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Draft proposed programme budget 2012–2013: the European Region's perspective

World Health Organization
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This paper seeks to emphasize the perspectives of the WHO European Region related to its work in the biennium 2012–2013 with regard to achieving the objectives set in the Organization's Medium-term Strategic Plan 2008–2013. The paper represents an initial attempt to articulate priorities and shifts, to explain the rationale behind the draft Proposed programme budget for the Regional Office and to identify current and future challenges for financing it, as well as possible strategies to overcome these. This paper should be read in conjunction with the global paper (EUR/RC60/10).

The Regional Committee is invited to comment and advise on the strategic orientations and the budget proposed in the paper, as well as on issues related to financing.

A draft resolution is submitted to the Regional Committee for its consideration.

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Executive summary

The programme budget is a key strategic document that outlines WHO's priorities and strategic directions. While it is a global document, the specificities of the European Region are reflected in the regional perspective of the global document.

The WHO budget is aspirational in the sense that, in accordance with the principles of results-based budgeting, budgeted amounts reflect the resources required in order for the Organization to meet the objectives and to deliver the planned products outlined in the proposals for 2012–2013. As such, at the time of budgeting, a gap will nearly always exist between the resources needed and those actually available.

In terms of the 2012–2013 biennium, at the time of the Regional Committee's sixtieth session in September 2010, only the amount of assessed contributions (ACs) and some voluntary contributions (VCs) whose expiration date goes beyond 2011 are known available resources. These two sources represent only 29.3% of the total budget, while the remaining funds need to be raised in the course of the next biennium –for the purposes intended and in a timely manner.

Emphasis should therefore be placed on matching the priorities of WHO (as set by the Regional Committee and the World Health Assembly) with funding opportunities.

These priorities include greater investments to tackle noncommunicable diseases (strategic objectives – SOs – 3 and 6), to strengthen the health system, and particularly the public health infrastructure (SOs 10–12) and to address the root causes of ill health and health inequity, including the socioeconomic determinants of health (SO 7). Additional funds must be mobilized for work towards these objectives, without compromising the important work being carried out in other key areas, such as communicable diseases, or jeopardizing the resources generated to that end.

In this regard, a separate paper on *The future of financing for WHO* is being submitted to the Regional Committee (document EUR/RC60/18). The Regional Committee's discussions and recommendations on that issue will feed into a global process, with a substantive discussion planned to take place at the 128th session of the Executive Board in January 2011.

For 2012–2013 the Regional Office is following a cautious and realistic budgeting strategy. This is evident from the fact that the Regional Office's proposed budget for base programmes in 2012–2013 represents a relatively modest increase of 26% when compared to 2008–2009 expenditures, while in other regions this increase is between 44% and 89%. (see Fig. 2, after paragraph 96).

An important challenge for the Regional Office stems from the fact that while most future income is not readily available at the beginning of the biennium and is highly unpredictable, staffing commitments are long-term with relatively little flexibility. This poses a financing risk, i.e. when the specific funding ends or is shifted to other areas that require other forms of expertise, it takes considerably longer to adjust the staff costs. Currently, close to 60% of total costs in the technical health areas (SOs 1–11) is constituted by staff costs. Furthermore, about 90% of the international professional staff are employed on longer-term contracts.

To strengthen the Regional Committee's governance and oversight functions, the Regional Director suggests that approved programme budgets should in future be regarded as a "contract" between the Regional Committee and the Secretariat, to ensure and lay the foundation of accountability for the delivery of expected results by the Regional Office. This is proposed to be accomplished in a three-step approach:

The Proposed programme budget 2012–2013 and its European perspective are presented to the Regional Committee at its sixtieth session in 2010, to discuss priorities and budget allocation by SO;

Following the approval of the global programme budget by the World Health Assembly in 2011, the Secretariat will prepare (in collaboration with the Standing Committee of the Regional Committee) and submit a package of performance indicators, together with a list of key deliverables, to the Regional Committee at its sixty-first session;

The package of performance indicators and key deliverables will be developed as part of the operational planning for the 2012–2013 biennium and will serve as a "contract" between the Member States and the Secretariat.

