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Performance-based budgeting in the public sector: between discourse and effective management

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1. INTRODUCTION

During the process of functioning of the financial mechanism at different levels of government and management in any country inevitably arises the problem of effective use of limited financial resources, since it causes a significant impact on the achievement of optimum parameters of the economy and decision of the priorities facing by the state. Theoretically, any society aspires to use its resources as efficiently as possible. Consequently, the need to assess the effectiveness and efficiency of budget spending is dictated by the demands of the society.

Almost all researchers in public finance have seen the prospects for growth of effective budget spending in reform and modernization of the system of management of the budget process. So, in the scientific community of the twentieth century have been initiated an attempts to make the processes of growth of performance of public expenditure equivalent to increase of cost efficiency in business. The solution to this problem have searched in the introduction of the foundations of development of effectiveness of government agencies and organizations and expanding the focus form cost management to management of results. Thus, in the 1930s of the last century in the scientific community emerged the term performance budgeting. Later, in the 1980s, it gave rise to the formation of a new term "new public management", that was characterized by D. Osborne and T. Gaebler (1992) as a set of new approaches to public sector management, which became the nucleus of intellectual thought in the field of public finance.

The period 1980-1990 was characterized by a general discussion of the strategy of reforming of public administration in accordance with the concept of New Public Management. Wherein, it should be noted that there was no common paradigm of reforms for all countries, the reforms were characterized by varying degrees of depth and radical (Meneguzzo, 2001) and currently in the field of public administration there is practically no international convergence of ideas (Manning and Parison, 2004). This could also be applied to current theory and practice of performance-based budgeting (PBB) (e.g., Pollitt and Bouckaert, 2004).

Thus, performance budgeting seems to be an old, yet open issue: the process of modifying of management of public finances in the world community proceeds ambiguously, having as bright supporters and opponents among both science and practice. And in this context, implementation of performance-based budgeting principles represents one of the main tools

which allows to reason about the management of the performance of budget expenditures from a practical point of view.

It is obvious that the full potential of these measures as the means of improving the social and economic effectiveness of public expenditure is impossible to reveal in a short time, as evidence the analysis of world experience. But, despite the difficulties, associated with the transition to a fundamentally new method of public expenditure management, the countries that have consistently implemented the PBBS technologies, since the 1950s, at the same time have developed and improved them.

Currently, to the greater or lesser extent, these technologies are applied not only in countries with developed market economies, but also in developing, and in countries with economies in transition. And, despite the fact that the processes of budget reforms in different countries are different, and in some cases they are not finished and there are no univocal results yet, their experience can be useful because all these countries share common goals: control over spending of funds and improving their distribution and effective use; improving the performance of the public sector; greater accountability of public authorities and public offices.

This manuscript is structured as follows.

In chapter 2 "Performance-based budgeting Systems. Background and analytical perspective" we review the literature that constitutes the background to research topic (that is, previous research on performance-based budgeting and difficulties of its implementing in public sector). Thus, we identify and examine major works on performance-based budgeting systems (PPBS) to summarize the findings and interpretations, and to highlight the main research issues and opportunities, intending to provide a critical review of the field in order to deepen this area, thinking into performance budgeting principles applied not only on a government wide basis, but also on the level of regions and provinces.

In chapter 3 "Research design and analytical framework" we detail our research design and suggested analytical framework by stating the specific purpose and research questions, the substantiation of specific case study, as well as the case overview, the methods employed, the analytical procedure, and the procedure of the data gathering.

In chapter 4 “Health care financing reform in Russia: a critical assessment” we carry out an assessment of the case (in particular, health care financing system) from a critical point of view, with the purpose of establishing the basis for evaluation of further case practice evidence.

In chapters 5 “Analyzing regional PBBS implementation: case practice evidence” and 6 “Empirical investigation and case study results – from discourse to practice” we report our findings as follows: evidence from the past efforts on PBBS implementation in order to establish the criteria of the reform process in chapter 5 (addressing our first research question); thick description of different levels of PBBS’ model application and actors’ involvement as we observed them in the field. This part of research was based on both thematic and narrative analysis, addressing our two research questions in chapter 6.

Finally, in chapter 7 “Discussion and conclusions” we discuss the evidence from the case study analysis purposely addressing to a major research question, along with the findings overall. Here we also draw final conclusions respect to the relevant literature we relate to, and some practical applications for future research.

2. Performance-based budgeting Systems. Background and analytical perspective

2.1 The conceptual debate about PBBS

2.1.1 Defining PBBS

Investigating about the literature on the concept of performance-based budgeting, it should be emphasized that it has its roots in both budgeting and performance measurement literature. The origin of the term has a long history. Herewith, it is appear quite *complicated to ascertain about the authorship of the very fundamentals of performance-based budgeting*. So, the concept of allocating resources to programs that are efficient and effective goes back to the beginning of the twentieth century (Mosher, 1975).

The general idea of performance budgeting was first appeared in the United States, and aroused after the period of Great Depression and then returned after World War II through the federal government's attempts of better spending decisions with expected performance. This process was commonly known as "performance budgeting" (U.S. General Accountant Office, 1997).

That period was characterized by the lack of budgetary theory that still haunts the field today. Indeed, a literature review realized by us demonstrates that today *there still no one single definition of performance-based budgeting*, as there is *no unified model of it* but rather many different patterns adopted by various countries exist[1] (Joyce, 1999). The definition and the scope of PBB has ranged from "a budget presentation that underlined the outputs rather than the inputs associated with government operations" (Diamond, 2003) to an integration of performance management components into the phases of the budget cycle used by state and local governments (Kelly and Rivenbark, 2011). However, most experts and observers of public budgeting generally mean by performance-based budgeting the allocation of funds to achieve programmatic goals and objectives as well as some measurement of work, efficiency, and/or effectiveness (e.g., Snell and Hayes, 1993; Garsombke and Schrad, 1999).

[1] According to Jack Diamond, "...owing to these many variants, the term itself has been interpreted differently at different times and in different countries".

Among the theorists there is no unity of views in the definition of the term "PBB". Conditionally, scientists who are engaged with research on distributive relations in connection to aims and results, could be divided into four main groups.

First. Scientists who identify PBB as a budget presentation that make a major accent to the outputs rather than the inputs associated with state functioning (e.g., Diamond, 2003). Still, such definition of PBB have a limited focus and do not cover adequately all of its aspects.

Second. Scientists who consider PBB as a mechanism to restructuring of government operations on the basis of programs and activities producing the outputs (e.g., Mikesell, 1999). Consequently, the term of performance budgeting is often used as a *synonym of program budgeting*, and besides the authors do not make a clear distinction between its associated orientations, such as planning-programming-budgeting systems (PPBS) and output-based budgeting, i.e. all three terms are often used interchangeably[2].

Third. Scientists who highlight accountability as the main aim of performance-based budgeting (e.g., Hager and Hobson, 2001). Such position actually equates PBB to a standard line-item budgeting, where performance information is not linked to the decision-making process regarding an allocation of funds.

Fourth. Scientists who identify PBB as a way to allocate resources in order to achieve specific objectives based on program goals and measured results (e.g., Carter, 1994). In compare to traditional approach, which is based on cost-funding estimates, performance budgeting is focused on spending results, i.e., using missions, goals and objectives it becomes possible to explain why the financial resources have being spent.

We would more agree with the comprehension of this last group of the scientists, since in this case the whole planning and budgeting process is a *result-oriented, and not simply expenses*. In other words, a key to understand PBB lies with the word "result" (e.g., Young, 2003). Furthermore, such vision of PBB is evidently closer to those progressive one, which gives, for instance, the OECD: "…performance budgeting links the funds allocated to measurable results" (OECD, 2008).

[2] Unclear statement is also due to the fact that, similarly to PBB, there is no unique definition or a model of program budgeting nowadays.

The OECD' studies are not limited to defining the essence of PBB, and, in accordance to the degree of the involvement of performance information into a budgeting process, is classify performance budgeting into types[3]:

- presentational budgeting;
- performance-informed budgeting;
- direct performance budgeting.

The first type - presentational budgeting (for instance in the United States) is a "basic" level of performance budgeting which means that performance information is presented in budget documents and it is not dedicated to the budget decision-making. If the resources are associated indirectly to proposed future performance or to past performance (which is taking place in Australia), this indicates to the second, performance-informed type of budgeting. In this case the performance information is important in the decision-making process. Nevertheless, it does not have a predetermined influence in decision-making and is used together with other information. And finally, the third type of performance budgeting is assume allocating resources based on the achieved. Still, direct performance budgeting is rarely used.

Different forms of performance budgeting seek to link the funding provided to government to the results they deliver, in order to increase efficiency and effectiveness of public expenditure. For this purpose, it makes systematic use of performance information in the budgeting process. In turn, the problematic point here is that the successful use of performance information for budgeting takes a long time and has many obstacles in the public sector. Achieving this specific aim could be possible by changing the research focus into using performance information at any stage of the budget cycle.

[3] By some authors (e.g., Shan and Shen, 2007) there could be recognized four categories of performance budgeting: performance-reported budgeting; performance-informed budgeting; performance-based budgeting; and determined budgeting. In this case the difference is performance-based budgeting, characterized by the presence of performance information which is essential for distribution of resources. However, it does not necessarily specify the amount of resources allocated. So, within this framework, there is a connection between the justification for particular activities and the final results, where the result versus individual activities or outputs is not excluded. With this information it becomes possible to understand which activities are cost-effective in terms of achieving the desired result.

Scientific publications of the last decades demonstrate a *tendency to a new comprehension of PBB*. This is due to a complex set of management and budgetary reforms (*public expenditure management (P.E.M.*), destined to improve the efficiency and effectiveness of the public sector and to contribute the achievement of fiscal stability (Robinson, 2008; Meneguzzo, 2001, 2003; Ongaro, 2009). Among the techniques adopted in the programs P.E.M., there should be distinguished PPBS and zero-based budgeting (together with the cost-benefit analysis) as "techniques of elevated coherence with the planning orientation" (Meneguzzo, 2001). A special attention is paid to the management of financial resources as well as a long-term planning of expenditure with the distinction of highly critical and less important areas of activity.

Such vision of the question led to a category of what is often referred to as managing for results, or management-for-result, or "performance management"[4], as it can still be defined (Poocharoen and Ingraham, 2003). Its basic starting point is maximal transparency about the outcomes which is attempted to be reached by government. On the other hand, it is assume the relationship of outputs and activities to those desired outcomes. Management-for-results tends to emphasize the *ex-ante* condition of performance expectations for entities, work units and individuals through the use of performance targets and standards.

The fact that performance budgeting and performance management are *two different categories* does not preclude that there is no relationship between. In particular, the performance budgeting tends to be less linked to detailed budgetary line-item controls, which is all the same one of the element of the broader managing-for-results theme. Nevertheless, often managing-for-result may have a context which is not concerned with budgeting at all[5] (Melkers and Willoughby, 2001). In spite of the close relationship between the approaches to performance budgeting and managing-for-results category, the view ultimately taken here by experts is, that, *PBB should be considered as a distinct specific concept* with the budgetary use of performance information as a core characteristic. In this regard, *it appears to be somewhat doubtful* the statement of some authors about reforming of the "public sector management system as the most important goal of PBB" (Kordbache, 2007). This would suggest that PBB would not actually go beyond the management cycle.

[4] The most common definition of this term which occurs in the literature is the use of formal performance information to improve public sector performance.
[5] E.g., the use of performance targets in human resource management.

Thus, based on the above and considering different conceptions of PBBS, we try to systematize the *definition* of it, thereby assuming that performance-based budgeting represents a result-oriented system that *integrates strategic planning, budgeting and evaluation of outputs*, as well as *evaluation and comparison* of the effective functioning of the practice of budget systems, *into all budget phases* which provides a distribution of budgetary resources in accordance to goals and priorities of a state policy.

2.1.2 Defining performance in PBBS: the problem of result identification

Deserves a special attention the issue of *controversy in grouping* the main components, or basics of PBB, which was a reason for a lot of scientific work dedicated and published in recent years (Diamond, 2005; Friedman, 1997; Garsombke and Schrad, 1999; Hager and Hobson, 2001; Hatry, 1999; Young, 2003; Kelly, 2002; Kordbache, 2007; OECD, 2002, 2006; Rivenbark and Pizzarella, 2002). Herewith, there are two extreme positions. According to the first position (studies contained in e.g., *Research Report of Legislative Research Commission, 2001*) the basics of PBB are: objectives; performance measures; linkage; and accountability. According to the second position (e.g., Segal and Summers, 2002), for this purpose there should be distinguished: result (final outcome); strategy (different ways to achieve the final outcome); activity/outputs (what is actually done to achieve the final outcome).

Classification of PBB components, represented by the second position, *call into a question*, since both "result" and "activity/outputs" *in fact can be attributed to performance measures* (i.e., the authors who hold the second position, consider the "results" and "activity/outputs" as different components of PBB, when in fact both are related to one component - indicators to measure the performance).

The core objectives of performance budgeting have been specified as "enhanced allocative and productive efficiency in public expenditure" (Robinson and Brumby, 2005). The same authors argue about the unduly narrow nature of many definitions of performance budgeting to be found in the literature, which relate too specifically to performance budgeting practice in particular countries or in particular time period. This conclusion seems to us rather inappropriate, since, as it was mentioned before, the need to adapt PBB relatively to national

characteristics, culture, priorities, level of fiscal stability etc. generate its various forms. Furthermore, examining the argument through its implementation among specific states could become a way to understand the use of performance budgeting.

Assess of the achievement of the strategic objective is accomplished by the use of outcome indicators characterizing "socio significant" effect, such as improving the welfare of citizens, public satisfaction with the quality and accessibility of services, increased life expectancy, etc. However, the definition of the end outcome of budgetary institutions is not an easy task, as far as the search for the social result within obtaining by the society specific services, such as health care, education, culture, social security requires going beyond the financial sphere. In this regard, the approval of professionals that budget institution's activity under PBB implementation should be fully described by the science-based system of indicators, including detailed description of the services, the necessary conditions and resources, contingent consumers, etc., are not baseless. Furthermore, it should be objectively evaluated by the system of accurate, clear, verifiable indicators that reflect the real contribution of budgetary institutions.

The selection of quantitative and qualitative indicators of efficiency and effectiveness is probably one of the most important and, at the same time, one of the most complex aspects of PBB. So, when we are talking about the key value of indicators of effectiveness of budgetary expenditures, it implies that these indicators should be the basis for assessing the achievement of goals, as well as the achievement of efficiency and effectiveness of the program. An incorrect choice of the indicators, in particular the choice of indicators incomprehensible for professionals, or failure formulation of indicators and their subsequent use may lead to ineffective management decisions. Hence, the *main parameters for the selection* of performance indicators, which would reflect the focus on final result, and thus, effectiveness of budget expenditures, can be considered:

- relation to the goals and objectives of providing services;
- utilization as reliable information received on a regular basis;
- uniqueness of the indicator, it must not duplicate other indicators;
- accessibility for a wide range of stakeholders;
- validity of the numerical values of the indicators;
- simplicity of calculation, analysis and use in reports.

In order to satisfy these requirements, it is important to identify the concept of the "result" for each case, fill it with concrete content. The complexity of the choice of such performance measures, which would reflect the impact of budget expenditures, refers to the fact that it appears to be the case that *until now in the world practice has not developed an agreed-upon, clear understanding of these terms* (particularly concerning about the terms "*outputs*", or that is to say, direct results, and "*outcomes*", or social results). The same applies to a common set of indicators that are recommended for use in a particular area of public services.

The notion of "effectiveness" is a multilateral, especially given that the word "effect" (from the Latin. effectus - performance, action) means as a result of any action, and the impression made by anyone on anyone. G. Khatri in his work "Performance monitoring in the public cooperation" states that the result is an event, phenomenon or condition related indirectly to the activities of the program or budget, but having direct relevance to the customer budget organization or to the population as whole. The frequency of occurrence of such events or phenomena is measured by the performance indicators. Effectiveness (or unit costs, productivity), according to Khatri, is the ratio of the volume of resources, usually expressed in money or man-years of labor, and the volume of products or the results obtained from the implementation of the program. (Khatri, 2005).

Existing in the scientific literature approaches to the definition of "cost-effectiveness of the budget" and "effectiveness of budget expenditures" indicate that most of the authors are of the view that the effectiveness is the result of economic activity, defined as the ratio of economic benefit to the cost, as generating this result. Wherein both economic effect and the costs have the same unit of measurement, in most cases valuation. Considering the same budget expenditures allocated for social spending, it should be noted that the specificity of these costs does not allow to fully determine the economic effect of costs in monetary terms.

Here below we provide a schematic vision of the main PBB key issues, or components (Exhibit 1) and the logic of the "construction" of performance-based budgeting (Exhibit 2).

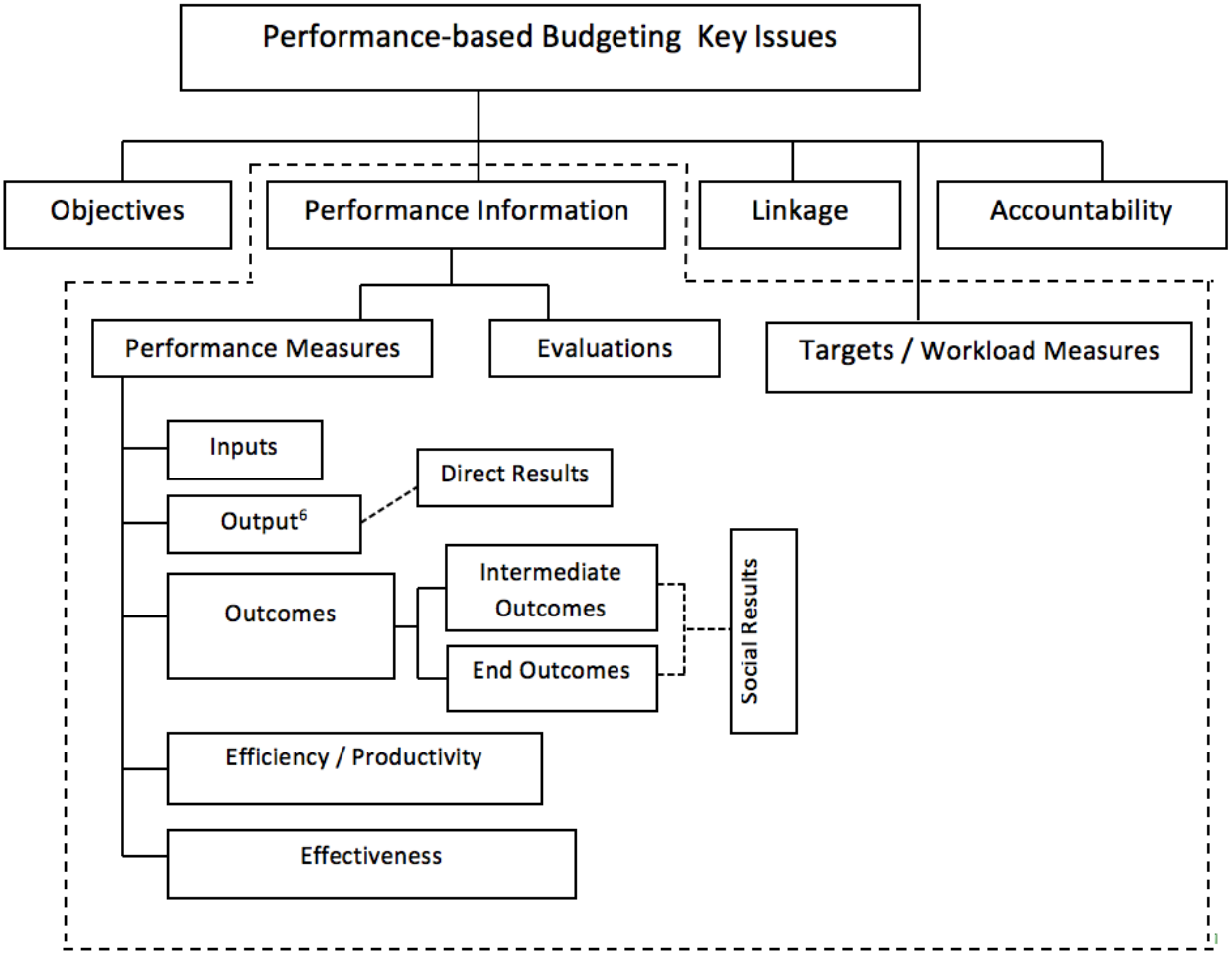


Exhibit 1. Placement of performance in implementing PBBS.

In compare to a traditional budgeting, PBBS, besides demonstrating the goals which should be achieved at a certain level of funding, used to allow tracing the relationship between resources spent on the program, activities that are performed within the program, services produced in the course of program execution and the final results.

In other words, PBBS' logic can be demonstrated by a sequence: an institution is planning the resources required, sufficient to carry out activities necessary to obtain a product that will lead to the achievement of the results. We also note that, PBBS add performance factor

[6] The notion of the product (output) may also include quality of services, i.e., their accuracy, availability, timeliness, customer satisfaction, etc., the characteristics that are often classified as the results.

to traditional aspects of budgeting thus distinguishing efficiency from effectiveness. Herewith, efficiency emphasizes on the useful utilization of the resources concerned while effectiveness considers the performance.

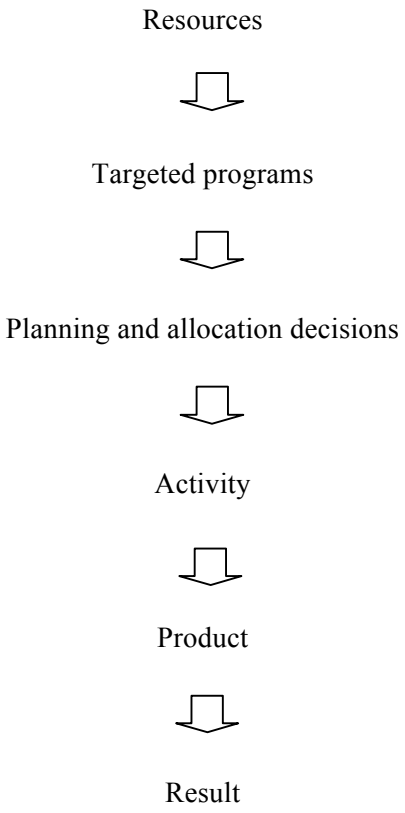


Exhibit 2. Logical sequence of PBBS building.

Thus, for the most efficient use of budgetary resources in public sector is necessary, first of all, to identify all the necessary elements of the production process, conditions, resources, labor operations to ensure receipt of the final result. Wherein, an important role is played by the system of incentives, the cumulative effect of which is able to direct the activities of budgetary institutions to achieve the declared objectives, and not another, more convenient one to reach and to report. This danger exists in any social system of the state in general to the smallest unit of budgetary institutions, as any production in one way or another is include the human factor, especially the production and provision of services. In this case, may be appropriate the idea that "any well-functioning organization should consist of people whose personal goals are achieved

with the implementation of the organization's objectives"[7]. In this case, actual results achieved will be identical to the declared expected by society.

2.1.3 Does PBBS work? The design school and its opponents

One of the important features that characterize the practice of performance-based budgeting is the *utilization of performance information* for the allocation of resources. While performance information has been developed and introduced in both management and budget process, in this section we concentrate on the budget process. The literature emphasizes both budgetary reforms and the usage of performance information to guide program decisions. Using performance information to guide budgetary decision making has also been a goal of budget reforms for decades (Grizzle, 1987; Schick, 1966).

However, the very first contributions to connect performance measurement and budgeting were rooted in a model of "executive budget" (from the 1900s through 1920), aimed at implementation greater control to budgeting as a counter to "corrupt policies, primarily centered in cities dominated by political machines" (Burkhead, 1956). The task of a later period were efforts to introduce greater efficiency into budgeting by concentrate on less costly ways to organizing for work and delivering outputs (Schick, 1966)[8]. Further reform's effort includes the initiatives for making the budget process focused primarily on the results achieved from the expenditure for government activities, rather than on the expenditures or activities themselves[9].

The debate on performance budgeting was then frozen. And, since 1980s, integrating performance measurement into budgeting and management process has become an increasingly popular practice (Berman and Wang, 2000; Cope, 1987; Hood, 1995; Grizzle, 1987; Poister and McGowan, 1984; Poister and Streib, 1999). This period can be considered as a *stage of revival of*

[7] Ackoff, R.L. Planning in large economic systems. Moscow: Soviet Radio, 1972. P.107.

[8] The example that can be given here is the Hoover Commission's "performance budget", which, rather than emphasizing items of expenditure (like salaries and supplies), was designated to describe the expected outputs resulting from a specific function or activity (such as training).

[9] The Planning-Programming-Budgeting System represented probably the most famous of these initiatives, as well as another specific sample which is zero-based budgeting.

performance-based reforms, primarily by a number of efforts have been made in the United States to review the current status of performance-based budgeting. On the other hand, they presented a part of international trend that is consistent with the "new public management", since, a significant growth in public spending and the difficulties in governing and coordinating of local administrations and public agencies encountered by the central governments, required for the '90s, major changes in the detailed planning and control.

A logical extension of these past efforts was reflected in the subsequent investigations related to "managing-for-results", which argues for a moving in the direction of "outcome-based" budgets instead of focusing on inputs. The tendency of budget process to focus on the allocation of resources to meet the needs of legislative area rather than the broader public interest is particularly criticized by the reformers.

Parallel to that, a more discursive text ranges over the general theme of performance budgeting (Friedman, 1997) that acknowledges the variety of terminology used to describe an essentially common process, with similar stages of analysis (strategic to operational; outputs and outcomes).

Performance budgeting re-entered the academic debate also under the impulse of the practice turn in budgeting research of the group of scholars, aspirated by the idea to draw a clear link between performance information and resource allocation decisions (e.g., Joyce, 1999). Another group have focused on comparing various performance measurement practices (e.g., Lee, 1997). During the discussion, most concur that *performance information may be best suited for support of managerial decision-making* (Cornett, 1998; Melkers and Willoughby, 1998) and point to the increased use of legislative requirements in providing the basis for performance-based budgeting. Further, they tend to support a notion that there is still a large variation in the presence of performance information and the use of this information for budgeting. This stream of research has contributed to the understanding of the efforts toward increasing the use of performance information in budget processes.

Thus, stimulated by this debate, over the 2000s much empirical research accumulated (Kettl, 2005; Pattison and Samuels, 2002; Sharp, 2001; Young, 2003; Diamond, 2005; OECD, 2005). In major cases empirical works are represented by case studies (Andrews, 2004; Tat-Kei

Ho, 2011; Gilmour and Lewis, 2006; Melkers and Willoughby, 2001; Moynihan, 2005; Wang, 2000). These studies showed that the uses of performance-based budgeting systems can be understood in two ways. According to the first, the subject matter should be considered in the broadest sense as it relates to its primary aims. This would include PBB's dual purposes of improving decision-making and elevation service delivery. The second way would be to examine the application and functioning of PBBS practice among specific states, as well as the evolution of the "new" performance budgeting model, increasingly being applied in industrial countries. For emerging market economies identifying its main components would be viewed as the prerequisites for converting their present budget systems to PBB model. In this regard there are studies addressed the problems which may limit the implementation of performance budgeting in some states (Poister and Streib, 2005; Xiaohu Wang, 2000).

Referring to a *criticism* on PBBS implementation there should be noticed that a common pessimistic opinion is that performance and program budgeting efforts lead to budget planning systems that are mechanistic, overly complex as well as overloaded with performance data which have little or no impact on actual decisions (Tandberg, 2009). Also recognized as a narrow conception of performance budgeting its tendency to create links only from past performance to present funding (Andrews and Hill, 2003)[10]. Furthermore, critics argue that performance budgeting is a "troublesome" enterprise because it is difficult to know how to use performance information (e.g., Gilmour and Lewis, 2006). The question that arises here if a program performs poorly, does that mean it should be cut because it is wasting money or increased so that it can do better?

On the other hand, there are case studies that demonstrate that on the local government level performance measurement do influence budgetary decisions; even so such results may occur at the program level rather than at the department level and during the appropriation process (Tat-Kei Ho, 2011). Thus, in particular, Andrews (2004), pointing to Florida's experience, states that it is likely that PBB will not penetrate the decision-making processes, if

[10] Despite this, as it is specified, for instance, by Robinson (Robinson and Brumby, 2005), it does not mean that all performance budgeting systems has this property: "…it is, in fact, links between funding and expected future performance which are the focus of some performance budgeting systems".

performance information data are separated technically from budgeting and accounting operations[11].

Summarizing, we would like to emphasize, that named criticism does not make a problem of an effective budget spending less actual. This is particularly important because each country implements its own model of PBB, relatively to its national characteristics, culture, priorities, level of fiscal stability etc. In this regard, the variety of comprehension of the mechanism of PBB should not be considered as disadvantage, but rather an advantage, which, in turn, may serve as a source of methodological framework' development. Hence, an examining the argument through its implementation among specific states could become a way to understand meaningfully the method of PBB.

2.2 Performance-based budgeting systems: Selected international experience

In recent years, a lot of works related to empirical research studies in PBBS which include case research, field surveys and interviews, field experiments have been published. This section is organized in the form of principal OECD' budgetary documentation overview. We dwell primarily on key aspect of the PBBS, namely use of performance information in the budget process. There should be emphasize, that the literature on PBBS' practice aspects is heavily biased towards English language-only sources. So we aware the fact that this distortion may limit a coverage area, and, in a certain sense, the results of the research. The challenges encountered by other countries when seeking to implement performance budgeting might offer helpful guidelines for future practice and research[12].

In most countries of the Organization for Economic Co-operation and Development (OECD) the introduction of PBB began in the late 1980s (or 1990s), and in some of the countries much earlier, with a main goal to improve accountability and effectiveness of public programs

[11] Here would be either appropriate to refer to Shah's (1998) institutional model of the public sector, that identifies three factors which are providing a framework for analyzing PBB adoption in the states, such as: performance evaluation ability, personnel ability and technical ability. The idea of the model is that *governments need to focus on more than just the technical side* when implementing PBB but to expand their reform space.

[12] An enterprise was not chosen as a unit of analysis since in that case the amount of the work would tend to be infinite, so we would prefer a national level.

(Lee and Wang, 2009). Since the first attempt to introduce elements of PBB was made, various modifications of it have been used in practice: the planning-programming-budgeting system (PPBS) (1962-1971), management by objectives (1972-1975), budget planning from scratch, or zero-based budgeting (1977-1981), and, finally, a "new performance budgeting" (from the 1990s.). In most cases the practice of PBB was expanded by introducing new legislation that required performance measurement and benchmarking (OECD, 2002; Willoughby and Melkers, 2005)[13].

Reputedly, the most complete version of PBB has been introduced in Australia, New Zealand, Great Britain, and the Netherlands. These countries have changed the structure of the budget to include information about the intermediate and final results of operations. Simultaneously, they adopted the accrual method (although the Netherlands was abandoned it later.) Canada and the U.S. have not made any changes to the budget classification, but instead have incorporated the results into strategic plans, which are also represented in the legislature. Canada has adopted a set of strategic objectives and program that supports all the budget documents. Programs of transition to a system of PBB are taken in France and Germany. The individual elements of the concept of budgeting for results are also used in several countries in Central and Eastern Europe, particularly in Bulgaria[14] and Latvia[15].

Even those countries who went to change their budget structure, face some challenges in integrating performance information into a budget process. For example, in the mid-1990s, the Swedish Government changed budget structure to better reflect the priorities of a state policy: expenditure was allocated to 27 areas and was created a software classification[16]. There have been several attempts to fully integrate financial information and performance information. Despite this, performance information is not generally used as a basis for negotiating or deciding on future resources. Still, it is used to monitor agencies' activities and to report on the results to parliament. The discussion of the draft budget to the government and parliament is usually in the

[13] Many have also shifted to report outcomes and build a strong link between performance and budgeting (OECD, 2002; Perrin, 2002).
[14] The first experiment was implemented in 2002 in the Ministry of Environment and Water Resources.
[15] PBB implemented in the Ministry of Agriculture.
[16] In Sweden, an experiment on the introduction of management by objectives and results began in the first half of 1960, in the 1988-1990 management by objectives and results was introduced in full for the entire public sector, while continuing to develop in the future.

traditional terms of expenditure trends and budget allocations and there is still a clear separation between the financial and performance aspects (OECD, 2007).

The question of integration of performance information in the procedure for approval of budget allocations of ministries OECD countries was settled in different ways. The approaches taken here can be grouped into two categories: formal and informal. The first category assumes a mandatory presentation of planned targets and (or) a report on the performance, along with budget requests. If performance information used in decision-making process, then comes to the fore the question of how achieved / planned outcomes affect funding. According to the second one, countries do not impose formal requirements for the use of the results in the formation of budget allocations[17].

Performance information, as a rule, makes a part of the report and submitted to the legislature. The requirement of submission of the planned target values, along with the budget application may cover all ministries, or apply only to a part of them. In some countries, this requirement only affects new programs or additional costs for the implementation of existing programs. In countries where the Ministry of Finance is involved in the formation of the targets, these figures are subject of the negotiation between the Ministry of Finance and sectorial ministries.

Most of OECD countries do not adhere to universal formal rules that governing the relationship between costs and the targets (a specific exception is New Zealand).

Australia and the UK have established the requirements according to which increased costs or new costs must be supported by targets or estimates of the impact. The current framework develops both performance measures and evaluations. At the national level, Australia operates within a developed financial framework. Performance management and budgeting are generally the responsibility of individual ministers and their departments and agencies. Thus, the current system is outcome-focused, concentrating on agency-level outcomes. Every department and agency within the general government sector is required to identify comprehensive and explicit outcomes, outputs and performance measures for the quantity, quality, price and

[17] In those countries where formal mechanisms for the universal use of performance information are not available, departments and agencies may submit such information to the Ministry of Finance, and use it in negotiations, but it will not play a significant role in the allocation of funds.

effectiveness of their activities. In the United Kingdom each ministry is developing a three-year spending plan and an agreement on the providing public services, including performance indicators that are coordinated with the Treasury. This is done in order to monitor the compliance of industry costs to priorities of state policy. Political and economic considerations affect the structure of expenditures, while the targets are used to relate the new or additional costs to the results to be achieved through these means. Thus, key objectives and targets are integrated into the decision-making process at a high political level (Scheers et al., 2005).

More detailed analysis permit us to underline some important benefits from the implementation of PBB, for both governments and for institutions. In particular, to advocate the benefits of government, there could be distinguished:

- regularly obtaining more complete information about the realization of government objectives and the use of budgetary funds in various areas of the state;
- the possibility of a more efficient allocation of budgetary resources among competing items of expenditure due to the more accurate and complete information on the implementation of programs,
- opportunity to compare several proposed options in terms of expected results and costs;
- identification and elimination of duplicative programs, as well as ineffective programs[18] (e.g., Forsythe, 2001).

At the same time, benefits for the institutions are:

- possibility of an independent expenditure of budgetary funds to achieve intended results;

[18] In 1999 the results of inspections leaded by Government Accounting Office, USA, was identified 61 programs that were proved to be ineffective. These programs have been divided into three groups:

1. programs / services that could more effectively be performed / provided by the private sector;
2. programs to provide outdated, not more actual services;
3. unprofitable capital investments.

In 1995 by Government Accounting Office was identified a number of programs that were duplicative. In particular, in the eight agencies implemented 50 programs for homeless.

- the possibility of at least approximately to establish the relationship between expected results and the amount of resources required, and to better plan their activities;
- opportunity to request reinforcements to increase the budget financing substantiated by economically viable calculation efficiency of the program[19] (e.g. Hatry, 1999).

OECD countries have positively evaluated the results of budget reforms related to the implementation of PBBS facing withal some significant challenges (Exhibit 3).

Exhibit 3: Selected international experience of PBBS implementation

Positively evaluated results	Challenges faced
Contribution to the ***identification of policy priorities*** in the short and medium term; aligning them to the activities of sectorial ministries	The successful use of performance information for budgeting ***takes time to implement and has many obstacles;*** one of the most complicated is that ***performance cannot be measured until the goals are transferred into measurable desired results***. There is a ***problem of a time lag***, when the actions taken today are effective only after some (often very long) time
Improvement of the quality of the monitoring of budget expenditures due to the inclusion of performance information into fiscal accountability	
Contribution to ***enhancement of the role and expand the horizon*** of budgetary planning; allowed to deviate from the justification of future expenditures ***through*** costs of previous years, linking to expected outcomes	PBB can distort the incentives of the budget process, give rise to a desire to ***manipulate the performance indicators and statistical data***
Creating conditions for ***improving the quality of governance***. More than ½ of OECD countries have implemented PBBS, which includes setting and monitoring targets	PBB has ***specific requirements for the qualification of staff*** of financial agencies since information about the effectiveness of government differs significantly from the ordinary financial information; PBB implementation ***also requires major changes in the means of automation*** of all stages of the budget process
Increasing the transparency of public authorities. 24 of 30 countries inform the public about the results of activities by reports distributing	

More than two-thirds of the countries used to include non-financial performance data of public bodies in their budget documents. Some of them have moved to an even greater extent, by modifying its budget classification so that it did include information on performance results (OECD, 2008). At the same time, in the majority of cases the Ministry of Finance does not use

[19] Department of Environmental Protection of Massachusetts appealed to state legislators with a request for funds for the concreting of municipal waste landfills. As a reasoning was mentioned a product which was the number of acres of concreted land. This did not convince legislators and the request was rejected. When the department cited a result as a justification, namely, reducing the amount of pollutants that can seep into the groundwater and get into drinking water sources, the funding has been obtained.

performance results to financially reward or punish agencies. The difficulty in linking funding to results reflects the fact that the issues and context surrounding budget decisions are complex.

All in all, performance budgeting provides a great opportunity to improve the efficiency of public spending, even though its implementation is not simple, rapid or cheap process. Furthermore, it is a very individual process, that considering the peculiarities of the national economy and public administration. Almost all OECD countries accustomed performance indicators of the authorities and public institutions in their budget process, while a direct link funding to performance indicators is used in only a few countries. This applies generally to small countries, and only for a limited range of public services.

2.3 Performance-based budgeting challenge for emerging markets: case of Russia

2.3.1 Interpretation of PBBS in Russian literature

A number of countries around the world, and many emerging market economies, including Russian, are attempting to improve their budget process and move to performance-based budgeting. It appears to be a very worthwhile and on the other hand difficult to achieve objective. The approach that can be taken here may differ according to the own national capacities, priorities and cultures of each state. Nevertheless, the countries do share some common objectives, such as: budget priorities - like controlling expenditure and improving the allocation and efficient use of funds; improving public sector performance; and improving accountability to politicians and the public. By identifying the main components of performance-based budgeting model, which appearing more and more being used in industrial countries, the goals faced by emerging market economies when converting their present budget systems to this model are determined and it is recognized that this conversion will not be easy and will require major efforts (Diamond, 2003).

In Russia, understanding the need to change the concept of the public finance management is due, primarily, to the fact that further development requires a systematic increase of the effectiveness of budget spending, while existing approaches do not allow to meet the growing needs in a more rational use of budgetary resources.

In economic literature there is no generally accepted translation of number of PBB' terms. The term "program-targeted budgeting" (literal translation from Russian) is used as Russian equivalent of "performance-based budgeting", referring to the fact, that in English-language literature there may be found the examples of the use of the term "resulted-oriented budget" as a synonym of "performance budget". Still, the term "performance-based budgeting" is used more like "resulted-oriented budgeting".

> *Different interpretation of understanding of PBBS can be explained by the variety of the concept of "effectiveness", or rather, its equivalent in English, such as the "effectiveness" and "efficiency", which, in principle, are considered as synonymous. However, in the economic literature being used certain interpretations of each of them: effectiveness – is the ability to achieve goals (no matter what price it was done), and efficiency – is the optimal value of the resources used and the results obtained (regardless of whether the goal is achieved or not). Thus, the Russian word "effectiveness" in English correspond to just two concepts, each of which has its own importance.*

As a fundamental principal of PBB is stated a provision of relationship between the allocated budgetary resources and the expected results of their use (Lavrov, 2004). In addition, budgeting over the medium-term is particularly emphasized as an essential part of the implementation of PBB, which is explained by the fact that most of the strategic objectives of socio-economic policy goes beyond one fiscal year. These approaches are implemented, for instance, in many countries of Eastern Europe and the Commonwealth of Independent States (CIS). For example, in Kazakhstan has been done a considerable work on improving the budget system and increasing the efficiency of budget expenditures[20].

Sufficient, but not a lot of literature on PBBS practice may be found. Generally, the works that represent PBB in Russia are conceptual papers and primarily focused on summarizing or analysis of PBB' international experience and capabilities of its distribution in Russian context (Bogorov and Korol'kov, 2010; Gamykin, 2001; Lavrov, 2003; Makashina, 2008; Belyaeva, 2010). The opinions about these last, in the majority, are positive (Roi, 2005). The exceptions can be concentrated and formulated as a misapprehension of the core principle of

[20] Resolution of the Government of the Republic of Kazakhstan from December 26, 2007 N 1297 "On the Concept for the implementation of the system of state results-oriented planning."

PBB by the ministries and departments from the one side, and unavailability of the existing budget system to adapt quickly from another (e.g. Makashina, 2008).

2.3.2 Preconditions of PBBS introduction in Russia

The topicality of PBB in Russian Federation is delineated in connection to an adoption of legislation on the reform of the budgetary process[21]. According to the official sources, Russian practice of performance-based budgeting begins from the period of 2000th which was characterized by the budget reform that implied a methodological approach to the planning and implementation of state and local budgets[22]. The first steps towards the introduction of PBBS elements into practice of financial management were taken in 2004. Key events related to the creation of a legal framework and practical implementation of PBBS, are presented in Exhibit 4.

The approach includes methods of allocation of budgetary resources matching with the goals, objectives and functions of the state according to the changing priorities of state policy. This approach involves the formation of the budget of the Russian Federation on the basis of the goals and intended results of public policy. Thereby, budget allocations obtained a clear link to the functions (services or activities), and the focus in their planning should concentrate on proving outcomes within budget programs. This also includes the introduction of the system of internal control. It is expected that the responsibility for decision-making is delegated to lower levels. Evaluation of administrators of budget funds should be based on performance.

