injuries.

Infant mortality remains high–15.3 per 1,000 live births in 2003, but maternal mortality is declining rapidly, having dropped from 65.3 in 1999 to 42.1 per 100,000 live births in 2003. One of the main reasons for maternal mortality is poor health among women, which has an index of 20–30%.

Table 2. Budget spending on healthcare, as % of GDP

1992	1993	1994	1995	1996	1998	1999	2000	2001	2002	2003	2004
2.1	2.5	2.0	2.0	2.7	1.9	2.1	1.9	1.9	1.9	2.0	2.1

Sources: Data for 1992–2000: UNICEF, MONEE database 2002; data for 2001–2004: Quarterly predictions, Almaty, 2005, №1 (09)

The legal basis for health services delivery

Article 25.1 of the Universal Declaration of Human Rights states that "everyone has the right to a standard of living adequate for their own health and that of their family, including food, clothing, housing, medical care and necessary social services." Article 12.1 of the International Covenant on Economic, Social and Cultural Rights recognizes the "right of everyone to the employment of the highest attainable standard of physical and mental health."

According to the 29th Article of the Constitution of the Republic of Kazakhstan, citizens of Kazakhstan have a right to healthcare and a free guaranteed volume of medical assistance. However, the State Budget never has the means to pay for the medical treatment in the volumes guaranteed by law. In 1995, the Government of Kazakhstan made an attempt to establish mandatory health insurance to solve the healthcare funding problem and adopted the "Law on mandatory medical insurance for citizens of the Republic of Kazakhstan." But this step toward a healthcare insurance system collapsed in scandal.[62] As a result, people do not trust the Government and this prevents the setting up of a new health insurance system.

In 1998, the President signed a decree "On initial measures to improve the health of citizens of the Republic of Kazakhstan."[63] A Government Decree[64] changed the Republic Center for payments for medical services was transformed into "Densaulyk" (Health), a state enterprise whose function is to monitoring public health and to provide a scientific basis for reforms in healthcare and official statistics.

The long list of decrees and regulations finally led to positive trends in healthcare in Kazakhstan.

[62] T. Imanbayev, the head of the mandatory health insurance fund, stole all the money and left Kazakhstan. At least, that was the explanation given by Kazakh authorities. The US granted him political asylum.

[63] Presidential Decree №3956 of 18.05.98 "On initial measures to improve the health of citizens of the Republic of Kazakhstan."

[64] Government Decree №1364 of 10.09.1999.

Public participation in the budget process[65]

Best Practices[66] recommend that a draft Budget and reports on its execution be open to the public, and that the Ministry of Finance actively promote an understanding of the Budget by the country's citizens and NGOs.

In the US and Western Europe, the executive publishes a "Citizen's Budget," which helps non-specialists to understand the key points of the draft Budget. It is oriented towards as wide a group of the population as possible, which is far broader than the regular readers of budget information from a country's capital and financial centers. Moreover, the governments of these countries provide the public with non-technical definitions of terms used in the budget and budget-related documents. This makes budget terminology more comprehensible to non-specialists.

In Kazakhstan, the law does not prevent public participation in the budget process but, in fact, these opportunities are limited. The draft Budget is not published and representatives of the executive do not hold any consultations with the public when identifying budget priorities.

A brief explanation of the Budget and its prospects is attached to the draft State Budget submitted to the Parliament, but it is not published and is not available to the public. Nor is a list of major budget terms attached to the draft Budget. However, such a glossary is available in the Budget Code.

Until recently, NGOs in Kazakhstan were not interested in budget work. In February 2003, the Public Policy Research Center, in collaboration with the International Budget Project and with the support of the Eurasia Foundation, conducted the first workshop on public participation in the budget process for NGOs from all regions of Kazakhstan. Since then, a number of NGOs have been monitoring Budget implementation in different areas. Budget analysis has been aimed at social support for disabled people, education, healthcare, the "Drinking water" program, and so on.

Still, the various levels of government in Kazakhstan do not publish "Citizen's Budgets" and they do not hold consultations with the public when developing budget priorities.

The draft Budgets have the standard list of indicators necessary for such documents: the revenue structure is classified by functional, administrative and economic categories. The expenditure structure in Kazakhstan is classified only by administrative and functional categories: economic classifications are not provided.

The content of the draft Budget does not comply with the requirement of comprehensive information, one of the major principles of a budget system identified in law. Draft Budgets do not contain information on quasi-fiscal activities, the state's financial and non-financial assets, tax expenditures, or the range of Budget program beneficiaries. Contingent liabilities in Kazakhstan are only partly highlighted.

A limited amount of information is provided on state debt, and the schedule and terms of debt repayment are not given, nor are new currency loans that are to be taken out and repaid. At the present time, the Kazakhstan draft Budget only contains

[65] See "The Budget Process in Caspian Countries: The experience of Kazakhstan and Azerbaijan" by M. Makhmutova, Policy Studies №2, 2005.

[66] OECD Best Practices for Budget Transparency, 15 May 2001.

information on debt limits at the end of the year and the total amount of interest paid.

In Kazakhstan, the Government also does not publish a draft Budget in the media after its submission to the Parliament. This means that the public gets incomplete information, mostly from statements by some members of the Government and the Parliament and from publications in the press. This does little to stimulate debate on key budget indicators, nor does it lead to comprehensive public awareness on this issue.

The process of Budget implementation is the most open stage of the overall budget process in Kazakhstan. Monthly progress reports on Budget implementation are published in the Statistical Bulletin and on the website of the Ministry of Finance. The format for presenting the data, methodology, definitions and budget classifications largely correspond to recommendations provided by the *IMF Manual on Government Finance Statistics* and OECD *Best Practices.*

Conclusions

An analysis of the current situation in SEE, CEE and Central Asian countries shows that the willingness of governments to adopt participatory practices and develop the capacity to organize and manage participatory platforms needs to be stronger, as does budget literacy among local communities. These will need to be raised to at least the minimum capacity level that is affordable and practical to implement.

Various players from civil society often lack the skills and experience to engage in constructive dialog with their governments. Moreover, they are discouraged from being more involved in budget matters due to the very technical, abstract and closed nature of the budget process. The process of demystifying and simplifying the budget process should be accompanied by raising general understanding of budget issues among the public, policy analysis skills among non-government experts, and advocacy skills in civil society in general.

There is a demand for training materials that reflect international experience and best practice in participatory budgeting that are appropriate to the economic, political and cultural context of SEE, CEE and Central Asian countries. Such materials should target government and non-government representatives alike. Practice shows that, apart from training, the exchange of know-how and experience among local governments and direct contact with their counterparts abroad can be very instrumental to introducing innovative practices.

It is equally important to concentrate on increasing the capacities of local media to understand budget processes, to present budget-related information to a broader constituency, and to conduct professional investigations of cases involving the embezzlement of public funds and corruption.

Chapter 3

A model for public oversight of healthcare spending

SEE, CEE and Central Asian countries are characterized by different levels of public participation and control over healthcare spending. Although most of these countries have already established some preconditions for dialog between the state and its citizenry, the model proposed here highlights critical points that need examining. There is no recipe for public watch initiatives that can be universally applied across contexts or jurisdictions, but there is a clear set of features that need to be built into any given process.

As broad experience and analysis have shown, the extent to which public agencies are accountable to citizens depends, among other factors, upon how organized the citizens are to exercise their voice and advocate. Without enough numbers, individual citizens are unlikely to be in a position to push for accountability when health systems are disinclined to be responsive. Thus, the role of civil society and NGOs comes to the fore and, with it, questions of their breadth, depth, representativeness and capacity. The role of NGOs extends beyond interest aggregation and advocacy, although these are certainly important and have received a lot of attention. NGOs are also critical for providing information on and demystifying health policies, regulations, and responsibilities, so that ordinary citizens can become knowledgeable consumers of health services, as well as informed voters.

As discussed in this paper, the complexity and specialized technical content of medical and health issues are barriers to the lay person's exercise of intelligent accountability and NGOs can be critical to overcoming these. NGOs often collaborate with the media to spread their message. Indeed, an active press is key to both generating and disseminating the information necessary for voters to hold public health officials and agencies accountable.

Characteristics that determine public involvement

Variations in the capacity of citizens to express their voice or in the willingness of providers to develop a better client focus depend on the sector and the level of services. A range of factors could explain this, including service features, such as the complexity of the technology involved, the geographical, social and remoteness of the providers, the extent to which the service is a shared common good or an individually consumable product, and so on.

Variations in the capacity to voice or to be customer-oriented can also be explained by the characteristics of various groups of clients: their social status, their geographical concentration, and whether they have a sustained or one-off relationship with providers. Where users interact infrequently and reluctantly with providers, as with secondary and tertiary treatment, a more effective way is to build responsiveness and client-focus among service providers.