Introduction

WHO's programme budget 2012–2013 – an integrated global process

1. The Organization's Medium-term Strategic Plan 2008–2013 (MTSP) was introduced in recognition of the fact that the vast majority of public health results are not achievable in a two-year period. Establishing Organization-wide expected results (OWERs) defined for a six-year period and measuring progress incrementally was considered to be a way of maintaining focus and establishing a system that would lend itself better to real monitoring of progress. This and the move to 13 strategic objectives (SOs) from the previous 36 areas of work were welcomed as a major improvement by Member States in the WHO European Region.

2. The MTSP covers three budget cycles. To rationalize preparation of the global programme budget and the subsequent operational planning process, development of the Proposed programme budget 2012–2013 focuses primarily on shifts in emphasis across SOs, alignment with country priorities, and the steps that need to be taken to close the gap between the Proposed programme budget and actual implementation.

3. This document – the WHO European Region's perspective – emphasizes the Region's viewpoint for 2012–2013 and presents its contribution to achieving the OWERs set out in the MTSP.

4. The detailed work of identifying the specific targets, outcomes and resource requirements at the level of expected results will be undertaken closer to the time of implementation, in conjunction with the operational planning process. Furthermore, the operational planning process will be more sequenced, beginning with identifying countries targeted for results, informed by the priorities expressed in the biennial collaborative agreements; developing indicators to measure performance in accordance with the Organization-wide planning framework; and elaborating and budgeting products and services in the Regional Office's workplans to deliver the expected results. Through these measures, it is intended to achieve more effective and efficient planning and implementation at all levels of the Organization.

5. In terms of the format of the document setting out the Proposed programme budget 2012–2013, there are two key differences from the Programme budget 2010–2011:

- the budget breakdown will be presented only at the level of SO by major office; and
- for each SO, there is an additional narrative section outlining the "Priorities and emphasis for 2012–2013" and describing key achievements and challenges to date, new areas of work, and areas to be given more or less emphasis, as well as changes in the distribution of functions and staff across the various levels of the Organization.

Regional orientations for 2012–2013

A new vision of "Better health for Europe"[1]

6. The European and global environment has changed considerably in the past ten years, introducing pressures, challenges and opportunities for all European Member States to improve their citizen's health and reform their health systems. At the same time, health has moved up on

[1] See also the Regional Director's "vision paper" *Better health for Europe: Adapting the WHO Regional Office for Europe to the changing European environment: the Regional Director's perspective* (document EUR/RC60/8)

the global and European political agendas. Member States and the WHO Regional Office for Europe, together with partners, need to engage in a common response to the health impact of the changing demographic and social landscape. The Regional Office needs to adapt its organization and operation to better support its Member States and strengthen its technical leadership in health policy and public health.

7. In order to make the vision of "Better health for Europe" a reality, and to ensure engagement with the international community, it is crucially important to develop a European health policy. This will provide a coherent and integrated framework and road map for health action at subnational, national and international levels. It will promote work on tackling the challenges shared throughout the Region by strengthening partnerships, enhancing health system performance and addressing country needs based on epidemiological and demographic realities, and it will advance evidence-based practice by reviewing the effectiveness of available public policy tools. Most importantly, it will explicitly shift the focus of health systems towards public health and disease prevention, pursuing health equity by tackling a wide range of health determinants both within and beyond the health system.

8. The new European context requires a strong WHO Regional Office for Europe with a commitment to public health excellence and innovation. The Organization needs to unite, bridge and integrate the Region by promoting common European values, advocating for health equity and promoting intercountry cooperation. It must be an evidence-based and quality-assuring organization, relevant to the whole Region with good programmes and staff, and guided by transparency and accountability.

9. The Regional Office can only function as a catalyst of excellence if its regional governance is strengthened and if new partnerships and coalitions for health are created. Only a strong, active and well-supported WHO Regional Committee for Europe can ensure that Member States are fully engaged in policy dialogue and decision-making. The mandate of the Standing Committee of the Regional Committee (SCRC) needs to be reviewed and its governance function strengthened, to make it more relevant to the way in which the Regional Committee operates. Furthermore, it is critically important for WHO to develop and sustain strong partnerships and joint action with all relevant European health stakeholders, including the European Union and specialized agencies of the United Nations system.

10. The Regional Office, including its country offices and geographically dispersed offices, must be fully functional and integrated, with clearly defined roles, functions and identities. All core strategic policy functions and technical programme development should be located or directed by a strong hub in the office in Copenhagen, supported by knowledge and evidence generated by the geographically dispersed offices, technical programmes and networks.