Exhibit 4: Main stages of PBBS implementation in the Russian practice

Year	Event
2004	Approved of the Concept of reforming the budget process (22.05.2004)
	Conducted the first experiment to introduce the PBBS in nine federal executive bodies
	Compiled the first report on the results and main activities (DRONDs) for 2005-2007
2005	Started implementing of a three-year budget planning (Resolution № 118 of 06.03.2005)
	Adopted a resolution on departmental target programs (19.04.2005)

[21] Russian Federation Government Resolution on May 22, 2005 №249 "On measures to improve the effectiveness of budget expenditures".
[22] E.g. Russian Finance Ministry website. Access mode: http//www.minfin.ru.

	Adopted a resolution on the order of conducting the register of expenditure commitments of the Russian Federation (15.07.2005)
	Completed an experiment in 9 ministries, allocated resources to implement PBBS measures
	Compiled DRONDs for 2006-2008
	Accepted the concept of administrative reform in 2006-2010 (Russian Federation Government Decree № 1789-p of 25.10.2005)
2006	Term financial plan approved by the Russian Federation for 2006-2008 (№ 399-p from 21.03.2006), the budget cycle for the first time in 2007 was done in the format of "rolling three-year plan"
	Conducted a second experiment on introduction of PBBS in sixteen federal executive bodies
	Prepared amendments to the format departmental target programs on the basis of understanding the negative experience of the implementation of departmental target programs
	During the budget process introduced Justification of budget allocations - a tool for planning and reporting on direct results
	Reduced first register of expenditure commitments of the Russian Federation
2007	Budget cycle for 2008-2010 is first implemented in the three-year budget format
	Registry of expenditure commitments of the Russian Federation is used in the preparation of the federal budget
	Justification of budget appropriations are used in the budget process (while only for explanatory note)
	Implemented on an ongoing basis experiment - assessment of financial management in the federal bodies of executive power. The result is not only the allocation of funds for PBBS implementation, but also much liberty available in budget funds
2008	Implementation of the Concept of administrative reform in 2006-2008
2009	Adoption of guidelines on drafting the studies of budgetary allocations of the main administrators of the federal budget for 2010 and the planning period of 2011 and 2012 (application number 3 to the letter of the Ministry of Finance of the Russian Federation of 01.10.2009 № 02-09-01/4670)
2010	Adoption of the Federal Law "On Amendments to Certain Legislative Acts of the Russian Federation in connection with the improvement of the legal status of state (municipal) institutions» № 83-FZ of 08.05.2010
	Adoption of the program of the Government of the Russian Federation to improve the efficiency of budget expenditures for the period until 2012 (approved by the Decree of the Government of the Russian Federation № 1101-p dated 30.06.2010)
	Adoption of the Federal Law "On the organization of public and municipal services» № 210-FZ of 27.07.2010

It must be emphasized that the process of establishing of the legal framework is not yet complete. In practice, the necessity and the expediency of introduction of PBBS, is explained due to the presence of a well-defined context, which include, for instance:

- situation when the traditional methods of improving the efficiency of budget expenditures is almost exhausted and cannot solve the problems of imbalance in the budget or lack of quality public services;
- budget crisis, which requires radical measures to reduce costs while retaining the achieved level of provision of public services;
- situation in which the budget is no longer a full value management instrument.

It may be the case that the root of this situation lies in the planning mechanism itself which is inspired by centralized planning. Thus, for example, Zhigalov (2009), claims about an ineffectiveness of the current structure of budget expenditures at all levels. This structure was the result of the transformation of the budget system of the RSFSR (Russian Soviet Federative Socialist Republic). Indeed, in compare to the other countries with emerging market economy, Russian practice of budgeting is based on centralized planning economy. The point is that, after the collapse of the Soviet Union, the country inherited a system of formally federal but essentially a highly centralized unitary state in which regional and local authorities were not significantly autonomous. Public administration was based on the planning, which bored the form of law, realization of which was compulsory and strictly controlled. So, it was assumed, that the mere execution of the plan ensures the efficiency of the public sector. Under current conditions, with the expansion of the rights and powers of local authorities, appeared a need to measure the effectiveness of public sector organizations.

There should be emphasized that up to the present time, the planning of budget expenditures was itemized conducted, that is, abstractedly from the quality of services, and budget execution was carried out through comparison of the "plan" and "fact". This situation made it impossible to reflect the efficiency of budget funds. The budget is mainly based on changes in the actual parameters of the past year. This is so-called planning system “from achieved”, or rather, the application to the current expenditure structure of the method of indexation, considering the correction coefficients. Such approach to budgeting, widely used in Russia until now, does not allow to achieve the objectives of socio-economic development, set by public authorities, as well as to plan the results of budget expenditures at all levels of budget system. In addition, the incremental method of budgeting can be used only if a developed system to prioritize spending.

The estimated expenditure framework which is based on reported data for the same items for expenditure of a last year, actually bypasses the problem of determining the results of financing. More precisely, the costs themselves are acting as a result, and in such circumstances it is impossible to determine the effectiveness of the financing of budget expenditures. The estimated budget expenditure planning procedure allows a goal-oriented spending of funds and a comparison of planned and actual amounts of funding. These facts, of course, are useful in the framework of the existing system of planning and financing, but have almost no relation to the determination of the effectiveness of public spending. With this approach, the reported estimate almost automatically generates a planned-oriented one, and this alternation can last long as he wants.

That is, within the framework of annual budget becomes actually impossible to determine the effectiveness of budget expenditures, since almost all significant economic and social processes occur over a longer period. Naturally, such a mechanism only increases social tensions today.

On the other hand, as some practitioners use to notice (e.g. Lavrov, 2004; Ushakov, 2008), some of existing traditions of planning, in particularly a medium-term plans of balanced budget, as well as “top-down” reporting approach, which are already present, providing a good foundation for the transformation of budget system in the Russian context. For example, in Sweden, which is now considered one of the leaders of reform in this area passed to the method of "top-down" only 10-15 years ago. Earlier there was used the method of "bottom-up", when the ministries prepared their applications for funding, and defended them in the higher authorities. In addition, a considerable experience of development and implementation of target-oriented programs on federal level was accumulated, which is also making a part of the budgeting by objectives and results. Finally, exist a regional finance reform fund, which is actually implemented as an element of PBB. Money from this fund is given to those regions that are making progress in managing their budgets (Center for Fiscal Policy, 2002).

2.3.3 The principal differences of PBBS from the existing model of budgeting

In compare to traditional “cost-oriented” model of budgeting, the PBBS model is based on the concept of clear binding of budgetary funds to intended results, that is, the planning and

implementation costs are based on the desired result. Herewith, the PBBS model is characterized by costs that are less detailed when in the case of planning. A primary importance acquires not just a "correct" budget spending, but the achieving of planned performance (Exhibit 5).

In terms of the effectiveness of each of the models, it should be noted that if the "ideal" version of "cost-oriented" model, that is one hundred percent of the plan, is possible to achieve, the optimization of correlation of results and costs represents quite a long process. The moment of the "ideal" performance of this process is not clear. However, this makes the model flexible and allow continuous improvement, increasing effectiveness with further development and identifying of new priorities.

Implementation of a detailed plan (in case of cost-oriented model) which was acting until the present time in Russia, does not affect positively on a socio-economic development of the state as a whole and its single regions, since many of the originally planned activities are usually unjustified and can often be irrational. As a result, in practice there is a need for a constant adjustment of the plan in order to improve its rationality that actually discredits the planning procedure, showing a formality of a high specification of costs. In turn, high decentralization of planning limits the duration of the planning period, making it practically impossible to implement a strategic planning targets. The object of control in cost-oriented model is the intended use of budgetary funds, conformity of spending to plan, while effectiveness, rationality, incurred expenses are moved to second place.

The logical question that may arise here is "why the introduction of PBBS had not begun earlier, or, in another words, what prevented the reforming of budgeting planning"? Moreover, that active studying of experience of PBBS implementation by foreign countries began in 2000, and these ideas have already been considered at the time as a promising vector for the Russian financial management system. As the evidence of international experience in reforming the budgeting demonstrates, introduction of PBB is directly related to administrative reform, the same as reform of intergovernmental fiscal relations, which have not yet completed in Russia[23].

[23] E.g., in most cases laws contain vague indications if expenditures commitment that entered by the State is its function, how much does it cost, how the costs should be considered, who provides a funding, who is involved in the costs of execution of these functions.

Exhibit 5: Traditional (cost-oriented) budgeting model versus PBBS model

Criteria of comparison	«Cost-oriented» model	PBBS model
Planning object	Budget expenses	Budget expenses and results
Movement on budget "vertical"	"Bottom-up"	"Top-down"
Distribution of funds	By cost (according to the functional, departmental, and economic classification of budget expenditures)	By program or strategic objectives designed to achieve specific results
Principles of budgeting	Justification of resource needs. Established, usually by indexing the amount of expenditures of the previous period	Justification of the priorities and expected results and effectiveness. Budget expenditures are related to performance indicators results through resources and activities required to achieve results
Planning horizon	One year	Medium term (3-5 years)
Limits of using of budget allocations	Funding is divided into target limits in relation to a particular goal. Unacceptable or extremely difficult transfers between items or sections of expenditures. Balances on budget account debited at the end of the year	Setting of long-term limits of budget allocations. Approved transfers between items of expenditures; possible to transfer unused funds to the next year and partial use of the budget allocations of the next year in the current year
Responsibility for the effective use of budgetary funds	Targeted use of budgetary funds in accordance with established procedures. Low level of delegation of responsibility; limited possibilities of budget process participants to act independently in order to enhance the effectiveness of budget spending	Results of performance. High decentralization and delegation of authorities. Setting of appropriate goals and allocation of financial resources in accordance to prioritization in spending. Individual units within the organization should be able to largely independently determine the best option to achieve the goals. Enhanced responsibility for the performance of activities. Focuses on the achievement of ultimate social results. An important role plays monitoring of performance indicators as a tool to assess the degree of execution of budget
Monitoring of budget execution	Implemented by external regulatory bodies (usually higher or specialized agencies). Focuses on monitoring the execution of budget expenditures	Implemented by external regulatory bodies, a specific role plays internal control. Controlled not so much the budget spending, as the achievement of goals and objectives

Scientists also point to more specific issues that impede the implementation of the new budgeting system. For example, the problems of a current structure of a rete of budgetary institutions, many of which are weakly connected with the functions performed by the ministries.

So, there should be done the steps related to the optimization of the budget sector, such as: reduction of redundant functions, the transfer of some budgetary institutions to municipalities, association of public institutions, etc. (Fund "Institute for Urban Economics"). Still, we would like to underline, that some of these steps, for instance, an identification and elimination of duplicative programs, as well as elimination of ineffective programs, are actually making a part of activities which imply the functioning of PBB. Or rather, these steps are not an obstacle as such. In this particular case, the reduction would be among the advantages of using PBB.

The last but not least important aspect of meaningful adoption of PBB in the case of Russia is the possibility of using of performance information in budgeting process. For today, one of the main obvious obstacles to the introduction of performance information into the budgeting process in Russian practice is the lack of a unified set of performance indicators, which would represent the degree of achievement of established objectives. Furthermore, indicators characterizing the social sector and social policies are mostly a form of macroeconomic proportions, and comparisons. Substantially less applicable are rates (or they do not exist), giving an idea of the living standards of the various segments of the population, which is formed through the budget allocation of funds. This reduces the visibility and transparency of the budget, limits its discussion of a thin layer of professionals.

The introduction of PBB in Russia was thus necessary and legitimate since it is effectively represent a logical continuation of reforms that were conducted and continue to be in the public sector in recent years. Currently, a program-target method of planning is already in use on federal, and partly on the regional and local levels of government, acting as a tool for improving the effectiveness of public spending. At the same time, the structure and dynamics of different levels budget's expenditure are weakly correlated with the objectives developed in accordance with their regional and municipal development programs; there are still many other unresolved issues. Evidently, the transformation begun needs its further development, as well as sustainability of the budgetary system requires an increase in the effectiveness of budget spending within the established priorities. In this regard, the problem of transition to a new model of resource-allocation budgeting for state and local government seems to be one of the most relevant for today.

3. Research design and suggested analytical framework

3.1 Purpose and Research Questions

Problems of increasing the efficiency of public expenditure management used to be at the center of the budgetary policy of almost all countries of the world. In today's social and economic conditions become more urgent improvements in the practice of budgeting for results, dramatically alters not only the content of all stages of the budget process, but also the very concept of public expenditure management. Today a number of countries around the world (including emerging market economies) are attempting to improve their budget process moving to PBB model. The approach that is taken here differs according to the own national capacities, priorities and culture of each state. Nevertheless, the countries do share some common objectives, such as: controlling expenditure and improving the allocation and efficient use of funds; improving public sector performance; and improving accountability to politicians and the public.

Thus, the logic of performance-based budgeting is looking beyond inputs or line-item expenditures so that to ensure the adoption of informed decisions, and choices that is grounded in measurable progress or achievement. In this context performance budgeting has emerged as a concept which has been both imperatively recommended and criticized among the science and practice. So, the New Public Management opponents claim that it is possible to manage the performance when this process is relative to an activity consisting of simple production functions and having a clear unambiguous results (e.g., Clark and Swain, 2006). While New Public Management steam and its supporters note that these simple functions can be managed within the framework of a traditional line-item budgeting (e.g., Osborne and Gaebler, 1992). In this debate we vote the side of NPM supporters as far as traditional bureaucratic approach of budgeting for centuries was based on unchangeable simplified procedures, aimed on funding estimates for the public sector. On the other hand, current criticism on performance budgeting contributes its further conceptual development as well as methodological improvement.

The **goal of this research** is to understand and explain how budgeting process in public sector is managed in a particular context of PBBS implementation.

In contrast with private sector, where the efficiency forced by the requirement for real profits over operating costs, and where the market is the test, no such test exists in public administration, and performance budgeting is one attempt to establish a public sector equivalent to the discipline of the market. By identifying the main components of PBBS, which appearing more and more being used in industrial countries, the goals faced by emerging market economies when converting their present budget systems to this model are determined and it is recognized that this conversion will not be easy and will require major efforts. This is the process that we intend to capture. The explorative **research questions** which broadly guide the work are (see also Exhibit 6):

How budgeting process in public sector is managed in a particular context of PBBS implementation? Upon what conditions this rule is implemented and what are the main prerequisites for any move to PBBS model?

In particular, from a critical perspective, the decisive research question we are starting from in order to deepen the whole discourse:

- *Identify the preconditions to realize the benefits of performance budgeting.*

And from an interpretive perspective:

- *Emphasize past efforts to connect performance measurement and budgeting in order to establish the criteria of the reform process;*
- *Explain how the rule of PBBS implementation is applied in practice;*
- *Understand how do the actors make sense of PBBS discourse.*

This research could so contribute to elaboration of theory on PBBS, as far as it find how nature of the measures taken with regard to adaptation of PBBS allow to assess the difficulties in its implementation. Achieving some of the specific aims of the research would tell something on the concrete meaning actors give to PBBS and how it comes (or not) to penetrate their work, what are the specific features for application (or not) of PBBS instruments.

Furthermore, it will allow to extend the debate on organizational, legal and methodological basis for the organization of the budget process. With the diversity of implementation of different PBBS patterns, a controversial remains a problem of integrating of

Exhibit 6: Research Questions frame

How budgeting process in public sector is managed in a particular context of PBBS implementation? Upon what conditions this rule is implemented and what are the main prerequisites for any move to PBBS model?

Posture	Research Question	Output	Examples in the literature
Interpretive: "discourse and cognitions"	***RQ1*** *Emphasize past efforts to connect performance measurement and budgeting in order to establish the criteria of the reform process*	Analysis of the strengths and weaknesses of PBBS is of a crucial importance in the implementation and development of its model in a given situation. In addition, each country brings to the PBBS process innovations depending on their capacities, priorities and culture. PBBS complexity thus serves as a *source of development of a methodological framework.*	Grizzle, G.A., and Pettijohn, C.D. (2002); Young, Richard D. (2003); Gilmour, J.B. and Lewis D. (2006); Ongaro, E. (2009)
	RQ2 *How the rule of PBBS implementation is applied in practice?*	In particular, we are interested, how the actors adopt to the objectives of effective budgeting, as well as to the redistribution of responsibility and distinction of authority. In other words: in compare to the formal side of the issue, *what are the consequences of the change in the budget format in practice?* Hence, the question that we ask here are: "*What has been done in order to approximate to PBBS model?*"	Harry, P. Hatry (1999); Kelly, Janet M. and William C. Rivenbark (2011)
	RQ3 *How do the actors make sense of PBBS discourse?*	Achieving this aim would help to *recognize a multilevel importance of model of performance budgeting in terms of the division of functions and responsibilities* on the budgeting process between the authorities. This allows to understand *how do local actors involved into PBBS implementation*, and *if there is (or not) an active process of interpretation and appropriation of PBBS concepts in a professional logic.* Or, that is to say, what is the result the actors expect from the transition to a new cost structure of the budget?	Robinson, M., and Brumby, J. (2005); Moyhihan, D. (2006)
Decisive: "power of discourse"	***RQ4*** *What are the preconditions to realize the benefits of performance budgeting?*	It will thus help to understand *what preconditions should exist before starting the transition to PBBS* and what are the basic problems that inhibit its implementation.	Hager, G., and Hobson, A. (2001)*; Diamond, J. (2002)

* Research report.

decisions on spending of budget allocations to the results achieved, the direction in which the modernization of management of budget process is actually traced.

Finally, this research will offer an attempt to bridge theoretical discourse and practice, namely in the sphere of financial management in public sector and municipal government in the direction of improving the methodology and procedures for budget planning, since it will not analyze only the presence of certain discourses, but also the actors' active engagement with them.

3.2 Case study selection and research object specification

3.2.1 The case study approach

In order to *delimit* the number of publications, empirical papers mainly addressing agencies-level were excluded from the sources. Similarly, highly technical work on topics such as efficacy of government-wide performance budgeting systems, key performance indicators and planning for performance was also excluded from the review. This seems to be justified when considering that the number of publications that could be found tend to be infinite when broadening the conversation about PBBS. Instead, we have broaden a conversation by choosing a sectorial budgeting system, in particularly a case of health care financing in Russia.

We decided to apply to a ***case study as a research strategy*** that is situated between concrete data taking techniques and methodological paradigms (e.g., Lamnek, 2005). It is probably the most appropriate strategy in our case since it is represent an empirical inquiry that investigates a phenomenon within its real-life context which can be used to accomplish various aims: from providing description (Kidder, 1982) to test theory (Pinfield, 1986; Anderson, 1983) and to generate theory (e.g., Gersick, 1988; Harris and Sutton, 1986). It is typically combine data collection methods such as archives, interviews, questionnaires, and observations wherever the evidence can be both qualitative and quantitative. Our intention is *theory generation from case study evidence* with the focus on understanding the dynamics present with single settings. It is important to underline that theory-building research begins as close as possible to the ideal of no theory under consideration and no hypotheses to test (Eisenhardt, 1989). Meanwhile, it is allow to explore causation in order to find underlying principles, thus presenting an explanatory case study (e.g., Baxter and Jack, 2008; Yin, 2009). In our particular case criteria are established for *selecting cases from historical records* for inclusion in the study (i.e. explanatory retrospective case study). Theory-building research typically combine multiple data collection methods, that provides stronger substantiation of constructs (Eisenhardt, 1989).

Why precisely case study as a research approach? As Darke and Shanks (1998) point out, referring to Benbasat (Benbasat et al., 1987; Yin, 1994), case study research is an appropriate research strategy where a contemporary phenomenon is to be studied in its natural context and "the focus is on understanding the dynamics present in single settings" (Eisenhardt, 1989). Case study research is considered to be particularly useful where "research and theory are at their early, formative stages" (Benbasat et al., 1987). These include areas where there is little understanding of how and why processes or phenomena occur, or where the experiences of individuals and the contexts of actions are critical. There are also research areas where theory and understanding are not well developed. These include areas where a phenomenon is dynamic and not yet mature or settled, or where terminology and a common language and set of definitions are not yet clear or widely accepted (as it is occur in our particular case).

Another significant point to emphasize here is that case study research can involve either single or multiple cases, and numerous levels of analysis (e.g., Yin, 1984). Some scholars' argue that single cases are superior to multiple cases for creating high-quality theory. On the contrary, different cases often emphasize complementary aspects of a phenomenon. In this debate we would rather share a point of view of those scholars (e.g., Darke and Shanks, 1998) which point out that there is no ideal number of cases, but the appropriate number of cases depends upon how much is known and how much new information is likely to be learned from incremental cases (e.g., Eisenhardt, 1991 referring to Thomas, 1990). That means *designing, shaping and scoping a case study* research *project in order to adequately answer a research question*. So, the number of cases to be studied depends on the focus of the of the research question. As discussed earlier, single cases provide for in-depth investigation and rich description. Multiple-case designs allow literal or theoretical replication and cross-case comparison. Eisenhardt (1989) suggests that both single- and multiple-case designs can be adopted for exploratory research. Where explanatory research is undertaken, *a single case may provide the basis for developing explanations of why a phenomenon occurs*, and these may then be further investigated by applying them to additional cases or other settings.

For this reason ***we have chosen a Russian case.*** In compare to the other countries which are practicing PBBS, Russia represents *an extreme circumstance*, that substantially allows the following type of generalization: "If it is valid for this case, it is valid for all (or many) cases", or, in its negative form: "If it is not valid for this case, then it is not valid for any (or only few) cases". The attempt to transform a current budget system into PBBS is due not simply to the fact that there is a world tendency of performance budgeting implementing. Among the countries with emerging markets, Russia's specificity is that the state is switched to the market mechanisms of economic

development in a relatively short period, and is having a strong link to the oil and gas budget revenues as a distinctive feature. In these circumstances, the policy is expanding the range of income sources of the budget. Search for ways to generate revenue requires an appropriate expenditure policy that supposed to be different in this sort of situation. Researchers claim that, while revenues are generated in a market economy, an expenditure policy is still tending to be affected by a planned economy. The need to PBBS implementing becomes more apparent because of a tendency of continuous growth in budget revenues on the one hand, and the world economic crisis on the other.

In Russia, the practical implementation of performance-based budgeting began in 2004 when at the federal level has been adopted the concept of budget process reform in the Russian Federation, the main purpose of which became a testing a new method of public expenditure management. The implementation of certain conditions in the concept showed that with all the advantages of the new method of budget management, there are a number of unresolved issues that have become a major obstacle to successful PBBS implementation. The most acute problems of implementation are at the level of the main managers of budgetary funds, which directly provide targeted budget expenditures, as well as their effective use in accordance with the principles of the new budgeting system. Currently, budget institutions do not form their own strategic objectives, so that their activities are still somewhat poorly linked to specific strategic objectives of the main managers of budgetary funds.

Another important issue was the imperfection of the mechanism of financial and budgetary control, which is not yet redirected to monitor the achievement of socially significant results of the use of budgetary funds. One example is the practice of funding health care, which, despite the experience of the national project “Health” and targeted health programs seemed to be still focused not on the goals, objectives and results of operations of these institutions, but on covering of current needs in the emerging costs.

According to some analysts, financial relations as the object of financial management of medical institutions with regard to their specific features are insufficiently investigated (e.g., Habaev, 2010). It is appear to be a case that until now there is no deep scientific study of the budget process in health care. There is a lack of modern science-based approach of performance monitoring regarding the efficient use of budget funds. The same concerns about the employee incentive techniques, which would be focused on the implementation of key health indicators; together with a comprehensive program of measures to implement these techniques in various types of medical institutions (hospitals).

Reimbursement of services of medical facilities in the system of compulsory health insurance refers to the regulatory-targeted financing, which is significantly more result-oriented in compare to the traditional, or estimated one. In this regard there is reason to believe that, in comparison to other areas, the Russian health care represents the sphere where the elements of PBBS introduced to the greatest extent. However, based on the experience of a number of regions, it can be concluded that the most complex mechanism of interaction by the introduction of PBBS refers exactly to health care. This served as one of the *main reason we have chosen the health care sector* as a research subject. An additional argument was the high proportion of the costs of the sector in the budget, which implies the possibility to get the best effect from the introduction of PBBS.

The complicity of the mechanism of interaction related to PBBS introduction is due to the features of organization of financial flows in the health system. The rest of the sectors (like, for example, education and social welfare) characterized by uniform conditions of the provision of financial resources: public institutions receive from the budget in accordance with the approved schedule and estimates, regardless of performance (with the exception of costs incurred by the funds received from the institutions of business and other income-generating activities, but their share in the total expenditure institutions are not too significant). The activities of medical facilities financed from several sources: the compulsory health insurance, budget, income from business and other income-generating activities. And for each of these sources, there are different terms exist for obtaining and spending, which significantly limits the ability of institutions to effectively expend funds as well as to guide them in a timely manner in the implementation of measures to achieve the "target" values of the parameters of the institution.

Therefore, our **research setting** is a set of long-term target (budgetary) programs in health (on a basis of Orel region) the emergence of which was associated to a process of the acceptance in 2004 of the concept of reforming of the budget process in the Russian Federation. The choice of this setting was not randomly chosen but selected due to three reasons: first, through theoretical purpose - these programs were introduced as one of the important tools of the successful implementation of PBBS based on international and already established federal practice in Russia. Second, selecting a set of programs as research setting allow to identify their common weaknesses (if any) and thus to minimize a probable distortion by smoothing a risk of having unilateral findings; and, finally, the fact that we had the chance to get easily access to the field via a key informant.

Our **research object** is performance budgeting, i.e. the technology of management of public finances that makes explicit the concept of a link of budgetary funds to intended results. The emergence of this technology was the result of an objective need to improve the effectiveness of budget spending, because current approaches were no longer enable to meet the growing need for a more rational use of budgetary resources.

3.2.2 Case overview: redesigning a national health care system

Protecting and promoting the health of the population is represent a multi-faceted system of public, social, socio-economic, and health care actions, which are based on the one hand, on the preventive focus, unity of medical science and practice, the widespread use of scientific and technical progress. On the other hand, the most complete and effective combination of the needs of the population for health care, drug supply and sanitary-epidemiological service with economic resources to satisfy it can become possible due to the development and implementation of evidence-based system of the activities carried out by state and local governments.

Today health services in the industrialized world are enmeshed in a crisis that is both profound and prolonged. Some of the reasons for this crisis are universal: they are largely economic. Others are specific to individual countries: they include national policy, methods of organization, funding, and socio-cultural values. During the past 20 years, real health-related spending has grown substantially faster than the real gross domestic product in most Western countries. This growth has resulted from a number of interrelated factors: extended health coverage under both public and private programs; health care demographic changes; general inflation; health care inflation in excess of general inflation; and more intensive use of health care services, as a result of new medical technologies and different diseases structures.

In addition to these universal problems, Russian health system faces serious difficulties which could be identified as follows:

(1) Lack of resource and financial support.
(2) Low effectiveness of the health care institutions (medical facilities).
(3) Inadequate quality of medical care in the presence of sufficient supply of the population with medical personnel and hospital beds.
(4) Inadequately low wages of health employees.

According to most researchers and practitioners, the current state of the Russian health care system can be rated as critical. Causes of the crisis are multi-layered. In part, this situation was provoked by the transition of Russian economy to the principles of the market economy in terms of price liberalization. High inflation level and the budget deficit have aggravated the problem of survival of public health, supported by state funding. In these circumstances, the rational strategy of not only development, but also the functioning of health care involves advancing the quality parameters change from quantitative. In the other direction, funds invested in this area, do not give proper results. The way to overcome such situation scholars see the need for a comprehensive reform of the Russian health care. This reform should include a system of measures to modernize and diversify the economy of health in general and ensuring the efficiency and effectiveness of each agency in particular.

Health care reform in the Russian Federation began with the adoption in 1991 of the law on health insurance and it happened when the Soviet Union still remained. Thus, we can say that Russia was the first of the Soviet republics began to reform health care (Exhibit 7).

Exhibit 7: The main steps of the Russian health care reforming process

Year	Legislative Act	Main Contents
1991		Abolished the Ministry of Health of the USSR. Acted the Ministry of Health of the Russian Federation
	The Law of the Russian Federation «On Health Insurance in the Russian Federation» (from 28.06.1991 №1499-1)	- planned to create a market mechanism of interaction between the subjects of health insurance with elements of competition. - assumed that health care providers and insurance companies will be economically interested in improving the quality of care and the effective use of funds
1992	***Order of the Ministry of Health*** «On a phased transition to the organization of primary health care on the basis of a general practitioner (family doctor)» (from 26.08.1992 №237)	Adopted the concept of transition to a single responsible physician, which has to become a general practitioner (family doctor)
1993	***Federal Law*** «Fundamentals of Russian legislation on health care» (from 22.07.1993 №5487-1)	Become in fact the main governing document establishing the legal, organizational and economic principles in the field of public health protection
	Resolution of the Government «Regulations on Medical Insurance Entities implementing mandatory health insurance» (from 11.10.1993 №1018)	- aimed at ensuring the constitutional rights of citizens to receive free medical care - supposed to create a fundamentally new model of health care financing via a specially crafted structure of the state off-budget funds

1996	***Federal Target Program*** «Family medicine» (developed by the College of Health Ministry)	The program was designed for 1997-2005 years and included three phases: - creation of a system of professional training, as well as regulatory, logistical and organizational framework; - introduction of general medical practice in the outpatient chain of regions of the Russian Federation in accordance with the target programs; - formation of a system of general medical practice throughout the Russian Federation
1997	***Resolution of the Government*** «The concept of health development of medical science in the Russian Federation» (from 05.11.1997 №1387)	Among the priorities identified: - provision of adequate financial resources to the volume of government guarantees; - development of the private sector in health; - increase people's interest in the preservation and strengthening of the health; - maximum medical, social and economic impact on the unit cost
1998	***Resolution of the Government*** «On approval of the state guarantees of free health care to the citizens of the Russian Federation» (from 11.09.1998 №1096)	Under the program, an attempt was made in order to balance the obligations of the state and resource provision for their enforcement
2000	***Order of the Government*** «The Concept of Health for 2001-2005» (from 31.08.2000 №1202-p)	The document notes the need for structural reforms in the health care system and change the functions of a number of medical services in order to strengthen measures to protect public health and disease prevention
2005	***The National Project*** «Health» (from 21.12.2005 №2)	The main purposes of the project (strengthen primary health care, strengthening of preventative health care, meeting the needs of the population in costly types of medical care) correspond to previously announced major areas of health care reform
2008	***Concept of Health care up to 2020*** (from 05.11.2008)	The key areas highlighted in the Concept are two: - promotion of healthy lifestyles and - the guaranteed provision of quality health care to the population

It took more than twenty years, and it should be noted changes occurred:

1. Today in Russia operating budget-insurance model of financing health care.
2. Not without problems implementing a program of state guarantees of free health care for citizens, adopted as one of the mechanisms for the implementation of the constitutional rights of citizens to free health care under the Concept of Health, adopted in 1997.
3. Developed and enacted mechanisms to ensure the additional drug supply.
4. A large amount of work carried out in accordance with the implementation of the priority national project “Health”.

However, in the financing and management of health care there are still many problems to be solved. In particular, they include:

- Dimensions of health funding from the budgets of all levels and at the expense of the compulsory health insurance does not provide the population with free medical services;
- Poorly developed competition in the market of medical services;
- Unresolved disunity of activity of agencies responsible for public health;
- Inadequacy of logistical basis of medical institutions.

At the same time, available financial and material resources are used inefficiently, increasing disparities in the provision of health care services. Meanwhile, it is known that the system of financing health care organizations determines the scope and nature of health care services delivered, as well as the hierarchical structure of the entire country's health care, from primary care (health center, clinic, general practice), and federal institutions including clinics that provide high-tech medical care. In this regard, creation of a model of financial relations, adequate to the needs of the population and takes into account the characteristics and nature of the various medical organizations in the regions of Russia, becomes a challenge. Even more relevant it appears because a multichannel budget-insurance financing which is currently taking place, is likely does not meet the direction of development neither Russian nor a worldwide science and practice of formation of financial relations in the provision of health services to the population.

Issues of budget-insurance model of financing of health care organizations are widely discussed in the recent literature, offering a vast variety of options for reform of the model (Exhibit 8).

Exhibit 8: Main streams in the health care financing reform*

The Main Streams	Authors
Emphasize the need of the introduction of an alternative approach of the organization of the health system, including public consolidation of efforts of government, business and the public	M. Fotaki, Resident expert TACIS; O. Chirkunov, V. Ivanov, A. L. Pidde
Consider a search of a balanced combination of the principles of the old and the new public management as an integral part of the reform in order to implement effective health policies; investigate on the effect of resource allocation at the level of medical services	L. M. Roshal, President of the National Medical Chamber; D. Egorenkov; P. Marquez, E. Freed, R. Atun, K. Chalkidou, V. De Geyndt, S. Salakhutdinova, J. Anderson, S. Shishkin, I. Sheiman, N. Lebedeva[24]
Believes that the modernization of the Russian health care should be primarily aimed at increasing life expectancy by reducing premature mortality from potentially avoidable causes	U. M. Komarov, Academy of Medical Sciences
It is believed that successful implementation of reforms and structural transformation of Russian medicine in practice in	A. Akopyan, U. M. Komarov, I. A. Togunov, V. N. Rybin, Y. A. Stepkina,

[24] Expert Group of the World Bank.

the first place require legal changes in health care, including giving greater clarity to the organization of the system of compulsory health insurance	A. L. Pidde
The problem of legal regulation of relations in the Russian health care system becomes a center of attention for a number of other authors	N. F. Gerasimenko, T. V. Kuznetsova, T. N. Makarova, L. V. Perekrestova, M. V. Vasiliev, O. S. Mokrova
Emphasize a key importance of payment system of medical care	L. E. Isakova, V. Z. Kucherenko, V. N. Denisov, E. A. Finchenko, I. M. Sheiman, O. Chirkunov
The basis for the modernization of the Russian health care should be changes in the provision of out-patient care, particularly in ensuring the quality and accessibility	S. V. Shishkin, I. M. Sheyman, V. M. Chernyshev, L. E. Isakova, G. N. Tsarik, M. Fotaki, M. V. Zhukova, I. Nazarova, K. N. Borisov, V. A. Alekseev[25]
The deficit of regional programs of government guarantees and high differentiation of fiscal capacity across regions result in significant differences in access and quality of health care	A. N. Borisov, A. E. Chirikova, L. S. Shilova, A. P. Arhipov, S. V. Shishkin, V. I. Starodubov, U. M. Komarov, R. A. Halfin, I. M. Son, K. A. Chernikova, E. G. Potapchik, T. V. Kuznetsova, V. V. Kookueva
A significant importance attached to the system of health care planning, as well as financial instruments such as: capitation, partial fund holding etc.	I. M. Sheiman, V. M Chernyshev, L. E. Isakova, G. N. Tsarik, V. N. Rybin, Y. A. Stepkina, V. V. Kookueva
See universal coverage of health services as a protection of the population from financial problems	S. K. Mamedova, A. A. Zhadan, K. Kessler[26]
The introduction of a single-channel system of financing health care is a direction that is supported by almost all Russian researchers	V. I. Starodubov, I. M. Son, A. V. Jurin, V. M. Chernyshev, S. V. Shishkin, N. B. Kanatova, S. V. Selezneva, V. A. Chernez, A. S. Zaborovskaya, G. E. Besstremyannaya, T. N. Makarova, T. V. Kuznetsova, I. A. Rozdestvenskaya, D. V. Piven, P. E Dudin, V. V. Kookueva, A. A. Kalininskaya, V. V. Stryuchkov

*Updated and expanded by the author based on excerpts from the article of Grinkevitch, Banin (2011).

Nonetheless, these proposals tend to be fragmented, focusing on solving one part of the common problem (for example, reducing the burden of mortality from the leading causes to solve problems of legal regulation of relations in the health care system, to preventative medical practices, etc.). This causes the regions to develop and implement their own approaches to the modernization of regional health services.

Despite such fragmentation of views on approaches to solving problems of the Russian health care system, the most topicality in this process of restructuring acquired an effective solution of the problem of resource allocation in order to improve the availability and quality of health care. This is also concern the issue of inconsistencies between the available sources of funding from the state and the implementation of guaranteed free medical assistance to the population, as well as the development of the insurance industry and the relevant regulatory framework.

[25] Professor, emeritus professor of higher education in Russia.
[26] Based on the World Health Organization (WHO) materials.

3.3 Methodological statement

The choice of the research methods was made due to the thesis argument, period of its execution and the resources available. Methodologically, we combine *empirical and archival research* initialized by Searcy and Mentzer (2003) i.e. we ground our study on the examination of both data originally generated for the research study and the consideration of previously recorded facts in order to represent the broad and the specific context of our research. The broad context is represented by the health care financing reform in Russia, and the specific context is a set of long-term target (budgetary) programs in health (the example of Orel region) we focused upon.

During the preparation and conducting of the study, we turned to the statistical data, including the data of budget expenditures effectiveness; public health expenditure data, for instance, targeted programs; to the research materials concerning the process of the public budget reforming in Russian Federation, and arising difficulties in this regard.

Furthermore, we turned to literature (periodicals) that reflects the organizational aspects of the planning and financing of health and the probable consequences of the implementation of PBBS model for health care system development and the provision of medical services, first of all from the point of performance. Thus, these studies relate to identify the nature of the transition (or the lack of itself) to a new type of budgeting.

Substantial part of our work has been associated with the preparation, administration and processing of the results of *in-depth interview*, which is an essential source of information for case study research (Yin, 1994). Conducting in-depth interview was necessary to obtain the information that can later be applied to the studied process. In this thesis we turned to the reconnaissance (exploratory) kind of interview.

We decided to apply a qualitative method so as to investigate in depth a single case, trying to get as much information as possible, considering dimensions that cannot be treated with quantitative techniques. On the one hand, this form of analysis may include a small study population, run by the simplified program and concise in terms of methodological tools. This is important in situations where the subject of study is one of insufficiently explored problems.

In this context an important source of information gathering for us was an *expert interrogation*, as one of the most appropriate for solving research problems method as well as one of the most important of the qualitative method. In Russian practice has not been accumulated yet a sufficient knowledge and there is almost no specific research studies. At the same time, the stage of transition of the budgeting system to a new model of budgeting seems to be prolonged (especially on the regional level), and in order to assess a real situation we have chosen a specialized survey. In this case the source of information are competent person which professional activity is closely

connected with the subject of our research. Expert interrogation was conducted by *interview* which implies a degree of trust between the participants, and requires considerable time.

Exploratory study provides an opportunity to get operational sociological data. Reveals people's attitudes to the actual problem or event, in our case the studied problem is *a functioning of budgeting process in public sector in PBBS' implementation context.*

In accordance to a number of participants we have identified the interview as individual, in accordance to a method of communication - as personal, in accordance to a degree of formality - as *"semi-structured"*. A semi-structured interview does not imply an available pre-prepared plan, and marked only the topic in general terms (Holsti, 1969; Seidman, 1998). In compare to a "structured", a "semi-structured" interview use to follow a predefined trace, but allowing the interviewee to move in a less limited way, so without following the trace cogently (e.g., Bichi, 2007). It should be remembered that obtaining information about the views always involves significant difficulties to achieve them, in compare, for example, to a study of facts and knowledge. So, an important issue here is a conformity of the contents of questions asked and the awareness of the respondent. In case we would choose to do a much more extensive questionnaire we would lose the influence of different levels of actors, and thus to understand all the levels we are going to select the semi-structured interviews.

A particular difficulty was related to the registration of the respondents answers. We abandoned the mechanical recording (tape) interviews at mutual will. Therefore, the main method of registration was recorded by taking notes[27].

The expert interrogation involved a participation of nine person. We felt it necessary to include in this group the representatives of legislative and executive authorities, experts in the field of economics, politics and budgetary analysis.

As a result, the group of experts included: 2 representatives - deputies of Orel regional Council of Members of Parliament; 2 representatives of the Department of Finance; 2 representatives of the Department of Health and Social Development; 1 representative of the Territorial Mandatory Medical Insurance Fund (TFOMS), 2 representatives of Public health care organization (Medical facility LPU - Regional hospital of Orel and Regional clinic).

According to the scientific potential, five people have scientific degrees and titles, including: 2 - PhD of Economics, professor; 1 - PhD of Economics, docent; 1 - PhD of Economics; 1 - PhD of

[27] Tape-recording of interviews is often suggested as a means of providing a complete description of the interviewee's responses and comments. Tape-recording can inhibit the interview, though, and reliance on tape-recordings can prevent the researcher from listening carefully and participating fully in the interview process. If the researcher is able to take rough but extensive notes during an interview and write them up in full within 24 hours of the interview, tape-recording should not be necessary (Walsham, 1995).

Medical science. Interviews with the experts were arranged in order to obtain the maximum open-ended responses to the following sets of questions:

1. What is the meaning of the term "effectiveness"? By what criteria is evaluated the effectiveness of the budget spending?
2. How the activity of various agencies (departments) is coordinated (or does not) to implement various measures of government policy and instruments for their implementation?
3. What measures to increase effectiveness of budget expenditures have been already implemented in to the planning process? If no, how ready the current budget system was for the transition to the new budget "rails"?
4. How the utilization of budget funds is being monitored in changing conditions? What problems have arisen in this case?
5. How the transition from estimated funding to program funding method is reflected on the volume and nature of the public services provided to the population?

We felt it necessary to conduct an additional round of interrogation in order to clarify some details which became apparent during the research process. So, the additional sets of questions were:

6. What are the main limitations of the planning and funding of health care today? And what are the main limitations in the implementation of budgetary programs in health?
7. How (if implemented) priorities used to be set when planning expenditures?

In this expert interrogation we also consider such aspects, as emotionality, non-verbal language etc. The processing (or encoding) of this kind of information obtained during the process of interview represent a considerable complexity. In analyzing the responses of actors we turned, inter alia, to the analytical framework of the typology of strategic responses that organizations enact as a result of the institutional processes developed by Oliver (1991).