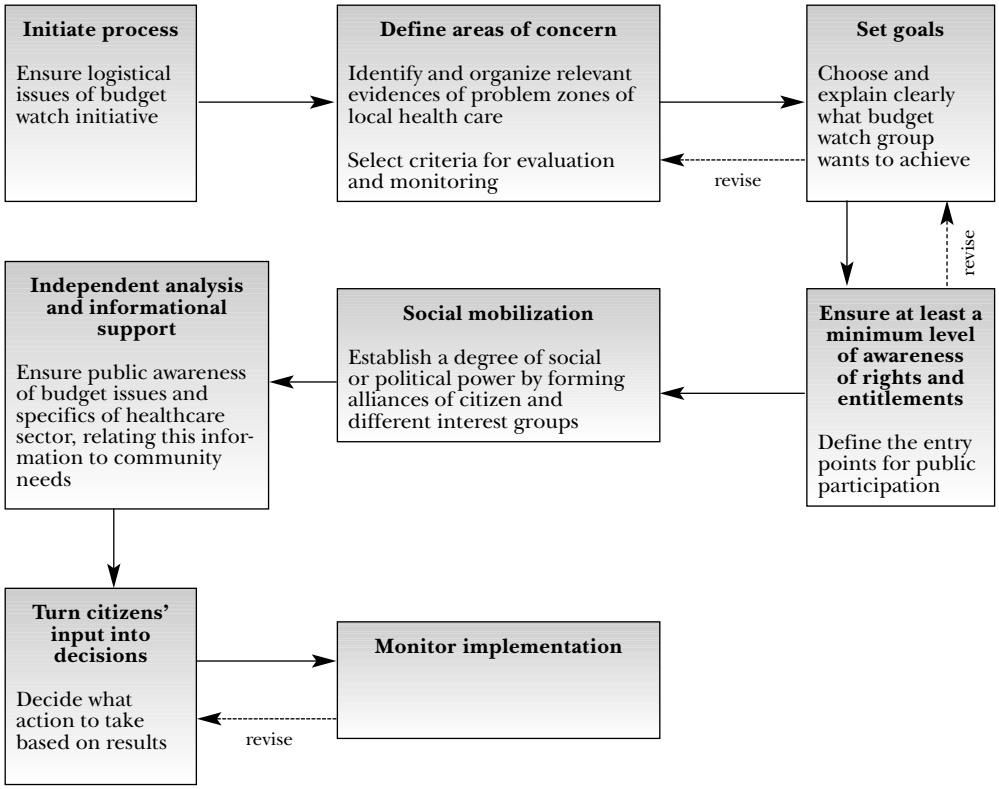
Hospitals, with their mix of professional staff, consultants, high technology, and short-term, irregular and unsustained interactions with clients, tend to be rather closed to interactions with the general public.

Tertiary healthcare is a technically complex issue, so the knowledge barrier can get in the way citizen engagement unless these people equip themselves with substantial technical skills—and then only to provide alternative design and delivery suggestions, not to engage directly in service planning. Community health is the issue that is the easiest for citizens to engage over, and officials are more able to see the potential in it.

NGOs—the driving force for public control

In preparing this model, worldwide experience in public watch was used, taking into account the local legal and institutional environment and proposing feasible changes where needed.

Scheme 1. Model for public watch initiatives



Step-by-Step Model

Participants

This model presupposes the active participation, or at least willingness to participate, of certain players:

- Civil society organizations (CSOs), that is, budget watch groups, policy research institutes, consumer protection associations, and so on;
- Local government units;
- Ministry of Finance (MF);
- Health Insurance Fund (HIF);

- State Audit Office (SAO);
- The media.

Step 1 – Initiate the process

A group of interested citizens that is planning to launch budget watch over healthcare spending should have at its disposal at least a minimal level of resources: (1) someone responsible for logistical issues, such as communicating among all interested parties, collecting preliminary information, making announcements; (2) premises that can be located, advertised, and serve as an office (3) communication capacities.

In this respect, CSOs play a leading role in the budget watch model since they represent the citizens' interests and have the power to organize and accomplish the initiative; the capacity to obtain information; and the knowledge to analyze this information and translate it into everyday language and make it comprehensible to the general public. Here, the capacities of existing policy research institutes and consumer protection associations can be of great use. For the sake of simplicity, these are all called budget watch groups in this model.

Step 2 – Define areas of concern

The first step in budget watch activities is to clearly determine areas of concern. It can be done in a number of ways:

- public opinion surveys on satisfaction with healthcare services;
- discussions with citizens in focus groups;
- in response to widely-discussed and well-known problems in healthcare delivery.

Quite often, citizens will describe problems in terms of undesirable conditions or symptoms rather than the underlying causes. So, it is very important to assess the symptoms of problems with healthcare and provide an explanation of how they arise in order to move to the next step—finding a solution.

Step 3 – Set goals

To ensure a legitimate and transparent process, it is essential that the NGO/interest group clearly formulate **the purpose of the initiative**, that is, what exactly they want to change. Citizens need to understand what they want to change or influence and how they might later control the results of their efforts.

At this stage, it is important to put together a set of criteria that will help put the symptoms in quantitative perspective. Concerns that are supported by well-articulated arguments based on objective criteria can help to form alliances with different interest groups. These criteria will also help to monitor changes or other consequences of the proposed measures. They can also be adjusted in the process of carrying out the budget watch.

The set of criteria need to:

- be relevant to the areas of concern;
- encompass all the important dimensions of the goal;
- provide a basis for measuring progress towards achieving the goal;
- measure any impact that is concentrated, tangible, certain and immediate;
- be acceptable to different population groups.

For example:

- waiting lists in general clinics and hospitals;
- adherence to the schedule of medical services;

- the availability of medications;
- the availability of necessary medical equipment.

Sometimes it is difficult to set quantitative criteria to measure the quality of health services. Often qualitative assessments have to measure impacts that are diffuse, intangible, uncertain or delayed.

For example:

- patient satisfaction with medical services;
- the quality of the environment in hospitals and clinics;
- logistical issues in general at medical facilities;
- accessibility and "bedside manner" of medical personnel;
- logistical issues regarding surgery hours.

Although criteria could be helpful to structure further analysis, there are a few risks that should be taken into account:

- Governments and the public tend to focus excessively on the worst performers. What we rarely ask ourselves is why there are not more poor outcomes, what are medical professionals already doing, what strategies do they currently use, that lead to good outcomes, how do they successfully avoid errors, and how might we build on these to help make healthcare even better?

- Inappropriately used, measurement and reporting can create an environment of fear instead of fostering quality improvement. Measurement alone does not improve quality and, indeed, when seen primarily as a way to improve accountability and to make judgments, may be self-defeating, reducing morale and causing the collapse of other quality-enhancing activities that are not part of the performance management strategy. As with any other healthcare intervention with uncertain impact, the use of performance indicators should be subject to some form of health technology assessment. Even when measures are accurate, interpretation of the results can be very difficult for several reasons. Because of random variations, it is often difficult to assess the degree to which variation reflects real differences in activity or outcome. Because of the small numbers or rare outcomes involved in any one hospital or primary care group, averages over several years are often needed. This makes it more difficult to act at that point, because adverse results may reflect performance in the past rather than the present.

- By focusing too heavily on a few indicators, other aspects of service that are not being measured or are not so measurable may get less attention. Thus, while the measured performance may improve, quality may fall in the less-scrutinized areas, possibly leading to a decline in overall performance. Depending on the indicators used, this can also engender a short-term culture. Actions to ensure good performance on this year's indicator could end up replacing more strategic thinking about how to make more fundamental long-term improvements.

- There is also the danger that data can be manipulated to improve measured performance. It is possible, for example, that cancer registrations, which are already imperfect, can be affected because this is used as measure of cancer incidence and extrapolated as an indicator of poor performance.

Some form of rigorous piloting should be carried out before launching routine use and full-blown evaluations. For example, a

type of "rubber windmill" exercise can be conducted in which data is presented to healthcare service stakeholders to see how they respond. When presented with data, they can be asked whether these are the areas which they would have chosen to measure, what additional data they would request before acting, and what action they would take.

When evaluating, the subject of evaluation should be clearly stated, that is, the quality of services or clinical quality. The latter is difficult to measure because of different factors that can affect the results of medical treatment.

Step 4 – Ensure at least a minimum level of awareness of rights and entitlements

Public initiatives should not be designed without taking into account the official environment, in the sense that each initiative directly engages local government bodies. More than that, the choice of form and mechanisms for public participation is shaped by the nature of the political regime, the institutional capacity of the local bureaucracy, and the power of the initiating group in its community.

Public control over healthcare spending should include a minimum level of awareness of rights and entitlements and the ways in which these are or are not met by public providers. The next step should include collecting information about healthcare rights, disseminating this and other information, and participating in the local policy-making process. It means studying:

1. The Law on disseminating information and other regulations that define what kind of information can be available, procedures for obtaining such information, time limits for responses, specifically stated off-limits information, and appeal procedures.
2. The legal basis for consultation and participation, that is, the administrative procedure laws, impact assessment laws that require that the dissemination of information regarding the impact of the certain policies before adoption, and requirements for consultations with interest groups.
3. Laws and regulations on state obligations regarding the level/quality of health services delivery.
4. Existing procedures, that is, how to request access to information, what information must be published, the cost of specific information, and general communication with the public. Even without legislation, policies can be supported by official requirements to consult with citizens, provide public notification, guidelines, and set standards.
5. Institutional elements, that is, who responsible, who coordinates, and who oversees. Specific institutions or centers, where individuals can get information and address their comments, suggestions and complaints, such as advisory councils, committees, and institutions for oversight or for complaints.

After this study, the budget watch group can define the entry points for public participation, who or which institution has at least a nominal mandate to support public initiatives, and on which basis social mobilization can be organized.