11. The needs and priorities of the Regional Office, under the guidance of the Regional Committee, should reflect the main disease burden of the Region and its determinants, derive from and be part of the ongoing dialogue on the European health policy, and also reflect WHO's global health agenda.

A new business model to support the new vision

12. An enabling institutional environment requires effective information and communications systems, long-term balance, sustainability and security of the Regional Office finances, and a positive environment for work that inspires and empowers staff. In order to achieve these goals, a new business model has been developed, which lays down the foundation for a financially sustainable Regional Office.

13. The three principal objectives of the new business model are i) to create room to manoeuvre; ii) to reduce financial risks and iii) to improve resource management – as explained in more detail in paragraphs 106–112 below.

14. A number of actions have already be taken to address this situation, including: closer integration of resource mobilization, budget and grant administration, and planning and monitoring functions, in order to support timely decision-making; ensuring full recovery of costs, and in particular of staff costs, for all contributions; increasing efficiency in the allocation of resources; and increasing confidence in the Regional Office, so that contributors provide funding with more flexibility and accept reporting on common results rather than on separate contributors' inputs.

Increased accountability and transparency

15. Another important element in increasing Member States' and donors' confidence in the Regional Office is to increase accountability and transparency.

16. The Regional Committee discusses and comments on the Organization's proposed programme budget, based among other things on the regional perspective set out in this paper. However, no explicit regional targets or indicators are discussed and agreed, in terms of what either the Member States or the Secretariat will commit themselves to achieving. In order to strengthen the governance and oversight function of the Regional Committee and its Standing Committee (SCRC), it is proposed to define and formulate a quasi-contract between the Regional Committee and the Secretariat, to ensure and lay the foundation of accountability for the delivery of expected results by the Regional Office. This is proposed to be accomplished in a two-step approach:

(a) The Proposed programme budget 2012–2013 and its European perspective are presented to the Regional Committee at its sixtieth session in 2010, to discuss priorities and budget allocation by SO;

(b) Following the approval of the global programme budget by the World Health Assembly in 2011, the Secretariat will prepare (in collaboration with the SCRC) and submit a package of performance indicators to the Regional Committee at its sixty-first session; these will be developed as part of the operational planning for the biennium and will serve as a "contract" between the Member States and the Secretariat.

17. The business plan and the associated action plan to give effect to the approaches set out above have been elaborated and discussed with the SCRC before the sixtieth session of the Regional Committee, and implementation began in July 2010.

The current context

18. These institutional changes will facilitate work on the pressing and evolving health threats that European citizens and health systems face today. Noncommunicable diseases and injuries, particularly cardiovascular disease and cancer, are currently the leading cause of mortality and morbidity in the WHO European Region, representing 91% of the disease burden and 94% of all deaths, including many premature deaths and suicides. These diseases are linked by common risk factors and underlying determinants, and much of this disease burden is avoidable. There is also an increase in the prevalence of mental disorders, which are among the most common contributors to chronic conditions in Europe.

19. Vaccine-preventable, vector- and food-borne and zoonotic diseases, hospital-acquired antimicrobial-resistant infections including multidrug-resistant (MDR) and extensively drug-

resistant (XDR) tuberculosis, chronic communicable diseases such as HIV/AIDS and epidemic-prone infections including influenza are threats to human health and safety in the Region, contribute significantly to health costs and require significant resources to support Member States in their prevention and control efforts.

20. Environmental risks are important determinants of health and contribute significantly to the burden attributable to noncommunicable diseases (such as cardiovascular and respiratory diseases associated with air pollution); in fact, as much as 20% of the burden of disease in the European Region can be attributed to environmental exposures and factors, including contaminated water, lack of sanitation and unsafe food. The effects of climate change, including rising temperatures, sea levels and frequency of natural disasters and extreme weather conditions, are also becoming increasingly evident. Lifestyle determinants (smoking, alcohol, diet, exercise and substance abuse) also have powerful effects on health, particularly in relation to noncommunicable diseases.

21. The capacity and efficiency of health systems must be considered within a new European health policy. The issue facing all Member States in the European Region is how to demonstrate value by improving performance and reducing costs while maintaining the European values agreed in the Health for All policy, HEALTH21 and the Tallinn Charter, namely solidarity, equity and participation.