The analysis of the regional long-term target budgetary programs in health was conducted within the framework of formal descriptive analysis of the document. For the analysis there have been involved a set of budgetary programs in health which is basically represent, together with a medium-term financing planning, one of the effective tool of PBBS implementing. Analyzing the programs, we focused primarily on the following aspects:

1. How goals and objectives have been formulated in relation to the results?
2. How the results have been coordinated to funding?
3. What are the indicators to evaluate the performance of the programs?

All in all, face-to-face semi-structured interviews were a prime source of information about the key players' impressions and cognitions. Interview guide is reported in Appendix 1.

3.4 Analytical procedure

We proceeded in the analysis following these specific steps:

1. Review of the official, formal organizational narrative on the performance-based budgeting systems. This particular step is mainly based on the documental sources we have, such as: the reporting documents (public annual reports etc.), governmental studies, and other minor organizational documents like working papers and power point presentations on the budgeting mechanism, descriptions on the Intranet web page, etc. This step of analysis is thus aimed on familiarization with the official organizational performance budgeting discourse, as well as on providing an overview of the whole case, thinking into performance budgeting principles applied not only on a government wide basis, but also on the level of regions and provinces, as well as specification of focus descriptions of each component of PBBS *as they are intended to be*. This is respond to RQ1 on emphasizing past efforts to connect performance measurement and budgeting in order to establish the criteria of the reform process.
2. Thick description of different levels of application of PBBS model *as we observed them in the field*. This part of research was based on both thematic and narrative analysis, with the specific aim to provide an analytical description of PBBS *as it reveals in practice*. In particular, we proceeded as follows. We divided all interviews by topics: how the effectiveness of budget spending is evaluated, how specific activity on budget changing is coordinated, what it consists of, who is involved, how it is linked to the public services provided, how it is monitored, etc. and how this all has changed over time and in compare with the formal side of the issue. We assessed the normative legal and methodological support of the budget process from the perspective of implementation of performance budgeting tools using coefficient method. This all contribute to responding to RQ4 on what are the preconditions to realize the benefits of performance budgeting. It is also respond to RQ2 on how the rule of PBBS' implementation is applied in practice.
3. Analysis on actors' involvement into PBBS implementation. This piece of analysis was based on interviews and actors' statements reflected in our ethnographic observations, in order to *reconstruct the local actors' own interpretations* of performance budgeting concept - in a professional logic - and it's comparison with the formal official PBBS discourse. In evaluating the actors' behaviors we used, as analytical framework, the typology of strategic responses that organizations (in our particular case they are local actors in the practice of PBBS implementation, i.e. representatives of legislative and executive power, as well as the

recipients of budget funds) enact as a result to institutional processes (in our case it is about the need to change the current approach of budgeting under the pressure of higher authorities) developed by Oliver (1991) and summarized in Exhibit 9. It thus responds to RQ3 on how do the actors make sense of PBBS discourse. It also responds in part to RQ4 on what are the basic problems that inhibit PBBS implementation.

Exhibit 9: Strategic responses to institutional processes (Oliver, 1991: 152-159)

Strategies ⟶	Tactics
Acquiesce	Habit; Imitation; Compliance
Compromise	Balance; Pacifying tactics; Bargaining
Avoidance	Concealment tactics; Buffering; Escape
Defiance	Dismissing; Challenge; Attack
Manipulation	Co-opting; Influence tactics; Controlling tactics

4. Analysis on the programs dataset. The goal was to explore the regional long-term target budgetary programs' practice (how much it is diffused, how it is evaluated, what are the approaches to programs, how they are focused to the final result and how they are linked to whole budgeting process, what are the common limitations, etc.) as a decisive tool of the successful implementation of performance budgeting based on both international and already established federal practice in the Russian Federation. This responds to RQ4 on what are the preconditions to realize the benefits of performance budgeting.

Exhibit 10 summarizes our analytical procedure.

3.5 Data sources and data gathering

Literature overview: The search was conducted using such *important keywords* as "performance-based budgeting", "performance information in budgeting", "performance budgeting in the public sector", "budget programming", "target-oriented planning" (Exhibit 11). The review on PBBS concept and those connected to it examines the main articles published on the subject since 1990s onwards in major journals circulated internationally. This time period is justified as far as the revival of the debate on PBB can be traced primarily to this period. In order *to delimit* the number of publications, empirical papers mainly addressing agencies-level were excluded from the review. Similarly, highly technical works on topics such as efficacy of government-wide performance budgeting systems, key performance indicators and planning for performance were

Exhibit 10: Analytical framework

How budgeting process in public sector is managed in a particular context of PBBS implementation? Upon what conditions this rule is implemented and what are the main prerequisites for any move to PBBS model?

Research question	Posture	Level of analysis	Data collection source	Method of analysis	Output
RQ1 *Emphasize past efforts to connect performance measurement and budgeting in order to establish the criteria of the reform process*	Interpretive		Documents	Archival	Summarizing of the official theory findings and interpretations, highlight the main research issues and opportunities
RQ2 *How the rule of PBBS implementation is applied in practice?*	Interpretive	Organization	Documents	Thematic analysis	Elaboration RQ2
		Actor	Interviews	Narrative analysis	Elaboration RQ2
		Actor/ Organization	Interviews + Documents	Narrative analysis	Thick description
RQ3 *How do the actors make sense of PBBS discourse?*	Interpretive	Actor	Interviews + Observations	Narrative analysis + Ethnographic analysis	Patterns of responses
RQ4 *What are the preconditions to realize the benefits of performance budgeting?*	Decisive	Organization	Dataset	Narrative analysis	Elaboration of programs
		Actor	Interviews	Ethnographic analysis + Narrative analysis	Elaboration RQ4
		Organization/ Actor	Observations	Ethnographic analysis	Cause-effect link of factors impeding successful PBBS implementation (case study results)

also excluded from the review. This seems to be justified when considering that the number of publications that could be found tend to be infinite when broadening the conversation on PBBS.

The *material is evaluated* in accordance to the classification context that allows to identify the relevant issues and to interpret the results. Problem context approach which was used in this research allows classifying the reviewed sources of literature, which can be derived deductively and inductively.

The *unit of analysis* has been defined as a single research paper/book. As the primary sources for this work were used the publications on the subject matter in the main periodicals (both English-speaking and Russian), major official reports available on the OECD website www.oecd.org, like OECD Journal on Budgeting, and IMF Working Papers.

The method used by us in order to categorize a wide range of literature on PBBS implementation may be classified as an archival research method in the framework for conducting and evaluating research. We *classify* the literature into three broad categories: conceptual literature concerning the importance of PBB; literature that highlights difficulties of implementing of PBB in practice; empirical literature on sectorial case studies. An in-depth literature review was conducted on purpose to summarize the findings and interpretations, and to highlight the main research issues and opportunities.

We examines the main articles published on the subject since 1990s onwards in major journals circulated internationally. This time period is justified as far as the revival of the debate on PBB can be traced primarily to this period. Naturally, we also used the materials of Russian periodicals as far as they used to reflect in an operative way the debate over the reform process of the budget system of Russia within the framework of programs to improve the effectiveness of budget spending and the various aspects of this process. They are original articles and expert opinions, statements of political figures, representatives of various political parties, published in the period from 2004 to 2012[28]. As a result, our list included: periodicals «Economic Issues», «Federalism», «Finance», «Finance and Credit», «Authority», «Russian Economic Journal»; materials of Fiscal relations research center (messengers), of The Federal Service for Financial and Budget Supervision, of Ministry of Finance of Russia; online magazine «Budget», «Problems of Modern Economics».

[28] Choosing 2004 as the start based on the fact that in this year as part of the reform of the budget process were first formed the new principles of performance budgeting.

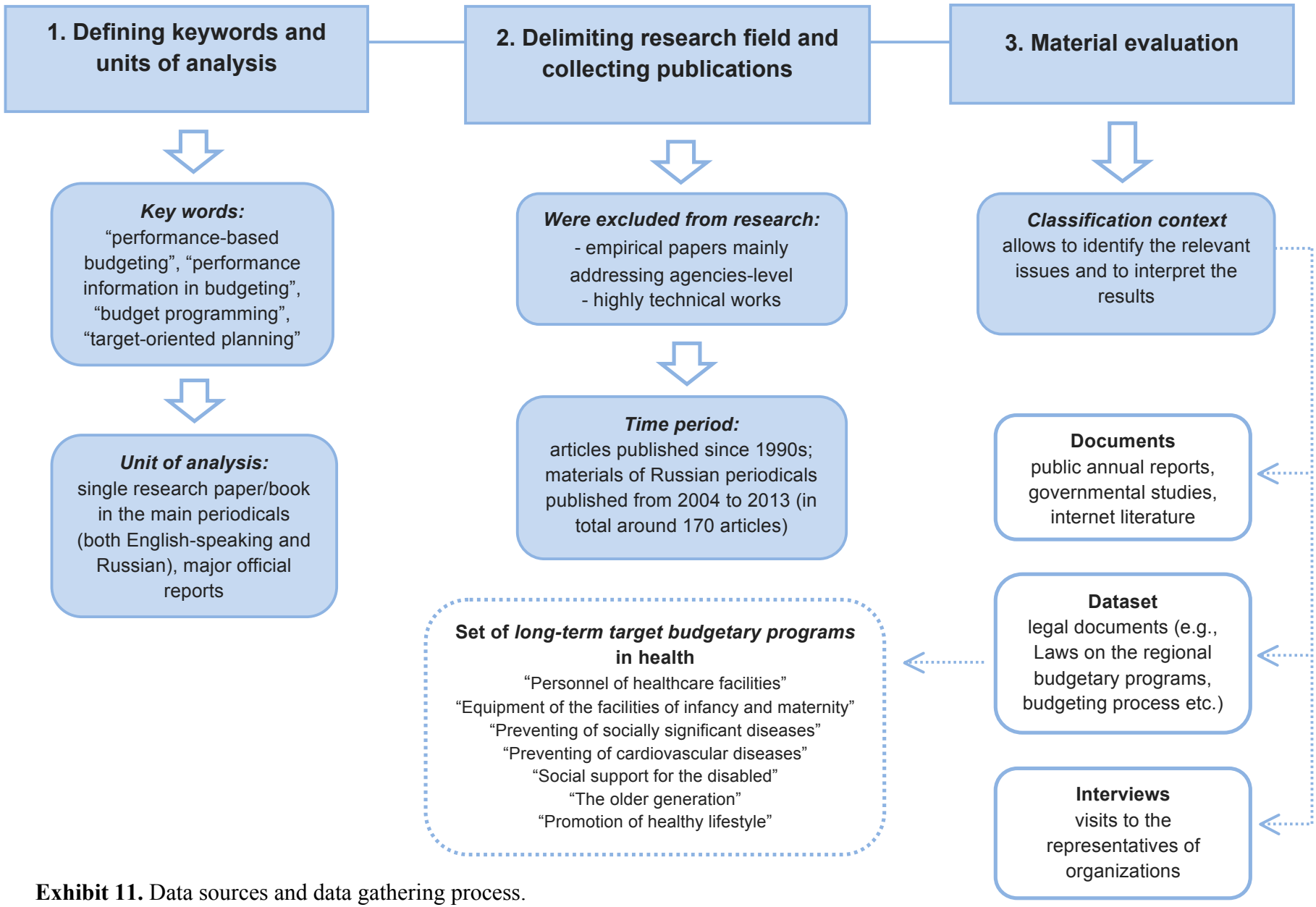


Exhibit 11. Data sources and data gathering process.

Documents: Public documentation related to annual reports, governmental studies, and internet literature were analyzed, providing important background information. We collected the documents relating to: improving of the effectiveness of budget expenditures of Orel region (Resolution of the Government of the Orel region up to 2012); concept of Regional Finance Reform (Order of the Board of the Orel region on the period 2008-2010); Program of state guarantees of free medical care in Orel region; key performance indicators of the Department of Health and Social Development of Orel region as an entity of budgeting (for 2010 and for the period up to 2012); as well as documentation related to the order of development, implementation and evaluation of public programs, including long-term regional target programs and departmental target. This served as the baseline of the research.

Dataset: We acquired a dataset containing longitudinal, quantitative and qualitative information on the projects (both concluded and in progress) proposed and carried out by professionals and other organizational members. All in all, dataset includes the following data: Laws "On the performance of the regional budget" for 2010-2011; Laws "On the budget of the territorial fund of obligatory medical insurance of Orel region in 2012 and the planning period of 2013 and 2014"; estimated budgetary expenditure (Medical facility LPU) that represents the classification of budget expenditures; long-term regional target programs with applications involving the structure of funding programs, feasibility study costs, a system of measures for the implementation of programs, the financing structure. We also turned to the statistical database on key health indicators in Orel region, and policy documents relating to the modernization of health care in Orel region in 2011-2012 with applications that characterize the target indicators and indicators of modernization program and a system of measures for its implementation.

Interviews: The visits to the organizations provide significant data for analysis, in particular interviews, including interviews with politicians (represented by deputies of Orel regional Council of Members of Parliament), clinical directors and technicians (represented by of the department of Public health care organization (Medical facility - Regional hospital of Orel and Regional clinic) and representative of the Territorial Mandatory Medical Insurance Fund (TFOMS), and administrators at various organizational levels (in particular, they are representatives of the Department of Finance and of the Department of Health and Social Development). These key actors have different positions within the organization, and different roles: as part of the project team (preparation of the draft budget), as users, or as external observers. The interviews conducted in such way expand a coverage area and help to maximize reliability of data, and thus, the results of the research.

4. Health care financing reform in Russia: a critical assessment

4.1 The organization and financing of health care system in the USSR

In recent years in the scientific literature dedicated to health care issues, almost on equal terms, there are several points of view. On the one hand, they express (equipped with a set of evidence) the notion that health care continues to be in crisis, defines the parameters of the crisis and proposes mechanisms for out of it (Komarov, Ivanov, Chirkunov, Roshal, Vasiliev, Mokrova, Lebedeva, Isakova, Fotaki, Alekseev). On the other hand, there are statements that there is a need of systemic reform of health care in the direction of strengthening of the role of health insurance and the transition to a single-channel funding, which requires legislative improvements. First of all, such improvements concern the sphere of redistribution of financial resources, as well as creating and improving of the functioning of relevant infrastructure of medical and insurance organizations, and improving of the state guarantees in order to provide free medical care and changes in the system of its financing (Akopyan, Pidde, Shishkin, Son, Starodubov, Kookueva, Selezneva, Chernyshev, Kuznetsova, Stepkina). There are also proposals for a return to the old health care system, which existed in the USSR.

4.1.1 Overview of health care organization. Principles of Semashko

According to experts, health care system in the Soviet Union was, if not the most productive, one of the cheapest and most profitable for the state, the largest in the world in the number of doctors and hospital beds (in 1988 in the USSR per 10 thousands residents had 131.3 hospital beds, in the United States - 51.2), and prefigured the national Health Service in the socialist state.

Health care system laid by the first Soviet People's Commissar Nikolai Semashko (1874-1949) was based on a few ideas: common principles of organization and centralization of the health care system; equal access to health care for all citizens; priority to motherhood and childhood; unity of prevention and treatment, elimination of the social bases of disease, Involving the public in the case of health care. All these ideas were developed by many leading physicians, both Russian and the world since the end of the XIX century, but the basis for public policy, they were first laid in Soviet Russia.

For the first time in the world in order to manage a centralized health care system across the state was organized a special organization - the People's Commissariat of Health, which has had in

charge all departmental, rural and health insurance institutions. Concentration of resources in the hands of one agency allowed, even with limited funds (and this problem is pursued a Soviet medicine all the years of its existence), to reach sufficiently serious results, at least in overcoming traditional infectious diseases, serious reduction of maternal and infant mortality, prevention of social ills and provision of health education.

There was created a network of secondary and higher education and academic medical institutions, medical-technical and pharmaceutical organizations with the purpose to ensure the functioning of health care system. Was built a system of medical institutions that ensured uniform principles of health care organization for the entire population: Midwifery Centers (FAPs) – District Clinic - Province Policlinic - Regional Hospital - Specialized Institutions.

There was created and functioned a network and structure of the authorities and institutions of health, was prepared a personnel potential, the population was provided with full based publicly available, qualified medical care on the basis of applicable at that time medical technologies. The access to health care was provided by the fact that medical care was free, and all citizens were attached to the district polyclinics domiciliary and in accordance to the complexity of the disease could be sent for treatment to the higher levels of the health care pyramid. Was organized a specialized system of medical institutions for children, which repeated the system for adults, from the district clinic to the specialized research institutes. For the purpose to support motherhood and infancy the same vertical system was organized - from antenatal clinics and maternity district clinics again to specialized institutions.

Were eliminated many diseases, as well as reduced performance indicators in many kinds of diseases (Chubarova, Shestakova, 1999).

All medical assets were owned by the state, the development of the system was carried out in accordance with centrally develop plans (Kaser, 1976; Ryan, 1978; Davis 1989). Public health facilities provided all kinds of medical services. Private medical activity was permitted only to a very limited extent.

National Health Service in general was governed by the Ministry of Health, but about 10 other ministries (e.g., the Ministry of Railways and the Ministry of Defense) controlled "departmental" subsystem of health care. Each of the 15 republics had the Ministry of Health, which run the establishment on its territory. The republics were divided into regions (areas) that had provincial health departments. Medical services in large and medium cities were controlled by city health departments. Cities and rural areas were divided into districts, and medical facilities were run

by the district health departments. Despite the fact that all medical facilities were state-owned, management was largely fragmented, since facilities were run by municipal and departmental authorities.

However, all the medicine could not be included into a single system. Along with health care facilities, administratively subordinate to the Ministry of Health and the Russian Academy of Medical Sciences (RAMS) with appropriate funding, a differentiated medical care was formed (for example, for the armed forces, railway men, miners, etc.) and so-called Fourth main nomenclature of the Ministry of Health of the USSR, which was equipped with personnel and equipment are much better than others.

Another level of differentiation is geographical: the city and the village still have significant differences in the provision of medical care. In the USSR, the average consumption of health care services (e.g., visits and hospitalization) was quite high, but inside the country there was a significant regional disparities in terms of health status and consumption of services, these figures varied considerably among 15 republics and 120 regions, which were parts of the USSR[29]. Differences in the quality of health services and consumption reflect differences in levels of public funding. For example, expenditure on health was above average for the population in the departmental subsystems, industrial enterprises and large cities and below average in the subsystems of medium-sized cities and rural areas (Davis, 1988).

Ministry of Health, above all, was responsible for the preparation and implementation of plans for the development of health care system. Planning and financial department of the Ministry in collaboration with the Office of Health and Medical Industry of the USSR (State Planning Committee) has identified common tasks for subordinated organizations, together with planning methodology, which included 2000 indicators and benchmarks, combined in to 17 groups (Popov, 1976). Planning and financial department of each of the republican Ministry was formally responsible for planning health in its territory, but in reality its activities was strictly controlled by central ministry. In accordance with centrally deployed targets, natural and financial standards and wage rates, regional planning departments of urban and rural district health authorities developed detailed plans and budgets of health care industry. Thus, the system as a whole can be characterized as a system of central planning, but organizationally fragmented.

[29] Wherein health indicators were significantly more varied by region rather than in the republics. And the differences between regions within regions were even more. Quality standards were also higher in the elite, departmental medical facilities and medical facilities of large cities, compared with facilities of medium-sized cities and rural areas.

4.1.2 Fundraising and its sources

An important feature of the Soviet health care system is that it provides a comprehensive universal health care, the free entitlement to which was guaranteed by the constitution to every citizen. Accordingly, officially all kinds of medical care were free[30].

The main source of funding for health in the USSR was the state budget at different levels. So, the Republican health care facilities functioned at the expense of the national budget, and the rest of the facilities - due to the budget of the areas in which they were located. Most of the revenue was collected through general taxation at the local, regional or Union level. At the same time, in financing of health care were involved various ministries, departmental system containing medical institutions, as well as large enterprises (industrial and agricultural), which provided their employees with health care according to the workplace. In addition, medical institutions received small amounts of direct payments made by the individual patient for some medical services (e.g., medical examinations for the purpose of social security). Insignificant part of the direct payments for health care services went to the general budget of the Ministry of Health from subordinate authorities as a tax. Ministry of Health and Ministry of Finance of the USSR aligned health financing between the republics and supported the all-Union health programs.

Health care funds were allocated in accordance with the five-year and annual plans. These plans defined the order of current and capital expenditures, expenditures on science and industry development, training and development, production of medical equipment and medicines, medical service and public health[31].

Unification of funds was vertically integrated with the purchase and supply of services through hierarchically defined budget process (Babanovsky, 1976). That is, the structure of the unification was also reflected in the procurement process, and organizing services (Exhibit 12). At the federal level, the state determines the distribution of tax revenues allocated to health care financing for the unification at the level of the Ministry of Health, departmental health systems, as well as some large enterprises (mainly to cover capital costs). Ministry of Health allocated funds to the subordinated health facilities, to 15 Republican health ministries, departmental health systems (to cover the cost of a certain kind of activity), as well as large enterprises (for current expenditures, such as salaries of medical personnel).

[30] This applies only to received outpatient medicines, while preferential groups of citizens (children, pregnant women, senior citizens, disabled, war veterans and others) were exempt from these costs.
[31] Health education, disease surveillance, and so on.

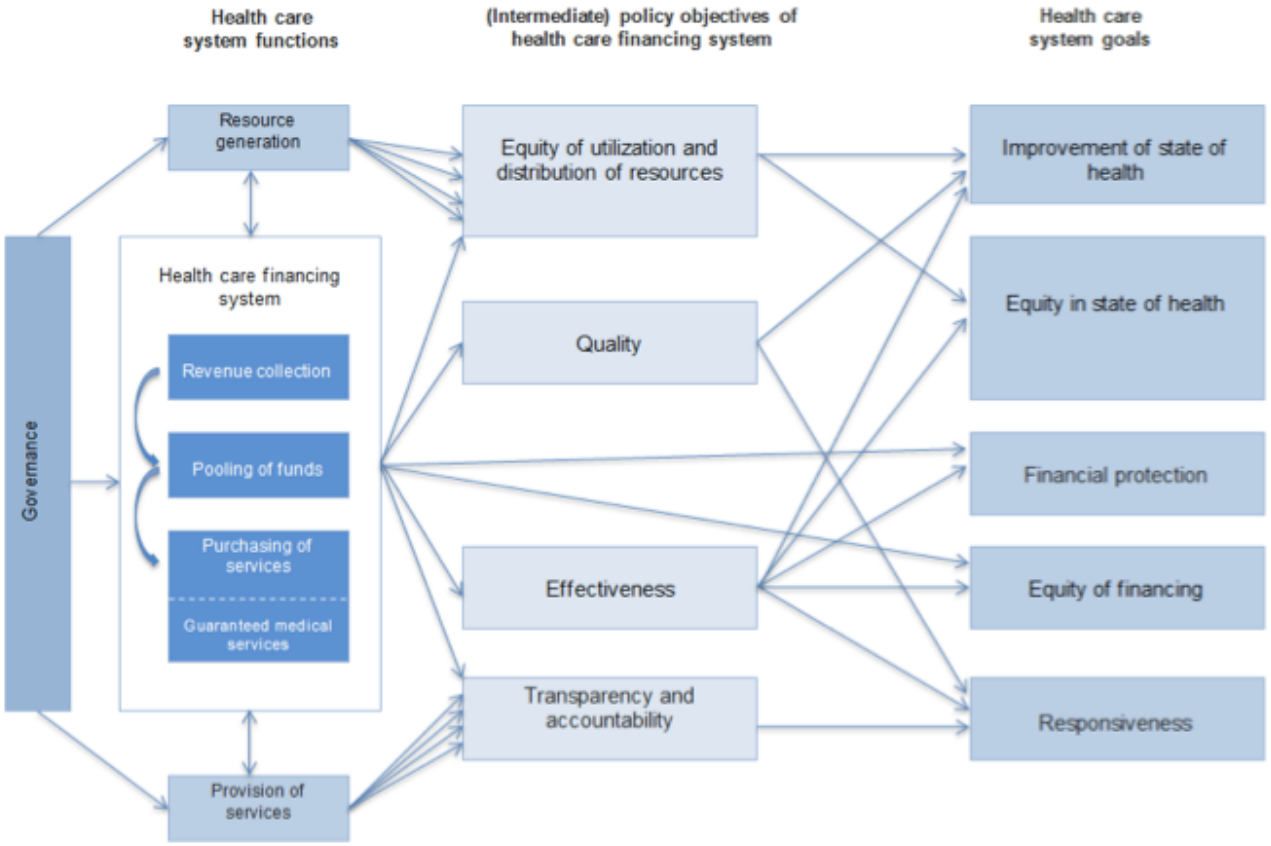


Exhibit 12. Relationship between financing system of health and its strategic objectives, the other functions of health care system and the goals of health care system as a whole (Kutzin, 2011).

Every Republican Ministry of Health allocated resources from its budget to republican medical facilities (for example, specialized hospitals), to the provincial departments of health management (Vinogradov, 1962). These last distributed the funds to the regional medical facilities, as well as to urban and rural health authorities subordinated to the region. Last distribution was carried out at the level of specific medical facility (policlinic, dispensary, hospital), which was subordinated to the lowest administrative level.

As a result, the structure of unification was highly fragmented – one the one hand, and, on the other hand, duplicated the geographical coverage. For example, regions included cities and provinces, republics included regions, and so, the same communities could be served by facilities subordinated to three different authorities. Consequence of vertical integration of medical care was duplication of medical facilities (for example, in many regional capitals functioned children's hospital and a specialized children's hospital).

Heads of medical facilities were formally responsible for the use of the allocated resources, but had a strictly limited control over the distribution of their budgets. Funds could be automatically

deducted from the account upon receipt of goods or services planned. Due to lack of markets supervisors could not use budgetary funds at their own discretion to purchase goods and services, and could not freely transfer funds from unspent budget items for the cost of another item. Considering these circumstances, management activities in the financial sector was of secondary importance.

4.1.3 Problems of the system. Health care financing from a position of goal achieving

For all its harmony, causing interest and many followers worldwide, health care system in the Soviet Union had some negative sides.

If on the first stage of the development of the idea of social conditioning diseases greatly helped in overcoming infectious diseases, further it caused unreasonably high hopes for social measures of prevention of diseases such as cardiovascular disease, cancer and many others, the causes of which are only partially dependent on life conditions.

Being attached to a particular doctor and certain hospital, patients actually were deprived of choice, making it impossible a competition between medical facilities and, in turn, caused a lack of attention to the needs of patients. Main health care expenditures (around 80%) were invested in inpatient care (which was seen as a major weakness of the organizational model of the Soviet and then Russian medicine), despite the fact that the most widespread type of medical care is a pre-hospital care, where normally used to begin and end treatment of 80% of patients. Gradual reduction in outpatient clinics began in the early 1990s, and in the following years, their number continued to decline (Exhibit 13).

Exhibit 13: Dynamics of values of outpatient care

	1985	1989	1990	1992	1993	1994	1995	1996	1997	1998	1999
Number of medical institutions providing outpatient care (in thousands)											
All Dept.	19,4	21,1	21,5	20,7	20,9	21,6	21,0	21,1	21,7	21,1	21,1
e.g., Ministry of Health system	17,1	-	18,9	19,0	19,0	18,8	18,8	18,6	18,2	18,0	17,8
Average number of visits per 1 inhabitant											
	11,1	10,0	9,5	9,0	9,2	9,2	9,1	9,1	9,1	9,1	9,3

Source: Goskomstat (State Committee on Statistics of Russian Federation).

It is believed that the main problem of the Soviet public health care (as well as modern Russian) was a persistent underfunding, which became more perceptible with the complexity of medicine and in rise in prices to it, whereupon, many modern therapies and medicines in the Soviet Union did not develop or were simply inaccessible for Soviet citizens.

As some authors point out (e.g., Nazarova, 2006), referring to official statistics[32], it is appear to be difficult to determine an exact volume of financing of health care (as a percentage of GDP) in the USSR, primarily due to the incompatibility of data. Likewise, it should be taken into consideration the complexity of capturing all the financial flows. Furthermore, if the expected results and volumes (and value) of services required to achieve these results are not described, the amount of funding requested cannot be reliably determined. Nevertheless, it cannot be denied, that if in the 1960-1970-ies health care funding was quite satisfactory, making about 8-8.5 % of GDP, then in the last years of the USSR it was reduced to 3-3.5%. The average salary of employees in health care, calculated relatively to the level of wages in all sectors of the economy, fell from 82% in 1965 to 70 % in 1985, despite the fact that the average level of education of employees in this sector was one of the highest among all sectors[33].

Reduction of the rate of spending growth primarily indicated the aggravation of the economic situation in the country. In scientific publications in recent years there are also common opinions on low priority of the Soviet health care as industry. It is assumed that this situation was a result of the so-called residual funding, which means that health care and social services receive funds only after the priority sectors, were provided with financing, which include defense, industrial development and other. Indeed, financial standards which serve to determine health care expenditures (such as expenses for capital construction, maintenance of buildings and the purchase of other materials) were set at unrealistically low level (Davis, 1989), which has had an important consequence for strategic purposes[34].

However, the term "residual financing" in this case may be used in an inaccurate way, taking in to consideration the fact that dynamics of the total public expenditures on health (inflation considering) suggests that public funding of the post-Soviet period had never reached the level of Soviet period. The same inaccuracy use concerns the assertion that the main weakness of the Soviet health care system was the neglect of the effectiveness as such.

[32] Social development of the USSR. The statistical data base, Moscow: Finance and statistics, 1990.
[33] At 2.3 times higher than the average for all industries.
[34] For example, in the early 1980s in the USSR standard pharmaceutical expenditures per patient day was 90 cents.

The term "effectiveness" in the sense in which it is interpreted today, was absent. Rather, the effectiveness was replaced by the goal of the execution of a plan, where the percentage of its execution actually served to measure the performance. After 1945, the population in the USSR needed to be ensured in overall comprehensive health service, and the solution of this problem in conditions of deficit of hospital beds and doctors, was possible, first of all, due to the intensive capacity increase. That is, with the increasing of quantity, performance indicators tended to improved (there was an increase in fertility and decline in mortality). Subsequently, trend of increasing capacity is remained, that along with worsening economic situation was the cause of decline of health care performance.

Funds were allocated to medical facilities on the basis of their occupation, which actually caused the "distortions" of the interests of the medical facilities, compromising the quality of medical services. Specifically, this situation could be expressed as follows.

The main indicator of occupation in hospitals were patient days, and in outpatient clinics such indicator was outpatient visit. In turn, this contributed to the excess of medical staff and hospital beds. They used to “absorb” major part of health care budget, while the appropriate investment in improving of the effectiveness of health services was not made.

At the end of the year, each hospital reported the actual occupation of the beds in the past year, on the basis of which received funds for a next year. Ultimately, for the hospital was advantageous to use as many beds as possible, to occupy them as long as possible and spend herewith for the treatment of complex cases less effort. Thus, in the period from 1970 to 1985, the number of physicians has increased by 75%, and hospital beds – by 35%. The number of doctors increased from 1.5 doctors per 1,000 population in 1950 to 4.2 in 1991, the number of hospital beds increased from 5.6 to 13.1 per 1,000[35]. On the one hand, considering the immense territory of the state, the country was fairly evenly provided by physicians and hospital beds. At the same time, the quality and potential of medical care was far less uniform (see the example above with the geographical differentiation). Increasing of the number of health care facilities, personnel and medical services were in line with the extensive development strategy and supporting this strategy fiscal incentives.

As for the clinics, their funding depended on the number of outpatient visits, which encouraged physicians not to engage patients and refer them to the next level of medical care. Thereby, clinics are really treated with less than 50% of patients who applied to them (which are

[35] For comparison, in the United Kingdom, the number of physicians was 1.6 doctor in 1991; number of hospital beds - 5.4 beds per 1,000 population.

then sent to the hospitals, where for the reasons mentioned above stayed for a long time, waiting for operations and medical examination). In the late 1980s, an average of one person had an average of 10 visits per year, the level of hospitalization was 20 admissions per 100 people, the average length of hospital stay was 19 days.

Consequently, the planning was based exclusively on the capacity of medical facilities, the funds were actually spent in vain and the quality of care suffered. Because of distorted interests of medical facilities, health care system was primarily a therapy-oriented, in which the principal place was occupied by hospitals, while the development of medical services was "unprofitable." Moreover, the fact that medical employees used to receive a fixed wage regardless of the progress made and the charge, did not contribute in improving health care. Since the responsibility of the Ministry of Health did not include the collection of statistical data on the costs of individual diseases, the actual cost of medical services, flows of funds outside the administrative units, the consumption levels of individual medical services and others, results of health care functioning were not announced.

Therefore, the main weaknesses of the Soviet health care system reflected, firstly, the weaknesses in the process of planning and budgeting; secondly, the existence of incentives for unsustainable build capacity ("quantitative incentives"); in third, the lack of competition between health care providers and, finally, the declines caused by the unsatisfactory performance of deficit economy. Thus, the increase of quality and effectiveness of diagnostic and medical service was missed. All these aspects of health care system remained at a relatively low level in compare to Western European countries.

The lack of interest as such in the discussion of the effectiveness of health care sector was due to the fact that this would inevitably require additional financial resources from the state. Weaknesses of health care, caused by underfunding, perceived as weaknesses of health care system as such. As far as health care budgets were a reflection of the health system development plans at each administrative level, and financial flows were mechanically determined by planning system of quantitative indicators, the issue of effectiveness in the management of funding was not considered so important. Deficit of qualitative medical services and medicines generated the need to pay for the best services, and the conditions of the crisis erupted in the entire system made it almost impossibly to eliminate the underfunding.

Nevertheless, according to experts, the Soviet method of financing of health care can be considered as a relatively fair, because the finance industry was almost entirely public, functioning

through general taxation or taxes on profits of enterprises, whereby in the USSR was achieved the goal of universal protection of the population from impoverishment due to illness. As it was noted earlier, most of medical services and medicines at inpatient care was provided to the population free of charge, the state subsidized medicines dispensed in outpatient care by prescription, and provided its citizens adequately paid sick leave and disability pensions. In reality, however, patients often had to pay for hospitalization or inpatient care, though not officially (Knaus, 1981; Sampson, 1987).

4.2 Motivation of changes in the Russian health care: chronology of the national reform

Since the early 1970s there was a gradual decline in budgetary funding of health care. A significant number of hospitals required rebuilding, equipment was physically and obsolescence out of use. Low wages of health employees provoked a spread of shadow business, such as the illegal payment of medical services by patients, speculation of rare medicines etc. The crisis in health care system was aggravated by the overall crisis of the economy[36].

Funding of clinics was regulated by number of outpatient visits, and hospitals – by patient days. This led to the practice of increasing the number of visits by each patient in an outpatient care and to lengthen the period of treatment in hospitals. Medical facilities was characterized by the disproportionate development of the most asset-intensive and expensive medical technology. The existing order of funding did not contribute to the intensification and effectiveness of work of medical personnel.

All this, as well as the funding gap identified the need to reform the health care industry. By the beginning of reforms, the existing system has been criticized, and as a way out of the crisis proposed the decentralization, which could increase the responsibility for the health of the population. The Ministry of Health was seen as a monopoly, and among the measures were offered a de-monopolization of health care facilities. Along with the development of private medicine, it was decided to introduce health insurance (both compulsory and voluntary), which meant the launch of market mechanisms.

First and rather modest attempt (in 1982-1986) to reform health care were ***experiments to increase the intensity of use of hospital beds of medical facilities*** by improving the diagnostic and treatment process. They were based on the empowerment of the rights of supervisors of medical

[36] This was due to the fact that up to 30% of health care facilities by the end of the 1980s contained by enterprises, organizations, collective farms and state farms, which are due to the economic crisis of 1993-1994, almost stopped to provide funding for these purposes.

facilities to change both the staffing ratios and the standards of workload and its financial incentives. For this purpose in medical facilities were created relevant funds. Increasing of intensity of hospital beds was carried out by material incentives of personnel without changing of financial and economic mechanism, so these innovations cannot be regarded as a prototype of health care reform. Under the experimental conditions the unit of payment become not the actual, but normative presence of patient in the hospital: a patient cured in a shorter period brought savings, on the contrary, his presence on the bed longer than the normative time was supposed to pay out of the fund. Hospital stay decreased by 1.5 days, bed turnover increased by more than 5%. In this situation, the question whether to hospitalize a patient, was not the main, and often hospital beds were occupied by "easy patients" - those who can be cured in a given period.

Next (1987-1991) was made a second, more serious step - introduced a ***new economic mechanism*** (NHM)[37]. It was then that for the first time was clearly expressed the need to pay not for a detailed chain of medical facilities, but the final results of the them.

Transition to economic methods of management involves changing the system of performance of health services primarily to the transition to the estimates by the end results (preservation and promotion of health, resource efficiency, social satisfaction, etc.). Requirements for the performance of health facilities and their departments are expressed as normative values of final outcomes.

The idea of the NHM was to use economic methods of management so that to enable health authorities to actively search for internal reserves and the most rationally expend funds. At the same time emphasized that the application of cost accounting principles in health care should be directed primarily to better meet the needs of the population for health care and only then for additional income, and ultimately strengthen the role of primary health care.

Funding at the territorial level under NHM performed according to the standard per inhabitant per year, and health care facilities received funds per unit of volume of activity: hospital - 1 patient treated, clinics - one attached to the resident, ambulance service - at 1 call, etc. The magnitude of norm of budget funding for the territories had to be determined differentiated, taking into account the needs of the population in medical care.

Clinics and hospitals were separated, and the holder of the basic funds under the new conditions was the outpatient service, which was paying for other medical facilities for inpatient treatment, consultation, ambulance and other types of medical care.

[37] New financing methods have been tried in St. Petersburg, Samara and Kemerovo regions.

In Kemerovo region clinic[38] began to receive funds based on per capita and acted as buyers of medical services for the people assigned to them. The budget of clinics considered costs for diagnostic tests, hospitalization, outpatient and emergency care. In hospitals and clinics set up independent medical associations who owned their own budget and were able to financially encourage their staff. To control the quality and methods of treatment have been established economic health standards designed to prevent cost savings by reducing the amount of necessary medical services. Salaries of medical personnel began to be affected by the labor participation rate, which takes into account the number of days of disability, delayed diagnosis, the amount of the vaccination, complications of disease, patients with claims and other indicators. The rate was used in order to compare the results of work within the team. Premium was also paid on the basis of the rate, although its calculation did not include the indicators of the quality of medical care.

The idea was to prevent the unnecessary hospitalizations. In such circumstances, clinic was interested in providing qualitative medical care to the maximum extent on their own.

So, primary health care facilities has obtained the opportunity to keep any saved funds. It was assumed that there should be a change of the structure of medical facilities with a primary development of pre-hospital forms of activity, as well as reduce of unnecessary referrals to specialists.

As the load on primary health care increased, the structure of specialized medical care changed. Departments of general surgery, children's and traumatological departments reduced the number of beds, and narrow-profiled departments, particularly cancer department - increased. In Samara region as a result of reforms, average length of hospitalization decreased by 7% and bed capacity - 5,500 beds.

Resulting savings were directed, in some cases for the creation of information systems and training, in others - for the purchase of new diagnostic equipment and personnel support.

However, the procedure of financing of medical facilities wore quite controversial character. So, in new conditions funding of hospitals was practiced on the basis of cost per patient day and the average duration of hospital stay, calculated for different profiles of patients. Wherein, the cost of patient day was taken into account empirically, on the basis of available, but not required resources. At the same clinics have got hard a rigid motive not to refer patients to the hospitals that could cause a risk of the lack of medical care. Thus, by "appropriating" the financial resources from the hospitals, clinics shared them within ourselves, and not the fact that the a distribution contributed to improve the quality of medical services. There was a need to move to ***fundholding*** not by clinics,

[38] Located in the south of Western Siberia, has a population of 3.5 million people, a developed industrial region.

but general practitioners (family doctors), which was considered as one of the main objectives of the NHM in relation to the priority development of primary health care.

The choice of general practitioner had to become a real guarantee of quality medical service for a patient, and the in case of dissatisfaction, he has the opportunity to move to another practitioner along with the insurance coverage. As Chirkunov (2011) points out, the problem in this situation is that a fund holder is primarily interested not in those patients which are constantly provided with his service, but the patients attached to him, those who never sought a medical care as they are healthy. Evidently, the consequences of the introduction of a tool such as "fundholding" it are too early to analyze today because of the relatively short period of its application. Most likely, they will be linked to the fact that the project “fundholding” is not based on actual cash flows, but on calculated models.

On the conclusion of analysts, the realization of full potential of new forms of management in health care failed because the question of the elimination of a residual principle of financing health care remained outside of the scope of the reforms. Amount of budget allocations according to the norm per capita determined by limited possibilities of budget, rather than the real needs of funds for the providing of qualified medical care. On the other hand, motivational mechanism of work of medical workers did not obtain a proper development, moreover, the center of gravity of the performance of health care began to move primarily in the economic sphere. Not always financial incentives combined with the results of labor, especially in hospitals, where funding was based on the patient treated, and control of the quality of medical care is rather subjective. Moreover, in such situations an asymmetry of information between physicians and patients is most pronounced due to the fact that doctors know about the disease and its treatment methods much more than patients.

In health care, as generally in the USSR economy of that period, market mechanisms represented a main lever, which could be run during the implementation of the ***compulsory health insurance*** (CHI)[39], where new market structure, such as insurance companies and health insurance funds, were independent of medical institutions intermediaries between doctors (medical services providers) and patients (buyers of medical services). The intention here was to make the intermediaries control spending by health care facilities, that should lead to the reconstruction of the health care system. Thus it was assumed that the insurance companies, by paying hospitals and clinics the cost of provided medical assistance to the population, should be economically interested

[39] Law "On Health Insurance in the Russian Federation" was released in 1991. The law was revised and 2 April 1993 replaced by a Federal Law, served as the basis for creating health insurance system. The law provided the introduction of two types of medical insurance: compulsory and voluntary.

in protecting the interests of patients. It was hoped that there would be competition between insurance companies as in the fight for consumers, and the providers of medical services.