Step 5 – Social mobilization

Successful public oversight must include some degree of community power. Such authority can be gained through social mobilization. Effective mobilization depends on, among other things, the capacity to attract allies from other and more powerful social groups. In that respect, it is important to create alliances of

citizens' associations and representatives of certain key groups:

- **Local administrations**

The State creates the environment for citizens to express their voice—and to a great extent determines the effectiveness of that voice—by virtue of the rights it extends to its citizens, the access it provides, and the opportunities for participation. That is why local governments are very important partners in the model presented here.

Although obliged by law to provide certain budget information, the unwillingness of local governments to participate in this model would make its implementation quite difficult, especially in a situation where there is no law on access to information and the court system is dysfunctional. The bureaucracy should be protected from political interference and subscribe, at least formally, to publicly legislated rules and procedures, and to a mission to work in the public's best interests, in relative autonomy from powerful social groups. Although few public administrations meet all these conditions, constitutional commitments to such conditions give citizens an essential lever with which to press for health sector probity, equity in service delivery and accountability before the public.

- **Service providers**

An alliance between citizen's associations and service providers can help to establish a two-way process for improving the situation with healthcare. Where service providers attempt internal reform, they can try to create—or at least increase the effectiveness of—their political base by supporting an external constituency for reform. Thus alliances between service users and key figures in the service-providing administration are critical resources for both parties in promoting responsive service delivery.

- **Political parties**

Multi-party competition can also offer opportunities for citizens' associations to increase their influence. Thus, civil society groups can pursue high-profile strategies to promote group interests or challenge state behavior, in the hope of interesting opposition parties in taking up their cause in the legislature.

In creating alliances, it is important to combine protest with constructive engagement with officials.

Step 6 – Independent analysis and informational support

Effective public control requires of citizens an understanding of budget issues, the specifics of the healthcare sector, and the ability to connect this information to community needs. Preparing informational support for public watch is the next step in the Budget Watch Model. For this purpose, budget watch groups can attract budget specialists. They can recruit specialists from among university graduates, local governments or the actual service providers.

The information needed for independent analysis includes:

- the structure of the budget system;
- the division of responsibilities among different levels of government, including in healthcare;
- revenue sources;
- the structure of healthcare expenditures;
- local budget implementation data.

Independent analysis should provide solid arguments in support of the choice of spending priorities and form a basis for citizens' decisions on the distribution of budget

resources. It should provide an answer to five key questions:

- Which decisions are made by the central government, local governments, and healthcare institutions?
- Where does public money mainly go?
- How effective is spending in specific areas of healthcare services and in the health sector in general?
- What are the alternatives for spending the money?
- How can these decisions be influenced?

Step 6.1 – Collect data

Data collection is the core of this model and it requires an active partnership between the central and local governments and CSOs. Given the reality, that is, the lack of communication between the Government and the general public, this can be the most difficult step in the entire process. The CSOs need to be ready to put enormous effort into getting the Government used to releasing the necessary detailed budget information.

This step has two main components:

- *Step 6.1.1 Giving budget watch groups open access to data*
- *Step 6.1.2 Collecting and organizing budget data*

Step 6.1.1 – Give budget watch groups open access to data

The Ministry of Finance, HIF, SAO and local government units are the main authorities in possession of data on healthcare spending. According to law, this data should be publicly available, but it is not easily accessible at this time. Providing budget watch groups with open access to sessions of the Verkhovna Rada and the local councils when the budget issues are discussed will ensure further transparency, which will facilitate the implementation of this model.

Step 6.1.2. – Collect and organize budget data

Since healthcare budget information is dispersed among a number of offices, the first thing that needs to be done is to collect the information in a single place. This will be the job of budget watch groups.

If a budget watch group wants to assess the effectiveness or appropriateness of budget spending, it needs to consider, not only expenditures made by budget organizations, but also those made by the private sector and the donor community. The tables here present possible strengths and weaknesses of data sources, which also need to be taken into account.[67]

These two guides contain very useful detailed instructions for the data collecting stage:

- Guide to producing national health accounts with special applications for low-income and middle-income countries; The World Bank, WHO, USAID; *http://whqlidoc.who.int/publications/2003/9241546077.pdf.*
- National Health Accounts Participants Manual; PHRplus and USAID; *http://www.iadb.org/sds/specialprograms/lachealthaccounts/Documents/Guide_NHA_Participant_Manual_EN.pdf.*

[67] See the Guide to producing national health accounts with special applications for low-income and middle-income countries by the World Bank, World Health Organization and USAID. *http://whqlibdoc.who.int/publications/2003/9241546077.pdf.*

Table 3. Strength and weakness of budget data by source

Origin	Strengths	Weaknesses
Government records • Budget expenditures • Economic censuses and surveys • Tax reports • Import and export statistics • Reports on transfers from external sources	• Most accessible of the different types of data • Reliable and accurate • Comprehensive coverage of the relevant activity • Available on a regular basis • Consistent reporting rules	• Official or unofficial barriers to data raised, attributable to government security practices (such as Armed Forces hospitals and dispensary accounts) • Data distorted or misrepresented to protect or advance a program • Data disaggregated into categories dictated by regulation expenditure control (which often differ from the provider or function categories required for health accounts) • Audited data accessible with considerable lag
Other public records • Ministry of Health annual reports • Financing and regulatory agency reports • One-time documents such as task force reports, white papers, parliamentary commission reports • NGO reports or studies • Academic studies • International agency reports	• Rich in details, focusing on specific issues • Frequently comprehensive for relevant cells in tables • Information collated for a specific inquiry that may otherwise not be regularly monitored	• Typically focused on single dimensions – restricted geopolitical, demographic, socio-economic, epidemiological scope • Variable analytical rigor • Classifications may not match those needed for health accounts
Insurer records • Individual companies • Industry associations • Special analyses of tax records or other official reporting requirements	• Restricted to medical care and related expenditures • More rapidly available after the end of the fiscal year than government budgetary reports	• Frequently weak on functional detail • Exclude co-payments, deductibilities and other patient financial liabilities • Absence of centralized information system or financial reporting • Unwillingness to share proprietary data • Difficulty in keeping track of all organizations in a rapidly-changing market makes it difficult to estimate an industry total

>> continued on next page

Origin	Strengths	Weaknesses
Provider records • Financing and regulatory agencies (administrative records and surveys) • Industry associations • Special analyses of tax records	• Specific and comprehensive for relevant cells • Records contain little spending that falls outside the boundaries of the accounts	• Difficult to assure that all providers are represented by data • Rapid turnover in small providers makes surveys difficult • Incentives exist to inflate expenditure claims in financing systems with reimbursement and to under-report taxable revenue • Basic records may not be adjusted when tax and other authorities "correct" for fraud • Reporting classifications designed for administrative and auditing purposes, not economic accountability
Household surveys and records related reporting • Censuses and surveys • Academic and non-profit institution studies • Marketing studies	• Cross-classification with relevant demographic, economic, social and other payer and user characteristics • The only source on information on spending that occurs in the "gray market" • Detail in liabilities available only indirectly through other sources	• Sampling and non-sampling errors in reporting can present major challenges to analysis and accuracy • Patient not always aware of the full cost of medical services records • Records relating mainly to personal medical services, few details may be usable to approximate the value of collective and public health services

Step 6.2 – Analyze the data

The second step of the model is to analyze the collected budget data. Such analyses can be done according to different methods such as NHA, PETS, cost-benefit, and more. Whatever method is used, it should be chosen at the beginning of the data collection stage, as different analytical methods require different kinds and scopes of data.

a. National Health Accounts (NHA)

The estimates generated during an NHA exercise can help to determine the level of efficiency of the healthcare system and to identify areas of under- or over-spending. Time trends in NHA format can demonstrate the impact of policy initiatives on public and private spending and o the productivity of the sector.

There are several methods for using NHA, which are divided in two groups: standard and non-standard approaches.

Standard approaches are those based on existing internationally agreed-upon concepts, definitions, classifications, and accounting procedures. They have been developed by the United Nations Statistical Commission over the last 60 years, through an extensive process of consultations and consensus-building.

The advantages of using standard methods include:

- uniform definitions for the boundaries of the health sector;
- standard classifications for inputs and services;
- valid comparisons across countries and over time.

Most importantly, standard methods make direct comparison of health system financial indicators with macroeconomic indicators used by Ministries of Finance and Central Banks possible.

The main disadvantage of standard methods is their relative rigidity. For this reason, some non-standard approaches have been developed that are based on extensions and modifications of the standard concepts and classifications, and/or on newly proposed sets of concepts, classifications, and accounting procedures. These allow greater flexibility in terms of data sources, health sector boundaries and classifications. For this reason, it becomes possible to report results in a timelier manner and to present data in a manner more relevant to the needs of health sector decision-makers.[68]

Given the fact that the NHA exercise will be done by non-government budget watch groups, the most appropriate method is the "Harvard method." It was created in 1980s and is based on administrative accounts.[69]

The Harvard method requires the following data:

- all types of expenditure data;
- the budget as executed;
- employer records of social expenditures;
- households goods and services spending surveys;
- NGO social spending and sources;
- spending at international and foreign aid organizations;
- insurance company records;
- healthcare provider records;
- social, demographic, economic and health data on health system beneficiaries.

The advantages of this method are:

- describes the flow of funds in a system, from funders to providers;
- flexible and adaptable to the needs of Ministries of Health;
- data organized in a manner relevant to health sector managers;
- reflects national priorities;

[68] *http://www.iadb.org/sds/specialprograms/lachealthaccounts/CreatingHA/Standard_Methods_en.htm#Standard%20Approaches.*

[69] This method has been implementing in Bangladesh, Bolivia, China, Colombia, Czech Republic, Dominican Republic, Ecuador, Egypt, El Salvador, Guatemala, Honduras, Hong Kong, India, Japan, Jordan, Mexico, Nicaragua, Peru, Philippines, Poland, Sri Lanka, Thailand, and Zambia.