Since 1992, changing the order of formation of budgeting. Health care expenditures were mainly determined by the level of economic development of regions regardless the actual needs. Inequalities in regional health care financing automatically lead to the reduction of opportunities for alignment at the expenses of the Federal Mandatory Health Insurance Fund (FMHIF). In most regions, hospitals and clinics were funded from a variety of sources: local budgets and mandatory health insurance funds (MHIF) that complicated the whole process of control and organization.

The introduction of mandatory health insurance since the very beginning held in the situation of increasingly unbalancing between economic and social systems of society, which undoubtedly contributed to the reduction of the expected socio-economic impact[40]. On the one hand, was laid the real mechanism of reforming and state regulation of health care in the transition to the market economy, and on the other, all levels of management showed obvious problems and disadvantages of the legislative, organizational, technological and psychological nature which has become an obstacle of the reform process (Reshetnikov, 2001). There was a partial duplication of functions of CHI funds and health care authorities. Funds moved along the extended chain, which is not always contributed to bring them up fully to patients (Exhibit 14). Significant financial resources were dedicated to the maintenance insurance funds and insurance companies. Different principles of financing of health care facilities (from the budget and from the CHI funds) impeded planning of health care costs, eroded economic and legal responsibility for the provision of specific types of medical care to the population, and contributed to the financing of excessive capacity of health facilities, regardless of the actual amount of work.

Health Care Reform with the beginning of the 2000s, composed not only by economic but also social reforms. Currently, as main directions of reforming of health care industry were highlighted the improvement of regulatory and legal framework as well as financial and economic mechanism, scientific organization of medical care providing, including the use of evidence-based medicine, the formation of attitudes among the population in favor of a healthy lifestyle and perception of health as the most important value in life.

Thus, systemic health care reform at the present stage involves at least three mandatory components:

[40] Content analysis of medical literature of the period 1997-1998 shows a lot of conflicting opinions about the ways to reform health care system. In most cases, representatives of the public health system had a negative attitude to this innovation, and representatives of the mandatory health insurance tried to prove that this is the only way of salvation of health care sector (e.g., Ivanova, 1997).

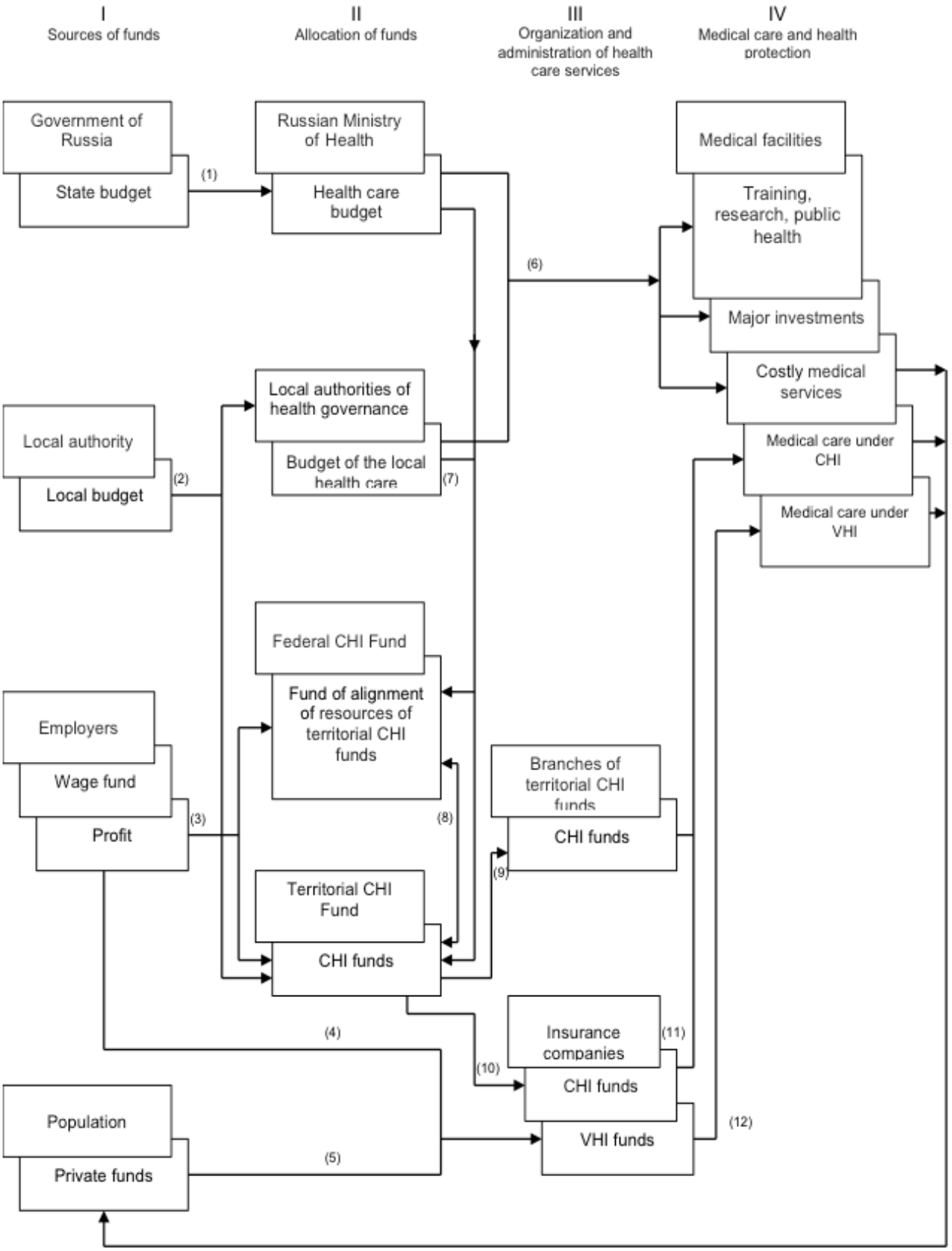


Exhibit 14. Health financing scheme, the statutory Health Insurance in Russia[41].

[41] H. Barnum, D. Chernochovsky, E. Potapchik (1993). *Abbreviations:* CHI - compulsory health insurance; VHI - voluntary health insurance.

- Financial and economic reform, including the restructuring of the health care industry;
- Improving the quality of health care management on the basis of scientifically grounded management technologies;
- Development of medical practice based on the principles of evidence-based medicine and on the results of clinical and economic analysis.

In fact, the need for reform of the financial and economic system of health care, the essence of which is the ***transition from cost management***, i.e. budget funds and mandatory health insurance funds to ***results management***, comes to the foreground. Wherein, the basis of the forming of expenditure of funds should become a "clearly defined objectives and quantifiable results of operations, as well as planned and agreed by all stakeholders workloads of medical facilities" (Tatarnikov, 2006).

4.3 Present mechanism of planning and financing of health

4.3.1 Difficulties of interpretation of findings

Solving of the problems of health financing has become one of the most important conditions to ensure the health of Russian citizens, especially as the current state of health care system in the country is considered by many experts as a crisis (Rimashevskaya, Migranova, Molchanova, 2011).

> *... According to an Internet survey conducted from November 2009 to January 2010 by Ipsos and statistical agency "Reuters", less than 30% of Russian citizens were satisfied with the services of the Russian national health system. At the same time the highest level of confidence in medicine has been demonstrated in countries such as Canada (79%), Sweden (75%) and the U.S. (51%).*

> *... In Russia there are about 50 000 hospitals, 43% of which are in need of repair, 30% - are in an emergency conditions. 57% of the equipment have been used for more than 10 years, of which 12 000 units of medical equipment need to be replaced.*

Unfortunately, not all financial flows in Russia can be registered, and therefore it is not appear to be possible to set the actual volume coming in health facilities. Data on the costs of departmental health are not available, information about the level of funding for regional health care are not always accurate, the inflow of private funds is mostly not registered – these are the main obstacles, as experts point out, of the definition of the actual costs of health care in Russia (Tragakes, Lessof, 2003). In addition, revenue accounting of hospitals and clinics from paid services is weakly organized. It is difficult to calculate even means that the population officially

spends on health care (especially medicines). Obtaining of a reliable data is also difficult due to the inflation, as well as due to the changes in the public accounting.

Due to all these data gaps and inaccuracies, the level of funding as a percentage of GDP is seriously diverge. According to the Foundation "Center for Strategic Research", the amount of public funding for health in the transition period (i.e. during the period 1991-1998) has decreased in comparable terms by more than 30%[42]. According to the source of the project TASIS, calculated on the basis of the needs identified by analyzing the level and structure of morbidity (as well as demand for certain medical services), for the period 1998 actual expenditure on health accounted for only 53% of the required amount. According to the estimate of the Institute of Economic Forecasting of the Russian Academy of Sciences, calculated by taking into account the dynamics of prices for various types of costs the health care industry, the volume of public funding declined over the same period by 76%. According to the same source, the amount of public funding on health in 2000 was approximately 3% of GDP[43], with public funding at constant prices decreased to 80% of the 1991 level.

Provided by the database "Health for All" of the WHO Regional Office information does not reflect fully the amount of financing of Russian health care as far as it consider only public funding (from the budgets and CHI funds) and does not include the costs of departmental health care[44], as well as expenses relating to individual voluntary health insurance, not to mention the informal costs. More realistic data is represented by "World Health Report", but it seems to be that the costs of departmental health are not taken into account as well. Additional difficulties arise when trying to compare health care expenditures in Russia with similar expenditures in other countries due to the fact that the official Russian statistics operates indicators different from those adopted in the OECD countries.

Although it is extremely difficult to obtain precise figures, it is obvious that after the collapse of the USSR, public health financing in real terms has decreased (Exhibit 15).

Dynamics of the total public expenditures on health, taking into account inflation, suggests that public funding of the post-Soviet period, had never reached the level of 1991. Growth of total public expenditures in 1993 (partly due to the introduction of CHI) later was quickly changed to their fall, and in 1999 their value was only two-thirds of the 1991 level.

[42] From the budgets of all levels and compulsory medical insurance funds.
[43] This value was lower than the recommended WHO social norm of 5-8% of GDP.
[44] It is assumed that the departmental health system, organized by a variety of ministries and enterprises to serve their employees, consumes up to 20% of the federal health budget, while to estimate extra to budgetary funding appears to be difficult.

Exhibit 15: Dynamics of public spending on health in real terms*

Source	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Total funding of health care	***100***	***80***	***108***	***98***	***72***	***71***	***81***	***67***	***67***	***71***
Budgetary funds	100	80	91	81	59	57	65	51	51	55
Compulsory health insurance funds	-	-	17	17	13	14	16	16	16	16

Source: Shishkin, S. Russian health care reform. Moscow, TEIS, 2000.
* The level of funding in 1991 is taken as 100%.

4.3.2 Budgetary health care financing in Russia today

According to official statistics, the Russian health care is mainly financed by the budget and insurance funds. Share in each of the sources in the financing of health care in the period from 2000 to 2010 is as follows: federal expenditures averaged 0.7% (% of GDP) and the consolidated budgets of the Russian Federation subjects (regional level) - about 2%; budgets of territorial extra-budgetary funds (including compulsory health insurance fund) - 1.3%.

Health expenditure in the federal budget for 2014 are expected to reach 462.1 billion rubles (10.5 billion euros), or 3.2 % of the total expenditures of the federal budget (0.6 % of GDP). For comparison, in 2013 health expenditures amounted to 503.9 billion rubles (11.5 billion euros). It is expected that expenditure on health in absolute terms in 2015 will not exceed 373.1 billion rubles (8.5 billion euros) and in 2016 their share will also decline. Analysis of the dynamics of the federal budget under the heading "Health" indicates a significant decrease in their comparison with the corresponding previous year (Exhibit 16).

According to the explanations contained in the conclusion of the Accounts Chamber of the Russian Federation, the reduction of federal budget expenditures on health care in 2013-2015, is primarily due to the fact that since 2013 the federal budget does not provide the intergovernmental transfers to the Federal Fund of Mandatory Health Insurance budget[45]. In addition, in 2015 were reduced federal expenditures for financial support of certain activities of the priority national project "Health" (measures aimed at promoting a healthy lifestyle among the population, including

[45] In order to conduct medical examination residing in institutions for orphans and children in difficult situations, to conduct additional clinical examination of working citizens, to provide additional care provided by general practitioners precinct , precinct pediatricians, general practitioners (family doctors), nurses, as well as cash payments to personnel of midwife stations, doctors, paramedics and nurses ambulance.

the reduction of tobacco and alcohol consumption, measures to develop the blood service on implementation of incentive-based cash payments), which from 1 January 2015 is planned to carry out at the expense of the CHI.

Exhibit 16: Expenditures of the federal budget under the heading "Health"

Indicator	2013	2014 (draft)	2015 (draft)
Draft law (2013-2015), billion rubles	***506,5***	***457,4***	***373,1***
to the previous year, billion rubles	-48,2	-49,1	-84,3
to the previous year, %	91,3	90,3	81,6
rates of growth by 2012, %	91,3	82,5	67,3
Federal law №371-FL (with changes) (2012-2014), billion rubles	***503,9***	***462,1***	
to the previous year, billion rubles	-50,8	-41,8	
to the previous year, %	90,8	91,7	

Source: Conclusion of the Accounts Chamber of the Russian Federation on the draft federal law "On the Federal Budget for 2013 and the planning period of 2014 and 2015".

It should be noted that the budget of the compulsory health insurance is essential in the structure of health care costs. In the next three years it will grow in relation to the revision of the premium rate c 3,1% to 5,1% (from 2011-2012 2% of the rate of insurance contributions to MHIF spent on the modernization of health care). At the same medical facilities (LPU) will be funded on the basis of services rendered, i.e. "money will follow the patient" and the citizen can independently choose the insurance company, medical facility and doctor. As a result, medical facilities funding will depend on the number of patients.

Despite the seemingly impressive on the absolute values of health expenditure, the share of total health expenditure from the budget (according to the Accounts Chamber of the Russian Federation) is an average of just over 4% of GDP, including the expense of the state which is about 3%, and by at the expense of the population more than 1%. For comparison, in the U.S. health care system needs used to spend more than 17% of GDP, in Britain and other developed countries of Europe, on average 10% of GDP and an average of 5% in Eastern Europe and the Baltics (Exhibit 17).

Exhibit 17: Structure of expenditures of budget systems of the "Group of Seven" and the Russian Federation (in percent of GDP)

Costs	USA	Japan	Germany	France	UK	Italy	Cana-da	Russian Federation		
	2009	2009	2009	2008	2008	2008	2007	2009	2012	2014*
Government services	4,8	5,2	6,1	7,1	4,5	9,0	5,0	3,4	2,6	2,9
Defense, public order and safety	7,2	2,5	2,8	3,0	5,1	3,2	3,1	6,3	6,2	6,4
Economic services	4,2	4,8	3,6	2,8	4,8	3,7	3,6	7,1	5,3	4,8
Protecting the environment	н.д.	1,5	0,7	0,9	0,9	0,8	0,7	0,1	0,1	0,1
Housing	1,3	0,8	0,7	1,9	1,3	0,7	0,8	2,6	1,9	1,8
Health	***8,6 (17,6)***	***8,4 (9,2)***	***6,9 (11,5)***	***7,9 (11,7)***	***7,4 (9,6)***	***7,2 (9,5)***	***7,5 (11,4)***	***4,3***	***4,0***	***4,0***
Recreation, culture and religion	0,3	0,1	0,7	1,5	1,1	0,9	1,0	0,8	0,8	0,8
Education	6,6	4,2	4,4	5,9	6,3	4,6	6,0	4,6	4,1	4,0
Social protection	8,9	14,8	21,6	21,8	15,9	18,8	11,9	12,1	12,6	12,8
Total cost**	42,0	42,3	47,5	52,9	47,4	48,9	39,7	41,3	37,6	37,6

Source: IMF data for the corresponding year. In parentheses are the data for 2010.
*Predictive estimate of the Accounting Chamber.
**The index value for the line "Total costs" may differ from the sum of the costs of the columns by 0.1 percentage points due to the statistical error.

However, a simple comparison of the volumes of financing would not be enough, because in this case it is necessary to compare the results as well. First, in order to achieve European life expectancy and mortality scale, domestic financing is clearly insufficient. Second, so as to achieve the Russian health care indicators, the financing may even be redundant. Thirdly, the funding system can be relatively less expensive, providing relatively higher rates of health of population in general at a relatively lower cost.

As an example, there could be given the UK and the U.S. cases. Comparison of health care financing and state of health in these countries shows that, although the United States spends on health care almost two times more than the UK with a significant proportion of private funding, health indicators in these countries are comparable, and some are even better than in the U.S.

> *For example, the maternal mortality rate in the UK is lower than in the U.S. (12 and 21 per 100 000 live births in 2010, respectively) and healthy life expectancy at birth is higher (79 years for men and 82 years for women in 2011 in the UK and 76 and 81 years, respectively, in the United States).*

Life expectancy in Russia is much lower (average life expectancy in Russia is 69 years[46], including 63 years for men and 75 years for women, and in developed countries they are 78 and 82

[46] Data for 2011.

years for men and women respectively), mortality, including child and infant, is significantly higher[47] (2-3 times higher) than in European countries. Along with the low birth rate (which is typical for developed countries), Russia faced a problem of high mortality in the working age (that is inherent in developing countries), resulting in a deprivation for the society of huge labor potential (Exhibit 18).

Exhibit 18: Key indicators of national health care systems, 2011

Indicator	USA	Japan	Germany	France	UK	Italy	Canada	RF
Life expectancy at birth (years)	79	83	81	82	80	82	82	***69***
Neonatal mortality rate (per 1000 live births)	4	1	2	2	3	2	4	***6***
Infant mortality rate (probability of dying by age 1 per 1000 live births)	6	2	3	3	4	3	5	***10***
Hospital beds (per 10 000 population)*	30	137	82	66	30,0	35	32	***97****
Physicians (per 10 000 population)*	24,2	21,4	36,9	33,8	27,7	38,0	20,7	***43,1***

Source: World Health Statistics. WHO, 2013.
*2005-2012.
** According to Goskomstat (State Committee on Statistics of Russian Federation) value of this indicator is 94.3.

If we analyze the structure and dynamics of the whole expenditure of the budget system of Russia in comparison with the structure and dynamics of spending in several countries (Exhibit 19-21), it is clear that the share of spending on health care budget system in Russia is significantly lower than the proportion of these costs of "Group of Seven", lower than in some countries with economies in transition, as well as some CIS countries. At the same time, the share of budget expenditures on defense, public order and safety as a percentage of GDP in Russia is much higher than in most countries, and is matched only by the United States.

However, international experience shows that it is necessary not only to increase spending on health care, but look for the most effective mechanisms, on the one hand, of mobilization, and on the other - the distribution of resources on public health. For Russia, despite the investments made in health, among the main concerns the problem of low efficiency severely limited resources.

[47] Largely due to the numerous complications of pregnancy, parturition and perinatal pathology.

Exhibit 19: Structure of expenditures of budget systems of individual countries with developing and transition economies and the Russian Federation (in percent of GDP)

Costs	China	Hunga -ry	Poland	Bulgria	Lithua -nia	Latvia	Esto- nia	Russian Federation		
	2008	2008	2009	2009	2009	2009	2008	2009	2012	2014*
Government services	2,9	9,2	5,8	4,4	4,0	4,6	2,9	3,4	2,6	2,9
Defense, public order and safety	2,7	2,9	2,8	4,4	3,2	3,3	4,5	6,3	6,2	6,4
Economic services	7,9	5,8	5,2	3,2	4,0	7,5	4,9	7,1	5,3	4,8
Protecting the environment	0,5	0,8	0,7	1,2	1,2	0,6	1,0	0,1	0,1	0,1
Housing	1,9	1,0	0,9	1,3	0,5	1,0	0,6	2,6	1,9	1,8
Health	***4,6 (5,0)***	***4,9 (7,8)***	***5,1 (7,0)***	***3,9 (7,6)***	***6,8 (7,0)***	***3,7 (6,7)***	***5,2 (6,3)***	***4,3***	***4,0***	***4,0***
Recreation, culture and religion	0,5	1,4	1,3	0,8	1,2	1,6	2,3	0,8	0,8	0,8
Education	3,7	5,2	5,3	4,2	6,8	6,7	6,7	4,6	4,1	4,0
Social protection	4,7	17,6	16,9	13,3	16,4	13,3	11,7	12,1	12,6	12,8
Total cost**	29,4	48,8	44,1	36,6	44,1	42,3	39,9	41,3	37,6	37,6

Source: IMF data for the corresponding year. In parentheses there are the data for 2010.
*Predictive estimate of the Accounting Chamber.
**The index value for the line "Total costs" may differ from the sum of the costs of the columns by 0.1 percentage points due to the statistical error.

Exhibit 20: Structure of expenditures of budget systems of selected CIS countries and the Russian Federation (in percent of GDP)

Costs	Ukraine	Kazakhstan	Byelorussia	Moldavia	Russian Federation		
	2009	2009	2009	2009	2009	2012	2014*
Government services	3,6	1,8	3,5	6,0	3,4	2,6	2,9
Defense, public order and safety	3,5	3,0	3,0	2,9	6,3	6,2	6,4
Economic services	4,6	3,4	11,5	3,4	7,1	5,3	4,8
Protecting the environment	0,3	0,1	0,3	0,2	0,1	0,1	0,1
Housing	0,8	1,8	3,7	0,9	2,6	1,9	1,8
Health	***4,2 (7,8)***	***2,7 (4,3)***	***4,5 (5,6)***	***6,4 (н.д.)***	***4,3***	***4,0***	***4,0***
Recreation, culture and religion	0,9	1,0	1,9	1,0	0,8	0,8	0,8
Education	7,2	3,9	5,8	9,4	4,6	4,1	4,0
Social protection	23,1	4,5	13,6	15,0	12,1	12,6	12,8
Total cost**	48,2	22,1	47,8	45,2	41,3	37,6	37,6

Source: IMF data for the corresponding year. In parentheses there are the data for 2010.
* Predictive estimate of the Accounting Chamber.
** The index value for the line "Total costs" may differ from the sum of the costs of the columns by 0.1 percentage points due to the statistical error.

At the beginning of 2010, the share of inefficient spending of the total budget of the Russian Federation on the health system was 7.6 % (for comparison, in 2007 its value corresponded to 5.3%). According to analysts, the main reason for it is the excessive number of personnel (particularly other), which accounts for about 80 % of inefficient spending (in 2007 - 66%) to poor management ambulance - 3.6 %, and ineffective control volume of inpatient care - 15% (4.7 % and 29% respectively in 2007). Growing of the share of inefficient spending recorded in 60 regions (the maximum number of spending in the Republic of Tuva). At the same time, the low share of inefficient spending is not always indicative of the prosperous state of affairs in health care, and can only be the result of an insufficient number of health facilities and the shortage of health workers (for example, in regions of the North Caucasus region).

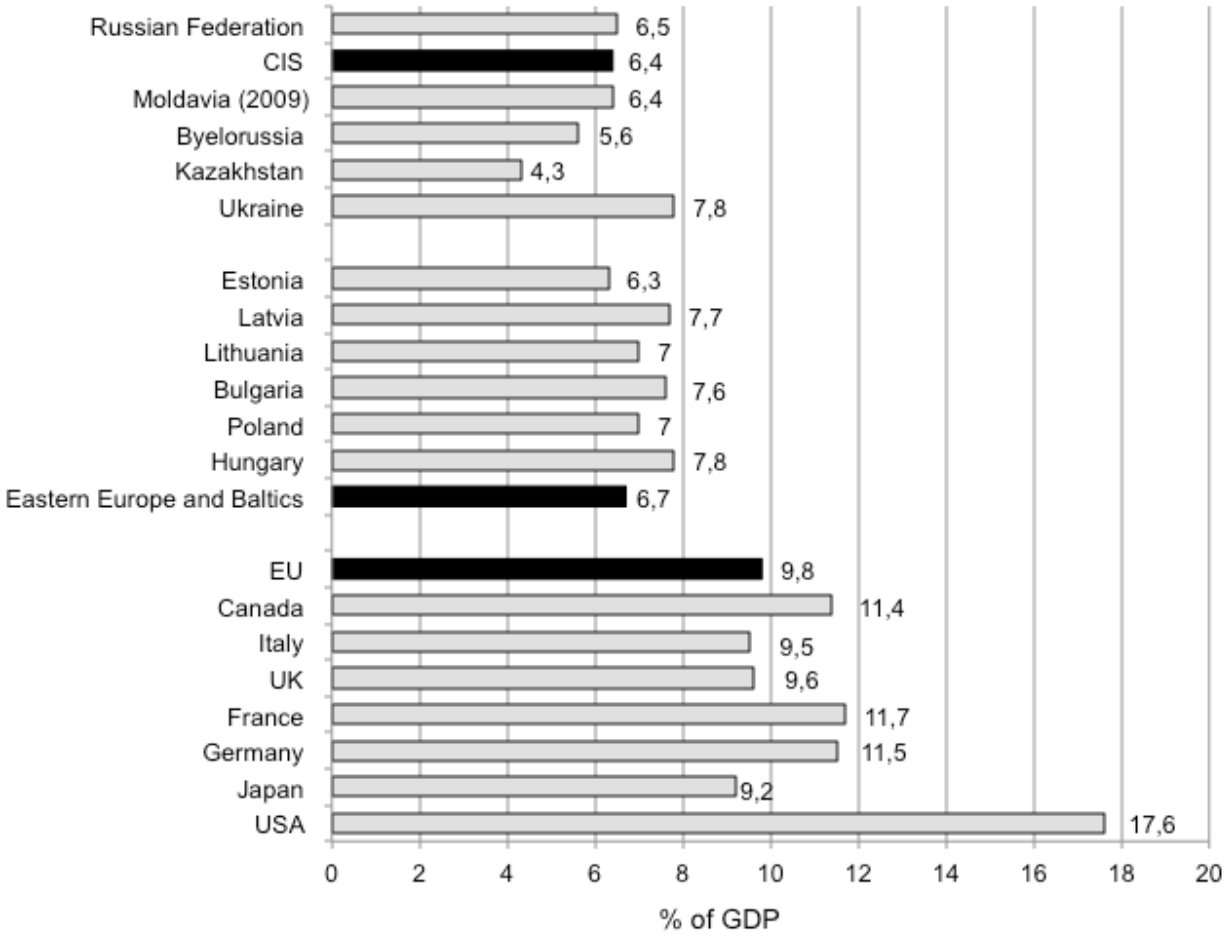


Exhibit 21. Total health expenditure across selected countries as % of gross domestic product (GDP) in 2010, WHO estimates[48].

[48] As it was already mentioned before, the issue of exact volume of financing coming in Russian health care appears to be particularly difficult, first of all, because not all financial flows can be registered. Second, the indicators used by official Russian statistics are different from those established by WHO. For this reason the share of total health expenditure from various data base may differ.

This raises the question of how to finance health care - in the world today there are different models. The traditional classification of health systems based on the method of organization and methods of financing of medical services, which can be represented as follows:

private health financing (often referred to as a system based on voluntary health insurance) - financed by employers or by the citizens, charities, etc., services are provided by private organizations (e.g., USA);

social health insurance (also referred to as an insurance model of financing) - mostly based on earmarked contributions for health insurance on the basis of income, services are generally provided by the government agencies (e.g., Germany, Austria, Belgium, Netherlands, France);

fiscal medicine - funded by taxes, which forming the revenue side of the budget, and then define expenditure on health, services are generally provided by the government agencies (e.g., United Kingdom, Sweden, Denmark, Ireland).

Main reallocation of the resources occurs between funding from public or private sources. At the same time public sources consist of government spending from the budget (taxes) and social health insurance systems in health care (the contributions of its members). Private sources include personal funds of citizens paying for medical services cash and private health insurance.

In Russia, private expenditures usually include voluntary insurance, official fees (co-payments) and so-called payments in an "envelope." Assessing of the scale of private expenditure varies over a wide range from 25 to 60 percent of total health spending. Some independent experts believe that during certain time periods means of the population, in particular for paid medical services, medicines and illegitimate payments accounted for about half of public spending. According to WHO data, the share of private spending accounts for more than 40% of total health expenditure (Exhibit 22), and most of them - more than 80% in 2012, - are private expenditure.

Despite this, a significant number of citizens do not have the ability to use paid medical services due to low income: according to recent sociological studies, about 30% of Russians cannot afford fee kinds of health services due to low credit, and this indicator may be increased by one-third, depending on place of residence.

Exhibit 22: Health expenditure in Russian Federation

Health expenditure	2000	2003	2006	2008	2012
Total expenditure on health as % of gross domestic product	5,4	5,6	5,3	4,8	4,0
General government expenditure on health as % of total expenditure on health	59,9	59,9	63,2	64,3	58,7
Private expenditure on health as % of total expenditure on health	40,1	41,0	36,8	35,7	41,3
General government expenditure on health as % of total government expenditure	12,7	9,3	10,8	9,2	9,7
External resources for health as % of total expenditure on health	0,2	0,2	0,1	0	…
Social security expenditure on health as % of general government expenditure on health	40,3	43,7	42,3	38,7	44,6
Out-of-pocket expenditure as % of private expenditure on health	74,7	71,1	81,5	81,3	87,8
Private prepaid plans as % of private expenditure on health	8,1	6,6	10,2	10,6	7,1
Per capita total expenditure on health (PPP int.$)	369	551	699	985	1277
Per capita government expenditure on health (PPP int.$)	221	325	441	633	749

Source: World Health Statistics. WHO, 2013.

In this context, there is a problem of equity in relation to health care financing. Method of financing can be considered as fair if the ratio of the cost of health care to non-food household expenditure is the same for all households, regardless of income, health status and use of health services. In Russia, with a high level of income inequality (Gini coefficient in 2011 was 0.410 for total revenues and for wages reaches 0,483) objectively there are significant differences in socio-economic status of patients.

> *Under the equity in this context is understood the ability to access to health care resources, and appropriate allocation of the burden of financing the health system between different socio-economic groups (e.g., World Health Report 2000). The basis of this comprehension of equity is the category of demand, which implies that a person really needs help for medical reasons. It may exist in humans, but not to be identified and realized. So, the access essentially means the possibility of a citizen to obtain the desired set of health services according to need.*

The feature of health care lies in the fact that collective action in the provision of health services may be more effective than the individual because of the special qualities of the medical services. These qualities do not allow the medical service to be read in full as a product that can be freely bought and sold on the market (e.g., Chubarova, 2004). Therefore, medical services do not meet the requirements of a pure market efficiency, which creates a serious problem both on the

demand side (uncertainty) and on the supply side (asymmetry of information between doctors and patients, motivation, etc.) (e.g., Chirkunov, 2011). Thus, the payment of medical services by a third party creates problems on both the supply side and the demand side[49].

Fiscal medical system, with both advantages and disadvantages, has an important advantage which consists in the fact that public funding provides control over the funds (as opposed to insurance systems) and implementation of national priorities, the main of which is the access of the population to medical care. In addition, centralized management enables effectively inhibit the growth of medical costs. In this regard, the budget system of financing of health services seems to be more in line with the reasons of both economic efficiency and social equity, providing a balance between them (Mechanik, 2011; Chubarova, 2004). Wherein, in the modern civilized world is accepted as an axiom that health care resources should be distributed equitably.

It should be emphasized that although different models of organizing of health services in the leading capitalist countries are used, become dominant the concepts according to which commercial approaches to health are not able to provide a more or less equitable distribution of health services, as well as the availability of quality health care for the majority of the population. Enhance the understanding that the increase in public spending on health advocates, on the one hand, the basic element of social sustainability of the economy, and on the other - the most important factor of growth and innovative security. Accordingly, most countries are now demonstrate a stable trend to seek new forms of "socialization" of production and sales of health services, the development of legal norms aimed at equalizing opportunities for citizens in access to quality health care.

4.3.3 Extra budgetary sources: the transition to a new funding principle

Despite the significant advantages of budget financing of health, currently defined a tendency to transform the mandatory health insurance funds in the main source of financing of national health care (e.g., Ivanov, 2012) and within the CHI redistributed a huge financial resources today[50]. Legitimate question arises in this situation is: whether effectively these tools are used? Does such a system really helps to improve public health and is it really available and free?

[49] The presence of an intermediary between the consumer / patient and the manufacturer / health employee in health insurance leads, on the one hand, to increasing of the cost of the system, since part of the funds diverted to the service of intermediary operations, and on the other - have incentives to over-consumption as a patient, and the doctor because they are not directly involved in the payment process, which also leads to an increase in health care costs.

[50] In the short term the share of insurance funds in the total amount of funding is planned to increase to 70%.

The main document that establishes the norms of the provision of free medical care, is a Program of state guarantees of free health care to its citizens, which is held annually (since 1998) was adopted by the Government. Since 2005, the annual volume of *standards of care by its kinds* in the whole Program of state guarantees based on one person per year were being approved. Standards are used for planning and financial and economic justification of the size of the *per capita standards of financial security*. These standards reflect the amount of budgetary allocations of the regional budget and mandatory health insurance funds, needed for compensation of the costs of providing free medical care based on one person per year. Standards of financial costs per unit volume of medical care are calculated based on the costs of providing it, and used to indicate the amount of funding provided by the mandatory health insurance. Herewith, regional public authorities of the Russian Federation in accordance with the Program shall develop and approve their (territorial) guarantee programs providing free medical care to citizens, including territorial mandatory health insurance program.

Thus enacted Program establishes the state guarantees, which specify type and the volume of free medical care that Russians can receive. This document actually shows the policy that the authorities adhere in order to provide a medical care to the population.

The Program is approved for a period of three years (for the next fiscal year and the planning period). In this document, in addition to the above-mentioned regulations, namely - the average amount of medical care standards, average standards of financial costs per unit volume of medical care, the average standards of financing per capita - establishes the procedure for the formation and structure of tariffs for medical care, as well as the ways of its payment. Until 2013 at the expense of the CHI five LPU expensive items were funded (so-called *basic tariff of CHI*), namely: personnel salaries, accrued payroll, payment of medicines, food and supplies patients. Maintenance and repair of facilities, purchase of equipment, retraining of personnel, and computerization process for state medical facilities were financed from regional budgets directly. From 2013 in the rate of CHI will include everything except the investment component - major repairs, construction, renovation and purchase of equipment[51].

That is actually a transition from cost-estimate and budgetary-insurance principle of financing of health care facilities within the framework of Program of state guarantees of free health care to the population to a *single-channel funding by insurance principle* with all expenses paid at the full rate on the basis of standards of medical care.

[51] Valid for greater than 100 thousand rubles.

... According to the estimates made by the Ministry of Finance, within the transition of financing of public health care facilities in the system of compulsory health insurance, budget will save up to 150 billion rubles (3,3 billion euros) for the period 2014-2016. The legislation provides that the federal health care facilities will be gradually included into the CHI system. As follows from the Federal Law of November 29, 2010 N326-FL "On Compulsory Health Insurance in the Russian Federation", ambulatory care will be transferred to this system of payments in 2014 at 50 %, in 2015 – at 100 %. Inpatient medical care will be funded according to the new scheme from 2014 in the amount of 3%, and in 2015-2016 – of 50%.

Experts of the Ministry of Finance believe that this approach will reduce the cost of the federal budget in 2014 to 34.2 billion rubles, in 2015 - 51.6 billion rubles, in 2016 - 64.3 billion rubles. However, the implementation of this model will be possible only after the solution of the problem of improving of the effectiveness of federal health care facilities when translated funding by CHI. There will be also necessary to analyze the activities of the federal government facilities and differentiate them into groups. Among other things, the Ministry proposes to improve a capacity planning of medical care, reduce "unreasonable demand for inpatient care" and phased out of the hospital premises the obsolete.

At the same time the implementation phase includes the transition of state and municipal health care facilities, especially hospitals and clinics, in the status of "new budgetary institutions" operating on market principles, primarily on the basis of self-financing[52]. Accordingly, is planned a reduction in the share of public expenditure allocated to the reproduction of these facilities.

As planned by the authors of the reform, the implementation of these measures will ensure the fulfillment of tasks to improve the quality and availability of constitutionally guaranteed free medical care, increase efficiency and optimize the use of available resources of hospitals and clinics. The above data suggests about the policy to expand a direct participation in the financing of health care by narrowing the sphere of state-guaranteed free (at the source) services. In reality, these actions are probably nothing more than a narrowing of the public sector and social sphere, and actual displacement of responsibility for its operation on the citizens themselves and thus provided budget savings (e.g., Muhetdinova, 2010). The legitimacy of this thesis is confirmed by "technical" nature of the new steps taken on the conditions and procedures for granting of paid medical services to the population, which indicates an intention to change the approach to financing of health care system[53].

[52] More, this mechanism will be examined by the example of a specific health care facility in Chapter 6 of the dissertation.

[53] So, according to a member of the executive committee bureau of Pirogov's movement of doctors Professor Yu. Komarova "... the trend is clear - to remove from the shoulders of the state responsibility for health care and pass it on to employers and citizens".

4.3.4 The "alternative" source: paid medical services

Despite its significant volumes, until recently paid medical services were virtually out of sight of the state. The only document regulating the procedure for the provision of paid services was a government decree of 1996, which allowed the public health care facilities do business in very limited quantities. At a higher level, the right of municipal and federal health facilities to treat for fee was established by a new law of the Russian Federation "On the basis of health protection" released in 2011. And from January 1, 2013 came into force a decision of the Government of the Russian Federation "On approving the procedure and conditions for the provision of medical facilities of paid medical services to patients".

> *Unofficially paid services in the public health system are already present for several years, and their volume increases. Analysts of the Fund "New Eurasia" in the study "Shadow health care market," estimated, that only every second respondent patient received medical care through mandatory or voluntary insurance. At least once purchased services through the cashier 41% of the respondents, paid to the doctor in "envelope" 22% of respondents. The volume of shadow medical services market in Russia, according to the analysts, is more than 180 billion rubles (4 billion euros).*

The advantages of innovations in the sphere of paid medical services, medical community considers the specification of such basic concepts as "paid medical services", "medical organization", "patient", "performer", as well as concrete definition of the conditions under which medical facilities involved in the implementation of the program of state guarantees of free medical care, can provide paid services.

But there are also disadvantages. Experts are alarmed by a lack of specificity and vagueness of many formulations, the reference to not yet adopted laws. The documents are not differentiated both free and paid services, as well as the procedure for their submission, there is no requirement to divide the flows of free and paid patients, it is unclear how should be stabilized a duty of medical facilities to inform citizens about the possibility of getting treatment by CHI Fund. Lack of clarity on key points, according to experts, can reduce the availability of health care for citizens.

Nevertheless, according to official statistics, at an average of private health care facilities in the region have a little over 2% of all health services, very few of them provides comprehensive medical services. And so far, private health organizations are not been included in the national health care system.

4.3.5 Health care financing in terms of budget reform

A distinctive feature of the changes made to the budget is the transition towards budgetary allocations exclusively on program-target principle in contrast to the previous estimate and cost-allocation policy.

Investigation on regulatory sources suggests that the process of reforming of the budget is currently in the stage of transformation[54]: documents reviewed are clothed in the *traditional cost-estimate form using program-targeted blocks*. Thus, since 2012 the main areas of economic and social policy of the state are determined based on a set of long-term programs that are developed in the framework of the state program of improvement of the efficiency of public spending. "Real" program formation of the federal budget, including a modification of the budget classification, will begin with 2014. Budget of 2014 is formed by 58% in the format of government programs. The structure of the state budget, i.e., taking into account the program and target blocks, includes the names of 42 state programs (39 of which are currently approved) and provides for their grouping by five fields: “New quality of life” (14 state programs); “Innovation and modernization of the economy” (17 state programs), “National security” (2 state program), “Balanced regional development” (4 state program) and “Effective state” (5 state programs).

The analysis of the data shows that the program part of the federal budget to 2013 and the planning period of 2014 and 2015 is approximately 97% of the total expenditures of the federal budget (varies slightly from 96.9 % to 97.1 %). Accordingly, part of the extra-program takes about 3 %. Budgetary provision for it amounted to 355 billion rubles in 2013 (344.4 billion rubles and 366.4 billion rubles for 2014 and 2015 respectively). "Development of Health care" is included, along with other areas (a total of 13 key programs) in the system block of programs "New quality of life." By the number of program areas the block “New quality of life” ranks second among the other key blocks. It should be noted, that this particular block in the federal budget provides the highest level of expenditure[55] that is expected to grow in the future. In 2013, the block "New quality of life" was more than ½ of the total expenditures of the federal budget structured for state programs.

Sectorial ministries and departments were identified as responsible for the development and implementation of state programs. There is also specified composition of directions and routines included in the public health care development program, which shows that the areas of program development includes health developed and implemented in the previous period the federal target

[54] Specifically, see the: Conclusion of the Accounts Chamber of the Russian Federation on the draft federal law "On the Federal Budget for 2013 and the planning period of 2014 and 2015"; On budgetary strategy of the Russian Federation for the period up to 2023: Decision of the Council of Federation of 26.11.2008 № 443-SF.
[55] It accounts for 30% of the total number of established government programs.

program (FTP), as well as the Priority National Projects (PNP). Thus, the composition of the new government long-term programs preserves the continuity of previously developed activities with a corresponding correction in the proposed implementation period.

All in all, according to data published by government sources, government funding of health is in line with the traditional budgetary allocations in this area: specific weight of other programs for the financing of the social sphere "Development of Health care" takes a middle position - 6,7 % of the total, followed by a decrease to 4.2 % in 2015[56] - after the "Development of the pension reform" (46 %), "Social support" (15.6 %), "Public order and combating crime" (14.8 %), and "Development of Education" (7.2 %). Reduction of the size of central budget funding towards the program "Development of Health care" is provided for the settings of the state program of improvement of the efficiency of budget spending in financing the social sphere. In the transition to the new conditions of institutional functioning[57], the enterprise and public sector organizations which have received the "freedom", will have to require to "gather additionally" missing volumes through entrepreneurial activities.

Presented in this chapter analysis suggests that in Russia, where significant financial flows cannot be fixed, it is difficult to draw definitive conclusions on the costs of health care, as well as to trace their dynamics. It is also logical to think that the state is not able to calculate all the real needs of the population in the types and volumes of medical care. These needs are determined individually and then formed into "the depths of the economic mechanism of medical institutions" in the form of specific medical services to the population. What the state apparatus in this case may affect - is a distribution mechanism at its disposal financial resources, which is particularly relevant in terms of their limitations.