- allows the inclusion of expenditures peripheral to the health system (education, environment, sanitation);
- appropriate for multiple payer systems;
- broad disaggregation by sources of funding;
- broader definition of health includes all activities that promote, restore, or maintain health;
- requires a modest-sized team and 6–12 months to produce the first round of estimations.

The operational challenges of the Harvard method are that it:

- examines only expenditures, which does permit an evaluation of the efficiency of the sector or its economic valorization;
- not standardized, reflecting mainly national concerns, making international comparisons difficult;
- lacks internal consistency;
- mixes production and financing perspectives;
- does not distinguish clearly between capital and recurrent expenditures;
- does not distinguish between intermediate and final consumption;
- institutionalization is as difficult as for the other methodologies.

The method is appropriate for public budget watch, since it can be applied by ministries of health, technical teams not linked with the government, universities, central banks, or national income offices. Moreover, there are several guides and manuals describing in detail the method and its implementation.[70]

Producing an NHA is not an easy job, of course, and it will not be perfect the first time around, but it will improve over the first few years of implementation. Since budget watch is not a single, isolated action, the most important thing is to start the process. The improvement and adjustment of methodology will come with practice.

b. Public Expenditure Tracking Survey (PETS)

Another method that can be used for data analysis is the Public Expenditure Tracking Survey (PETS). PETS tracks the flow of resources through the budget system in order to determine how much of the originally allocated resources reaches the level or entity they were intended for. It is useful as a tool for locating and quantifying political and bureaucratic "capture," the leakage of funds, and problems in the deployment of human and in-kind resources, such as staff, textbooks and drugs. It can also be used to evaluate impediments to the reverse flow of information to account for actual expenditures. The tool explicitly recognizes the fact that budget agents may have a strong incentive to misreport—or not report—key data. PETS copes with these data issues by using a multiangular data collection strategy, that is, a combination of information from dif-

[70] A number of guides can be of great use to a budget watch group: 1) Producer's Guide to National Health Accounts with Special Applications for Low-Income and Middle-Income Countries *(http://whqlibdoc.who.int/publications/2003/9241546077.pdf)*; 2) Instructor Manual to Producer's Guide to NHA *(http://www.iadb.org/sds/specialprograms/lachealthaccounts/Documents/Guide_NHA_Instructor_Manual_EN.pdf)*; 3) Participant Manual to Producer's Guide to NHA *(http://www.iadb.org/sds/specialprograms/lachealthaccounts/Documents/Guide_NHA_Participant_Manual_EN.pdf)*.

ferent sources. It carefully considers which sources and respondents have incentives to misreport and then identifies data sources that are the least contaminated by such "incentives." The triangulation strategy of data collection serves as a means of cross-validating the information obtained separately from each source.[71]

c. Quantitative Service Delivery Survey (QSDS)

The primary aim of a QSDS is to examine the efficiency of public spending, incentives, and various dimensions of service delivery in provider organizations, especially on the frontline. QSDS can be applied to government as well as to private for-profit and not-for-profit providers. It collects data on inputs, outputs, quality, pricing, oversight, and so forth. The facility or frontline service provider is typically the main unit of observation in a QSDS, in much the same way as the firm is in enterprise surveys and the household in household surveys. A QSDS requires considerable effort, cost and time compared to some of its alternatives, surveys of perceptions, in particular.

Both tools (PETS and QSDS) explicitly recognize that an agent may have a strong incentive to misreport or not report key data. This incentive derives from the fact that the information provided, for example, by a health facility partly determines its entitlement to public support. In cases where resources, including staff time, are used for other purposes, such as shirking their duties or doing business on the side, the agent involved in the activity will most likely not report it truthfully. Likewise, official charges may only partly capture what the survey intends to measure, such as the user's cost of service. As noted, PETS and QSDS deal with these data distortions by using a multiangular data collection strategy, carefully considering which sources and respondents have incentives to misreport, and identifying data sources that are the least contaminated by these incentives. Triangulation serves as a means of cross-validating the information obtained separately from each source.

In the PETS–QSDS approach, the main departure from cost function literature is the explicit recognition of the close link between the public sector service provider and the rest of the public sector. Providers of public services typically rely on the broader government structure for resources, guidance about what services to provide, and how to provide them. This dependence makes them sensitive to system wide problems in the transfer of resources, institutional frameworks, and the incentive system that private providers do not face.

Like other micro-level surveys, PETS and QSDS require careful design and implementation. At least some members of the study team should have prior experience with such surveys. The intuitive appeal of PETS and QSDS can belie the complexity of their planning and implementing.

d. Cost-Benefit Analysis

The collected data can be also analyzed using some simple cost-benefit analyses, although it is never "simple" to do such analyses when health is the issue. The difficulty lies in the fact that human life and health need to be expressed in numbers and be given a price-tag. Still, some cost-effectiveness analysis of budget spending is worthwhile.

In their first years, newly-formed budget watch groups can start by doing simple cost-benefit analyses or applying the NHA and

[71] More detailed information about PETS can be found in Jan Dehn, Ritva Reinikka and Jakob Svensson's *Survey Tools for Assessing Performance in Service Delivery* (*http://www1.worldbank.org/publicsector/pe/PETS1.pdf*).

PETS methodologies to a particular identified problem, whether that is the cost-effectiveness of a specific service or provider, a local policy, or whatever. In the following years, as the capacity and the expertise of the budget watch group grow, it can start producing a real NHA or full-fledged PETS.

Step 6.2.1 – Disseminate the results

Any analysis has little value if it does not receive publicity and is not widely discussed with stakeholders. Since the aim of this model is not only to identify possible problems or the misuse of budget funds but also to suggest reasonable solutions that are broadly acceptable, the analyses must be widely discussed with central and local governments, civil society, the expert community, the international donor community, and, of course, the media, which will provide the necessary wide-scale publicity.

The effective dissemination of budget watch results requires that the group prepare a communication strategy that covers how to communicate the results, what kinds of discussions to organize and where, whom to involve, which institutions, organizations or persons to use as allies, and so on. Any strategy will most probably be modified in the course of work, but it provides a helpful general framework for the communication activities that need to be implemented.

Step 7 – Turn citizens' input into decisions

When the problems of measurement and interpretation have been solved, the next step in the process is to decide what steps to take next, based on the results. Of course, the best outcome would be a solution that is readily accepted by the authorities, but this is not very likely to happen. Generally, governments, be they central or local, are not interested in changing their modus operandi and spending habits without considerable public pressure. This is where civil society and the media need to join forces to achieve positive results. When an initiative is supported by objective, authoritative analyses, the chances of succeeding grow considerably.

Across countries and over time, various responses have been developed, including formal approaches such as investigation, facilitation, training, investment in problem areas, and less formal approaches such as the publication of results for other health professionals or the general public. It is important for NGOs involved in the initiative to plan to clearly articulate a framework for action, and how this will be organized and supported.

This step is crucial to the success of budget watch initiatives and, indeed, to all other forms of public participation. Interested citizens should carefully choose when there are clear choices and decisions on which they can provide input, when community values need to be considered, and when it is time to articulate. The "right" times include:

- just before elections;
- when a budget is being formulated;
- when a budget is being approved;
- when a budget progress report comes out.

Campaign in the media

As international experience shows, many successful citizen initiatives have used the media or other public communication form to catalyze a response from local administrations. This can be done either by exposing poor service delivery or corrupt behavior by officials, or alternatively by reinforcing positive innovations in service delivery.

To promote the concept of "policy windows" for successful policy implementation, NGOs can prepare a series of articles for the press that discuss policy options and their impact on quality of life. They can also turn to local TV by suggesting a topic related to the problem of financing healthcare.

Public exposure of poor quality services may have little effect on politicians—and none at all on civil servants—, since their position or job security is not necessarily contingent on quality service delivery. However, media campaigns designed to mobilize voters on these issues, particularly during election periods, can arouse more direct responses, particularly from politicians anxious to extend their stay in office.

Protest or threaten a public protest

Officials whose jobs are not linked to client satisfaction and politicians outside election periods can often be indifferent to voter concerns, particularly if these are articulated by groups without the capacity to launch massive lobbying efforts, or to leave the system and buy their services from a private provider. For such groups, protest action offers one means of attracting the serious attention of policy-makers. The effectiveness of protests will depend upon the breadth of the community support network the group has, the type of protest activity, the way it is covered by media, and the representatives of the state they are targeting.

Step 8 – Monitor implementation

For monitoring purposes, use the set of criteria that was defined at the beginning of the process, Step 4, when the problem was defined and goals were set. During the progress of the budget watch initiative, these criteria may have been revised.

External advice and outsourcing for local governments

Outsourcing can be a way for local governments to lessen the workload on civil servants, while outside consultants can provide an objective look at its internal processes. Most of the countries for which this model is being proposed have at least officially declared public involvement in the policy-making process a part of their government strategy. Although even commitments to promote public participation that have been enshrined in law do not necessarily lead to practical implementation, governments will generally be interested in collaborating with NGOs on this issue.