The author has an impression that the Soviet health care system, often criticized in the recent literature, by the logic of its functioning in fact was much closer to the PBBS model than the current system. Thus, the Soviet system was characterized by performance, and, most importantly, the drafting of the medium-term (five-year) plans in accordance with the objectives. In addition, tight control system has been organized for the execution of plans in a timely manner and in a line with the objectives, along with control over the targeted use of the allocated budget funds. Until

[56] Spending cuts by the area "Development of Health care" is due to significant reductions in budgetary allocations from the federal budget for measures to improve the system of medical care for patients with vascular diseases, cancer patients, improvement of high-tech medical care, the development of new effective treatments.

[57] This, in particular, comes to the Federal Law of 08.05.2010 № 83-FL (as amended on 07.05.2013) "On Amendments to Certain Legislative Acts of the Russian Federation in connection with the improvement of the legal status of state (municipal) institutions".

now, the health care industry is actually "hold" due to Soviet design. The only serious drawback is that with the arrival of market mechanisms were not thoroughly formed the "right" incentives for all participants in the budget process.

Health care reforms of Russia, which started in the 1990s, were aimed at replacing existing models of health care financing, aimed at providing free medical services by public health facilities to ensure equal access for all categories of the population to health care, to a new system, based on the principles of health insurance. These reforms were also associated with the decentralization of health financing and management, as well as the increasing of the role of the Federation and local authorities in solving the problems in health care field. The main motive of the transition to a mixed model of health care financing was a lack of public funds and the need to mobilize resources from other sources. Arises a paradoxical situation when health funds are not enough, but the choice is made in favor of the obviously more costly and less transparent funding model. That is, the option of financing health care in Russia, selected under conditions of limited resources for health care, is initially expensive and leads to the need to increase funding for health. Consequently, it legitimate to suppose that there should be selected such option of financing system, which would allow to transform allocated funds in to the effective system of providing quality health care, but not just to increase spending on health.

5. Analyzing regional PBBS implementation: case practice evidence

5.1 The financial context and health expenditure structure

5.1.1 Health care budget and distribution of funds

Today the system of allocation of funds from the funding bodies to medical institutions and then to continue to medical facilities, is actually consist of two almost unrelated components. One is represented by the federal and local authorities, i.e., we are talking about *budget financing*, other - health insurance, and thus, represents *insurance financing*. The relative role of these components in different regions of the Russian Federation is different. Today, insurance and budgetary resources in each region are involved in the financing of health care to a different extent, which depends on local economic and political situation.

Local authorities in economically disadvantaged ("poor") regions experiencing more difficulties. Until now, the attempts of the Federal Fund of CHI to equalize the conditions of financing of health care in all regions of the Russian Federation were not sufficient so as to cope with the very different state of regional health budgets, and eventually a growing inequality.

> *In 55 subjects (regions) of the Russian Federation health care costs per capita are below the national average, in 33 subjects - above. The minimum value of this parameter in more than five times less than the average, and the maximum - 2.5 times more*[58].

In economically successful regions territorial CHI funds also operate better, and therefore uneven funding is compounded. Until the moment of the introduction of the single-channel financing, i.e., until 2012, in order to equalize conditions of financing were allocated only 5.5% of all insurance proceeds - as noted by analysts, no more than a symbolic amount[59].

Since 2012, changes a redistribution mechanism of mandatory health care insurance funds. Now, in order to align the financial support of the minimum (basic) part of CHI program among the regions, the entire volume of CHI funds received from insurance premiums at a rate of 5.1% initially accumulates in the Federal Fund and after transferred to the regions in the form of subsidies[60], calculated on a uniform procedure for all regions. Wherein, they are having a right to exercise an additional financial support for basic tariff of CHI (above received subventions), as well

[58] Tacis, Review of Russian Health Care Finance System.
[59] This value consisted of interest payments received by the territorial CHI funds (part of the contributions came in the territorial funds, the other - to the Federal Fund of CHI to equalize conditions of the insurance fund in the Russian Federation).
[60] Unlike grants, refundable in case of improper use or use during not previously defined timeframe.

as to introduce additional types and amounts of medical aid, financial support of which will be funded from the budgets of regions of the Russian Federation.

Under the pressure of changing circumstances local authorities choose different methods of allocation of funds (Exhibit 23). Basically, they combine new and old principles of financing, and the speed and success of the transition to new ways of working are extremely different in different regions of Russia. The materials of the WHO European Office notes that in some areas, a new method of funding is not used at all, in others it moved only a few areas, it is embedded in the third, but without the participation of insurance companies that are considered the CHI scheme of financing disadvantageous for themselves.

Exhibit 23: Differences in approaches to modernize health care between the regions of the Russian Federation

Approaches to health care modernization, as of 2010 (according to directions of modernization)	Regions of the Russian Federation
Introducing a mechanism of placement of municipal contracts (task-order) providing health care services[61]	Kemerovo, Smolensk, Kirov, Arkhangelsk, *Orel*, Tyumen, Amur, Kursk, Yamal-Nenets Autonomous Region, Ust-Orda, Buryat Autonomous Region
Various embodiments of planning and coordination of health care volumes:	
- By district principle	Moscow region
- By the method of program-oriented planning of budgetary services	Kirov region
- By records of real activity of surgical hospitals	Pskov region
- On the basis of the approved medical office functions	Republic of Mari El
- With a specification by types of visits (primary, recurrent, prevention, dispensary, home visits, etc.)	The Republic of Tatarstan
- In terms of cases of completed treatment in outpatient conditions that do not require all-day surveillance, considering surgery (outpatient surgery)	Tyumen region
- Implementation of the system of indicative planning of financial costs on the basis of uniform standards and norms of expenditure	Udmurtia
Testing of elements of single-channel financing of health care facilities through the CHI system	Chelyabinsk, Kostroma, Irkutsk, Penza, Kaliningrad region., Krasnodar region, Tuva Republic, the Republic of Karelia

Source: based on Grinkevitch, Banin (2011).

[61] State (municipal) task - document establishing requirements for the composition, quality and (or) volume (content), conditions, procedure and results of the provision of public (municipal) services (works) (in accordance with Article 6 of the Budget Code of the Russian Federation).

Despite the fact that all the major parameters of health care modernization in the Russian Federation entered the Government Decree of 17.11.2008 № 1662-r, to approve the concept of long-term socio-economic development of the Russian Federation for the period until 2020, the widespread implementation of routine they did not receive until 2011.

How, then, the health services are paid in Russia? The scheme of funding flows in health is presented in Exhibit 24.

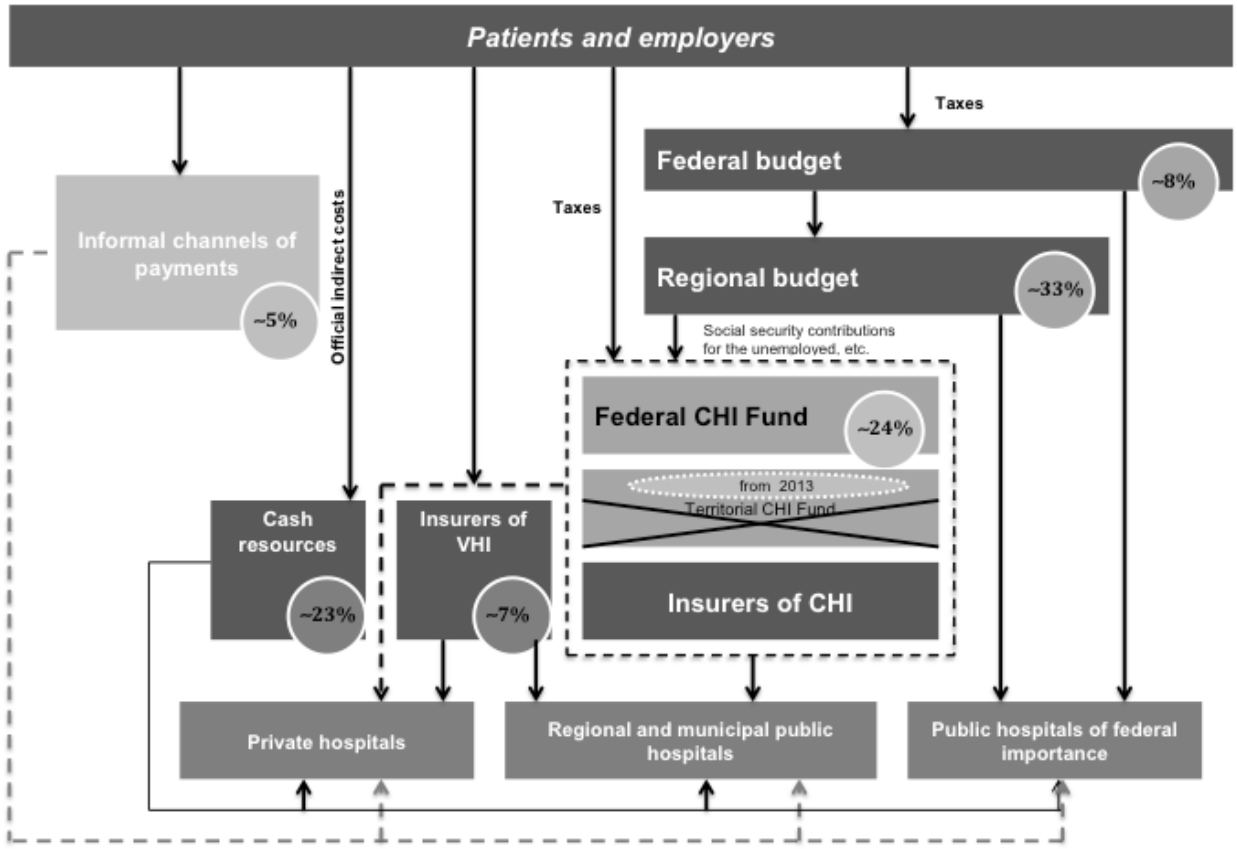


Exhibit 24. Scheme of funding flows in Russian health care (Health care in Russia, PwC).

Health budget is annually made by the Ministry of Health and Ministry of Finance. They study the costs of health programs and health care facilities that receive federal funding through taxes - Ministry of Health, and the federal target programs. In addition, the Ministry of Health and the Federal Fund of CHI used to calculate each year how much funds will need to provide a core set of free medical services (the program of state guarantees) for the country as a whole and for each region of the Russian Federation, adjusted for morbidity data. The results of calculations are approved by the Ministry of Finance. Then, on their basis, each region of the Russian Federation

receives recommendations on health care costs for next year. Recommendations have the force of law. Volume recommended by regional health costs is as follows: two thirds of the funds should be used to pay for a core set of free medical services in primary and secondary care (via CHI funds) and third - to pay for secondary and tertiary care and regional health programs (from the regional budget).

Level of employers' contributions to the CHI is defined by the federal authorities. The level of contribution of local authorities and non-workers[62] is not legally established, and each region of the Russian Federation establishes its own. In accordance with the Health Insurance Act, all contributions to the CHI, as the budgets and employers, as well as contributions from local health authorities (derived from tax revenues, rental and other income) should be combined into a general fund of regional or local health.

Usually, however, the authorities of the Russian Federation contribute only part of the funds needed to pay for health care of its population. As a result, funds of regional CHI system constitute only a third of the required two-thirds, but not two thirds of all costs on regional health. Local authorities, instead of paying CHI's part for unemployed people prefer to allocate funds directly to medical facilities, as thus it is easier to adjust their spending. Third of the costs on regional health (in particular, highly specialized medical care) is vested in the regional budget. The bulk of these costs goes to regional medical facilities and a small proportion - in medical institutions at the federal level.

Therefore, total funding of regional health depends not only on the recommendations of the ministries, but on the previous requirements of medical institutions (depending on personnel, the bed capacity and fixed costs), the ability of the authorities to receive the income, well-established rules and methods for distribution of funds of the regional CHI system (taking into account the fact that local employers are not always able to fulfill their obligations under the CHI).

Sometimes, the two main financial flows joined by additional. They are formed by means received by the medical establishment for service contracts - between the enterprise and the medical establishment; between the insurance company and departmental medical institution. Another likely source of funding of public health care facility is a voluntary medical insurance. Significant contribution to the total amount of funds made by the paid health services. It seems that none of the additional financial sources are not taken into account in the health budget and not adequately controlled, but they bring in all probability, a considerable amount of money in health care.

[62] This category includes, in particular, the elderly, children, the disabled and unemployed citizens.

CHI funds collected premiums and transfer them to insurance companies based on per capita. Insurance companies (in their absence - territorial funds or their affiliates) conclude contracts with medical facilities and pay for their services in accordance with the methods that contribute to a more economical use of resources. Payment methods have to be comply in line with the interests of the financier and the volume of assistance provided. But in fact they are often based on the usual approach to the funding, and the implementation of new methods that would force hospitals to strive for economic efficiency, is hardly been applied by the insurance companies.

5.1.2 Execution of health expenditures: regional practice data

It is appear to be difficult to determine accurately the structure of the distribution of funds in health care, as well as to determine the amount of its funding as a percentage of GDP. Nevertheless, there clearly can be seen several trends (Exhibit 25).

Exhibit 25: The structure of the health care budget of Russian regions, % on average

Expenditure items	1994	1996	1998	1999	2010
Wage fund with accruals	35,4	27,4	32,0	33,9	54,3
Food supply	5,2	5,6	5,3	5,4	4,7
Medicine provision, consumables	10,8	11,7	13,3	13,7	17,0
Capital investments	18,7	7,4	9,0	10,5	10,6
Extraordinary items	29,9	47,9	40,4	36,5	13,4
Total expenditure	100,0	100,0	100,0	100,0	100,0

Source: Tacis, Review of Russian Health Care Finance System; Federal State Statistics Service of the Russian Federation.

Share of capital investments and the cost of improvement of health care facilities has declined sharply. It was the greatest in the 1970s, and was characterized by rapid construction and distribution of medical facilities. In modern conditions, these costs were significantly reduced, and the construction has almost stopped. A significant proportion of health expenditure (on average by region) is one for medical provision, which growth occupies a special place in health care spending. This growth is due, above all, to increase of prices and massive import. At the same time, the spreading of private pharmacies, taking place in recent years (along with the continued growth of prices for medicines), become a sort of motive of the increase of the attractiveness of hospitalization: hospitalization due to free medicine supply are becoming more beneficial to patients, and more costly to health care system in general.

Accessing data on the performance of the territorial budget expenditure sections and subsections of the functional classification of Orel region in terms of health (Exhibit 26), there should be noted the following facts.

In the structure of the regional budget expenditures, planned expenditure on health as average for the considered time interval (2009-2013) composes slightly more than 16.6% of the total costs, thus taking the 4th largest space after the section "Social Policy" (18.1%), the section "Intergovernmental transfers" (18.5%) and the section "National Economy" (18.6%), which takes the largest share. Slightly lower than the share of health spending is the share of expenditures under the heading "Education", that composes 16.1% of the total expenditures of the regional budget. This is followed by sections that occupy a small share in the cost structure of the budget area. Thus there is underperformance plan on health expenditures - 81.5% on average over 5 years, with an average value of the plan execution for the whole region in costs of 88%. Almost wholly the plan observed in the section "Intergovernmental transfers" (95%), a high percentage of the plan execution under the section "Education" (almost 91%) and "Social Policy" (about 90%). Lowest in comparison with the above articles percentage of the plan is observed in such sections as "Debt service" (75.2%) and "Housing and communal services" (77.6%).

The report on the performance of the regional budget for 9 months of 2011 does have a low percentage of financing and mastering of the expenses (44.4% of the year plan) due to the fact that the costs of purchasing of equipment according to the regional target and federal programs (including the program of modernization in health) were to be held at the end of the year due to the tenders.

Nevertheless, at the end of the reporting period (end of 2011) the percentage of the plan has not reached the average value of the region and corresponded to 64.2%, i.e. actually spending on health care in the budget of Orel region amounted not to 20.2% of the total expenditure, while almost a half. While analyzing the structure of the costs execution of subsections of health, it is clear that the greatest underperformance plan is observed in the subsection "Inpatient care" (45.8% of the year plan). As a rule, the main parameters which determining the costs under this subsection are hospitalization and length of hospital stay. The foregoing gives a reason to believe that the main cause for failure of the plan for health care expenses in 2011 still was the underfunding of hospital care, but not of healthcare modernization programs that were supposed to enter into other sections. During the first 9 months of 2013 the execution of expenditures under the heading "Health" was 58.6% of the plan with a reduction to 2012 levels by 3893.5 million in connection with the receipt in 2012 of the federal budget for the modernization of health care, which in 2013 have not been received.

Exhibit 26: Execution of expenditures under the heading "Health" of the regional budget (Orel region) in comparison with other sections and subsections of the functional classification of expenditure

Title	2009		2010		2011		2012		2013 (9 months)	
	Plan*	Report**	Plan*	Report**	Plan*	Report**	Plan*	Report**	Plan*	Report**
Government services	3,9	91,2	4,6	95,4	4,6	93,3	3,4	94,5	3,3	55,8
National defense	0,08	95,4	0,01	97,8	0,1	99,4	0,1	99,9	0,2	46,4
National security and law enforcement	3,6	99,3	3,7	99,9	3,4	98,9	0,8	103,0	1,0	42,3
National economy	18,0	99,7	17,5	99,8	17,5	99,1	18,1	101,6	22,1	47,1
Housing and utilities	2,9	96,4	0,2	93,9	4,3	93,1	4,0	77,9	3,6	26,9
Environmental protection	0,05	97,3	0,04	93,6	0,04	98,8	0,04	97,5	0,04	52,4
Education	7,1	98,3	7,2	100,4	21,4	99,3	21,6	98,9	23,1	59,8
Culture and cinematography	0,8	99,7	0,8	99,3	0,9	99,6	0,9	99,3	1,2	52,4
Health	***7,9***	***91,8***	***7,8***	***98,5***	***20,2***	***64,2***	***27,8***	***94,6***	***19,2***	***58,6***
Including:										
- *Inpatient care*	*48,1*	*99,7*	*44,2*	*99,9*	*49,7*	*45,8*	*36,8*	*87,8*	*15,2*	*73,5*
- *Outpatient care*	*6,4*	*98,0*	*5,3*	*99,9*	*8,9*	*98,1*	*7,8*	*95,9*	*6,3*	*73,2*
- *Medical care in day hospitals of all types*	*0,9*	*97,3*	*0,8*	*100,0*	*0,3*	*100,0*	*0,2*	*100,0*	*0,3*	*53,9*
- *Emergency medical care*	*1,2*	*99,9*	*1,3*	*94,5*	*1,0*	*95,5*	*3,6*	*99,5*	*4,3*	*72,1*
- *Sanatorium and wellness medical care*	*1,5*	*96,8*	*0,5*	*100,0*	*0,2*	*100,0*	*0,1*	*100,0*	*0,2*	*73,6*
- *Provision, processing, storage and security of blood and its components*	*3,5*	*97,6*	*3,9*	*99,9*	*1,5*	*99,9*	*1,0*	*100,0*	*1,4*	*73,1*
- *Sanitary and epidemiological welfare*	-	-	-	-	-	-	-	-	*0,03*	*71,4*
- *Other health related issues*	*38,4*	*79,9*	*43,9*	*96,8*	*38,5*	*77,6*	*50,4*	*98,8*	*72,3*	*53,0*
Social policy	18,0	94,3	17,2	95,7	18,8	98,5	17,6	96,9	18,8	62,3
Physical culture and sports	0,1	99,5	0,2	94,1	0,9	98,9	0,9	99,4	1,4	26,2
Mass media	0,4	99,9	0,4	97,7	0,4	100,0	0,3	100,0	0,3	63,3
Public debt service	0,2	100,0	0,3	98,6	0,2	86,7	0,4	61,1	1,7	29,7
Intergovernmental transfers	36,8	97,6	40,2	99,0	7,2	101,0	4,1	102,1	4,1	74,8
Total expenditures…	100,0	96,8	100,0	98,5	100,0	91,6	100,0	96,9	100,0	55,3

Source: Author's calculations based on data from the performance reports of the regional budget of Orel region for the corresponding period. *As a percentage of total expenditure. **Percentage of plan execution (report in relation to the plan).

In 2014, the planned regional budget expenditures on the socio-cultural sphere, which in particular includes the costs of health care, are related as follows. In general, the cost of socio-cultural sphere occupies 66.4% of the regional budget expenditure, where the largest share of expenditure is on education (23.2%), social policy (19.7%) and health (19.6%). It is therefore necessary to state the growth of health care costs over the period under review. It is obvious that there is a situation in which a substantial redistributive burden of the execution of expenditure on health rests on a territorial level of budget system.

Finally, returning to the structure of expenditures under the section "Health" and their execution on the subsections, it should be noted a significant advantage in favor of the section on "Inpatient care". Throughout 2009-2011 its share was the highest (47.3% on average over three years) compared to other subsections that, in principle, is the regularity[63]. Despite this, in the last two years, its share began to decline, so the average for the whole period was just less than 40%. Cased an interest such subsection as "Other health related issues", which actually took the largest share in the structure of expenditures - 48.7% on average in 2009-2013. This significant weight in combination with loose concept of the purpose of the subsection, makes it a priori "opaque." In third place is the subsection "Patient care".

5.2 Criteria of the reform process (RQ1)

5.2.1 The legal regulation experience of the PBBS components – organizational level

What tools, or basic elements, should be used in order to successfully implement the PBBS, i.e., to provide a correlation of the final results and the direct results of the authorities to the financing in the medium term?

Conditionally, PBBS tools used today can be divided into two main categories. One category is the *goal-setting and planning tools* which ensure the unity of existing policies as a whole and in its various branches; the other is represented by *implementation tools to identify goals and objectives.*

Specifically, on the basis of international and already established in the Russian federal practice, the above categories include four major tools:

[63] In many countries, the costs of inpatient treatment ranged from one-half to two-thirds of total public expenditure on health care (in the Russian Federation - 50%).

- Reports on the results and main activities, which define the strategy of the executive authorities
- Programs defining tactics of work, linking funding with immediate results
- Prospective (medium) financial planning
- Register of expenditure commitments, allowing uniquely define the scope of the budget of existing commitments and to give the possibility to implement a medium-term financial planning on the basis of accurate data on the obligations of public authority (of the Russian Federation, of a region, or a municipality) to provide budgetary financing.

The last two tools have been currently enshrined in the Budget Code of the Russian Federation, their use is regulated by current budget legislation. While the first two names of the tools that are actually planning and goal setting tools may differ from those listed above either of these tools can be combined with each other. It is important that there should be respected a general principle: there must be a document that defines the activity strategy, and a document defining tactics in relation to the allocation of financial resources. All indicated tools should have a clear relationship to each other and be integrated into the budget process (Exhibit 27).

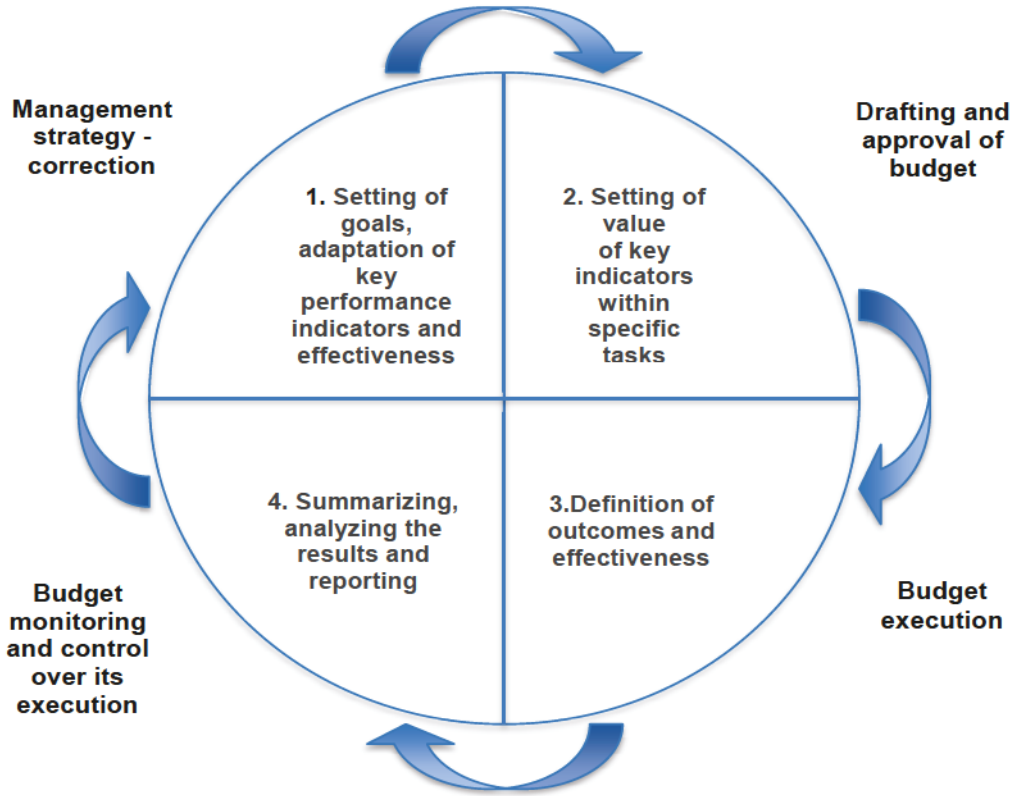


Exhibit 27. PBB system at all stages of the budget process (A. Malinovskaya, I. Skobeleva, 2011).

There may be a legitimate question about how - "bottom-up" or "top-down" - the system should be designed so as to ensure its goal setting optimality? Taking into account the Russian mentality and the practice established, it is generally considered that the best option is the formation of the "top" system. That is to say, targets strategic activities should be established (and coordinated) by a superior authority/agency. For executive authorities such agency may be a supreme executive agency, in particular, government, administration, etc., for budgetary institutions it may be executive authority in charge of which they are located. While the competencies to determine the tactics of work is better to fixed directly to performers - executive bodies or budgetary institutions, respectively.

Exhibit 28: Implementation tools of PBBS

Tools of performance-based budgeting	Laws and regulations governing the use of tools	Year begin implementation
Reports on the results and main activities of subjects of budget planning	Government Decree of 22 May 2004 № 249	2004
Priority national projects	Decree of the Government of the Russian Federation of November 14, 2005 № 1926-p	2005
Departmental target programs	Art. 179.3 of Budget Code of the RF, Government Decree of April 19, 2005 № 239	2006
Register of expenditure commitments	Art. 87 of Budget Code of the RF, Resolution of the Government of the Russian Federation of July 16, 2005 № 440, Methodical instructions of Russian Ministry of Finance	2006
Conducting of public purchase of goods, works and services on a competitive basis	The Federal Law of July 21, 2005 № 94-FZ "On placing orders for goods, works and services for state and municipal needs"	2006
Justification of budget allocations	Art. 6 of Budget Code of the RF, Order of the Ministry of Finance of Russia from April 17, 2008 number 47n	2007
Prospective (medium) financial planning	Federal Law of April 26, 2007 № 63-FZ	2008
Cashbox planning	Art. 217.1 of Budget Code of the RF, Order of the Ministry of Finance of Russia from November 27, 2007 number 120n	2008
Monitoring of financial management	Order of the Ministry of Finance of Russia dated 10 December 2007 № 123n, Order of the Ministry of Finance of Russia from April 13, 2009 number 34n	2008
Formation of state (municipal) assignments	Art. 69.2 of Budget Code of the RF, Government Decree of 29 December 2008 № 1065, Government Decree on September 2, 2010. Order number 671 of the Ministry of Finance of Russia, Ministry of Economic Development of Russia № 526 dated October 29, 2010 № 136n	2009

Taking into consideration the federal and regional experience in establishing the legal framework for the implementation of the principles and methods of PBBS (as well as the competencies of state and regional authorities to regulate budget relations) one can talk about the need of parallel implementation of measures on the legal regulation of a number of interrelated questions, which will be discussed below.

Maintenance of registers of expenditure commitments

According to the formulation contained in the Budget Code of the Russian Federation, the registry of expenditure commitments is "used in the preparation of the draft budget set (list) of laws ... causing the public regulatory obligations and (or) legal basis for other spending obligations with the relevant provisions of the laws ... the evaluation of volumes of budget allocations necessary for the performance of obligations included in the registry". In other words, the registry serves as an important information resource that allows to combine all the information on expenditure commitments to be financed from the budget of the corresponding level. First legal acts on the formation of registries of expenditure commitments began to be take in the regions of the Russian Federation in 2004, after the adoption of the Concept of reforming of the budget process, but fixing of this tool in the legislation at the regional level began actively a year later.

In most cases, the regions of the Russian Federation have adopted the acts which were governing the procedure for forming of the registers and establish their type. In some regions was introduced the practice of adoption of the registries (for example, in the Altai Republic, Vladimir, Nizhny Novgorod and Tomsk regions). Enshrined in the form of regional acts, registers can be divided into the following groups[64] (Exhibit 29).

Exhibit 29: Registers of expenditures classification

Form of the register of expenditure commitments	Number of regions of Russian Federation
Based on methodological recommendations for regions, excluding information about the financial estimates of expenditure commitments (described only legal component and delineation of expenditure responsibilities)	7
Based on methodological recommendations for regions, taking into account information on the financial estimates of expenditure commitments	11
Based on the federal standard of the register	53
Elaborated independently	4

[64] This group only applies to those regions in which resolved the issues of forming registers expenditure commitments (75 of 89 subjects).

Thus the organization of a form of the register of expenditure commitments at the regional level has been settled in different ways.

In some cases, this task is on self-charge of a financing authority, where the issues of interaction with executive authorities of the other regions of the Russian Federation on the preparation of registers are not regulated[65].

In other cases, it is assumed that the documents on which the data are entered in the register of expenditure commitments must be submitted to the relevant executive authority of the region of the Russian Federation, and the maintaining a register itself should exercise financial authority[66].

Finally, the registers may be compiled by executive authorities of the regions of the Russian Federation, and be summarized by a financial authority[67].

In the regions, which legal regulation includes a financial evaluation of the expenditure commitments, financial authority is only responsible for a consolidation of the information from fragments of the registers compiled by other authorities of executive power. It seems that the options, when in the preparation of the registry financial institution interacts with other bodies of executive power, are more successful because they allow to entrust a part of the responsibility for the contents of the registry on these (executive) bodies, and as a result to provide a more adequate perception of their own performance in terms of its impact on the volume of budget expenditures. In addition, in circumstances where the registry should provide financial evaluation of the expenditure commitments (as is the case in 11 of 75 regions on the basis of data Exhibit 29), the concentration of all the powers of keeping the register by the financial authority can cause an unjustified overload of its employees, and a distraction from other problems of the financial authority.

Question of the update data in the registry is also solved in different regions in different ways: there are options offered a systematic updating of data in accordance to change of expenditure obligations (laws, treaties, agreements, etc.), and options to update the registry one to three times a year (taking into account the stages of the budget process), and a combination of these options (Plieva, 2007). Obviously, these nuances, namely the content of the register of expenditure commitments, as well as the required frequency of updating, depend on the purpose for which one plan to use this register.

[65] For example, in Stavropol region, Kamchatka, Magadan, Tomsk regions, the Jewish Autonomous Region.
[66] For example, in the Republic of Tatarstan, Primorsky Krai and the Khanty-Mansi Autonomous Region.
[67] For example, in the Republic of Sakha (Yakutia), Krasnodar, Irkutsk, Kirov, Kurgan, Leningrad, Novosibirsk, Omsk, Perm, Tambov, Chelyabinsk Region, Yamal-Nenets Autonomous Region.

In some regions (especially in Orel, Irkutsk, and Krasnodar Region) norms about the purpose of a regional register of expenditure commitments similar to rules on the assignment of a federal registry.

In another case (for example, in Leningrad region and Primorsky Krai) the register suggested to be used solely for the purpose of drafting the regional budget expenditures, i.e., the its role in the medium-term financial planning is not explicitly assigned.

In many regional acts, that is typical mainly for those regions of the Russian Federation, where a financial evaluation of the expenditure commitments is not provided, the purpose of the registers is not specified at all.

These examples actually demonstrate a weak relationship, or actual lack of unity of approaches on this issue at the regional level. It is likely that until the budget legislation will not be amended by appropriate necessary changes, uniquely characterize the purpose of the registers of expenditure commitments in relation to the budget process, different approaches to address these issues at the regional level will continue to take place. Analysis of the entire array of legislative and normative legal documents, contracts and agreements, which are responsible for the emergence of expenditure commitments, demonstrates the inadequacy of the definition of expenditure commitments, and its introduction (or establishment). In some cases, budgeted costs may be allocated in the registry expenditure commitments, and then chosen them legal acts.

Among all the tools of PBBS, to the registry of the expenditure commitments the most closely related tools are departmental target programs and medium-term financial plan.

Procedure of formation and implementation of regional and departmental (budgetary) target programs

Institute of targeted programs existed in the Russian Federation while having costly financial planning and, moreover, was already settled in the budget legislation. However, the use of this instrument was, as it is becoming increasingly evident today, not well established for the introduction of the required methods of PBBS.

In order to strengthen the role of targeted programs, as well as to revise the application of already functioned at the federal level, the federal target programs[68], it was decided to introduce such a tool as departmental target programs. Unlike federal programs, institute of departmental

[68] We were talking about them in the paragraph 4.3 “Present mechanism of planning and financing of health: difficulties of interpretation of findings”.

target programs is a completely new for the Russian practice: the requirements applicable to them, are in the planning for the medium term based on the identification of problems, setting goals and objectives, develop a set of activities and the justification for the resources that directly linked to achieve results (targets).

The principal differences between the federal (FTP) and departmental target program (DTP) can be represented as follows (Exhibit 30).

Exhibit 30: Federal target programs versus departmental target programs: principle differences

Principle positions of differences	FTP	DTP
Level of approval	Government	Subject of budget planning
Nature of the program	Intersectoral	Внутриотраслевой
Contents of program activities and events	Large volumes and long implementation period	Less large
Principle of cost planning	In accordance with the plans of the Government of the Russian Federation	Within the budget of subject of budget planning

In general, the preparation of any target budget program shall follow the logic: the needs of the population in this area - the corresponding function of government - resources - activities - immediate (direct) results – final results - performance indicators.

Wherein, we would like to draw attention to the difference between the concepts of "departmental target program" and "long-term target program", both used at the subnational level. One of the main "omissions" of long-term programs is considered the collective nature of responsibility, which is often impede the evaluation of the contribution of individual sectors of the administration in the achievement of stated goals and objectives of the municipality in general. Long-term target programs of the municipality is considered appropriate to apply for solving the problems of interdepartmental character, that cannot be resolved within a normal course of current activities, as well as to achieve strategic targets of the development of the territory defined in the documents of socio-economic planning. While departmental target program involves enhancement of the responsibility of subjects of budget planning for the achievement of concrete results as quantified inasmuch represents an independent tool of targeted-program management to achieve the goals and objectives of a particular industry.

According to the established federal regulations, departmental target programs can be formed in two ways:

- approved departmental target program (or targeted program of the department) and
- analytical departmental target program (or analytical program of the department).

The difference between them is their purpose: approved program is a self-contained document and represents a set of interrelated activities aimed at solving a specific tactical tasks. Some of its positions are included in the report on the results and main activities of the territory. Whereas analytical program is nothing like grouping of costs, a kind of analytical basis in preparing the report on the results.

Thus, legal regulation of procedures related to departmental (budgetary) target programs found in more than 20 regions of the Russian Federation. Nowadays, a number of government programs in the regions ranged from 13 (in Amur region) to 37 projects (in the Republic of Sakha - Yakutia. Wherein the period of their validity is 3 (Kirov region) to 9 years (Khabarovsk Region).

Characterizing adopted in these regions legal acts, worth paying attention to the following.

In most regions (where the relevant legal acts on approval, development and implementation of departmental target programs were adopted after the approval of the federal acts) implemented standards are completely analogous of federal regulations documents. Meanwhile, there are other options and practice of implementation of departmental target programs. Their purpose varies: in some regions of the Russian Federation, they are prepared so as to solve the challenges of implementation of the state policy in the established areas, sectors, types of economic activities[69], in others - in order to implement complex planning activities of subjects of budget planning and to enforce certain authority and functions in the respective fields[70].

Although the laws adopted at the regional level, are based on the norms of the federal position, but can be significantly reworked.

> *In particular, within the framework of the Regulations on the departmental target programs of Belgorod region, their analytical type has not been distinguished; targeted programs are approved by the regional government, and not by the subject of budget planning. Separately was approved the Registry of indicators of performance of departmental target programs and expenditure budget area, as well as the procedure provided corrections of the department's budget based on the level of*

[69] For example, in Krasnoyarsk and Altai territories.
[70] For example, in Omsk and Tomsk regions.

achievement. The practice of fixing of similar documents is quite unusual for regulatory policy approaches and is found in some other regions of Russia.

In Tver region target budgetary programs differ substantially from the federal prototype and include two parts: the "program component" and "overarching activity" thus covering almost all the activities of administrators of targeted programs. Budgetary target programs are used in the budget process in the preparation of the budget and partly included in the regional budget.

In rare cases, the legal acts concerning the departmental target programs could be taken before their legitimize at the federal level, and therefore differ significantly from the federal act, both in form and in content. In fact, in these regions[71] institute of departmental target programs was integrated into the existing system of regional programs.

Relatively important difference from federal regulation is that one of the regions was further elaborated exactly what position are checked during the examination of departmental target programs. In addition, as part of the passport of the program was approved a table "Basic indicators of the program", which provides the information on indicators of achievement goals of the program and overall volume costs of the program for a planning period (by year).

Finally, there are rare cases when the concept of "departmental target program" was enshrined on the level of the regional law[72]. In addition to this concept, the law also identified three kinds of budget target programs: the socio-economic development of the area; regional targeted programs; branch targeted programs.

Thereby, the analysis of the interrelated features of departmental target programs among the regions allows us to highlight the most significant. First, it is the duration of the implementation of departmental target programs. Secondly, their structural composition. Third, the approach to assessing the effectiveness of implementation of the developed measures. And if the first two criteria, in principle, are common for other types of programs, the third, i.e., evaluation of the effectiveness of measures reveals features of the departmental target programs.

All in all, the introduction of target programs (along with the medium-term financial planning) which has been already widely used at both federal and regional or local levels of government, represent one of the "critical" tools of PBBS implementation in the Russian practice

[71] In particular, we are talking about the practice of implementing of departmental target programs in Stavropol Region and the Republic of Khakassia.
[72] In particular, in the Republic of Karelia.

today. Wherein, regional features of use of the target-program methods[73] of management differ quite seriously. Among the major problems of transition of regions and municipalities on the program principle of budgeting was primarily isolated the imperfection or lack of strategic documents, as well as poor drafting regulatory programs, as well as the delay in starting work on the formation of the programs and the organization of the transition process. Moreover, there are contradictions and conflicts between the governments of finance and economy, the complexity of implementation of innovations at the federal level and the formation of program budget structure (in particular, in Orel region).

Implementation of reports on the results and main activities

Reports on the results and main activities, which are annually submitted by subjects of budget planning, are the main instrument of sectorial planning and reporting. It determines the range of powers and responsibilities of the chief administrator of budget funds in accordance with the amount allocated to the budgetary appropriations. In fact, this is a document, which presents in a systematic form the activities of the subject of budget planning for the current and planned periods of time in the context of the goals, objectives, activities and performance indicators.

A key characteristic of the report, which distinguishes it from other instruments of PBBs, is a link of substantive aspects of the entity of budgeting with actual and projected budget funding. This is possible thanks to the fact that the report includes all the basic parameters of the corresponding activities of the authority in the reporting and planning period (usually three years preceding the current year and the three years covered by the current municipal budget), the structure and uses of its allocated budgetary allocations.

Sample structure of the report might look as follows:

- Section 1 "Goals and objectives"
- Section 2 "Spending commitments and income generation"
- Section 3 "Cost targeted programs and non-program activities"
- Section 4 "Distribution of costs for the goals, objectives and programs"
- Section 5 "Effectiveness of budget expenditures"

Formation technique of reports, as well as the procedure for their submission and consideration in the budget process get approved by the regulatory legal act of the municipality. Sample forms of tables included in the report are given in the Appendix 2.

[73] Target-oriented principle of allocation of funds, or, as it is called, the program budget is often equated with performance-based budgeting, although this is not entirely true.

Study of methodological literature suggests that to date more than 30 regions of Russia used to take measures aimed at introducing a system of reports in the budget process and the establishment of a regulatory framework governing their preparation and use. In some regions there are only normative legal acts containing an indication of the need for preparation and use of reports of the results of the main activities in the budget process, while the documents governing their preparation and use, at the moment have not been identified.

As is the case with the target budgetary programs, the conceptual apparatus on the reports in regional legal acts is almost identical to the conceptual apparatus as enshrined in federal law. The question of the purpose of the reports in the regions as a whole resolved similar to the federal level manner. Some differences occur only in a few cases, when similar interregional differences are increasingly technical than fundamental.

The approval process of the reports is also organized differently: in some regions, they must be approved by a Collegium of the Administration, in others - agreed to a special commission. In some regions, the issues of the approval (endorsement and agreement) of the reports have not yet resolved at all.

It is of certain interest the drafting of Perm region, which is fundamentally different from the one proposed at the federal level (and actually duplicated in most regions) model of the reports. So, it is planned to introduce two types of reports instead of one, "reports of the expected results" and "reports on the results." These documents are planned not by the subjects of budget planning but directly by the budget recipients themselves.

A common weakness of systems of the reports of almost all regions can be considered a poorly defined incentives to achieve the planned results in the reports, as well as ongoing monitoring procedures to achieve results. Despite some exceptions, in general, the regions of the Russian Federation when implementing the system reports are “using” the federal experience with all its shortcomings. As a result, according to analysts, today reporting system cannot yet be regarded as fully integrated into the budget process. As a result, according to analysts, today reporting system cannot yet be regarded as fully integrated into the budget process. Furthermore, the practice of compiling of the reports in regions reveals difficulties in establishing goals and objectives for specific budget managers, selecting appropriate indicators to assess their achievements and linking these indicators with the necessary funding. Generally, the system of the reports of the results and main activities cannot yet be regarded as built at the subnational level, and in fact, exactly this tool should facilitate the implementation of the results of the budget process.

Medium-term financial planning

Introduction of PBBS in to the practice of finance management is usually accompanied by a transition to a long-term (mid-term) planning: planning of activities of the institution, as well as the budgetary allocation for its implementation is not done on a one-year, but the next few years, usually for three years. The main causes of the transition to a long-term planning are as follows.

First, in order to achieve planned results requires some funding, not only from the current budget, but also from the budgets of future periods.

Second, measurable effect from the implementation of some programs cannot be identified for one financial year, so the indicators of results of the current fiscal year may not be the basis for assessing the effectiveness of the program[74].

That is why in the budget planning process it would be "ideally" to take into account the results of which are expected to be received in the future in the process of implementation of the program. In this case the expected results can be based on monitoring data of achievement in the past (Exhibit 31).

In general, medium-term financial planning institute was settled in a quite vague manner by the Budget Code, although its new edition has specific meaning of certain positions (Article 174 of the Budget Code of the Russian Federation as amended by Federal Law of 26.04.2007[75]). So, as amended provides that the medium-term financial plan is developed annually in the form and manner established by the supreme executive authority of the region of the Russian Federation. However, the rules on monitoring results or procedures for monitoring medium-term financial planning and further excluding the results of this monitoring, are still missing in the document.

The Law provides that values of a medium-term financial plan and the main parameters of a budget project should match each other. Nevertheless, a medium-term financial plan is not actually built into the budget process, as not included in the documents whereby the budget is prepared. Until 2013 as the target value was process of budgeting for the next year as part of the multi-year (three-year) budgeting, which is updated annually and is shifted to one year in ahead. This procedure can be considered as a sort of partial, but guarantee of the predictability of budget allocations in line with the objectives. Finally, starting in 2014 (for 2014 and the planning period of

[74] E.g., for assessing the effectiveness of medicine treatment programs it is take time to identify the percentage of successfully identified patients.
[75] Article 174 "Mid-financial plan of the Russian Federation (municipality)".

2015 and 2016) the budget legislation designated the parameters of medium-term financial plan for the sub-national level.

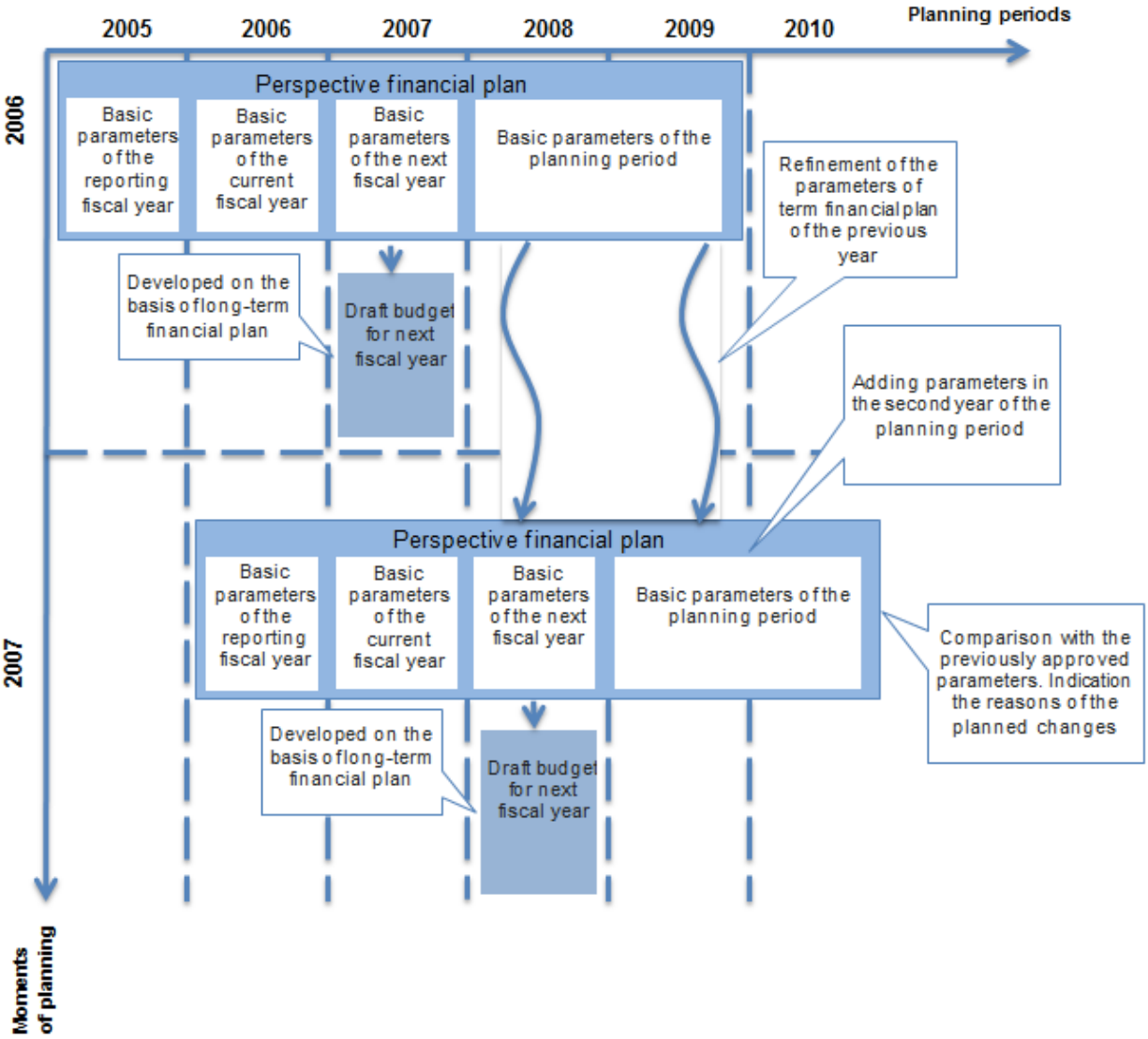


Exhibit 31. Designing of medium-term budgeting (I. Azizova, 2010).

Laws and regulations documents, relating to medium-term financial plan were developed and approved at least in 35 regions of Russia. In other cases there are only indirect mention of the medium-term financial planning, for example, under the description of the procedure for compiling the register of expenditure commitments. In many regions the legal regulation of the medium-term financial planning is limited to fixing of the norms in normative legal acts that regulating the budget process (or budget structure) in the region. Such rules mainly coincide with the provisions of Article 174 of the Budget Code of the Russian Federation.

The key ideas of the organization of procedures of the medium-term financial planning at the regional level vary a lot through the use of fundamentally different approaches to the formation of the medium-term financial plan. Understood differently even its appointment, which ranges from "... the need to create conditions to ensure a balanced and sustainable budget system" and "integrated forecasting of financial implications of developed and implemented reforms ..." to "monitoring of long-term negative trends and timely adoption of appropriate measures" ().This discrepancy is due to the fact that to date not all the regions have introduced yet a new terminology that reflects the key areas of fiscal reform. Regions, who took a sample of the federal model-making of a medium-term financial plan, consolidated the rules on the formation and distribution of existing budgets and assumed obligations; in other regions, on the contrary, the issue was dropped.

The organization of compilation of a medium-term financial plan assigned mainly on regional financial authorities. The forms of a medium-term financial plan, established in regional acts may differ. So, it may contain data or only on a regional level, or also on the local and the consolidated budget. Wherein, indicators of limiting volumes of medium-term budgeting plan are also used only in certain regions.

Linking of the process of forming of a medium-term financial plan using registries of expenditure commitments contained only in some regions[76], mainly in the context that the budgets of existing commitments should be formed on the basis of registers expenditure commitments. Many regions forecast the approval or endorsement of the developed medium-term financial plan, as a rule, by the supreme executive authority. In some regions such powers delegated to special bodies (for example, by a Collegium of Administration). Further, the approved version of a medium-term financial plan has to be published, but not in all cases.

Thus, the practice of medium-term financial planning at the regional level runs in various ways. Each of the chosen option has some merit financial, economic and organizational character. In almost all cases the regions managed to lay a key idea which is a "three-year sliding".

Considering the outlined of this paragraph regional experience of PBBS implementation, identify the stage of PBB implementation in Russia seems to be difficult due to a combination of features of both “costly” model of budgeting, and performance budgeting in the budget process regions. Along with the regions of the Russian Federation, which have achieved good results in the introduction of PBBS tools, many regions are dominated by so-called conservative approach to the management of the budgeting process. However, it is possible to identify some features

[76] This aspect, in particular, regards the Altai Republic, the Republic of Tuva, Krasnodar region, Amur, Belgorod, Vladimir, Voronezh, Ivanovo, Kostroma and other areas.

characteristic of the approaches that have been used at the subnational level in the regulation of the use of PBBS tools.

First, the introduction of named tools into the budget process of different regions in most cases occurs as appropriate federal regulations were adopted, that entail a reproduction of federal approaches without taking into consideration regional particularities and priorities of their territory development.

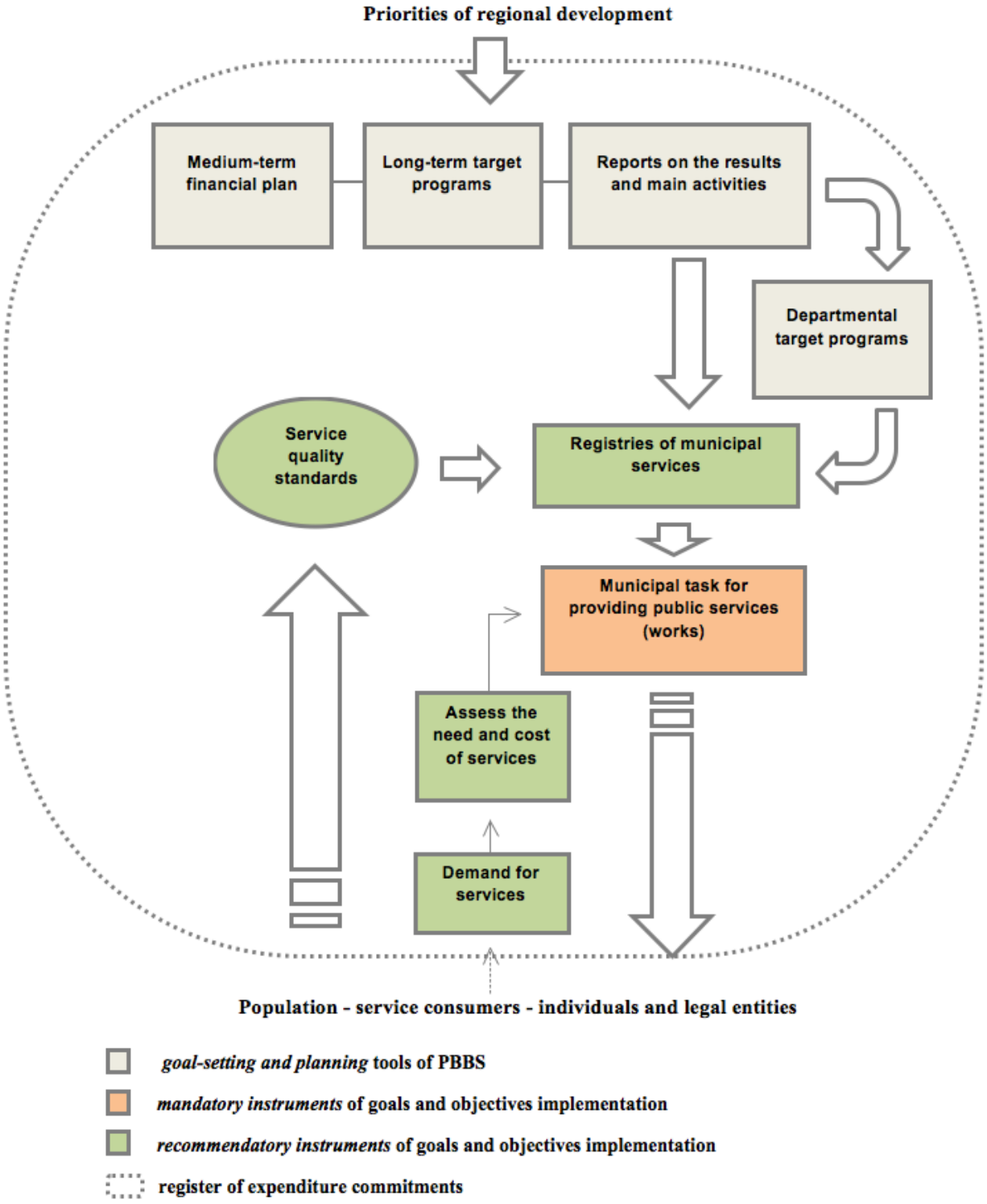
Secondly, it is still difficult to talk about the interrelation of different tools of PBBS and their embeddedness in the budget process at all stages. Often these tools cover budget drafting stage and later in the budget process or are not used, or poorly interconnected.

Thirdly, the problem of modernization of existing information bases (registry of the expenditure obligations, consolidated budget revenue and expenditure, etc.), as well as the integration of existing and new information resources, requires the provision of an electronic system design as a set of interrelated budget components.

5.2.2 The multilevel applications of PBBS model – actor level

So, the key idea of the PBBS is a link of outcomes and costs to achieve them. The important point is the fact that such a linkage should exist at all stages of the budget process: and drafting, and approval and execution of the budget, and reporting, and budgetary control. Of course, the relevant rules should get a consolidation as a regional law on the budget process, as well as in the legal acts governing the detailed procedural aspects of their implementation. Thus, it should be considered, that the law governing the budgetary legal relationship regarding introduced PBBS tools, should be linked closely (Exhibit 32).

Thereby, information of costs obligations should be used in the formation of reports, the medium-term financial planning and budgeting; draft budget should match the medium-term financial plan; targeted programs (both departmental and regional) should be considered in the preparation of reports and, in turn, formulated according to the objectives and tasks which were set for the appropriate authority and reflected in the reports; additional budgetary funds should be allocated based on the results of activities (including programs) of entities receiving budgetary funds, etc.



Source: Updated and expanded based on materials of guidelines of Association "Council of Municipalities," Khabarovsk Region, http://cmo.khabkrai.ru

Exhibit 32. The mechanism of interaction of the main PBBS tools.

When applying the procedures for working with reports and programs, it is important that a connection between these documents is clearly regulated, their embeddedness in the budgeting process, as well as the description of systematic monitoring procedures so as to achieve the expected performance.

Regulation of a medium-term financial planning should cover not only the medium-term financial issues compiling the plan, but in general to emphasize the relationship of the application of PBBS tools in the budgetary process, and finally, to create opportunities for planning budget expenditure in the medium term, taking into account the performance.

At the ***stage of budget planning*** the main aspect is the budget allocation according to the previously achieved and planned results. In ***approving the budget***, conclusions about the acceptability of the planned and actual performance in relation to budget financing should be done by legislatures.

At the ***stage of budget execution***, the administrators of budget funds should take all possible measures to manage financial resources and administrative measures so as to optimize the organization of own activities in order to achieve the best results. ***Reporting on the implementation of the budget*** should have a section, describing the planned and actual performance. Control should cover as the budget execution, and the results achieved at the expense of received budgetary resources.

At the beginning of work on the budget draft for the next fiscal year there should be done the evaluation of the expenditure obligations of public authority within the framework of the register of expenditure commitments in the medium term.

Then, considering the results of the selected scenarios of the development on the basis of forecasts of macroeconomic performance there should be evaluated a budget revenue opportunities in the medium term and, considering the results of the register of expenditure commitments, developed perspective (mid-term) financial plan.

At the same time, based on the available for each authority (local authority) budgetary resources and the priorities of development of territory in the medium term, established in policies, programs of its socio-economic development, the corresponding messages (including the budget) should be determined mid-term targets indicators of government (local authorities) of strategic nature. Document, which sets these parameters in conjunction with the amount of financial resources is a report on the results and main activities.

Tactic works for the medium-term perspective (up to a set of specific activities), with clearly defined indicators, also in conjunction with the financial resources, should be determined in the budget (departmental) target programs.

The draft budget for the next fiscal year shall be prepared on the basis as currently applied forecast of the state of macro-economic parameters for the next year, and within the parameters of long-term (mid-term) financial plan and the expected strategic and tactical performance established for each of the public authorities (local governments).

During the execution of the budget and budget implementation of targeted programs there should be formed (on a mandatory and regular basis), along with reporting on budget execution reports, reporting data on the achievement of the planned strategic and tactical performance of the authorities (local government). In order to be involved into the planning system (based on the results of recent activities of public institutions) there should be also planned and evaluated recent activities of public institutions by comparing the results of performance with funding at all stages of the budget process.

So who are the "actors" in the practice of implementation of PBBS tools? The structure and the relationship between the participants in the process of planning and budgeting of Orel region is represented in scheme (Exhibit 33)[77].

In order to execute the budgetary competencies, Orel region forms a system of legislative and regulatory acts, defining features of the budget process at the territorial level. Thus, if the duties and powers of the executive and financial authorities are determined primarily by the budgetary legislation, the content of the legal framework depends on the priorities of fiscal policy pursued by the region and the extent of implementation of PBBS tools. Thus, the ***highest executive authority of the region*** in the face of the Governor approves the order of the draft budget (budget and medium-term financial plan), as well as the formation and financial security of the state task, conduct the registry of expenditure commitments of the region, the order of development, approval and monitoring of the implementation of long-term programs and since 2011 - the state programs.

At the same time, the introduction into the budget process such tools as departmental target programs, medium-term financial plan, monitoring of the quality of financial management of chief administrators of budget funds[78] (i.e., public authorities whose competence is realized in the budget process at the stage of its implementation in the formation of budget revenues) is carried out on the own initiative of the region. It should be noted, that the process of regional finance reform in Orel began relatively recently.

[77] Explanations to Exhibit 33: 1 - bringing the parameters of the socio-economic development of the territory; 2 - preparation of a draft of the expenditures; 3 - submission of the draft budget for consideration; 4 - approval and adoption; 5 – execution (i.e., approval of the report on the execution of the budget).

[78] See, for example, the Regulation on assessing the quality of financial management of the main managers of the regional budget on July 22, 2011 № 229.

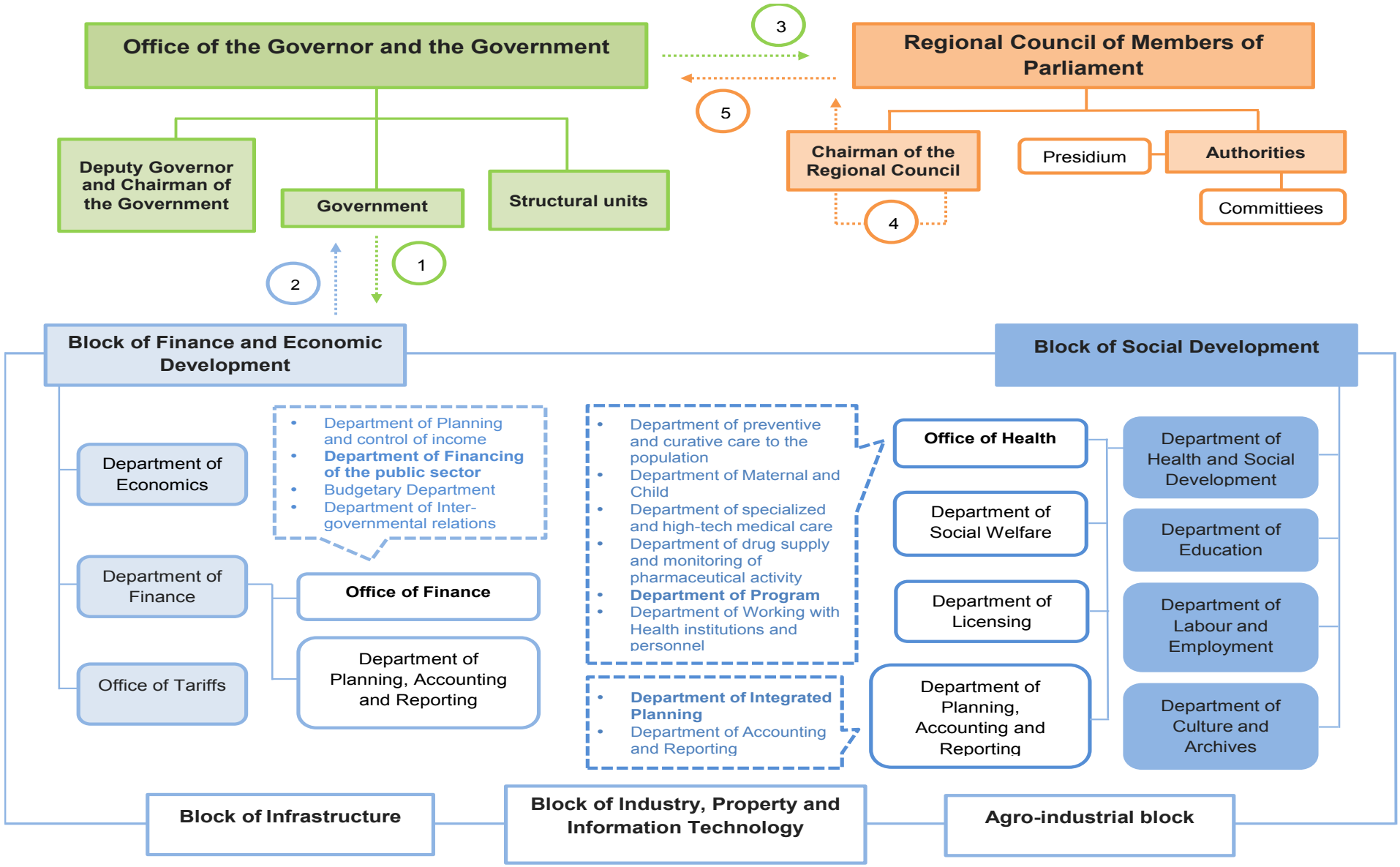


Exhibit 33. The structure and the relationship between the participants of the process of planning and budgeting. *Explanations: see page 114.*

Conditionally, the *evolution of the budgeting process areas can be divided into three periods* of reform. *The first* involves bringing the current budgeting system in accordance with the requirements of the Budget Code of the Russian Federation in connection with the adoption of the Federal Law of April 26, 2007 № 63-FL[79]. This period covers the time period from 2007 to 2009.

The second period is connected with the implementation of the Concept of Regional Finance Reform in 2009-2011 (the actual implementation was scheduled for 2008-2010). Since 2012, started *the third period* of restructuring, characterized by "a full-scale introduction of program-oriented principle of organizing the activities of the executive branch" in the development and implementation of programs to improve the efficiency of public spending. The above activities are covered in the aggregate regional finance program undertaken by the Department of Finance, which represents the authority of executive power of the special competence of Orel region. In this program, to the introduction of elements of PBBS was dedicated a separate section entitled "Implementation of medium-term results-oriented budgeting".

Features of the draft regional budget, the procedure for its consideration, approval, order of changes of the budget area, compiling reports on the performance of the regional budget and its approval is set by law of Orel Region, 6 December 2007 № 724- RL "On the budget process in Orel" (Hereinafter - the Law №724-RL). This law sets a list of participants in the budget process in the region. It should be noted that the need for regulation of the budget process at the subnational level is debatable. On the one hand, the list of participants in the budget process and their powers is established by the Budget Code of the Russian Federation, in connection with which the duplication of similar provisions in the legislation of the sub-federal level seems to be redundant. From the other hand, the Budget Code also provides for the possibility of establishing the features of budgetary powers of the budget process, which are public authorities of regions of the Russian Federation, by the regional legislation.

In the process of drafting of the regional budget and medium-term financial plan are involved: ***Department of Finance*** area (which, along with the Department of Economics and Office of Tariffs of Orel region constitute a block of Finance and Economic Development), ***chief administrators of income*** of regional budget revenues (bodies of executive power of the special

[79] According to the amendments, was making the transition to the medium-term financial planning. Among the main innovations can also be identified: a reduction of the legislative approval process of the federal law on the federal budget from 4 to 3 readings, planning costs, based on the division of existing commitments and received, approval of the basic principles and positions of the budget classification of Russian Budget Code with simultaneous expansion powers of state and local governments in its detail. These changes were aimed at bringing Russian budget classification to international standards, as well as the introduction of an integrated plan with the budget classification accounts of budgetary accounting.

competence), ***recipients of regional budget*** (departmental budgetary institutions, such as health care, education, etc.). Furthermore, doing this work, the public authorities performing the functions of non-budgetary authority. For example, the Department of Economics develops the forecast of socio-economic development, and its preliminary results of the expected socio-economic development for the current year, provides methodological guidance and coordination of the preparation of long-term projects of regional target programs.

Organization of the draft regional budget provides the use of such planning tools as the forecast of socio-economic development, the main directions of budgetary and tax policy area, register of expenditure obligations, medium-term financial plan, etc. Since 2012 this list was supplemented by the public programs. And if the forecast of socio-economic development of the region allows to estimate the financial and tax potential of the territory (in terms of volumes of regional budget revenues for the next year), then the registry of the expenditure commitments reflects the "cost" side of the priority areas of government regulation. In this case, the predicted dynamics of socio-economic parameters serves as a benchmark for determining these priorities, aimed at balancing the economic development, and these priorities, in turn, determine the change in the proportions of the budget allocation.

In 2009, under the Concept of Regional Finance Reform in Orel region were have been developed and adopted legal acts regulating the design, implementation and evaluation of public programs[80] area, including long-term regional target programs and subroutines, departmental target programs and individual activities of the executive government of Orel region. Besides that, was formed a legal and methodological framework for the implementation of the medium-term financial planning, as well as the formation of order planning budget allocations. Later, in order to improve the effectiveness of budget expenditures there has been expanded its program component. The vast majority of regional state institutions received the status of public institutions of "new type" (so as to base their work on the self-financing). Autonomous institutions in the structure of the regional government agencies have taken a small proportion, which is typical for the majority of Russian regions.

Formation of the principles and directions of the budget (and tax) policy of the region in accordance with the Law № 724-RL is the exclusive prerogative of the Regional Government, and their development is carried out by executive authority of special competence in the field of finance and tax policy (Department of Finance). However, the legal framework of fiscal relations in the

[80] Resolution of the Government of Orel region from June 29, 2009 № 69 "On working with long-term regional target program", Resolution of the Government of Orel region from June 30, 2009 № 76 "On the development, approval, implementation and monitoring of departmental target programs Orel region".

region does not provide a procedure for promulgation of the main areas of fiscal policy and their design as a separate document. Basic principles and budget policy directions are included in the list of materials to be provided to the Regional Council of People's Deputies together with the draft budget, so their role is primarily to explain the logic of the current draft budget. It seems that the approval of the main directions of fiscal policy as a separate document, legally binding, would provide a higher level of fiscal discipline and, as a consequence, the responsibility of the budget process.

Forming of the registry of the expenditure commitments represents the assess of the volume of appropriations, i.e., the limiting of the volume of funds provided in the fiscal year which implementation is necessary for the execution of the existing commitments of the region, their validity and feasibility, as well as the quality of budget planning. For these purposes, the region of the Russian Federation establishes the most appropriate timing for submission of information, specifying the finance authority and the chief administrators of budget funds and registry form, i.e., the required level of detail. In accordance with the Resolution of the Government[81], Department of Finance forms a consolidated register of the following dates: Planning registry - no later than 1 July of the current financial year, adjusted the registry - not later than February 15 of the next financial year. The timing of preparation of this document is provided with sufficient consistency with the budget cycle at the regional level, however, the presentation of data makes it difficult to use for planning budget allocations. In practice, indicators of the registry are not applied in the preparation of the draft budget for the next financial year, i.e., predominance of a formal nature of connection of the registry of expenditure obligations and procedures for the area of the draft budget is obvious.

In Orel region, as in most regions[82], for the purposes of budget planning is been used a form of the registry of expenditure commitments based on allocation of types of expenditure obligations in accordance with kinds of budget allocations stabilized by the Budget Code of the Russian Federation (i.e., based on the position of the responsibility of the federal registry). In fact, the register is forming in two inconsistent forms, which implies additional time on the formation of the document. Methodological aspect of this problem is supposed to be resolved by changing the budget classification: at present, the Ministry of Finance developed approaches for streamlining the types of expenses of budget classification in accordance with the types of budget allocations. Technical tool to overcome this problem is to automate the preparation of the registry, allowing the

[81] Resolution of the Government of Orel region № 82 dated 30.06.2009 "On Approval of the Procedure for registry of the expenditure commitments of Orel region".
[82] E.g., paragraph 5.2 “Exploring of the legal regulation experience of the PBBS components”.

document to be set due different forms based on a common information base, consistent with the performance budget reports and the consolidated budget estimates.

The main and most difficult stage of implementation of budget reform in the Orel region is considered the transition to medium-term budgeting, i.e., the formation of the budget for the next fiscal year and planning period. In order to organize the transition to the medium-term budget in 2007 was made necessary changes to the law "On the budget process in Orel region". In addition to the basics of the process of development, approval and implementation of the medium-term budget, the Law now contains a legal basis for holding public hearings on the draft regional budget and the draft annual report on the implementation of the regional budget. Subsequently was adopted a relevant law of the Orel region June 16, 2008 № 783-RL "On a public hearing in Orel region," which establishes the procedure for organizing and holding of public hearings[83].

The first experience of such a budget was the formation of Orel Region Law № 735-RL, "On the regional budget for 2008 and the planning period of 2009 and 2010". Today, the task is to secure the area of the practice in the long term, improve the order of the draft budget, the development of a methodological framework of budget planning. The next stage of the reform is supposed to fulfil the planning practice of the regional budget in accordance with established procedures, including public hearings. At the same time, in order to ensure the openness and transparency of the budget approved, all materials to the draft budget for the next fiscal year and planning period should be placed in the media simultaneously with the introduction of the draft budget to the Regional Council of People's Deputies.

In order to execute the requirements of budget legislation, a compulsorily medium-term financial plan was developed. Indicators of the medium-term financial plan can be specified in the design document for the next period, but, at the same time, the medium-term financial plan adjustments when changes in the budget or in terms of the expected significant changes in the parameters of the macroeconomic development of the area is not required. Herewith, the basis for the calculations of the budget allocation for the planning period are the parameters of the budget for the next financial year (i.e., indicators approved by the budget law). The most widely used method of calculating of the budget allocations for the planning period is an indexing method, i.e., by

[83] In order to execute these provisions of the legislation, was developed and adopted the resolution of Collegium of Orel region on June 23, 2008 № 202 "On approval of the drafting of the regional budget for 2009 and the planning period of 2010 and 2011 and the Order of the development of socio-economic development of the Orel region for 2009 and the forecast parameters until 2011", which regulates the procedure for drafting a medium-term budget.

clarifying the parameters of the plan for the planning period and adding the parameters to the second year of the planning period.

Indices used for the purposes of budget planning, fluctuate in the medium term, which determines a substantial variability of basic parameters of calculating of the medium-term financial plan, as well as their low reliability and informational value on the expiration of a relatively short period of time. In this regard, compliance of the budget parameters and medium-term financial plan is provided only at the stage of drafting of the budget and its consideration of the regional Council of People's Deputies in the first reading. Next in the budget process medium-term financial plan is almost never used.

Examining the issues of performance budgeting, the authorities of the region emphasize the need to pay special attention to the issues of goal-setting, i.e., positioning of the "system of goals, objectives and indicators of achievement in each public authority in the medium term"[84]. Currently, these issues are set only at the level of social-economic planning and forecasting, where the main directions of development of key performance indicators and socio-economic status are formulated. However, the practice of preparing and submitting of reports on the results and the main directions of public authorities in Orel region is currently missing.

Nevertheless, it is appear to be difficult to give a comprehensive assessment of all transformations based solely on the legal and procedural documents. Most of the transformation is carried out in a relatively recent period of time, and is associated with the need to bring the practice of budgeting in accordance with the requirements of the Budget Code of the Russian Federation. As is undoubtedly a positive result can be attributed the ordering of practices in the compilation of the regional budget. At the same time, the budget process of Orel region, as most Russian regions, is characterized by the problem of low level of coordination of PBBS tools, on the one hand, and budgetary flows - on the other. Complication of organizational planning procedures and associated workflow is also a negative aspect. Study of regulatory implementation of PBBS tools by state authorities suggests that Orel region can be attributed with greater certitude to those regions of the Russian Federation, the budgeting process of which is still developing, dominated by a conservative component.

[84] Excerpt from the College of Orel region Orders from 10.12.2008 № 450-p "On Approval of the Concept of Regional Finance Reform of Orel region in 2008-2010".

6. Empirical investigation and case study results – from discourse to practice

6.1 How the rule of PBBS implementation is applied in practice? (RQ2)

6.1.1 Thematic analysis

Based on the material stated in the previous chapter, we have made an attempt to assess the availability of normative legal and methodological support of PBBS tools applied in the budget process. Assessment is carried out on the basis of fixation of fact of approval of orders (and/or methods) of PBBS tools used in the budget process. A list of these documents is provided below in Exhibit 34. When making a list of the documents (laws, regulations of the Government, guidelines, etc.) were taken into account the provisions of both the federal budget legislation, the tasks defined in the annual budget and the Epistles, forecasts of socio-economic development, and actually achieved results of PBBS implementation at the regional level. As a basis were taken the elements of a methodology for monitoring the quality of management of regional finances, developed by the Ministry of Finance of Russian Federation[85], and has been used in a similar calculation for the other regions of the Russian Federation technique (e.g., M. Solomko, 2012), which we modified forth by the latest changes in legislation and practice of PBBS implementation.

The values of the weighting coefficients are conventional and are used for purposes of this study as an example. Weighting factor equal to 1, is set for PBBS tools which receiving more widespread practice of PBBS implementation (such as register of expenditure commitments, prospective (medium) financial planning), especially in those regions where are implemented the programs of regional finance reform. Weighting factor equal to 2, is proposed to establish on referring on those PBBS tools which having the most «advanced» character (such as reports on the results and main activities, service quality standards, monitoring of the quality of financial management of chief administrators of budget funds etc.).

According to the results of the evaluation of the availability of normative legal and methodological support, with varying degrees of implementation of PBBS tools in the budget process, we define one of the three possible models of budgeting: conservative, developing or advanced. Herewith, ***«conservative»*** budgeting model is recognized if *none of the regulations cited as characterizing the degree of implementation of PBBS, was not approved* at the legislative level (sum of points weighting factors is 0). In other words, conservative budgeting model provides for a minimum level of implementation of PBBS tools (or elements) within the mandatory requirements

[85] On the exercise of monitoring and assessing the quality of management of regional finances: the order of the Ministry of Finance from 03.12.2010 №552 URL: http://www.minfin.ru

of the budget legislation of the Russian Federation. Thus, it is possible to ascertain the presence of a normative legal and methodological support, the formation of which is directly provided by the Budget Code of the Russian Federation and therefore havening a mandatory nature.

We can talk about ***«developing»*** budgeting model, if in the organization of the budget process is been used *at least one of the components which the most widely spread in the practice of budget reform* (in our specific case the range of points must be from 1 to 8 points inclusive). It is believed that the regions with the given model budgeting are actively involved in the process of reforming of the budget process, guided by the conditions of the federal legislation in this area, the federal program documents and the whole experience of the federal center.

Finally, if into the budgeting process *was implemented at least one of the components of advanced character* (in the simultaneous presence of all the components which have been widely used), the budgeting model can be attributed to the type ***«advanced»***. In this case, the sum of weighting coefficients points would be in the range of 9 to 16. Within this model of budgeting, regions implement the budget reform faster (compared to most of the regions of the Russian Federation) pace, introducing whose of PBBS tools, for which the current guidelines of the federal level either are not elaborated enough or absent.

Conducted analysis allowed us to conclude that Orel region can be attributed to the number of those regions belonging to so-called developing budgeting model. In addition to the established by budget legislation mandatory legal acts, in the region were taken some of the most widespread legal acts and methodological materials describing the appropriate degree of integration of PBBS tools. Estimation value (according to the table) is equal to 2 points.

Separately, we have also assessed the presence of normative legal and methodological support, the formation of which is directly provided by the Budget Code of the Russian Federation (having mandatory nature), providing a minimum level of PBBS implementation.

The score in a similar way was based on the principle of fixing of the fact of the existence of an appropriate legal act. If the legal act regulating the procedure of budgeting, has been approved, the indicator is set equal to 1. Otherwise, the indicator is set equal to zero. List of mandatory legal acts regulating the budget process which was used in order to make the evaluation, is presented in Appendix 3.

Exhibit 34: Assessment of normative legal acts, characterizing the introduction of PBBS tools into the budget process of the region (as of 01.01.2013)

Kind of activity	Name of the normative legal act		Value	Weight coefficient
	Widely spread documents	Documents of «advanced» nature		
Planning	Procedure and methods of tender distribution of budget allocation for execution of the commitments accepted		«1» - approved; «0» - not approved	1
	Procedure and methods of compiling of reports on results and main activities of the entity of budget planning		«1» - approved; «0» - not approved	1
	Procedure for determining the standard costs of delivery of public services (works) and regulatory costs for the property located in the operational management of state institutions		«1» - approved; «0» - not approved	1
	Methods and procedures for project of the evaluation of program documents and effectiveness of the implementation of long-term regional target programs		«1» - approved; «0» - not approved	1
Planning, control	Procedure for the development, approval and monitoring of implementation and adaptation of departmental target programs		«1» - approved; «0» - not approved	1
	Procedure for the development, approval and monitoring of the implementation and corrections of government programs		«1» - approved; «0» - not approved	1
Forecasting	Procedure and methods of forecasting of budget revenues (using the formalized approach)		«1» - approved; «0» - not approved	1
Control		Procedure and methods of assessing the effectiveness of budget expenditures (including the cost of budgetary investment)	«1» - approved; «0» - not approved	2
		Procedure and methods of performance audit	«1» - approved; «0» - not approved	2
Control, analysis	Procedure and methods of assessing the quality of financial management exercised by chief administrators of budget funds		«1» - approved; «0» - not approved	1
Operational control, monitoring		Procedure and methods of diagnosis of fiscal risks and operational management	«1» - approved; «0» - not approved	2
Accounting		Guidelines for the implementation of management (analytical) accounting	«1» - approved; «0» - not approved	2

... Decree №81 dated 30.06.2009 Decision of the Government of Orel region ***«On approval of the techniques and procedures for the evaluation of projects of program documents and effectiveness of the implementation of long-term regional target programs»***

... Decree №76 dated 30.06.2009 Decision of the Government of Orel region ***«On the development, implementation and monitoring of departmental target programs»***

Conclusion about the conformity of the legal requirements of the budget process to the requirements of the Budget Code of the Russian Federation can be made, if the summary score is equal to 10 points, that is, all of the legal acts are adopted. If the summary score is less than 10 points, the region of the Russian Federation is recognized as a public organization with inadequate budgetary process (on the basis of state regulatory and legal framework of the budget process). Thus, as a result of the analysis, a summary score of Orel region accounted for 10 points.

Provided in this section technique, in our opinion, is attractive and acceptable on the basis of the following items. While forming an assessment of the organization of the budget process under conditions of implementation of the PBBS model, the technique comes from a distinction, on the one hand, the requirements for the mandatory components of the organization of budgeting (represented by the positions established by the budget legislation, compliance with which is classified as a deviation from the proper organization of the budget process). On the other hand, it distinguishes innovations which concern the PBBS' tools implementation having recommendatory character. Thus, the technique enables to identify the limitations and the drawbacks in the field, and furthermore, to compare alternative approaches to budgeting.

6.1.2 Formation of a program budget in PBBS application context

For assessment and prioritization of budgetary policy it is considered to be important that mechanisms of registration of information about the effectiveness of the programs implemented in the budget cycle. One of such mechanism is the budget expenditure classification.

Modern budget expenditure classification does not establish fully the relationship between the functions of a particular territorial entity and its socio-economic objectives by linking the authorities of each of chief administrators of income of regional budget revenues and activities of regional policy in a particular area.

Cost distribution in accordance to programs and subprograms is made within sections and subsections, whereby the focus is on the allocation of budget funds for a variety of small items, while the expected results of expenditure in accordance with the policy priorities of the region are not justified. Program budget classification contributes to a greater extent the elimination of these drawbacks, by forming the cost according to the objectives of budget programs, thereby solving the

problem of identification of action of authority related to a particular set of activities aimed at achieving certain goals.

For example, Moscow's budget for 2012 and the planned 2013-2014 period was based on the program-oriented principle. Structure of target items of the program budget classification of Moscow includes:

- *targeted items of public expenditure of state programs;*
- *target items of non-program activities in the field established by public authorities;*
- *target items of other non-program costs.*

Three-year budget of Moscow is 90% of the state programs, implementation period which is 5 years, which is allowing to conclude long-term contracts and in a certain sense to ensure a predictable economic development. In the implementation of 16 state programs are involved more than 50 agencies.

Budget classification of program budget is implemented on the basis of certain principles of the formation of the budget programs themselves, their relationships and clear classification. Currently, there are a variety of directions and classification of targeted programs, such as based on the objectives, timing, level of formation, etc. (e.g., Molchanova, 2010)

For the purposes of program budgeting it is useful to clarify the existing criteria for the classification of programs, namely the level of formation, purpose, timing, and allocate further - in particular, departmental affiliation, tasks. We tend to classify budget programs, taking as a "starting point" the level of government, which is coordinated with appropriate programs (Exhibit 35).

How target-oriented budgeting principles are embedded in the regions of the Russian Federation? What are the positive elements which can be distinguished in a regional practice of forming and planning expenditure budgets in terms of their program component?

We have examined both the practice of forming the program budgets, and the program component of the regional budget expenditures of Orel region in terms of implementing the principle of program-oriented budget allocation, and have evaluated them from the perspective of the theoretical aspects of the budgetary expenditure classification of the program budget. For the formation of analytical conclusions were studied regional budget expenditures by category classification of expenses (Exhibit 36), and calculated the proportion occupied by the regional target programs in the budget structure area (Exhibit 37).