Providing external advice and outsourcing for local governments requires a higher level of expertise and broad experience on the NGO side. Expertise from outside government ranges from high-level strategic advice in developing legal and institutional frameworks to planning events and providing the technical support to conduct them, such as web design. Drawing on external expertise provides the government with an opportunity to learn from others. Outsourcing events handling, for example, can also lessen the workload on internal services.

Training for budget watch activities

Conducting an effective budget watch requires specific skills. Many of these skills can be developed and made available within CSOs. Workshops can prepare existing personnel to plan and conduct budget watch activities. Attracting individuals with prior professional experience and capacities in this area as both experts and volunteers can also help develop and enhance in-house skills.

The full range of skills needed to establish a working budget watch includes: strategic, political and fiscal competencies; process design, moderation and facilitation abilities; and communicational skills. Knowledge and experience in communication techniques—such as those common to journalism, public relations, publishing and advertising—is certainly helpful, especially for many technical tasks.

Chapter 4

Sample healthcare budget analyses

The Truskavets (Ukraine) municipal budget

Residents of Truskavets, a resort town in Western Ukraine, are dissatisfied with the quality of healthcare services they are provided with. One of the reasons is the messy situation with budget funding for municipal healthcare that has developed over the last decade. To begin with, the planned level of funding is typically inadequate to cover the cost of salaries, utilities, medications, hospital meals, and building maintenance. Yet even these approved expenditures are never disbursed in full.

In 2004, as an example, spending on medication was UAH 0.10 per clinic visit, UAH 0.05 per dental visit, UAH 0.61 per emergency ambulance call, and UAH 0.87 per day per patient in hospital bed. Such a situation makes it impossible for medical professionals to properly carry out their duties and rouses justified censure among patients.

In addition, budget allocations do not cover expenditures to develop treatment facilities: repairs and renovations or purchases of new equipment and instruments.

For instance, the book value of fixed assets at the Truskavets Municipal Hospital is UAH 23,678,500 although the average age of the hospital's equipment and instruments is 22 years. The hospital cut 140 beds and 190 positions between 1996 and 2005, but this has not improved the situation.

These kinds of circumstances raise the question of changing the approach to the way healthcare spending is planned in the city's budget.

The Truskavets budget process

Before drawing up expenditures for budget-financed institutions, including healthcare facilities, there needs to be a budget request that reflects the yearly costs of operating for a given institution. The budget request is then submitted to the municipal financial department and the Main Health Department of the oblast administration.

These departments then analyze the budget requests and adjust them in accordance with the control indicators[72] of the Ministry of Finance. Afterwards, the budget requests are returned to the municipal financial department.

The municipal financial department next prepares a draft budget for standing commissions to consider, jointly with community organizations. This draft is elaborated along two lines. The objective of the first is to bring healthcare spending in line with the proposed figure without worsening the provision of healthcare services—which is quite unrealistic. The objective of the second is to look for ways to increase healthcare spending. Based on their debates, the sessions of commissions involving community organizations produce a draft budget that is submitted for consideration to the Municipal Council.

The decisions of the Municipal Council are published in local press: *Dzherela Truskavtsia*, *Frankova Krynytsia* and *Perspektiv*. Afterwards, the budget process goes into the second stage: drawing up an expendi-

[72] That is, plan of revenues and expenditures set by the MinFin for every local government.

tures estimate according to economic classification codes.

As there are not enough funds to implement all that is needed to provide healthcare services according to current legislation and regulations, the commission and the public once again review top-priority and mandatory expenditures. Notably, Municipal Council policy guarantees funding for certain "protected" budget items: payroll costs, medications, hospital meals, and social transfers. In addition, the law requires mandatory payment for utilities. Treatment facilities are not provided with utilities unless these expenditures are allocated in their budgets. **Table 4** shows that spending on payroll takes more than 75%, meaning that only 25% of funding is left to support all other expenses—which is, once again, completely unrealistic.

In short, all debates at commission sessions involving the public are narrowed to the issue of how to divide this remaining 25% in the most rational manner, given that they need to cover guaranteed utility payments (heating, water, electricity and gas). In reality, utility costs take up to 15% of the available healthcare budget.

After approval by the deputy commission and community organizations, the draft distribution plan is submitted to the mayor for adoption.

Once approved, budget spending is analyzed on a quarterly basis. This issue is discussed at sessions of the Municipal Executive.

As the Municipal Executive Committee includes three representatives of CSOs, this issue is somewhat under public control. The Municipal Executive Committee meets during the last week of the month following the end of the quarter. The Executive's decisions are published in the local press.

Components of the Truskavets budget

What item makes it into the Truskavets budget depends on the city's revenues and the estimated amount calculated by the Ministry of Finance. On average, healthcare spending constitutes 23–24% of total expenditures in the city's budget.

Revenues that formed the Truskavets municipal budget for 2005 are shown in **Table 5**. These include:

- personal income tax;
- profit tax for communally-owned enterprises;
- rent on land;
- internal taxes on goods and services and some non-tax revenues.

These revenues help support the town's budget-financed institutions, including medical facilities.

Although Truskavets is designated as a town of oblast importance, healthcare is financed solely out of the municipal budget. All responsibility for the level of funding is placed on the city's government—the Municipal Council. However, residents of outlying territories also use the services of Truskavets hospitals. During the last four years, there have been unsuccessful attempts to negotiate transfers to the Truskavets budget for the treatment of patients from other places such as the city of Drohobych, Drohobych County, and the town of Boryslav. The problem is that, to include transfers, the councils of these various entities need to agree to transfer the

money and local mayors and councils need to sign agreements to do so. In practice, this is very difficult, as there is no way to influence top officials in other places to comply. At most, these councils will sometimes agree to transfer purely symbolic amounts—that do not do anything to improve the balance sheet for the healthcare institution that is providing services to residents from these territories.

Analysis of Truskavets budget expenditures

The estimated Ministry of Finance (MinFin) indicator is generally lower than the municipal financial department's estimated figure (see **Table 4**). Thus, UAH 12,624,200 in revenues is taken into account to determine intergovernmental transfers according to municipal calculations but only UAH 12,274,100 according to the MinFin.

The amount of city's revenues that is not considered in intergovernmental transfers calculation is UAH 4,581,600, while MinFin calculation for this indicator is UAH 2,806,900. Total revenues from the General Fund, that is, without subventions and funds remitted to the State Budget, were UAH 15,416,800 according to municipal calculations and UAH 13,292,000 according to the Ministry. An analysis of 2005 municipal budget items and draft 2005 Budget items compared to the MinFin planned control indicator is presented in **Table 4.**

This Table clearly shows a planned shortfall of UAH 1,070,000 in healthcare, given that spending on payroll is UAH 3,400,500 or 75% of costs. Clearly, it is impossible to ensure the operation of a healthcare facility and provide full-range healthcare services under such circumstances.

This can be further illustrated with the help of other figures. Total healthcare spending is UAH 4,530,300, while payroll costs are UAH 3,400,500. Thus, a mere UAH 1,129,800 is left to cover all other expenditures. The minimal need for utilities, based on 2004 rates, is UAH 552,000. After deducting this amount, only UAH 577,800 is left for all other costs: medications, hospital meals, the maintenance of buildings, medical equipment and elevators, cleansing agents, medical forms, insurance for staff, washing equipment and instruments, and other day-to-day commodities.

It is possible to start with purchasing medications as a priority for this amount. However, based on current norms, medication for in-patients costs UAH 491,600, while medications for emergency departments cost UAH 85,200, and funds are needed for out-patient reception at clinics, including UAH 431,600 for subsidized population groups. In short, it is impossible to fully support patients even just with medications, not to mention other items, such as meals.

The annual planned number of one-day stays per patient at the Truskavets Municipal Hospital is 75,735. The standard cost for meals/day/patient is UAH 4.05, so UAH 306,700 is needed for this purpose. All these facts make it clear that it is impossible to allocate such expenses on meals for patients in the budget. Real spending stands at UAH 90,000–100,000 per year or UAH 1.20–1.30 per one-day-stay per patient. This makes it impossible to adhere to proper care standards. A similar situation has developed around other budget items. According to forecasts, the situation will not change in 2006.

Recommendations

In our opinion, a budget has to guarantee funding for a certain amount of activity. This could be the provision of first aid, assistance to pregnant and nursing women and children, and other specific types of medical assistance, depending on financial resources. Additional funds could come from insurance companies, insurance funds, organizations, enterprises, and so on.

At present, the only way out of this situation seems to be for treatment facilities to receive funding in accordance with agreements for work done. Such agreements must be concluded between local governments and providers of healthcare services. In other words, those who order some work—in this case, the provision of healthcare services—must pay for the work done. In this way, the volume of work will identify the need for beds and personnel.

Ukraine has legislation that makes it possible to use contractual relations in healthcare services. The Law "On procuring goods, work and services for public funds" provides for the possibility of procuring healthcare services for both central and local budget funds, targeted state funds and social insurance funds. Moreover, this Law allows such procurements from business entities of any type of ownership.

The potential "customers" of healthcare services could be managers of public funds, such as:

- the central and local governments;
- enterprises, institutions or organizations set up according to established procedure by government bodies and authorized thereby to receive public funds, to undertake commitments and to make payments.

It is possible for customers of healthcare services and a healthcare facility to work together on the basis of a contract for a specified volume of services over a specific period of time. The cost of these services would be determined by the provider, based on the approved budget. This should ensure the financial and organizational independence of healthcare institutions.

For this purpose, in 2001, Truskavets Municipal Hospital was given the status of a communal non-profit enterprise[73] providing healthcare services. Here, the customer could be the Oblast Department of Health. However, the hospital has not begun to operate as a communal enterprise because the local government body was not prepared to work with the hospital on a contractual basis. So, everything continues as before, with all the same troubles and problems.

[73] Registration Certificate №137 of 25 June 2001.

Budget watch on transparency of healthcare spending in Macedonia

Healthcare in the Republic of Macedonia continues being almost entirely a national function. Although negotiated by the Ohrid Framework Agreement, the intended decentralization of healthcare functions did not happen.

Art. 3 of the Framework Agreement explicitly includes healthcare in the list of services for which local governments' powers should be substantially increased. The decentralization of healthcare is also included in the Constitutional Amendments and is obliquely referred to in the legislative annex of Ohrid.

In the spirit of the Framework Agreement, the initial draft of the Law on Local Government (LLSG) proposed an ambitious decentralization of healthcare functions that raised considerable concern among sector experts. According to them, such broad decentralization would complicate ongoing reform within the sector. Shifting facilities to local governments would make privatization more difficult, they argued, and might also lead to a highly inefficient use of facilities, as many municipalities were too small to permit all but the most rudimentary forms of primary care to be provided on an efficient scale. Municipalities could, of course, address this problem by sharing facilities through a referral system, but this would be rather hard to organize under current political conditions and interethnic relations.[74] All those discussions lead to considerable amendments in the Bill prior to the final vote in the Parliament. Under the adopted version, the municipal role in the healthcare facilities' management was limited to representation in the local boards of the public healthcare facilities.

Under the final LLSG version, municipalities nevertheless take on responsibility for: "governing the network of public health organizations and primary care facilities to include representation of local government in all the boards of all publicly-owned healthcare facilities; health improvement; preventive activities; protection of the health of workers and protection on the job; health oversight over the environment; oversight over contagious diseases; assistance to patients with special needs (mental health, child abuse, and so on); and other areas that are determined by law."[75]

A check of the municipal budget of City of Skopje for 2005 shows that financial resources specifically for implementing healthcare-related responsibilities had not been allocated. The budget itself could be found in the *Official Gazette*[76] of the local government unit. For 2006, however, a detailed budget is available only in Albanian so far.

A check of the budgets of other local government units shows that funds for healthcare-related programs have not been allocat-

[74] See *FYR Macedonia Decentralization Status Report*, World Bank Report №24305, September 2003.

[75] LLSG, Art. 22 (1) 9.

[76] *http://www.skopje.gov.mk/*.

ed in any of them. In some of the local government budgets, there is not even a line for healthcare activities.

Since the Macedonian Health Insurance Fund is the authority responsible for healthcare system funding, we decided to redirect our efforts from local government budgets, which obviously have nothing to tell us about healthcare spending, to HIF spending.

We want to emphasize that the comments here are not a cost-benefit analysis. They aim to analyze the state of transparency, availability of data, and the options for exercising public control over HIF spending.

During the last five years, the Health Insurance Fund has become one of the most criticized institutions in Macedonia. In their recent reports, both the IMF and the World Bank direct severe criticism regarding healthcare reforms in Macedonia, the system's efficiency and spending transparency, pointing to the role played by HIF in these negative developments.

According to a 2004 IMF report:[77] "Inefficiency and corruption in the state Health Insurance Fund (HIF) and state-owned healthcare facilities are the major source of the poor performance in the health system." The World Bank's "FYR Macedonia Decentralization Status Report" says: "The healthcare system is plagued by financial problems, mismanagement (in both HIF and healthcare institutions), and questionable spending priorities."[78]

During its February 2005 mission in Skopje, IMF desk chief Franek Rozwadowski was sharply critical of the (non)implementation of healthcare reform and the lack of transparency in healthcare budget spending, which have leaded to inefficient spending of taxpayers' money and a worsening in the overall quality of healthcare services.

Given these kinds of problems, the World Bank and the IMF started providing assistance to the Macedonian Government to improve the management of HIF and reduce the opportunities for corruption and mismanagement. The World Bank is also supporting the Government in its commitment to implement cost-saving measures, which includes new tenders for pharmaceuticals and other efficiency gains.

Meanwhile, with the aim of improving financial tracking, the Ministry of Finance has taken steps to transfer HIF's account balances into the Treasury's Consolidated Account. Another step toward better transparency in HIF's operations and spending was to publish the findings of a State Audit Office (SAO) audit, which included critical remarks on inefficiency and fraud. As of the beginning of 2006, the last audit is available on the SAO website. Like previous audit reports, it contains a number of criticisms and recommendations concerning the expenditure transparency, poor accounting and transactions reporting systems, and lack of compliance with laws.

Some of the SAO findings address current public procurement and contracting practices that offer little effective control over contract enforcement. Since HIF is the authority responsible for such tenders, it selects the suppliers but does not have appropriate tracking system to control enforcement. HIF concludes a contract with the chosen supplier for an overall quantity. The contract does not, however, stipulate how the contracted quantity will be distributed among healthcare institutions. Every healthcare institution orders medical supplies from the winner in the tender and then the invoices go to the Fund.

[77] Ibid., IMF staff report on Macedonia.

[78] See *FYR Macedonia Decentralization Status Report*, World Bank Report №24305, September 2003.

Due to its poor accounting and recording system, which reflects reluctance among HIF managers to track their spending, the Fund is not able to actually enforce the entire contract, that is, what was actually delivered: Was it more than negotiated or less? If less, where did the rest go? And so on. The lack of an effective tracking system impedes efficient supply management in the first place while allowing for different kinds of manipulations, like diverting supplies to private medical facilities that have no contracts with HIF, for example.

During the last audit, SAO discovered that HIF does not apply equal accounting practices to public and private healthcare service providers. Public healthcare institutions receive advance payments for their services, while private institutions are only refunded for services already provided. That unequal treatment creates complex financial interrelations that are, moreover, not tracked by an effective monitoring system to determine the balance between prepayments and actual services rendered.

The SAO report also says that a cross-check between HIF's accounts receivable/payable and the healthcare institutions' books showed discrepancies in the amounts. This, in combination with the public procurement problem, is a serious indicator of how unclear a picture there is of cash flows within the system. The poor accounting and transaction recording systems make it nigh impossible to make any assessment of efficiency and, thus, to make any improvements in this area.

Given such serious problems with mismanagement, the critique by the IMF Desk Chief during his February mission actually sounds quite mild.

A check of the HIF website shows that it contains information about transfers to the health institutions and their reports. The data is too aggregated, however, and is not suitable for any cost-benefit analysis. As the SAO report shows, even direct access to detailed HIF accounting data does not allow for such analysis. This will only be possible if full information is available from all sources, meaning HIF, healthcare facilities, the Public Procurement Bureau, suppliers, and so on.

The newly-adopted Law on Free Access to Public Information will now provide a legal mechanism for requesting information. The law goes into force in June 2006 and will establish conditions for more effective public control over HIF spending, in addition to the SAO and Ministry of Finance. Using legal mechanisms for receiving public information, non-governmental budget watch groups will be able to try to evaluate the transparency and cost-effectiveness of spending—not just its compliance with the law, as SAO and the Ministry of Finance are currently obliged to do—by collecting data from as many sources as possible. Budget spending can clearly comply with applicable legislation without ensuring that this spending is also effective and of benefit to the community that is funding it.

Table 4. Truskavets Draft budget 2005, '000 UAH

Item	Expense Code (KFK)	Fulfill-ment in 2003	Expected fulfillment for 2004	Minimum need for 2005 based on budget survey	MinFin guideline figure for 2005 (adj. 12.24)	Difference between need and guideline	Draft Budget for 2005	Payroll costs	Payroll share of Budget, %
Expenditures tied to interbudget transfers		10,427.10	11,884.40	13,526.30	10,485.10	3,041.20	14,467.80	11,632.30	80.40
Administrative offices	10.116	1,314.80	1,537.40	1,524.00	630.90	893.10	1,597.70	1,232.90	77.17
Education	70.000	4,561.40	5,412.60	6,037.60	4,448.50	1,589.10	6,872.00	5,775.60	84.05
Healthcare	80.000	3,367.40	3,704.80	4,974.70	3,904.70	1,070.00	4530.30	3,400.50	75.06
The arts	110.000	878.50	843.60	1,100.00	384.70	715.30	948.60	830.60	87.56
Social security w/o subventions	90.000	290.00	366.00	460.00	480.60	-20.60	499.20	392.70	78.67
Territorial Drop-In Centers	91.204	245.90	300.00	390.00	460.50	-70.50	420.00	319.80	76.14
Local Youth Services Centers	91.101	44.10	66.00	70.00	20.10	49.90	79.20	72.90	92.05
Physical education and sports	130.000	15.00	20.00	30.00	89.00	-59.00	20.00	0.00	0.00
Additional financial resources					447.30				
Unallocated reserves					99.40				
Expenditures not calculated during budget transfers		2,254.70	2,862.60	2,929.20	2,806.90	122.30	2,179.00		
Residential building & maintenance, including:	100.000	2,000.20	2,647.50	2,600.00	0.00		1,900.00		
Urban renewal	100.203	1,748.90	2,042.50	2,100.00			1,600.00		
Capital residential renovations	100.102	251.30	605.00	500.00			300.00		
Programs and events for state bodies involved in youth affairs	91.103	6.80	7.00	7.00			7.00		
Spending on social security from local budget, including:		195.20	168.10	232.20	0.00		184.00		
Utility subsidies (excl. veterans of war and labor)	91.207	79.00	47.40	58.30			50.00		
Other forms of assistance	90.412	116.20	120.70	173.90			134.00		