Exhibit 35: Classification of budget programs, depending on the level of governing

Criteria / **Types of programs**	**Formed and funded at the federal level**	**Formed and funded at the regional level**	**Formed and funded at the local level**
Level of governance	***Federal***	***Regional***	***Municipal***
Timeline for implementation	As a rule, a ***long-term*** (5 years or more)	***Medium-term*** (3-4 years) and long-term	As a rule, ***short-term*** (1-2 years)
Departmental affiliation	***Departmental*** (have a single administrator responsible for the implementation), ***interdepartmental*** (have several chief administrators, one of which is endowed with the functions of coordinator and is responsible for implementing of the program)		
Purpose of the program depending on the task	***Strategic*** (investment programs that involve long-term objectives of strategic)	***Strategic, tactical***	***Tactical*** (suggesting solutions to current problems of operational management)
Mechanism for selecting programs	Carried out the ***ranking and selection*** of projects, programs, all selected programs are funded at 100%		Generally all programs are accepted in accordance to the ***approved list of services***
Types of budget allocations	Any kind of budget allocations, including intergovernmental transfers		Allocations for the provision of public services
Procedure for review and approval	Examined by the Commission on Budgetary Planning, approved by government decision (federal, regional, municipal etc. level of authority)		Examined by the budgetary planning commission, approved by the order of department

The basic criterion for the classification of expenditures of the regional budget is departmental affiliation. In particular, the Department of health and social development of Orel region is assigned to code 010. Next, budget expenditures are differentiated by sections for each agency in accordance to the areas of activity (for example culture and cinema, public health, social policy, etc.). Within each area (or section) are allocated separate sub-areas (or sub-sections) (e.g., youth and health of children; inpatient care, high-technology medical care, outpatient care, social services for the population, etc.). The names of sections and subsections, their codes are set by the Budget Code of the Russian Federation, are the same for all the level of the budget system of the Russian Federation. Total budget legislation includes 14 sections and 100 subsections.

Exhibit 36: Classification of expenditure of the Department of health and social development of Orel region

Indicator of budgetary classification	Departmental code	Section, subsection	Expenditures, thous.
Education	010	0700	34901,9
Culture and cinematography	010	0800	4371,2
Health including:	010	0900	**4545932,5**
- ***inpatient care***	010	0900	***1071522,3***
- ***implementation of regional programs of modernizing of health care among the regions***	010	0900	***262565,3***
- ***hospitals, clinics, midwifery centers,*** *including:*	010	0900	***694473,2***
high-technology medical care	010	0900	*103981,5*
centralized purchase of medical supplies and equipment	010	0900	*27393,6*
support of the subordinate institutions	010	0900	*563098,1*
- ***maternity hospitals***	010	0900	***34466,1***
- ***implementation of public health functions***	010	0900	***78011,3***
- ***financial support for the purchase of diagnostic tools and antiviral medications for prevention, detection, treatment and monitoring and treatment of persons infected with human immunodeficiency virus and hepatitis B and C***	010	0900	***9383,5***
- ***purchase of equipment and consumables for neonatal and audiological screening***	010	0900	***5472,9***
- ***measures aimed at improving of medical care for patients with cancer***	010	0900	***63154,9***
- ***outpatient care***	010	0900	***375165,3***
- ***reserve funds***	010	0900	***806,9***
- ***implementation of regional healthcare modernization programs***	010	0900	***5425,2***
- ***implementation of standards of medical care, increasing the availability of outpatient care***	010	0900	***3371,6***
- ***support of the subordinate institutions***	010	0900	***57158,9***
- ***hospitals, outpatient clinics, diagnostic centers***	010	0900	***34655,5***
- ***activities aimed at promoting a healthy lifestyle among the population of the Russian Federation***	010	0900	***1097,0***
- ***social assistance and social payments***	010	0900	***189551,8***
- ***other gratuitous and irrevocable transfers***	010	0900	***152314,4***
- ***co-financing Fund***	010	0900	***85172,9***
- ***medical care in day hospital of all types***	010	0900	***12636,1***
- ***emergency medical care***	010	0900	***19487,8***
- ***sanitary and health improving care***	010	0900	***8018,3***
- ***provision, processing, storage and security of blood and its components***	010	0900	***71817,5***
- ***other health related issues***	010	0900	***1280103,5***
Social policy	010	1000	3272564,7
Total expenses...	010		7857770,3

Source: compiled by the author based on the law of Orel region on June 28, 2012 "On the performance of the regional budget for 2011".

In 2012 the Department of health and social development of Orel region provides for expenditure of the four sections: 0700 "Education" 0800 "Culture, cinematography," 0900 "Health", 1000 "Social Policy".

By the budget 2012 funding were provided 26 regional target programs, 9 federal target programs. By 20 programs the execution was held within the planned values. By 8 programs the execution was below the average, including the field of health (4 programs). In general, the budgetary allocations for the implementation of regional target programs amounted to 2 billion 961.6 million rubles, or 74 percent of the specified plan that is 4.2 times higher than in 2011, including at the expense of the federal budget of 2 billion 228 4 million rubles, and 733.2 million rubles from the regional budget. Costs for the implementation of the interdepartmental investment program for 2012 were formed in a volume of 2 billion 18.5 million, or 94.4 percent of the specified plan, including 1 billion 75.4 million - at the expense of the federal budget and 943.2 million - at the expense of the regional budget of Orel region. As a result, the level of program activities, both federal and regional, were amounted to 23.3 percent of total expenditures.

The regional budget of Orel region is characterized by a significant fraction of the cost differentiation, conducted through the regional target program in sections of the budget classification. The analytical data presented in Exhibit 37 shows that under the current practice of budget planning, the share of the regional target programs is slightly less than 6% of the total costs of the regional budget.

Expenditures which are characterized by the highest weight of program costs are: “Housing and utilities”, “Physical culture and sport”, “Culture and cinematography”, “National economy”. Five sections of expenditures do not have any program component. Such absence, regarding the section "National defense", is objectively related to the fact that under this section are only targeted subventions to local budgets for the implementation of measures on the primary military registration (i.e., to perform state functions). Section "Public debt service" objectively does not contain a program component, as it provides financing of payments on debt. Lack of program expenditures under the section "Mass media" can be considered as a drawback, since in this area to establish development targets would not have been a certain complexity in order to direct for their achievement budgetary funds under the program (as in the section "Health" or "Environmental Protection", for example). In addition, the four sections of the classification the share of program expenditure is less than 4%.

Exhibit 37: Share of program costs and costs of the regional budget of Orel region

Section	The share of program costs under the section classification, %
Government services	2,0
National defense	0,0
National security and law enforcement	11,0
National economy	11,5
Housing and utilities	30,7
Environmental protection	0,0
Education	4,5
Culture and cinematography	16,1
Health	***3,6***
Social policy	2,1
Physical culture and sports	22,3
Mass media	0,0
Public debt service	0,0
Intergovernmental transfers	0,0
Total share of program costs in the regional budget	5,8

Source: on the base of the law of Orel region on June 28, 2012 "On the performance of the regional budget for 2011".

The expenditures of regional budget, related to health care, are included in the programs to a lesser extent. Based on these data we can conclude that it is possible to talk about the program budget with certain reservations. Therefore, at the present stage Orel region has more than significant opportunities for expansion of the implementation of the program principle into budgeting process.

Nevertheless, it would be wrong to assume that all the costs of all sections should be presented in the form of programs. Program budgeting principles require the concentration of all costs within a certain budget major priorities (programs), allowing different versions of their constituent elements. In addition to target programs, large (state) programs may include various forms of expenditure, common goals and objectives within the strategy of development of the state and territory.

It is also necessary to note such feature of planning of program costs as the distribution of activities (routines) and financing of a program in several sections of budget expenditures classification. Thus, each program can be a tool for the implementation of several functions (functional areas) of the authorities of a region, as well as the state authorities of the Russian Federation, and local self-government.

Expenditure data on regional target programs of Orel region, which is scheduled in sections of the regional budget "Health", is systematized in Exhibit 38.

Exhibit 38: Regional programs funded under the section 010 "Health"

Program	Expenditures, thous.	Subprogram	Expenditures, thous.
Preventing of socially significant diseases in Orel region in 2011-2015	61599,2	"Oncology", including: activities in the field of health, sport and physical culture, tourism	35270,3
		Activities of regional program of healthcare modernization	26328,9
Complex of measures to assist of those person who have served a sentence of imprisonment, and to facilitate their social rehabilitation in Orel region in 2010-2012	80,0	Activities in the field of health, sport and physical culture, tourism	80,0
Moral and patriotic education of citizens for 2011-2015	3504,0	Activities in the field of health, sport and physical culture, tourism	3504,0
Comprehensive measures against drug abuse and illicit trafficking in 2010-2015	400,0	Activities in the field of health, sport and physical culture, tourism	400,0
Energy conservation in Orel region for 2011-2015 and for the foreseeable future until 2020 under the interdepartmental investment program	1000,0	–	1000,0
Priority actions for the prevention, diagnosis and treatment of cardiovascular diseases in 2011-2015	19345,3	Activities in the field of health, sport and physical culture, tourism	2981,8
		Activities of regional program of healthcare modernization	16363,5
Promotion of healthy lifestyle among the population of Orel region (2009-2011)	1000,0	Activities in the field of health, sport and physical culture, tourism	1000,0
Equipment of the facilities of infancy and maternity with modern medical equipment for 2010-2015	74467,9	Activities of regional program of healthcare modernization	74467,9
Purpose-ZERO	3500,0	Activities in the field of health, sport and physical culture, tourism	3500,0
Total...	164896,4	–	–
Total expenditure under section	4545932,5	–	–
Share of program expenditure in the total expenditure under section, %	3,6	–	–

Source: on the base of the law of Orel region on June 28, 2012 "On the performance of the regional budget for 2011".

In total the structure of expenditures of the Department includes seven regional long-term target programs and two regional target program totaling 164,896.4 thousand rubles. Thus, the program costs in the total expenditure on health in the region were 3.6% and 2.1% of the total expenditure by the department.

Assessing the practice of budgeting from the position of the theoretical principles of the budgetary expenditure classification of the program budget, it is impossible not to draw the following unimportant conclusions.

The *first conclusion* is actually the absence of a clear classification of budget programs and methods of their formation. Definition of the nature, role and place of the long-term, departmental and interdepartmental programs targeted in the budget process, the order of formation, implementation and evaluation of their effectiveness should be the responsibility of the relevant public legal education.

In budgeting process of Orel region, departmental target program is a document which defines the objectives and tasks aimed at implementation of the state policy in the established areas and kinds of economic activities. The program contains a complex of measures to address the problems, indicating the necessary financial resources, expected results and the implementation schedule. Long-term program represents a set of implementation measures coordinated with tasks, resources, and time which allowed an effective solution of the most significant issues related to social, economic, environmental and cultural development of Orel region. Thus, because of a lack of a clear definition of departmental and long-term program it is appear to be difficult to identify their essential characteristics and distinguish from each other. In general, these definitions contain features characteristic of any programs: goals, objectives, activities, resources, results and deadlines.

Herewith, despite the fact that the procedure of development and implementation of departmental target programs at the legislative level was approved back in 2009[86], their introduction into the budget process is not yet evident. The budget expenditure classification by the Department of health and social development of Orel region contains no rows, reflecting the costs of departmental target programs. Implementation of regional departmental target program "Development of Agricultural Cooperatives for the years 2014-2016" will begin in Orel region in 2014. The program is currently being developed by the Department of agriculture of the region.

The *second conclusion*, which is actually a consequence of the first - a violation of the principle of autonomy as such, when the expenditure commitments of budget programs should not "interfere". This situation arises from the absence of the statutory secured clear classification, definitions and essential characteristics of the budget programs. Thus, in the decision of the Government of Orel region emphasizes that "departmental target program is implemented by one

[86] See in particular the decision of the Government of Orel region from June 30, 2009 №76 "On the development, approval, implementation and monitoring of departmental target programs of Orel region".

agency, is developed for a period not exceeding three years, is not subject to division by the subprograms and is implemented as part of governmental subprograms of Orel region"[87]. On the one hand, specification of the features of departmental target programs should help to prevent further errors in the methods of their formation at the regional and municipal levels. On the other hand, such an interpretation of departmental target programs, suggesting their inclusion of other government programs, negatively affects the transparency of budget expenditure classification in general.

On the basis of the emphasized theoretical principles of the budgetary classification and grouping of target budget programs, we made an attempt to present the program budget for the Department of health and social development of Orel region (Exhibit 39), taking into account the above conclusions.

Program budget, representing the amount of expenses of the chief administrator of the program budget, taking into account the characteristics of each classification program allows to build a system of goals, objectives and activities in order to achieve the strategic outcomes of socio-economic development of public institution. There should be distinguished departmental and interdepartmental, long-term target programs and non-program expenditures in order to allow the establishment of a public authority responsible for the implementation of programs, as well as execution of expenditure commitments which not included in the program part of the budget expenditure classification. Let us explain some of the proposed formation of the budget classification of the program budget for the Department of health and social development of Orel region.

First, a group of departmental target programs included two target programs: the program "Complex of measures to assist of those person who have served a sentence of imprisonment, and to facilitate their social rehabilitation in Orel region in 2010-2012" and the regional program "Promotion of healthy lifestyle among the population of Orel region (2009-2011)". The basis of this criterion was taken the exclusiveness of administrator of budgetary allocations (i.e., of the Department of health and social development), and, consequently, the individual nature of responsibility. In contrast to the collective nature (as it can be observed in the case of long-term programs) it allows us to estimate the contribution of individual units of the administration in achieving the set of goals and objectives of the municipal entity as a whole. In addition, activities of these target programs do not coincide with the activities of long-term programs, and are short-term, that also distinguishes departmental target programs.

[87] See the above-mentioned document.

Exhibit 39: Classification of expenditure of the program budget of the Department of Health and Social Development of Orel region

Indicator of budgetary classification	Departmental code	Code of the target section	Expenditures, thous.
Departmental target programs including	010		1080,0
- program "Complex of measures to assist of those person who have served a sentence of imprisonment, and to facilitate their social rehabilitation in Orel region in 2010-2012"	010	5221000	80,0
- regional target program "Promotion of healthy lifestyle among the population of Orel region (2009-2011)"	010	5225200	1000,0
Interdepartmental target programs including	010		8404,0
- long-term regional target program "Moral and patriotic education of citizens for 2011-2015"	010	5221400	3504,0
- long-term regional target program "Comprehensive measures against drug abuse and illicit trafficking in 2010-2015"	010	5221800	400,0
- long-term regional target program "Energy conservation in Orel region for 2011-2015 and for the foreseeable future until 2020 under the interdepartmental investment program"	010	5223700	1000,0
- long-term regional target program of improving of road safety "Purpose-ZERO" for 2010-2015	010	5225600	3500,0
Long-term regional target programs including	010		155412,4
- long-term regional target program "Preventing of socially significant diseases in Orel region in 2011-2015"	010	5220400	61599,2
- long-term regional target program "Priority actions for the prevention, diagnosis and treatment of cardiovascular diseases in 2011-2015"	010	5224500	19345,3
- long-term regional target program "Providing of facilities of infancy and maternity with modern medical equipment"	010	5225400	74467,9
Non-program expenditure	010		4381036,1
Total...	010	-	4545932,5
Share of program expenditure in the total expenditure under section, %			3,6
Share of non-program expenditure in the total expenditure under section, %			96,4

Source: compiled by the author based on the law of Orel region on June 28, 2012 "On the performance of the regional budget for 2011".

Secondly, four long-term target programs funded by the Department of health and social development in collaboration with other agencies that cannot be attributed to departmental target programs, were included in the interdepartmental target programs. The remaining three regional

target programs were included in the group of long-term regional target programs. Period of their implementation suggests that the problems posed by these programs cannot be resolved in the normal course of current activities, and are aimed at achieving the strategic targets on the territory.

Third, non-program expenditures of the Department of health and social development were allocated in a separate group, which allows to determine the medium-term relations proportion of program and non-program expenditures. Ultimately, it also helps to create a more transparent and open mechanism for accounting elements of the program budget, establishing the level of accountability for results of socio-economic development of the territory.

Finally, the transformation did not affect the content of programs, their activities and performance indicators. Adaptation of budget classification similar to that proposed by us in the practice of the budget process should be based on needs and on the basis of a single budget system, differ in the degree of detail and organizational orientation. Thereby, the important issue becomes a connection of budget classification with the organizational structure and functions of the principal administrators of budgetary funds. On the part of the public finance system, it is assumed that it must ensure the integration and systematization of information on the state of budget target programs.

6.1.3 Features of practical application for sectorial budgeting

Analysis of the features of practical implementation of PBBS tools, namely long-term regional target programs (LRTP) in the health care sector was carried out in accordance with the plan shown below.

1. General characteristics of long-term regional target programs.
2. Approaches to their formation.
3. Approaches to evaluating of the effectiveness of program implementation.
4. General disadvantages (or limitations) in the implementation of LRTP (which we will examine in the last chapter).

   At the same time, when studied of approaches to the formation of long-term regional target programs and indicators to measure the effectiveness of their implementation, we paid a particular attention to some aspects such as:

   - How goals and objectives have been formulated in relation to the results?
   - How the results have been coordinated to funding?

- What are the indicators to evaluate the performance of the programs?

We should remind that the use of long-term target programs as an instrument of socio-economic development of municipal authorities is defined in Article 179 of the Budget Code, which establishes the authority to define the order of decision-making on the design, examination and approval of the draft programs and their implementation in the executive bodies of local government. In addition, the local administration must approve the procedure and criteria for evaluating the effectiveness of long-term target programs.

6.1.3.1 General characteristics of long-term regional target programs (LRTP) in health

Financial ensuring of LRTP is provided in accordance with the State Program of Orel region "Development of the health care industry in Orel region for 2013-2020", by implementing specific executors of programs – health care facilities of the region from the regional and federal budget. The program includes: a list of long-term regional target programs (example "Personnel health care facilities of Orel region for 2012-2015"), list of subprograms (example subprogram "Personnel maintenance of the health care system for 2013-2020"), target indicators and indicators of state programs, stages and terms of the state program, expected results of the state program (Exhibit 40).

Program goal is to ensure availability of medical care of Orel region and effectiveness of health services, the amount, type and quality of which should correspond to the level of morbidity and needs of the population, the latest achievements of medical science. The total amount of funds for the program is (in the amount of programs) 83 655 467.9 thousand rubles.

The program includes a block of long-term regional target programs in health, including the following:

1. LRTP "Providing of facilities of infancy and maternity with modern medical equipment" for 2012-2014.
2. LRTP "Priority actions for the prevention, diagnosis and treatment of cardiovascular diseases for 2011-2015".
3. LRTP "Preventing of socially significant diseases in Orel region in 2011-2015" (is indicated as an example in Exhibit 40).
4. LRTP "The older generation for 2011-2013".
5. LRTP "Promotion ofhealthy lifestyle among the population of Orel region for 2012-2016".
6. LRTP "Social support for disabled (accessible environment) for 2012-2014".
7. LRTP "Personnel of health care facilities in Orel region for 2012-2015".

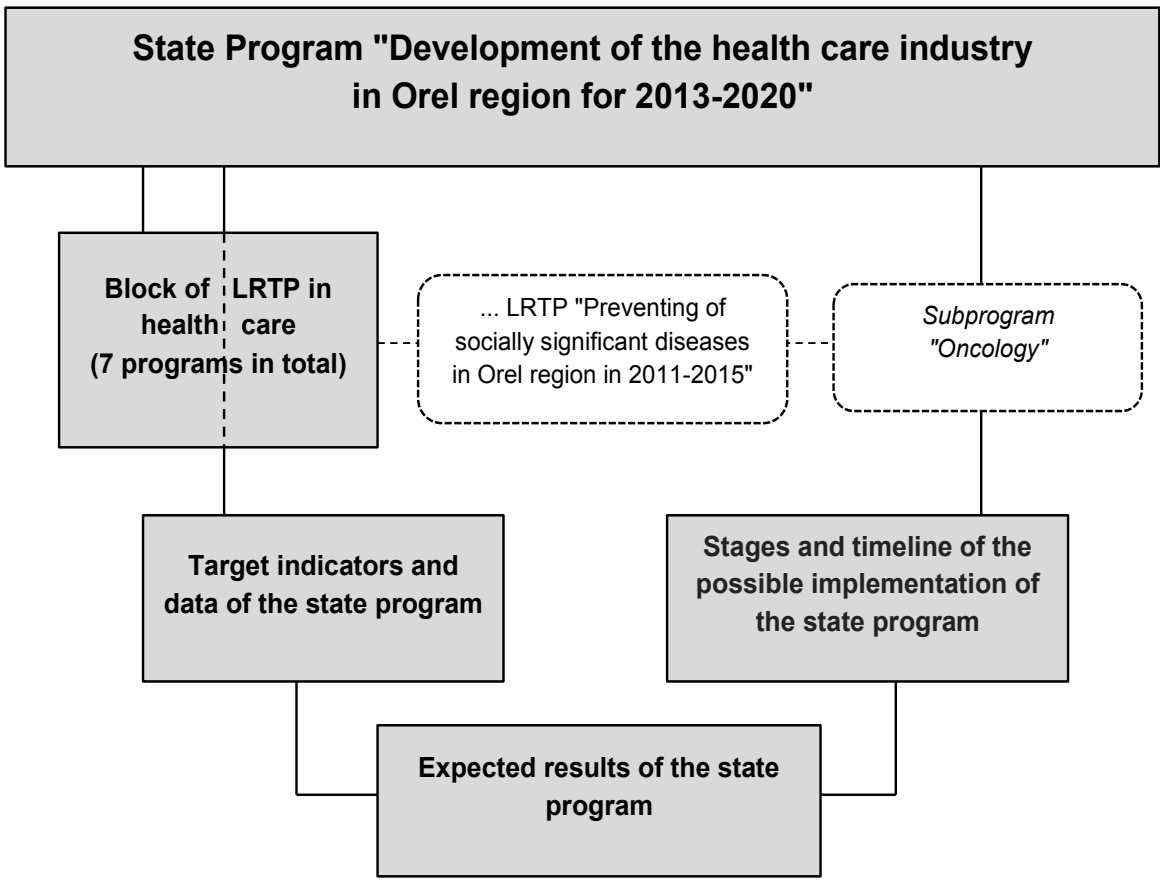


Figure 40. Scheme of the state program of health sector development in Orel region for 2013-2020.

Each of these programs has the following prerequisites:

- Passport of the program;
- Characteristics of the problem (the objectives), the solution of which is provided by the program, including the analysis of its causes, the expediency and need for program-target method;
- Goals and objectives of the program;
- Timeline of the program;
- Text description of the expected socio-economic outcomes of the program;
- List and description of program activities, including the composition of activities, information of the necessary amounts of funds allocated from the local budget and the timing of each event;
- Target values of the implementation measures and performance indicators of program by years for its implementation and end outcomes;

- Distribution of competencies and responsibilities of the main administrators of budgetary funds, responsible for its implementation;
- Justification of the resources needed to implement the program.

All LRTP are approved by the relevant resolutions of the Government of Orel region. The basis for the development of LRTP is order of the Governor of Orel region and (or) disposal of the Government of the Russian Federation. In all cases, the state customer of the programs is the Government of Orel region; responsible executive (state coordinator) – is Head of the Department of Social Welfare of the Department of health and social Development of Orel region. The main developer of the programs – is the Department of health and social development. All those details, along with the timelines of the program's implementation, the amount and sources of funding, goals and objectives, the most important target indicators and parameters, as well as the expected outcomes of the programs and social performance are contained in Passport of the program (see Appendix 4).

6.1.3.2 Approaches to the formation of LRTP

Considering the content of LRTP in health, it may be noted that, unfortunately, in some cases, the regional programs perceived as an analogue of federal target programs. An exemplary program is "Preventing of socially significant diseases in Orel region in 2011-2015". Its feature is the presence of subprograms ("Oncology", "Diabetes", "Mental disorder", "Tuberculosis", "HIV infection" and others - a total of 9 subprograms). Wherein, goals, targets, indicators and parameters, expected outcomes and indicators of socio-economic benefits are defined as the target for the program as a whole, and subprograms. However, achieving of final results depend on many factors, such as morbidity, impact ecological status (oncology), lifestyle of the population (HIV infection), the social situation in the region (tuberculosis), etc., for which the Department of health and social development cannot exert direct influence. Herewith, in this program was not detected any methodological approach for determining the extent to which this or that reduce of morbidity or mortality was due to the activities of the Department of health and social development.

Positive in the formation of LRTP, in our opinion, is a fairly high their differentiation: in Orel region was formed more than one program, which reflects all the activities of the Department of health, and the block of target programs in accordance with the directions of development of health care industry.

At the same time, in some cases, *funds of LRTP appear as additional funding* for health care facilities. Example of such a program is LRTP "Personnel of health care facilities in Orel region for 2012-2015", approved by the resolution of the Administration of Orel region. Its main objective is to provide health care field by trained professionals, professional development and training of medical and pharmaceutical employees, increase of social security of medical and pharmaceutical employees. As a key target indicators and measures are established: the indicator meet the need for additional training; rate of increase in wages. Finally, as expected outcomes of the program are scheduled increase of the availability and quality of medical care, as well as increase of ensuring with specialists with higher medical education for the medical facilities with low health understaffing of medical personnel. We would like to remember that the current health care system of Russia is characterized by an imbalance between the primary care and specialized medical care, when the level of development of primary health care is extremely low and tends to worsen. At the same time, world practice demonstrates the understanding of the law: the higher the proportion of primary care physicians in the total number of doctors (the ratio of the lower proportion of specialists), the less money is needed to achieve the final results of a health care system. Despite this, in the program "Personnel of health care facilities in Orel region for 2012-2015" there is no clear formulation of specific tasks aimed at solving this problem.

The majority of LRTP (except LRTP "Social support for disabled (accessible environment) for 2012-2014") does not provide for the cost of capital investment and R&D, and dedicated funding will be spent entirely on the cost item "Other needs". This allocation of funds is an indicator of the fact that this problem can be solved within the current funding, while target programs should combine and operating costs, and development costs.

In conclusion, the characteristic of the approaches to the formation of most LRTP is *no indication of a system for monitoring* activities of subordinate institutions.

6.1.3.3 Approaches to evaluating of the effectiveness of program implementation

It is expedient to emphasize at once that, for today, despite a great attention paid to improve the effectiveness of budget spending by the government, regions and municipalities, the system of evaluation of the effectiveness is not developed yet. A normative document, issued at the federal level and regulating the procedure for the selection of target indicators by regions also does not exist. Accordingly, each region of the Federation selects indicators, as best it can. It is reasonable to assume that the evaluation of the effectiveness of LRTP, taking as a basis in the calculation

indicators which incorrectly reflect the objectives of these programs, implies getting the results different from the reality.

Nevertheless, it would be wrong to say that there is no any standard establishing of the questions of assessing the effectiveness of budget expenditures by the executive bodies at all. Budget Code of the Russian Federation (Article 34 "Principle of effectiveness and efficiency of budget funds") stipulates that "...in the preparation and execution of budgets of participants in the budget process within the established budgetary authority they should proceed from the need to achieve the desired results with the least amount of funds or achieve the best results using a certain amount of budget funds". That is, at the heart of assessing of the effectiveness seen the result for the expenditure of funds in relation to the costs. From the above principle also derives that in order to evaluate the cost-effectiveness, it is necessary to compare them, or with the cost of a similar administrator of budgetary funds in one fiscal year, or the costs of the same administrator of budgetary funds, but for different periods.

It is important to understand that the evaluation of the effectiveness within the target item describes specific operations with money, and the evaluation of the effectiveness for the implementation of the state program – describes activities of the authority in terms of strategic planning and the ability to achieve planned expenditure. In this regard, and approaches should be different (e.g., Astashova, 2011). At the regional and municipal levels the positions of government and local government bodies[88] contain standards on improving the effectiveness as well as providing the complex of relevant measures, but not on the assessment of the effectiveness.

Recognize this fact as a fault of regional administrators of budgetary funds would not be quite right, given that the practice of evaluating the effectiveness has not been adopted yet at the federal level, and takes place in those countries where the introduction of PBBS has been going on for many years. Despite this, below we give some features of the actions of main administrators of the budget funds of Orel region in terms of their inconsistencies to the "advanced" PBBS principles.

The first thing we would like to note that the *choice of executors* of LRTP. Taken into consideration that in all cases the developer, administrator and executor of the programs is one and the same subject of budget planning (i.e., Department of health and social development), is not excluded such an aspect as "foreseeability" of the result of performance evaluation. This means that there is a probability of having a direct impact by the executor of target program on the value for

[88] See, in particular: Decree of the Government of Orel region from 29.03.2011 № 96 (eds. from 22.07.2011) "Approval Program "Improving the effectiveness of budget expenditures in Orel region for the period until 2012".

those indicators where the statistics depends on the actions of the executor himself, i.e., so-called administrative resource.

Second - is the *lack of a comparative analysis of the effectiveness of various programs* in the evaluation of socio-economic benefits of the program activities. In particular, one could compare LRTP pursuing a common goal (e.g., increase in life expectancy), or compare subprograms within a single LRTP. In the first case it is advisable to use the analysis of the "cost-benefit", i.e. when the original result set, but there are different ways to achieve it. An alternate method is the "cost-benefit" (which can be applied in the second case), when, based on this analysis, as a result of the reallocation of funds from one subprogram of a single LRTP to another, it would be possible to achieve significant positive results (for example, as a result of the reallocation of funds from the subprogram "HIV infection" of LRTP "Preventing of socially significant diseases in Orel region in 2011-2015" into the subprogram "Vaccine Prevention" of the same LRTP).

Finally, the third feature, typical not only for Orel region - is the use of performance indicators for the current fiscal year as the basis for assessing the effectiveness of the program. It is known that a measurable effect on the number of programs cannot be detected in a single financial year. E.g., for assessing the effectiveness of drug treatment programs it is take time to identify the percentage of successfully treated patients. Further, most of the target indicators of long-term target programs are based on annual statistics published in February-March of the year following the reporting year, and the key decisions on prolongation of target programs, their inclusion in the budget, etc., must be taken six months earlier, in September-October-year reporting, that is, the time when the process of review and approval of the next year's budget. Accordingly, in practice, the authorities are forced either to decide on the target program in autumn, but based on incomplete statistics, or make decisions next spring, but given the fact that the budget is already complete and approved, and the space for this target program may already not be found.

6.2 How do the actors make sense of PBBS discourse? Responses to institutional processes (RQ3)

What is the meaning of the term "effectiveness"? By what criteria is evaluated the effectiveness of the budget spending?:

(approximately the same answer was given in the executive and legislative authorities, referring to the federal budget legislation) *"... all in all it is improvement in performance at constant or reduced costs".*

That is, the effectiveness is primarily with the ratio of the result and the costs incurred. In accordance with the Presidential Decree № 825 "On the evaluation of the effectiveness of the executive authorities of the Russian Federation" senior officials of the regions report to the federal government in the long list of indicators (or, at least, should report). According to these indicators, the Ministry of Regional Development composes a rating of the effectiveness of executive bodies of regions of the Russian Federation. The volume of ineffective spending is defined in absolute monetary terms, while the Ministry has developed for itself a formula that calculates the ineffective spending for each region of the Federation (but this approach is only of the Ministry of Regional Development). In fact, the region distance considerably from each other.

Technique that uses the Ministry of Regional Development, raises many questions concerning how the procedure of calculation of ineffective spending is truly related to ineffective expenditures. In fact, ineffective is considered the spending on redundant infrastructure. But the answer to the question to what extent the infrastructure is really redundant, is far from obvious. As it was noted in an interview with one of the representatives of the Department of finance, the existence of rating the effectiveness of the authorities has little influence on the activities of these executive authorities, therefore attempts to reconsider seriously this mechanism have not been taken yet.

According to one of the experts – at the level of hospital (answer from medical facility "Regional hospital of the city of Orel") *"An indicator of "effectiveness" for us is the indicator "treated patients" and/or "complete case"*[89]*. According to the standards of Territorial CHI Fund, complete case is referred to a patient who was discharged after 4*

[89] The term "complete case" enshrined in law in accordance with the state guarantee of the provision of free medical care to citizens as a way to pay for health care (with a distinction between "complete case of hospital treatment" and "complete case of treatment in the clinic", etc.).

days of hospital stay (up to 2012 this norm was adequate to a period of 14 days). In fact, the hospital is "interested" in the discharge of patients after 4 days, although, of course, he can stay there longer, but in this case, the funds for reimbursement for the medical facility above a certain limit will not be refunded".

We suppose that this example shows that the notion of "effectiveness" is associated primarily with allocated resources and the ability to "meet" the statutory norms without actually binding to the "social" results. On the one hand, the reduction of norms of duration of hospital stay in this case should help to reduce the average duration of hospital stay and the number of day hospitals themselves. On the other hand, there is a risk of re-hospitalization in order to obtain new financing. As a result, the effectiveness of the activities of medical facility are difficult to interpret unambiguously.

At the level of clinic (answer from medical facility Regional policlinic №1)

"... performance indicators as such we have not calculated, with the exception of indicators for paid medical services, which concern a calculations of their profitability, but not effectiveness".

At the level of Territorial CHI Fund the situation is similar, the indicator of the effectiveness cannot be calculated, except for paid services.

How then the effectiveness of budgetary funds in terms of PBBS implementation can be calculated?

"... For today, while there is no specific methodology, executive authorities as one of the indicators consider future returns in the budget area in the form of revenue, based on the ruble invested today. However, this indicator can be used primarily in industries such as agriculture (subsidies to the livestock industry in accordance with the target programs) and other sectors of the economy. In health and education, it is "preferable" to focus on the social impact, which in numerical terms is extremely difficult to determine" (in the Department of health and social development under the effect of social indicators intend the decrease of mortality, life expectancy, etc.).

Wherein the ***control over the efficient use of budgetary funds*** consists in comparison of the actually achieved state of the health care industry, with a baseline at the beginning of the target program. At the federal level the calculated indicators are: improving the demographic situation, increase of welfare of the population, increase of quality and accessibility of health care, etc. On average over the Russian Federation these figures have the same value, and Orel region about the

same proportion expect to increase or decrease its values and then compared the “fact” and the target value.

How the activity of various agencies (departments) is coordinated (or does not) to implement various measures of government policy and instruments for their implementation?

The transition to the new principles of the budgeting requires, first of all, a redistribution of responsibilities between both authorities and institutions subordinated to them, since in order to achieve certain goals, it is necessary to clearly understand the limits of one’s responsibility. Therefore, a certain part of the measures to improve expenditure effectiveness is devoted to the division of the authorities. Since the programs should be formed not on a departmental basis, but on the principle of achieving the goals, all departments (except force departments) should transfer the provided funds (for example, the maintenance of health facilities and provision of health services) in the state program "Development of the health care industry".

Herewith, administrators of budgetary funds remain the same departments as before the transition to the principle of program-targeted use of funds. Another important element is goal-setting, and therefore the activity of controls should be decomposed into clear goals, objectives, activities and indicators for their implementation. Most fully meet these issues the reports on the results and main activities. In Orel region practice of their compilation is not yet presented.

> As noted by one of the experts (answer from the representative of the Department of finance),
>
> *"... in general, the implementation of complex of the activities in accordance to the Program of increase of the effectiveness of budget expenditure runs quite difficult. It was assumed that the program will partly simplify the procedure of the interrelations between main administrators of budgetary funds and subordinated facilities. Attempts are being made in order to streamline a service delivery system, so as to make it clear what service and what quality should be provided by the facilities. That is, on the one hand, these measures are aimed at improving relations formalized in the provision of public services and the budget allocation between those who provide these services. On the other hand, it should help to raise awareness of the citizens. However, still there is some confusion here".*

In particular, we are talking is about the State Program of Orel region "Development of the health care industry in Orel region", which includes a block of long-term regional target programs, also there other regional target programs, as well as federal target programs acting in Orel region

for co-financing. All these tools duplicate each other in many aspects. If it were possible to aggregate them into a single state program, then everything would be transparent, and most importantly there would be a clear mission of the authorities.

An attention should be paid to such an important point, as the ***responsibility*** of the subjects of the Russian Federation (i.e. regions) to implement the programs to increase of effectiveness of budget expenditures. Analysis of the regulatory framework indicates that at the legislative level, such a responsibility is not prescribed. Nevertheless, in today's fiscal reforming, elaboration of programs becomes a necessity. In particular, the implementation of Law 83-FZ provides for the mandatory implementation of measures to improve the effectiveness of spending. Thus, the "relationship" with the federal center are built with an eye on what is being done in the region to increase the effectiveness of public spending. In particular, the results of monitoring of the implementation of regional programs to improve cost effectiveness, along with the other conditions are the reason for the provision of additional financial assistance from the Federation to the regions. Furthermore, the requirement of effective budget spending is fixed in the Budget Code of the Russian Federation (Article 34 "The principle of effectiveness and economical use of budgetary funds").

How (if implemented) priorities used to be set when planning expenditures?

As was noted by one expert (answer from medical facility Regional policlinic №1):

"... We would set priorities, in certain cases they are absolutely necessary for us, but we are completely limited with autonomy. Costs should be clearly tied to the volume of allocated funds. Prior to 2003, the structure of hospitals and clinics were centrally organized; from November 2003 occurred a decentralization in governance and clinics received the right to manage their finances. Despite this, to date, they have no opportunity to reallocate funds in accordance with the priority areas of spending, as it is prescribed by the superior organizations".

"... In such cases, i.e. in case of the need to increase funding for priority expenditure items, we would have to ask the higher authorities to take off from us outpatient visits, that would result in decrease of the vacancies and increase the tariff".

What are the main limitations of the planning and funding of health care today?

Regions are free to decide on the choice of specific methods of payment for medical assistance under the Program of state guarantees. Wherein methods of payment for medical care and rates of payment for medical care under compulsory health insurance are set by the agreement

between the authorized state authority of the region, Territorial CHI Fund, representatives of health insurance companies, professional medical associations, trade unions and health professionals. The correction coefficient for the cost of medical care profiles and specialties, as well as appropriate approaches to creating methods to pay for medical care, are set by the regions themselves, taking into consideration the recommendations of the Ministry of Health and the Federal Mandatory Medical Insurance Fund, and regional particularities. Currently, medical care payment methods vary greatly in different regions, and are grouped as follows.

1) When paying for medical care provided in an outpatient conditions:

- per capita funding of attached individuals in conjunction with pay-per-unit volume of care - for medical services, per visit, for treatment (complete case);

- per unit of volume of medical care - for medical services, per visit, for treatment (complete case);

- per capita funding of attached individuals considering performance indicators of medical facilities, with the inclusion of the costs of medical care provided in other health care facilities.

2) When paying for medical care provided in a hospital:

- per complete case of treating a disease;

- per complete case of treating a disease included in the appropriate group of diseases (including clinical and statistical group of diseases).

3) When paying for medical care provided in a day hospital:

per complete case of treating a disease.

4) When paying for emergency medical care, provided out of medical facility (at the place of the call):

- per capita funding;

- per call for emergency medical care;

- per capita funding in conjunction with pay-per-call emergency medical care.

Lack of unity in this matter raises a serious drawback, which is the diversity of approaches to the choice of payment for medical care that does not allow to analyze comparing the costs, as well as effectiveness and quality, without which it becomes impossible to judge the effectiveness

and efficiency of health care in general. The acuteness of this problem is amplified by the fact that in the Russian Federation in-patient expenditure account for over 50% of total public expenditure on health care (in many western countries the share is between half and two-thirds of total government expenditure), wherein the main parameters determining the costs are hospitalization and length of hospital stay. That is, in fact from the survey conducted by us follow that the question of how the definition of effectiveness on the level of medical facility is not a priority at the moment. At the same time according to the results of a review of international experience[90], which includes the results of more than 300 studies on the effectiveness of inpatient medical care, was concluded that the average cost-effectiveness of hospital is 85%. This means that hospitals could provide services to more than 15% under the same cost, or provide the same range of services, reducing costs by 15%[91].

We can say that for today has been made an attempt to implement an integrated approach to the use of methods of payment for medical care in different regions of Russia. With the same time, there is an evident influence of a number of constraints:

- firstly, the lack of complete and reliable data on the actual resource security and a different level of preparedness of medical facilities;
- second, a variety of methods for accounting and calculating the actual costs in medical services;
- third, the lack of uniform approved methods for calculating tariffs for medical care, including common reference of average cost of various inventories.

In medical facility (“Regional hospital of the city of Orel"), taken in to consideration its orientation (day hospital, fulltime hospital and outpatient care) as a method to pay for medical care is used:

1) per unit volume of medical care - for medical services, per visit, for treatment (complete case) - payment of medical assistance provided on an outpatient basis;

2) complete case of treating a disease - when paying medical care provided in a hospital.

Having the ability to select the method of payment for medical care medical, medical facility could choose a more "progressive" method of payment, such as per capita funding of

[90] From the Letter of Ministry of Health of the Russian Federation on 20 December 2012 № 14-6/10/2-5305 recommendations about the direction of "Methods of payment for medical care under the program of state guarantees on the basis of groups of diseases, including clinical and statistical disease groups (DRGs)".
[91] Herewith, there were no significant differences between hospitals of USA, Europe or other regions.

attached individuals taken in to consideration performance indicators of the medical facility, with the inclusion of the costs of medical care provided in other medical facilities[92].

At the level of clinic (answer from medical facility Regional policlinic №1)

"... The main drawback of planning of the activities of health care facilities, in my opinion, is that we actually "tied" to a self-sufficiency. And this despite the fact that this clinic is not-for-profit organization, and from the regional budget from 2003-2004, it is practically not funded. Funding for the 90% comes from compulsory health insurance fund, calculated for actual visits planned in the Program of state guarantees. Exceeding of regulatory values are not funded. Limits and standards are set in a strictly centralized manner, state tariffs "descended" in accordance with specialization (oncologist, therapist, etc.)".