Item	Expense Code (KFK)	Fulfill-ment in 2003	Expected fulfillment for 2004	Minimum need for 2005 based on budget survey	MinFin guideline figure for 2005 (adj. 12.24)	Difference between need and guideline	Draft Budget for 2005	Payroll costs	Payroll share of Budget, %
Mass media	120.000	48.00	40.00	50.00	0.00		48.00		
Radio	120.100	12.00	14.00	20.00			18.00		
Newspapers	120.201	36.00	26.00	30.00			30.00		
Reserve funds	250.102	4.50		40.00	0.00		40.00		
Total expenditures (excl. subventions from State Budget)		12,681.8	14,747.00	16,455.50	13,292.00	3,163.50	16,646.80	11,632.30	69.88
Subventions from State Budget for social security programs	250.331	2676.90	2,074.20	2,432.00	2,456.20	-24.20	2456.20		
Costs transferred to the State Budget	250.301	694.00			1,789.00		1,789.00		
Other subventions	250.380					0.00			
Total General Fund		15,358.70	16,821.20	18,887.50	15,748.20	3,139.30	19,103.00	11,632.30	60.89

Budget surveys from various entities did not reflect the rise in the minimum wage to UAH 262 as of 1 January 2005, or the rise to UAH 282 on 1 December 2005. The draft Budget calculates all expenditures to reflect these wage rises.

Table 5. Calculation Indicators for the draft budget for the City of Truskavets, 2005, '000 UAH

№	Name	Revenues for 2002	Revenues for 2003	Revenues for first 11 mos. of 2004	Expected fulfillment for 2004	Draft 2005 budget	MinFin calculation indicators for 2005
	Revenues tied to interbudget transfers	**7,660.60**	**10,746.70**	**9,185.70**	**10,126.30**	**12,624.20**	**12,274.10**
1.	Personal profit tax (for minimum fixed tax), personal income tax	6,116.40	8,785.60	6,997.70	7,687.70	10,021.20	
2.	Fixed tax on personal incomes	74.70	97.90	74.90	80.00	80.00	
3.	State excise tax	135.50	119.50	89.10	115.00	45.00	
4.	Fees for trade license for certain commercial activities	376.60	587.10	902.10	1,025.00	1,200.00	
5.	Fines and other penalties raised by administrative committees	0.10	34.50	17.60	17.90	18.00	
6.	Single tax for SMEs	755.50	1,105.10	1,094.50	1,190.00	1,250.00	
7.	Fees for state registration of business entities	17.60	17.00	9.80	10.70	10.00	
8.	License fees for retail trade in alcohol and tobacco products	184.20			0.00		
	Revenues not calculated in interbudget transfers	**2,241.50**	**2,602.80**	**3,620.80**	**4,098.30**	**4,581.60**	**2,806.90**
1.	Local taxes and fees, including:	747.20	1,064.90	816.20	875.40	868.50	
	advertising tax		9.80		1.60	1.70	1.70
	communal tax		171.70	173.70	200.10	215.10	215.00
	hotel tax		100.70	246.60			
	parking fees		2.10	0.80	1.60	1.60	1.60
	market fees		242.90	405.10	392.80	420.80	420.00
	fees for issuing blueprints for an apartment			0.20	0.20	0.20	0.20
	resort fees		174.20	189.90	173.00	187.00	187.00
	fees for the right to use official symbols		23.80	25.10	26.10	28.00	28.00
	fees for a POS permit		22.00	23.50	20.80	21.00	15.00
2.	Land fees	1,040.60	1,356.50	2,528.20	2,660.00	3,300.00	
3.	Interest income for bank deposits	6.90	4.20				
4.	Manufacturing tax	23.00	19.60	14.70	15.00	13.00	
5.	Fee for rental of state-owned premises	73.30	146.80	158.50	165.00	100.00	
6.	Profit tax on communal enterprises	350.30	10.60	29.30	309.00	300.00	
7.	Other	0.20	0.20	73.90	73.90	0.10	

№	Name	Revenues for 2002	Revenues for 2003	Revenues for first 11 mos. of 2004	Expected fulfillment for 2004	Draft 2005 budget	MinFin calculation indicators for 2005
	Total revenues to General Fund	**9,902.10**	**13,349.60**	**12,806.50**	**14,224.60**	**17,205.80**	**15,081.00**
	Equalizing subsidies			**68.30**	**68.30**		
	Additional subventions from State Budget			**265.10**	**331.40**		
	Money transferred to the State Budget	**-886.20**	**-694.00**			**-1,789.00**	**-1,789.00**
	Total revenues to General Fund (less subventions and money transfers to the State Budget	**9,015.90**	**12,655.50**	**13,139.90**	**14,624.30**	**15,416.80**	**13,292.00**
	Special Funds	**1,655.70**	**8,239.10**	**10,727.30**	**12,597.10**	**10,967.60**	**4,628.10**
1.	Revenues from expropriation of communal properties	82.40	3,688.20	2,815.30	3,340.00	300.00	1,242.90
2.	Revenues from the sale of land plots and non-material assets	470.00	2,274.80	5,365.10	5,948.00	9,440.00	1,513.50
3.	Transport carrier fees	72.50	185.20	223.50	225.50	215.00	212.70
4.	Fee for license to sell petroleum products at POS	3.10	5.80	7.30	8.30	9.00	3.80
5.	Incomes of specific government entities	891.80	2,057.10	2,247.40	3,006.30	978.60	1,534.00
6.	Pollution fee	6.30	8.30	15.00	15.00	15.00	12.60
7.	Targeted funds (incl. expenditures on farming and forestry)	129.60		44.40	44.40		92.60
8.	Other revenues for Environmental Protection Fund		19.70	9.30	9.60	10.00	16.00
	Total of both General and Special Funds	**10,671.60**	**20,894.60**	**23,867.20**	**27,221.40**	**26,384.40**	**17,920.10**
9.	State Budget subventions	2,469.80	3,403.50	1,624.60	2,697.90	2,686.20	2,686.20
10.	Available cash balance on account				650.00	1,000.00	
	Grand total	**13,141.40**	**24,298.10**	**25,491.80**	**30,569.30**	**30,070.60**	**20,606.30**

Appendix

Case studies

A brief overview of local government websites in Ljubljana, Budapest and Dublin

A quick review of local government websites in Ljubljana, Budapest and Dublin, the capitals of Slovenia, Hungary and Ireland, shows a range of approaches to public communication.

Ljubljana

The Ljubljana city website[79] has one main shortcoming: it is only in Slovenian. Nevertheless, if the visitor can read Slovenian, it is consumer-oriented and user-friendly. There is a special section called a "Catalog of information of public interest (Katalog informacij javnega znacaja[80]). It consists of a list of all people working in the municipal government with contact details, including phone numbers and e-mails for direct communication. There is also a list of all regulations and documents that might be of some use for the residents of this city.

In terms of fiscal transparency, the city posts available financial reports and all related statements on its site, so that issues related to budget revenues and spending are clear and transparent.

Budapest

The website of the City of Budapest[81] contents information in both Hungarian and English. Navigation is easy. The information in English is well organized, with the most interesting information regarding fiscal transparency at the local level in a separate part, called Legal and financial information 2003. According to this text:

- Regulations concerning the operation, structure, duties and powers of the City of Budapest are laid down in Act №LXV of 1990 on Local Governments and in General Assembly Decree №7/1992 (III. 26), which concern the Rules of Procedure of the City, enacted on the basis of the powers granted under this law.

- To fulfill its duties, the City of Budapest is 1) provided with its own assets; 2) subsidized from the State Budget and 3) entitled to collect its own revenues, of which the most important power is the right to impose local taxes.

- Municipal duties and powers are vested in the local governing body, the General Assembly. This Assembly holds regular meetings once a month, but additional meetings may also be convened in cases specified in the Rules of Procedure. Citizens may be present at public sessions of the General Assembly as observers.

- The General Assembly has one public hearing a year where citizens and representatives of local organizations may pose questions of public interest or make recommendations. A citizens' forum may also be convened to handle specific issues of public interest, in preparation for major decisions affecting the capital, to provide direct information to citizens and community organizations, and to solicit public opinion.

[79] *http://www.ljubljana.si/.*

[80] *http://www.ljubljana.si/zamescane/kijz.html.*

[81] *http://english.budapest.hu/engine.aspx?page=localgov.*

- To make its work more transparent and easy for the residents of Budapest, the General Assembly has a Committee of Civic Organizations and a Community Outreach Committee.

On fiscal and budgetary transparency, there are four additional texts on the Budapest website: the Regulation of Financial Management, Budgetary Management between 2000–2003, Auditing, and the Financial Strategy of the City.

Dublin

The Dublin City Council website[82] is the best one of the three reviewed. It is excellently organized and, most important, it presents fiscal information in a very transparent way. It also provides clear explanations[83] of:

What is "freedom of information"?

The Freedom of Information Acts of 1997 and 2003 provide every person with certain legal rights:

- the right to access official records held by public bodies listed in the Act; and
- the right to be given reasons for decisions taken by public bodies that affect the individual.