"Since 2004, the estimate of income and expenditure of the clinic was replaced by the plan of financial and economic activities, but the principles of its compilation is actually the same as for estimates. In recent years the plan is prepared for one year and the medium term. In 2013, the plan laid to 2014-2016. Regulatory framework for planning process remains centrally limited. Planning department of the Clinics is not involved in the correction of standards, they are completely set at Territorial CHI Fund and the Department of Health and social development".

We should note that in interview with two representatives of the medical facilities, more or less clear answer to the question "What is the scheme of funding of health care today?" we have not received. According to 1st representative of medical facility, since 2004 was actually practiced a single-channel funding as follows: funds from the regional budget is directed to the Territorial CHI Fund, which then sets the tariffs for medical services and pay for the services of medical facilities. While the 2nd representative was undecided with the answer.

At the level of executive authorities of special competence (answer from the representative of the Department of health and social development)

Another "block" of the problems is associated with came into force the law (Federal Law of May 8, 2010 83-FZ), which is the main document governing the reform in budgetary sphere. According to this law, all state (municipal) institutions are divided into state-owned (fully financed

[92] The most efficient in the world practice today accepted to the methods of payment for medical care methods on the basis of groups of diseases, including clinical and statistical groups of diseases. In Russian practice, there was not accumulated considerable experience in this field yet.

from the budget), budgetary (for example, some educational institutions - state-owned - partly financed from the budget), and autonomous. In order to enable them to define their status, legislators gave time (transition period) - up to July 1, 2012. If the institution is not ready to fundamentally change the system of financing, it can choose the status of public institution (until the institution is not determined the new status, it should function according to the norms stipulated for state-owned institutions). If we are talking about public institutions, the funding comes within the approved estimates. Budgetary and autonomous institutions are funded differently. They are provided with subsidies in order to perform state assignments. Budgetary institutions have the right to render services within the established by the government state assignment for a fee (of course, if this option is legally admissible). In that case the subsidies are calculated on the basis of planned revenue. The largest share today undoubtedly falls on public sector institutions.

*"... Herein, the **problem is to determine the value of standards of one public service**. Before the transition to market economy mechanisms, these ratios were scientifically justified; today, over time, we have actually "left" scientifically based standards (primarily due to their "obsolescence"), without introduction of new regulations (e.g., food standards in schools: food staffs counted in accordance with their cost - food standards). In modern conditions, scientifically based calculation of cost standards of public service in the budgetary facilities is obstructed by the lack of new techniques (e.g., how to determine the standard cost per bed-day with all the articles included there - wages, cleaning of rooms, food supply, soft equipment, electricity, etc. taking into account the effects of inflation, and so on?)...*

... The question that may arise here is: were there such scientifically based standards earlier? The complexity of their calculating in the transition to target-oriented principle of budget allocation is caused, primarily, by the disparity between the structure of the budget classification to the requirements of the program-oriented principle as such: all costs today are divided in to programs, and the former mechanism for calculating the standards becomes impossible to use (old standard cannot be used because it is calculated using the same methodology for health, and the new one cannot be calculated because the budget expenditures now are divided according to program belonging, but not according to the cost items). That is to say, standards should be developed for each spending program since every program is designed in order to meet its specific objectives".

Another limitation of the Law 83 -FZ is the fact that, since science-based rules for determining the cost of public services are not available, it turns out that to budgetary institutions, in particular educational institutions and medical facilities, was given an opportunity to establish the

structure of certain expenditure items. So, for example, before entry into action of the Law, expenditure item "wages" was highly detailed, i.e. contained concretized amounts on wages for junior staff, head physician etc. Now there is no such specification, whereby supervisors are able to use this opportunity to their advantage, i.e. the whole process become less "transparent, but within the established by law minimum. The law establishes a minimum salary, which cannot be underestimated, and the decisions of the various allowances are made by the supervisor himself. Specifically, such decisions can be based on so-called quality management system, which can be used in some universities or medical facilities.

As a result, due to the complexity of simultaneous transition to normative and per capita method of financing in public sector, the Department of finance of Orel region in its Methodical recommendations for the calculation of the cost of public services, allows the use of the formation of an alternate accounting method for calculating the per capita cost of public services. This method of accounting and planning costs of providing public services includes calculation of the cost of the public service per unit of its rendering, but is determined on the basis of the amount of actual costs for existing units of public services in budgetary institutions. This approach is chosen by the chief administrators of budget expenditures as a transitive one, before the adoption of the procedure for determining of standard costs based on industry-specific framework.

Why the PBBS method cannot be fully implemented then? Taken in to consideration the fact that the target programs are funded (even if not 100%) at the expense of the federal budget?

Answer of one the deputies of Orel regional Council of Members of Parliament:

"... the reason is the lack of indicators as such to measure the effectiveness of budget expenditures in accordance with the new approach. The Law 83-FZ has no scientific justification of the cost of one public service".

"... The PBBS approach (PBBS term and target-oriented principle of financing are used interchangeably) cannot be completely realized if the budget is not enough provided with own revenues". In particular for the implementation of target programs budget of Orel region is provided by own income by about 5% - in terms of the amount required for its implementation, and 95% is financed from the federal budget. Volume of program funding from the regional budget will vary depending on the priority of a program (the construction of major facilities of federal significance, such as perinatal center of Orel, which is almost entirely funded from the federal budget). That is, the 95% in accordance with the program is provided with super-modern equipment, etc. and the capacity of the regions (depends on donor / recipient). *"... In any case, the only federal funding is*

not enough to efficiently and to fully implement the program, and if there is insufficient equity at the regional level, the program is being implemented "at a minimum" (too many problems to effectively distribute these 5%)".

What measures to increase effectiveness of budget expenditures have been already implemented in to the planning process? If no, how ready the current budget system was for the transition to the new budget "rails"?

Despite the changes introduced in the budget legislation, until now the regional budget drawn up and approved for one financial year. Transition to the formation of the regional budget in accordance with the program-targeted principle is scheduled for 2014, in 2013 the same year made a "pilot" tentative version of the regional budget, based on a three-year period.

"... The main problem in this case is to calculate how much money we will eventually need to implement measures necessary to achieve the results that are directed by the target programs, and on this basis to form the program budget. However, based on the budget classification and budget reporting in the form in which they are now, the Department of finance is not able to understand what the goals actually pursues the chief administrator while spending budget funds, and for what tasks they are used. The current budget classification does not allow to form the budget, and, moreover, to report on its performance in an accessible form for specialists, not to mention the citizens". (From the answer of the representative of the Department of finance)

> *"...* ***In practice it is the same budget that was before the programs have been implemented****, summed in accordance with the programs, but on the basis of available resources. This is actually all the difference, that's the "downside".* It means that for today there is no scientifically based methodology in general, and particularly the allocation methodology for each program in accordance with the routines that should be detailed at the regional level.

At the same time, funding for the development of the sectors as health care remained unchanged, as well as the priorities in budget allocation as such have not changed. That is, to date linking goals and objectives with a budget in a single logical chain has not yet succeeded. Apparently difficult comes the realization of the fact that the budget money should be spend not just on salaries of officials, teachers, doctors, etc., but be "fastened" for achieving the result.

But the main reasons for the difficulties of the transition from budget financing to the funding of public services are seen as following:

- Lack of uniform standards of public service delivery;
- Inability to perform all regulated requirements for the process of the public service provision within the existing budget;
- Lack of interest from the side of main administrators of budgetary funds and budget recipients in innovation because of possible risks of transition.

How the transition from estimated funding to program funding method is reflected on the volume and nature of the public services provided to the population?

In practice, the policy of "poor" (or subsidized), and the "rich" (or recipients) regions varies. This is due to the fact of various "opportunities" of these regions of out of the crisis: due to slow growth of income tax, and, as a consequence, low revenue base, subsidized regions have a small revenue base (Exhibit 41). While the rich regions, are gradually emerging from the crisis, and showing (although slow) increase of income tax. At the same time *"... highly subsidized regions, including Orel region, are on the verge of a severe reduction in transfers. For such regions, the first measure is still spending cuts".* In the next step, ones can already talk about improving the effectiveness of spending, while available for recipients regions. Currently, this task is rather complicated, because of too much different socio-economic development of the regions: 74% of tax revenues of the consolidated budget of the Russian Federation received from 10 regions of the Russian Federation, which are inhabited by 29% of the whole Russian population.

Exhibit 41: The share of own sources of revenue and grant revenue (as a percentage of total revenues) of selected territories

Name of calculated index	2009			2011		
	Own incomes	Gratuitous receipts	Other incomes	Own incomes	Gratuitous receipts	Other incomes
In Orel region	***47,6***	***44,8***	***7,6***	***48,5***	***42,5***	***9,0***
The minimum value for the Central Federal Area (CFA)[93]: Kostroma region	43,2	39,6	17,2	44,2	36,1	19,7
The maximum value for the CFA:						
Moscow	80,3	4,7	15,0	77,6	10,9	11,5
Moscow region	63,1	17,7	19,2	69,9	10,2	19,9
On average in the CFA	51,9	38,0	10,1	58,0	31,1	10,9
On average in the Russian Federation	61,1	27,3	11,6	65,6	23,1	11,3

Source: calculated by the author based on the Goskomstat (State Committee on Statistics of Russian Federation) data.

[93] Central Federal Area includes 18 subjects (regions) of the Russian Federation.

Financial authority, based on projected revenue, determines the limit amount of funding (which is then transmitted to the health care sector) and the actual costs of the last period on the basis of existing and accepted expenditure commitments. I.e. this funding is calculated based on the actual costs of the previous period (the same method "from achieved") and on the existing and accepted expenditure commitments. Before 2013, at the expense of CHI were funded 5 items of expenditure - wages, accrued payroll, medicines, nutrition, soft equipment. The remaining items of expenditure financed from the regional budget. That is, the cost of patient-day included salary accrual, medicines, nutrition and soft equipment; other costs, such as electricity, housing etc. were funded from the budget.

From 1 January 2013 financial provision of medical facilities, operating in the CHI system, is carried out by intergovernmental transfers, allocated within the territorial CHI tariff. Thus, the costs which were financed from the regional budget, were transferred to the CHI system, including the expenditures for works and services for the maintenance of property (except major repairs, which are financed within the interdepartmental investment program). Besides the above items, directly financed from the budget expenses are specialized medical care (social protection, psychiatric hospitals, court-medical-examination, aid for emergencies), assistance to citizens who do not have medical insurance policy. Next, the Territorial CHI Fund pays to insurance companies, and they pay to medical facilities on the basis of activities performed.

The main difficulty in this mechanism is to find a method by which there would be possible to reallocate costs between the Territorial CHI Fund and regional budget. *"... The introduction of PBBS would be much easier without the Territorial CHI Fund. Health insurance funds do not assume responsibility for the effective use of public funds. As a consequence, there is little transparency both in the distribution of the means and the control. Effectiveness of the budget means is the responsibility of the region, and the region fins it difficult to figure out who and whither the money was spent".* (From the answer of the representative of the Department of health and social development)

Problem: the medical insurance is not supported by a clear regulatory framework in terms of determining sources of financing of certain types of medical care[94]. By 2015, should be developed a mechanism defining a specific volume of allocating funds for an ambulance. Why there is need of a separate method of determining the amount of funding the ambulance? Ambulance belongs to the

[94] For example, the Law 326-FZ says that from 2015 a high-tech medical care will be funded by CHI funds. But still there is no clear established mechanism of its funding (the same applies to ambulance: it remains unclear which approach to use in determining standards of financing (for example, that should be set as the norm - 2 or 5 floor when ones calling an ambulance? etc.).

so-called specific areas of health care (e.g., cardiological and other types of care) where it is impossible to determine the unit of service similar to other types of medical care.

"... There is no transparency, all is very confusing! For example, the separation of the types of assistance may be even within the same disease, and then some items need to be funded by CHI funds, and some at the expense of the regional budget. Divide them in practice is very difficult, even if at first glance it seems that the means are common: part of the funds transferred to the CHI Fund, part of the funds from the budget, and some of its own means available to have CHI Fund. Wherein, it is necessary to provide a specific medical service for a patient, and this service should be recalculated properly".

What is the work of the Department of health and social development (as the subject of budget planning) consists from in connection to the transition to the PBBS format?

Department of Health and social development, under the leadership of Head of the Department, is developing a state Program "Development of the health care industry"[95] (based on the volume of the resources of the regional budget). Volume of co-financing at the level of the region is determined in accordance with the methodology approved at the federal level. This volume is calculated for all types of diseases according to the Program (co-financing rate varies in accordance with the target programs within more or less than 5%). *"... The Program "Development of the health care industry" represents all costs included in the earlier item of budget classification "Health care".* The Program, in turn, is divided into subprograms that in the regions actually replicate similar federal program, but excluding regional specifics. That is, even if the calculations are taking into account the social impact, the specification of costs is carried out using purely technical procedures (in fact it is a "fault" of the Department of health and social development, since, having information about the regional specifics about of the state of health, it could modify the program!).

Among the major problems of transition of the region on the program-based mechanisms of budgeting, there should be noted, first of all, imperfect (as is the case with long-term regional target programs) or lack of strategic documents and the delay in starting work on organization of the process of transition. There are also some contradictions and conflicts between the authorities of management of finance and economy, and finally, the complexity of forming the program structure of the budget.

[95] Resolution of the Government of Orel region from April 30, 2013 № 153 "On approval of the state program of Orel region "Development of the health care industry in Orel region for 2013-2020".

7. Discussion and conclusions

7.1 Preconditions of PBBS model and cause-effect link of factors impeding its implementation (RQ4)

7.1.1 General disadvantages in the implementation of LRTP

It is recognizes that LRTP should reflect link of its goals, objectives and activities with the system of target indicators. Only the definition of performance indicators for each activity and the proposed changes in their values allows to make all the activities targeted and quantitatively determined, which is necessary for the control of solution to the problem of development, grounded in the program, and the subsequent qualitative and quantitative assessment of the extent of its success.

Analyzing a block of LRTP of Orel region, we encounter a number of contradictions.

First, the *formulation of objectives is often duplicate the formulation of purposes*. So, the aim of LRTP "Promotion of healthy lifestyle among the population of Orel region for 2012-2016" is to "create a motivation for maintaining a healthy lifestyle among the population of Orel region", and as the objective is to "educate citizens the hygiene skills and motivating them to refuse of bad habits, including help for quitting tobacco and alcohol consumption". Similarly, LRTP "Preventing of socially significant diseases in Orel region in 2011-2015" aims to "prevent the spread of social diseases", while its objective is to prevent disease, and as events is indicated "development of specialized medical care in municipal institutions".

Secondly, there is a mixture of the conceptual apparatus of the PBBS, whereby *activities can be specified either as problems and as a result*. In another case, output indicators were specified as indicators of socio-economic effectiveness (i.e., expected results). Thus, the purpose of LRTP "Social support for disabled (accessible environment) for 2012-2014" is "...to create conditions for unhindered access to priority facilities and services in the vital areas for the disabled and other people with limited mobility," and one of the final results of the program – is to "increase in the number of traffic lights equipped for the hearing impaired and visually impaired persons with disabilities ...". In this case, increasing of the amount represents an output, or a direct result, but cannot be attributed to the social end result.

Third, a number of LRTP is characterized by the *groundlessness of numerical values* of programs indicators, when their numerical values do not consider statistical data, analysis of regional features, etc., that is actually with no connection with reality. In other cases, the programs

do not provide data on the dynamics of the proposed indicators of intermediate results. To this conclusion we arrived on the basis that quantitatively measurable indicators of LRTP activities are not presented in the financial reporting of the Department of health and social development of Orel region as the subject of budget planning. However, it should be noted that the description of the performance goals and objectives of LRTP is not limited to the qualitative component that is certainly a positive thing.

Fourth, some programs (LRTP "Promotion of healthy lifestyle among the population of Orel region for 2012-2016") present the aims and objectives, which involve *interaction with other subjects of budget planning*. Example: Department of health and social development as one of the objectives indicates training of medical professionals and citizens with the effective methods of disease prevention. Obviously, this task involves the interaction of more than one authority - the authority responsible for health care (Department of health), the authority responsible for education (Department of education). In addition, the ultimate goal of the program also depends on the overall improvement in the standards of living (which to some extent depends on the work of the Department of economics).

And *last but not least, the inherent weakness* in the majority of target programs in the health care sector - is the lack of practice of determining of the priorities in the implementation of program activities and alternatives of the target program in the case of changes in the conditions of its financing. In other words, there are no different options of program indicators, in case of the worst scenario, the conservative and the optimistic scenario of funding. In LRTP analyzed by us were not given alternative ways to achieve the planned results. Ultimately, when budget cuts on LRTP is declining funding for all measures, thus reducing the effectiveness of the program.

7.1.2 Cause-effect link of factors impeding a successful PBBS implementation

The analysis of the responses of representatives, as well as the analysis of data set and documentation, permitted us, on the basis of the case study results, to arrive to a *conclusion about the existence of cause-effect link of factors* impeding a successful PBBS implementation.

Substantially, we divided these factors into three blocks in accordance to the effect caused by them (see also Exhibit 42).

1. ***Comprehension of the term "effectiveness"*** per se, which causing the following mistakes or disadvantages:

- *Improper use of conceptual tools of PBBS and target-program approach*, which could cause mixing of terms, lack of unity of terms etc. Activity could be indicated both as an objective, and as a result. Thus, for instance, in one of the long-term target budgetary program in health "Preventing of socially significant diseases" the activity "…Development of specialized medical care" was indicated as a goal, which might be actually formulated as a "…Disease prevention".
- Quite a serious misstep is the existing practice of the *evaluation of the effectiveness on the basis of correlation of dynamics of indicator of effectiveness and funding level*. Department of health and social development of Orel region assesses the impact of each indicator on the basis of the relationship of dynamics of the indicator and the volume of its funding. For negative values of the dynamics, while maintaining or increasing the volume of its funding, the rate is unsatisfactory. For positive values of the dynamics, while maintaining or reducing its funding, the rate is high. Thereby, the evaluation of the program with negative dynamics with the same level of funding or with a major funding was negative. While the evaluation of the program with positive dynamics with the same level of funding or less was positive. This example demonstrates that the administrators of budget funds are mostly concentrated on the dynamics of the effectiveness indicators, but not the effectiveness as such. As a result, programs with low efficiency, but positive changes are seen as a positive fact. Economic evaluation of the effectiveness of program does not apply to those activities, the title, the content and (or) performance of which is significantly changed compared with the previous year. This leads to the fact that they are excluded from the total estimated number of activities. In turn, such comprehension of the effectiveness predetermines the destinations of budget allocations, since it is based on data which is different from reality.
- *No results were compared with the indicators of the effectiveness* of the other regions (who have reached larger or smaller result for the same money), or, at least, with the "own" performance indicators achieved in the previous period (how the region has performed in the reporting year - the result is achieved for more money, for less money or, in comparable prices, for the same money obtained the same result). In this case, in order to estimate the effectiveness into account are taken performance indicators and achieved values are compared with the planned indicators. It would seem that here there is a result, and a comparison. But in fact is used only the result of a specific region, and so as to assess the effectiveness the results should be compared. Evaluation of such a

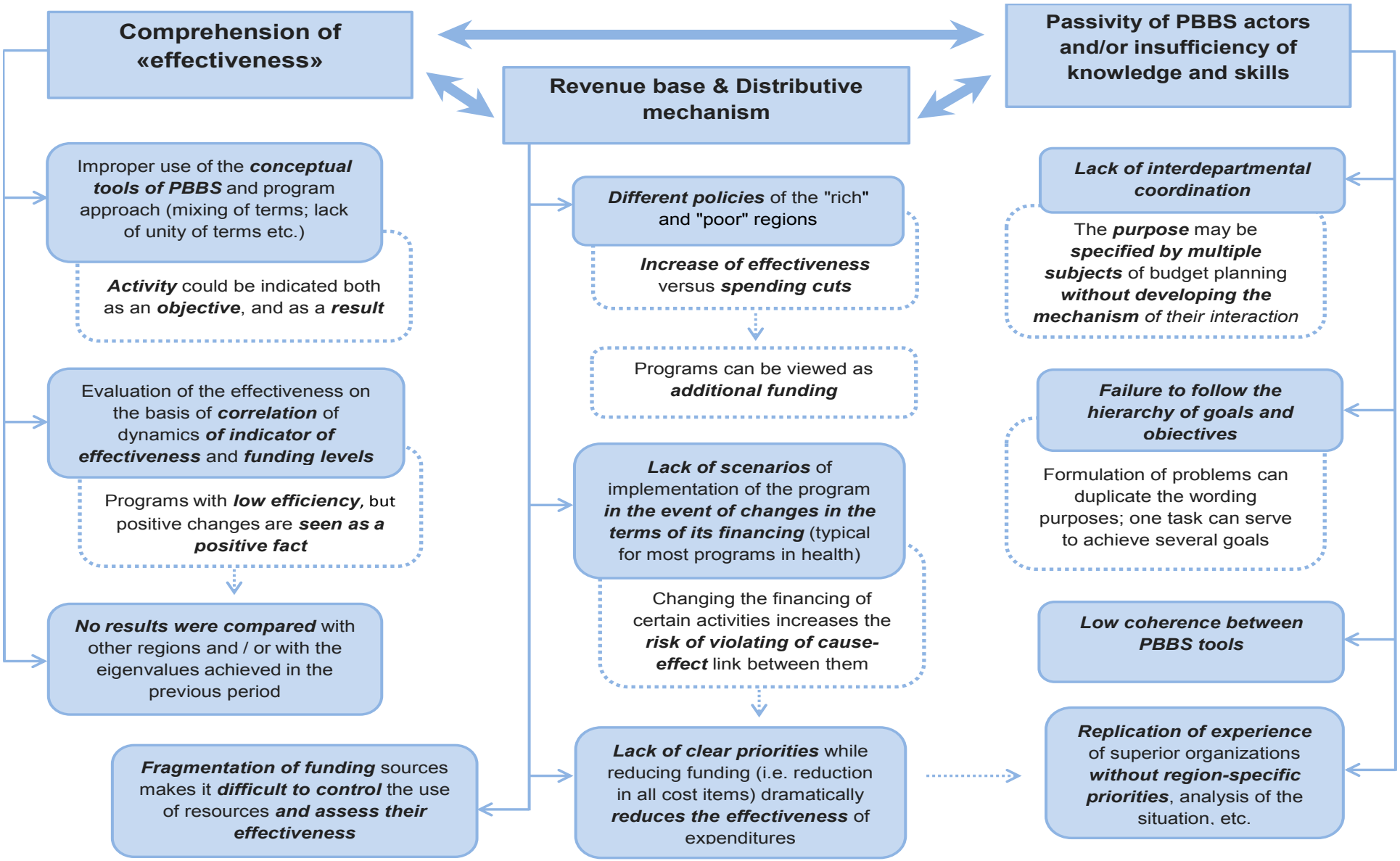


Exhibit 42. Cause-effect link of factors impeding a successful PBBS implementation: the case study results.

- comparison cannot be expressed by numerals, and may be performed only in the phrase "more effectively than" or "less effectively than".

2. An important role plays ***revenue base and distributive mechanism***, designated as a separate block, which can also be divided into a number of contradictions, namely:
   - Differences in policies implemented by regions in the transition to a new budgeting model. It is revealed that the *policy of the rich and the poor regions is all different*, and the first measures resorted to highly subsidized regions, are still spending cuts. Regarding low subsidized regions, then one can talk about improving the efficiency of spending. In addition, *the "poor" regions may considered* the PBBS tools, especially *target programs, as a source of additional funding*: in practice through programs they often solve problems that can be solved within the current funding. This is evidenced by the high proportion of spending on other needs within the framework of program activities. In turn, the relationship with the federal center is built with caution on what is being done in the region in order to improve the efficiency of budget spending. In particular, the Russian Ministry of Finance monitors the implementation of regional programs to improve efficiency, the results of which are including the reason for providing additional financial assistance to the regions. In other words, there is a risk of creating a situation where "the rich become richer," "poor become poorer".
   - Attention should be paid to one major drawback, which is inherent in most of the regional target programs in health. The existing practice of such programs *is not intended to identify options (scenarios) of the program in the event of changes in the conditions of its financing*. As a result, while reducing the cost of long-term regional target program missing a clarity exactly which activities are crucial and which are secondary. Changing the financing of certain activities of the program increase the *risk of violation of cause-effect link* between them, which reduces its program-target potential. The exception rather than the rule is to correct the goals and objectives of the program, a list of program activities while reducing funding in compare to the plan, that enhances a declarativeness of a target program.
   - *Lack of clear priorities in the implementation of program activities*, understanding which of them are the key, and what is their contribution to the achievement of the target program, leads to the fact that while reducing budget financing of program there is a reduction of funding for all measures and, as a consequence, the effectiveness of the program become significantly reduced. *Consequence of the absence of the establishment of priorities in the spending* of budget allocations *leads to the replication of the*

experience of parent organizations at the federal level without actually region-specific analysis of the particular situation, etc. (We have attributed this lack to a separate block of the factors hindering a successful implementation of PBBS model).

- Finally, a *high fragmentation of funding sources*, which makes it difficult to control the use of the allocated budget on the one hand, and to evaluate the effectiveness of its use on the other. Thus, the budgetary institutions of the region in the health care sector today are funded from the regional budget, mixed source consisting of the regional and federal budgets, mandatory health insurance funds and income from revenue activities.

3. Finally, the third block of factors impeding a successful implementation of PBBS (the same based on the results of case study), is a ***passivity of actors-participants*** of the process of PBBS implementation ***and/or insufficiency of knowledge and skills***.
   - *Lack of interdepartmental coordination*. As its goals and objectives, subjects of budget planning (e.g., Department of health and social development) may indicate such goals and tasks that are a-priori involves interaction with other departments. For example, it is obvious that such a goal as training of medical specialists and citizens the effective methods of disease prevention involves the interaction of more than one authority - the authority responsible for health care (Department of health and social development), the authority responsible for education (Department of education). In addition, the ultimate goal of the program also depends on the overall improvement in the standard of living (which to some extent depends on the work of the Department of economics).
   - *Failure to follow the hierarchy of goals and objectives*. Unfortunately, many of the executive staff of the regional authorities do not have sufficient knowledge and skills in the application of PBBS approach, and as a result hierarchy of goals and objectives is not complied. For example, the formulation of problems often duplicate the formulation of the objectives, or one objective serves to achieve several goals (and not vice versa), etc.).
   - *Low coherence of PBBS tools between themselves*. Analysis of the regional practice of PBBS tools implementation showed that, despite the efforts made by the participants during the PBBS model implementation into the budget process, in most cases, departments do have a mechanical approach for the preparation of the relevant documentation. Often the PBBS tools cover budget drafting stage and later in the budget process or are not used, or poorly interconnected.
   - And the last factor, which has already been mentioned above, is the *direct replication of experience of superior organizations, excluding regional priorities and specificities*. In

some cases, target programs in health are seen as an analogue of federal target programs. Of course, the main objectives of the authorities should be coordinated with regional and / or federal priorities, while taking into account the strategic priorities of the territory and analyze the situation. In addition, copying of the experience leads to the repeating of possible errors and weaknesses.

Exhibit 43: Factors impeding successful PBBS and institutional strategic responses

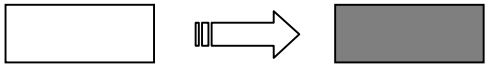
Factors impeding successful PBBS implementation	**Strategic responses to institutional processes**				
	Acquiesce	Compromise	Avoid	Defy	Manipulate
Comprehension of "effectiveness"					
Revenue base & Distributive mechanism					
Passivity of actors and/or lack of knowledge and skills					

- no particular strategy could be applied
- low degree of strategic response
- moderate degree of strategic response
- high degree of strategic response

While analyzing the responses of the representatives, as well as data available, we have tried to apply "The strategic responses" model (Oliver, 1991) to their "behaviors", and organize the results as a cross-link between type of responses and the factors impeding PBBS implementation we talking above (Exhibit 43). In case of the necessity of elaboration and applying new approaches of evaluating effectiveness of budget expenditures, subordinated administrative and managerial structures often mimicking institutional models or/and in general accepting the above established rules and norms. In some cases, their activity is also characterized by shaping the criteria (e.g. comparison of the actually achieved state of the health care industry, with a baseline at the beginning of the target program). In other situations, they tend to avoid the innovations since the old model seems to be more convenient habitual for administrators. However, this does not necessarily mean lack of initiative: having an initiative, "lower" managerial levels do not have enough potential of professional economic knowledge for the introduction of innovations (like in the case of choice of expenditure priorities). Finally, records of Exhibit 44 evidence a presence of captive relationship between possible legislative inconsistencies and inaccuracies on the higher (federal) level and resulting impacts on the organizational level of region.

Exhibit 44: Relation of factors impeding successful PBBS implementation in connection with problem-arises level

Problem-arises level		Comprehension of "effectiveness"		Revenue base & Distributive mechanism				Passivity of actors and/or lack of knowledge and skills				Link with problem-arises level
		Use of conceptual tools	Approaches to evaluation	Budgeting policy	Fragmenta-tion of funding	Lack of scenarios	Lack of clear priorities	Lack of inter-departmental coordination	Failure to follow hierarchy	Low coherence between PBB tools	Replication of superior experience	
Federal	Legislative											Captive
	Organiza-tional											Relative
	Accounta-bility											
Regional	Legislative											Relative
	Organiza-tional											Captive
	Accounta-bility											Weak
Local	Legislative											
	Organiza-tional											Captive
	Accounta-bility											Weak



- Degree of variation of relationship (from "no relationship" to "strong relationship")

Legislative level - level of adoption of laws, decrees, legal acts, methodological support, etc. ensuring the implementation of PBBS tools in budgeting practices.

Organizational level - level including the "technical" side of the organization of budget process, including the distribution of powers between the appropriate authorities, construction of hierarchical relations, formation of goals and objectives etc.

Accountability level - level including budget reporting, taking into account the stages of the budget process.

7.2 Looking into the future based on the lessons of the past

Today, a number of countries, including the countries with emerging markets, trying to improve their budget process by recourse to the performance-based budgeting model. Analysis of international experience shows that to date a single universally accepted definition of this concept does not exist. In the conventional interpretation it comes to a link of costs and results into a single logical chain (Lee et al., 2000; Carter, 1994; Young, 2003; OECD, 2008), to the program-target method as budget planning system (Snell and Hayes, 1993; Mikesell, 1999), although the features of PBBS method are not limited by the only programming (Dawson, 1995; Hager and Hobson, 2001): performance-based approach has an impact on all stages of the budget process, whereby the performance-oriented nature acquires as budget execution, and control over its execution.

The complexity of the concept of the PBBS is also due to the fact that the achievement of the effectiveness of this method is largely determined by the multi-level of its application (Kelly and Rivenbark, 2011): from planning of expenditure of public authorities and local government expenditure planning to individual administrators and recipients of budget funds - ministries, departments, state agencies, state enterprises, in each case having its own characteristics. For politicians, as well as lawyers, the PBBS means, primarily, presentation and analysis of budget requests in a form that provides the public the most effective choice. For executive administrators this concept means, among other options, more flexibility and freedom to maneuver, as well as greater personal responsibility and greater exactingness to subordinates. Finally, for ministries and departments, it can mean greater autonomy, flexibility in decision making and greater responsibility for the use of funds allocated to them (e.g., Ushakov, 2008).

Herewith, the approach used as the basis for the implementation of PBBS tools, varies depending on the capacity of a country, its priorities, mentality and culture of the population, where the mentality is as important as other aspects. What unites all the models of such a transition, it is the general objectives pursued by different countries. Despite academic criticisms regarding ambiguity in understanding the PBBS mechanisms, in this variety, we can see the advantage rather than a disadvantage, that, in turn, can serve as a source for the development of the methodological base (including the basis of unsuccessful attempts). As shown in this research, to full understanding of PBBS concept we should take in to consideration the examining of the problem through a concrete case as an attempt to answer specific research questions.

The research also deepens comprehension of the importance of establishing priorities in spending, revealing a presence of direct and indirect impact of it on the effectiveness of budgetary

funds. We found out that this aspect is somewhat missing concept in the literature on PBBS. At the same time, in the case of a certain category of public services, this aspect becomes even more important (health care services, in particular have such a feature, when medical interventions of therapeutic and preventive nature may be economically ineffective, but medical and social effect requires realization of these activities). This was what concerns ***contribution to elaboration of theory on PBBS.***

Contribution on extending the debate on organizational, legal and methodological basis for the organization of the budget process:

The results of our analysis testify in favor of the thesis about a complexity of changing the logic of "costly"-based budget model of management which is characterized by limited autonomy of budget recipients of spending their budget allocations. About the effectiveness of the applied methods in some cases ones can reasoning mainly theoretically. It is obvious, that practice of planning and financing not the results, but the products (in the form of services), so well-established in the public sector, despite its shortcomings, is ultimately stable, inasmuch as it is familiar and comfortable both for administrators and recipients of budget funds.

With all the diversity of the PBBS implementation, controversial remains a problem of integrating decisions on the spending of budget allocations to the results achieved (Andrews and Hill, 2003; Gilmour and Lewis, 2006). This evidence supports the idea that it appears to be the case that until now the world practice has not developed a clear understanding of the quantitative and qualitative indicators of effectiveness of budgetary expenditures. Presumably, primarily due to the lack of established at the legislative level measures of final performance, there was not yet developed formal criteria by which it can be concluded if the public (budgetary) funds were spent effectively or not. In practice, under the ineffective expenditure actually means inappropriate use of funds, which in fact corresponds to "costly" logic of planning.

Contribution to bridge discourse and practice, namely in the sphere of financial management in public sector and municipal government:

Several research positions confirm the thesis about the importance of a primary modification of the control system (Hager and Hobson, 2001; Robinson, 2009), and then establishing of new principles of budget planning that has been done in almost all developed countries, where is being implemented the PBBS. Before new financial mandates have been delegated to the executive authorities, was established an overall adequate control system. In turn, this finding suggests such

an aspect as a readiness of the whole system for the introduction of such a fundamentally new method of public expenditure management as PBBS.

In particular, what we are talking about is the possibility of creating a mechanism which, on the one hand, would allow to build the relationship between indicators of socio-economic development of the territory and budgetary funds. On the other hand, the challenge is also to develop and introduce a mechanism of administration, not directly related to the financial component. Thus, seems to be justified a perception of PBBS as a diverse concept of budget process management (e.g., Shah, 1998), involving fundamental changes in the approach to all system components of the system of budget management: from planning and goal setting, to control and motivation. The lack of such understanding is equivalent to risk of implementing of PBBS as a formal project, not built into the actual processes, or contrary to the ultimate goals of reform, eventually losing the ability to use all of its potential. Wherein, while continuing in practice doing actually the same things, will expect different results.

Not always subordinated administrative and managerial structures are looking for "easy" ways to introduce and / or escape from the institutional processes (as evidenced from the results of the analysis of case study). Often, having an initiative, "lower" managerial levels do not have enough potential of professional economic knowledge (in our case the same applies to budgetary facilities) for the introduction of innovations. Furthermore, it is obvious that in common interests will dominate the bureaucratic component since economic knowledge of the administrative apparatus is substantially higher.

In this research we demonstrate a presence of a cause-effect link of factors impeding successful PBBS implementation in connection with problem-arises level. Just as the various "tools" of PBBS implementation (i.e., program budgets, strategic planning documents, etc.) should be linked and integrated into the budget process, in the same way various levels of government should interact both vertically and horizontally. This mechanism should be transparent and understandable to all participants involved, otherwise it may create a situation where every administrative and managerial level involved in the mechanism of realization of innovations, is based on its subjective understanding, creating, as a result, numerous contradictions. Last but not least importance for embedding of PBBS elements in to budgeting practice has a revenue base, in connection with which the approach applying by “poor” and “rich” areas will differ.

Limitations and directions for future research:

By this research we conclude that practical application of performance-based budgeting at the same time creates the basis for the affirmation that the performance budgeting as a system of budget management represents quite a complex financial innovation, which, in all probability, will have a long-term nature, and in the process of its development there should be taken in to account the world experience of the theory and practice of budgeting for results.

The research has purposely focused on an exploration of how budgeting process in public sector is managed taken in to consideration a particular context of PBBS implementation. An exploration of conditions and the main prerequisites to realize the benefits of performance budgeting was beyond the scope of this work. Nevertheless, having now answered the research questions and understood what the main preconditions should be, monitoring of how resources can be allocated in these new conditions, according to what criteria, could constitute an interesting area for future research. Also, indeed open remains the issue concerning the mechanism for determining priorities in budgetary expenditure in terms of PBBS implementation.

While conducting this research we aware a possible risk that transparency is not always present in the responses of the participants of expert interrogation. To minimize probable distortion we abandoned the mechanical recording (tape) interviews; second, along with expert interrogation we combine different data sources; and third, the fact that we had a chance to get access to the field via key informant might contribute smoothing a risk of having unilateral findings.

Finally, we did not focus on comparison with other practices, but concentrated on a single-case design adopted for this study in order to conduct an exploratory research, since a single case may provide a better basis for in-depth investigation on explanations of why a phenomenon occurs. However, even though this study does bring about a specific case reflection, this could be extended to a general context, and be further investigated by applying the given explanations to additional cases or other settings. This too remains an area to which future research could be directed.

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Appendix I – Interview guide

0. General information

Reciprocal introduction

I ask about the interviewee's role(s), for how long has he/she been staying in this organization, what areas are related to his/her past professional experience.

1. Un-structured part

Can you tell me what your work consists of? How long have you been in this role? Can you mention the aspects by which it changed (or did not) since the beginning of the budget process reform?

2. Semi-structured part

2.1 Focus on the performance measurement

What is the meaning, from your professional point of view, of the term "effectiveness"?
By what criteria the effectiveness of budget spending is valuated?
What activities are carried out by your department to achieve the objectives?
How goals and objectives are formulated in relation to the results? And what indicators are used to evaluate the performance? What's new?

2.2 Focus on planning process

For your opinion, what are the main limitations of the planning and funding of public sector today?
While planning expenditures, how do determine the importance of the activities?
Have been any measures to increase the effectiveness of budget expenditures already implemented in to the planning process? What are they? How the activity of your organization/department is coordinated in this case?

2.3 Focus on budgeting

How ready the current budget system was ready for the transition to the new budget "rails"?
How the utilization of budget means is monitored in changing conditions? What problems arise in this situation?
What are the fundamental differences between embedded program-oriented budget from the previous allocation mechanisms? How the results are coordinated to funding in this case?

Appendix II – Key performance indicators for the Department of Health as a subject of budget planning (example)

Indicators	Unit of measure	Reporting period	Planning period	Target value
Goal 1. Preventing the spread of social diseases and other threats to life and health, providing of the sanitary and epidemiological welfare				
Objective 1.1 Disease and other life-threatening health conditions prevention				
1.1.1 Average life expectancy of patients with chronic pathology after the diagnosis		…	…	…
1.1.2 Deaths from accidents, poisonings and injuries				
1.1.3 Mortality from cardiovascular diseases per 100,000 population				
1.1.4 Shabbiness of cancer pathology				
1.1.5 The incidence of tuberculosis				
…	…	…	…	…
1.1.11 Procurement of donor blood				
1.1.12 Development of specialized medical care in state and municipal facilities, including high-tech				
Objective 1.2 Provision of sanitary and epidemiological welfare of the population				
1.2.1 Vaccination coverage against influenza				
1.2.2 The number of measles cases with a view to its complete elimination by the year …				
…				

Appendix III – Mandatory legal acts regulating the budget process

1. Regional law defining features of the budget process
2. Procedure for preparation of the draft budget (the draft budget and medium-term financial plan)
3. Procedure for compiling the register of expenditure commitments of the region
4. Procedure for the development, approval, implementation, monitoring of the effectiveness of long-term programs implementation
5. Procedure for the formation and approval of state assignment for the provision of public services (works)
6. Procedure and method of planning budget allocation for the next year and planning period
7. Procedure for compiling and operating of the consolidated budget revenue and expenditure of the region and budget list of chief administrators of budget funds
8. Procedure for compiling and operating of the cash execution of the budget plan of the region
9. Procedure of execution of the budget (including the authorization of payment of monetary commitments) of expenditures and sources of financing the budget deficit
10. Procedure of completion of operations on budget execution in the current fiscal year

Appendix IV – Passport of a long-term target budgetary program

Name of the program	LRTP "Providing of facilities of infancy and maternity with modern medical equipment" for 2012-2014 (далее также - программы)
Evidence to development of the program	Disposal of the Government of Orel region on March, 23 2010 the approval of the Concept of long-term target program "Providing of facilities of infancy and maternity with modern medical equipment" for 2012-2014
Customer of the program	Government of Orel region
Program developers	Department of health and social development
The program manager	Head of the Department of health and social development
Responsible executive of the program	Head of Office of health of the Department of health and social development
The purpose of the program	Increasing the availability and timeliness of care for children of Orel region
Program objectives	Technological preparation of the facilities of childhood and obstetrics for equipment placement; provision of the facilities of childhood and obstetrics with medical equipment
Target indicators of the program	Share of prepared premises in the total number of requiring repairs; proportion of analysis conducted at the newly acquired equipment from total number of analysis on existing equipment in the hospital; the proportion of patients who experienced similar techniques on existing equipment; the infant mortality rate; the maternal mortality rate
Timelines	2010-2014
Amounts and sources of funding for the program	Total need for funding from the regional budget – 1.000.000,0 ths. rubles, including by years: 2010 – 30.000,0 ths.rubles 2011 – 265.000,0 ths.rubles 2012 – 265.000,0 ths.rubles 2013 – 235.000,0 ths.rubles 2014 – 205.000,0 ths.rubles
Including the costs directions	capital investments – 0; research and development – 0; other needs – 1.000.000,0 ths. rubles
Expected final results	High availability and quality of specialized, including high-tech, medical care to the patients of Orel public health institutions "Children's Hospital" and "Orel perinatal center"; declines in: infant mortality rate to 6.25 per 1000 live births; maternal mortality rate to 11.7 per 100,000 live births; growing share of the total number of trained premises from requiring repairs; growing share of analysis conducted at the newly acquired equipment from total number of analysis on existing equipment in the hospital; growing of share of patients who experienced similar techniques on existing equipment up to 100%