Freedom of Information and Dublin City Council

The Act requires Dublin City Council to respond to requests from the public for information held by the Council. Dublin City Council is obliged to:

- acknowledge receipt of a request within 14 days;
- make a decision on the request within four weeks (eight weeks in certain cases).

If the City Council does not respond within four weeks, this is considered a refusal and the enquirer can proceed to the review stage.

Available Assistance Manuals

Dublin City Council has two publications available to help citizens understand the organization and the types of information it maintains.

- Section 15 Reference Book—Guide to the Structure, Functions, Powers, Duties, Services and Records of Dublin City Council.
- Section 16 Information—Rules, Procedures, Practices, Guidelines, Interpretations and Precedents used by Dublin City Council for the purposes of Decisions, Determinations or Recommendations.

Who is the Information Commissioner and how to contact them?

The Office of the Information Commissioner is an independent office with powers to review decisions made by Dublin City Council. Where a review has been undertaken, the Information Commissioner's decision is binding on the parties concerned, subject to appeal to the High Court on a point of law.

The site gives the address where appeals in writing may be made to the Information Commissioner.

[82] *http://www.dublincity.ie/.*

[83] *http://www.dublincity.ie/your_council/our_organisation/freedom_of_information.asp.*

Regarding reporting procedures, the website presents reports for 2000, 2001, 2002, and 2003. It also notes that all local authorities are obliged to prepare and adopt an Annual Report in relation to the performance of their functions. A draft of this report is submitted to all members of Dublin City Council, and is officially published once they approve it.[84]

The municipal websites of Ljubljana, Budapest and Dublin give access to fiscal information to a great extent, including annual reports, fiscal plans, and so on. If some information is not posted on the website, it is clearly mentioned how to find it or who is the council employee responsible for it, so individuals and organizations can enquire directly.

Participatory budgeting in Porto Alegre—promoting responsive government

The Porto Alegre model is the best-known and most distinctive participatory budgeting program. Launched in 1989 in the city of Porto Alegre, on the initiative of the newly-elected Workers' Party, it has since spread to almost 100 municipalities in Brazil, and has been implemented at the state level in Rio Grande de Sul. It is widely viewed as a successful experiment in participatory democracy that has contributed to the goals of poverty reduction while increasing trust in public institutions.

In the years before 1989, Porto Alegre was a city in an uncertain financial state because of de-industrialization, in-migration, indebtedness, and a poor revenue base. Major fiscal and other reforms in Porto Alegre were initiated between '89–'91, yielding spectacular achievements in subsequent years. Credit for this has been given to a participatory budget process. Since 1989, the Workers Party has won three consecutive municipal elections in Porto Alegre, which one leading journal has called 'the city with the best quality of life' in Brazil.

While focused on the formulation phase of the budgeting cycle, the Porto Alegre model also encompasses budget analysis, tracking and monitoring activities. Under Porto Alegre-style participatory budgeting, residents and CSOs directly participate in making budget decisions through a year-long cycle of mass citizen forums, thematic assemblies addressing specific issues such as health and education, and the election of dedicated citizen-delegates who form a Participatory Budgeting Council. This Council reviews the final budget proposal. The process is used to allocate budget resources, using a quantitative scheme to prioritize spending according to need and preferences, to establish broad social and economic policy priorities, and to monitor public spending.

Among the most spectacular results in Porto Alegre largely attributed to participatory budgeting are an increase in the number of households with access to water services from 80% to 98%; a rise in the proportion of children served by municipal sewage systems from 46% to 85% over the same period; a doubling of enrollments in public schools; and, perhaps most striking, a more-than 50% increase in tax receipts. The last is attributed to increased budget transparency, which has positively affected locals to pay taxes.[85]

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[84] *http://ww.dublincity.ie/your_council/our_organisation/finance/index.asp.*

[85] For a more detailed description of the structure and organization of Porto Alegre-style participatory budgeting programs, see, for example, Wampler (2000) or de Sousa de Santas (1998).

Expenditure tracking in Uganda—promoting efficiency[86]

The Public Expenditure Tracking Surveys (PETS) for Uganda show that, instead of introducing more generalized public sector reforms, it may be more effective to target reforms and interventions at specific problem spots. For example, PETS taken in 1996 pointed to the fact that non-wage expenditures were much more prone to leakage—theft—than money spent on salaries. The surveys also demonstrated that leakage occurred at specific points within the Government—typically at the local government level. This information was then used to implement more focused and more effective interventions.

Following the publication of the first PETS findings, the Ugandan Government acted immediately to improve the flow of information. It made budget allocations transparent by: 1) publishing amounts transferred to the districts in newspapers and radio broadcasts; 2) requiring schools to maintain public notice boards to post monthly transfers of funds; 3) requiring accountability and information dissemination in the 1997 Local Governance Act; and 4) requiring districts to deposit all grants to schools in their own accounts and delegating authority for procurement from the center to the schools. This not only made information available to Parent-Teacher Associations, but also signaled to local governments that the center had resumed its oversight function.

An evaluation of the information campaign using a repeat PETS revealed significant improvements. While schools on average were still not receiving the entire Government grant—and there were delays—, capture or leakage had been reduced from an average of 78% in 1995, to 18% by 2001.

Participatory research and advocacy in the UK

A two-year participatory research and advocacy campaign to generate information and raise awareness about the impact of environment pollution on breast cancer addressed medical professionals and health authorities to argue for better primary prevention programs and more detailed analysis of breast cancer data. The campaign challenged the relative neglect of research on breast cancer and gave voice to a relatively silent subset of healthcare clients—women at risk of breast cancer.

National women's budget initiative in South Africa

The initiative analyzes public spending patterns in terms of their likely impact on the economic and social position of women. A civil-society initiative that replicates a state-based budget-analysis initiative in Australia, this project has inspired similar programs in Canada, Jamaica, Tanzania, Uganda, and Mozambique. The aim is to monitor government commitments to gender equity by tracking spending on gender-sensitive policy measures, as well as spending patterns through the public sector, and to demonstrate new ways of monitoring and evaluating spending from a gender perspective. The accent is ex post budget analysis, since there is limited access to state budgets before they are published. These efforts rarely include attempts to audit actual spending, as this information is also restricted in South Africa.

[86] The Public Expenditure Tracking System in Uganda is explained at *http://www.worldbank.org/participation/web/webfiles/cepemcase5.htm.*

Social audit—a tool for Local Agenda 21 in Sutton, UK

Social Audit is a consultative tool that organizations can use to understand, measure and report on their social performance. It was used in Sutton's Local Agenda 21 Forum, a partnership that brought together council officers, councilors, volunteer organizations, community representatives, and local business in order to establish a new, more structured focus to improve the achievement of sustainable development objectives. NGOs with close links to the council and the community managed the process, together with the Forum review sub-group and a team of voluntary auditors. A range of stakeholders groups was consulted through questionnaires, workshops and interviews. The Social Audit opened up dialog regarding the LA21 Forum on process, which was restructured, as a result, to include a larger and more active network.

Participatory wellbeing needs assessment in the UK

Supported by local regeneration partnerships and specialist area health promotion services, this is a consultative mechanism that has graduated into a framework for improving understanding and communication between clients and professionals, as a way to enhance responsiveness. It is based on the use of Participatory Appraisal with and by a wide range of stakeholders. In the Sutton case, a team of providers and residents, many of whom normally do not participate in local government (single mothers, ethnic minorities, the elderly, the mentally or physically handicapped), in articulating needs and developing alternative service delivery proposals. These were then negotiated with service providers. Outcomes included improved inter-sectoral working relations and increased resident involvement in planning and decision-making.

The Uganda Debt Network—building trust between the public and the state[87]

The Uganda Debt Network is an advocacy coalition of over 100 NGOs. Since 1999, it has been conducting budget analysis, tracking and evaluating performance, and working at the local and district level organizing budget consultations between local governments and communities. The UDN has since expanded its budget monitoring activities from 2 to 17 districts in Uganda. It conducts quarterly field surveys, using researchers and community members, to track actual spending on poverty relief and other issues (Shultz, 2002: 19). The organization is represented at several levels in the national budget process, including on the finance ministry sector and poverty eradication working groups. It is also consulted on medium-term expenditure framework issues. The budget process in Uganda is now described by UDN as being a highly transparent one and the country is seen as an example for other nations, especially in sub-Saharan Africa.

Since its formation in 1996, the UDN has developed an unprecedented relationship with the government. "Over time," says Zie Gariyo, the head of the Center, "interaction [with the government] deepens as

[87] See *Strengthening Participation in Public Expenditure Management: Policy Recommendations for Key Stakeholders* by Jeremy Heimans, Policy Brief №22, OECD Development Center, 2002.

experience deepens, and friendships and relationships are built." The strength of these relationships varies across levels of government and government departments. The UDN says it has a much stronger relationship with the Ministry of Finance than the Ministry of Agriculture, for example. Gariyo acknowledges that a potential pitfall of the UDN's work is that the organization might become too close to the government and lose its critical voice, but he also points to the lasting gains made by the UDN because of this relationship, such as the fact that community-based monitoring of public spending at the local level is now incorporated into budget processes of several levels of government.

The UDN says the challenge now is for it to maintain its capacity to "keep up" with budget-making processes. The network has only two or three staff members currently capable of engaging in high-level budget work. Its capacity is further constrained by the fact that, at any given time, some staff must be in the field to collect the kind of data on public spending and service delivery at the community level that will add value to budget formulation processes.