22. While it can be argued that socioeconomic determinants surpass elements such as health system capacity in terms of their effect on health outcomes, public health and health policy experts all agree that a coherent approach should address the full spectrum of these factors. Many of these determinants are amenable to effective interventions, and increased investment in health promotion and disease prevention is essential, alongside more efficient therapy and rehabilitation for individuals affected by disease. In many countries, current investment in population-based health promotion and disease prevention services is lamentably low. Indeed, the average health expenditure devoted to prevention in the European Region is just 1% of the total, despite the enormous potential to save lives and costs to health systems by fostering healthy environments and lifestyles.

23. To address the above public health challenges and to deliver on the objectives and results of the new vision captured in the Proposed programme budget 2012–2013, the work of the Regional Office in the coming biennium will be organized in six main areas:

- health policy, social determinants, the life-cycle, gender and vulnerable populations (SOs 4, 7 and part of SO 10);
- communicable diseases, health security and environment (SOs 1, 2, 5, 8, and food safety in SO9);
- noncommunicable diseases, prevention and health promotion (SOs 3, 6, and 9)
- health systems (SOs 10 and 11);
- information, evidence, science, research and innovation for policy-making and technical programmes (SO 10); and
- governance, including partnerships with Member States and other organizations (SO 12) and enabling and supportive functions (SO 13).

Health policy, social determinants, the life-cycle and vulnerable populations (SOs 4, 7 and part of SO 10)

SO 4: To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals

SO 7: To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches

SO 10: To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research

Developing a European health policy as a framework aimed at: addressing health inequities within and between countries and their underlying root causes – the social determinants of health; giving more prominence to public health challenges and priorities; adopting a life-cycle approach and focusing on vulnerable groups (older people, people living with disabilities, migrants, the Roma population, etc.). This will mean putting health at the centre of major developments in the Region; promoting health as a government responsibility; and engaging a broader range of stakeholders from different sectors.

24. The Member States in the WHO European Region, together with the Regional Office, need to work together to develop a European health policy that responds to the current health challenges and prepares for the future, promotes regional values and aims for health, in the light of current determinants of health and inequality within the European Region, and provides a coherent and integrated framework and road map for health action in the Region. A policy that will be rooted in "today's realities" but will nevertheless also dare to tackle "tomorrow's dreams".

25. To support elaboration of the European health policy and national health policy developments, the Regional Office will commission a European study on social determinants and the health divide, which will focus primarily on the evidence, policy implications and assessment of progress in Member States.

26. Addressing socially determined health inequities requires dealing with the "causes of the causes": the unequal distribution of power, income, goods and services, globally and nationally, that result in unfairness in the immediate, visible circumstances of people's lives – their access to health care, schools and education, their conditions of work and leisure, their homes, communities, towns and cities, in other words, their chances of leading a flourishing and healthy life. The basic actions needed are summarized in the World Health Assembly's resolution on "Reducing health inequities through action on the social determinants of health" (WHA62.14) adopted by all WHO Member States in May 2009. A more detailed report summarizing the extensive evidence on the topic was issued by the Commission on Social Determinants of Health (CSDH) in 2008.[2]

27. Addressing the social determinants of health requires strong political commitment, effective and high-performing health systems and policy coherence across government policies.

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[2] Commission on Social Determinants of Health. *Closing the gap in a generation: health equity through action on the social determinants of health*. Geneva, World Health Organization, 2008.

In order to achieve this, a given country requires well-functioning public health programmes and institutions capable of influencing policy-making across health and other policy sectors. Stakeholders range from academic/research institutions to ministries and governmental entities to nongovernmental and civil society organizations.

28. European experience shows that in order to initiate, sustain and mainstream the social determinants of health approach, it is of paramount importance to have a critical mass of human resources properly located within health systems, programmes and at cross-government level. This critical mass should have adequate skills and know-how and be accountable for the reduction of health inequities. Skills and know-how need to cover both general knowledge on how health inequities manifest themselves in a given country and specialist know-how on how to address them.

29. The WHO Regional Office for Europe will place particular emphasis on supporting ministries and partners in developing comprehensive strategies to addressing intersectoral and governance-related aspects, as well as constraints related to inequitable systems of financing, human resources, primary health care, pharmaceuticals and infrastructure, working in close collaboration with key international partners.

30. The Regional Office for Europe will continue to work closely with WHO headquarters in this area, leading efforts to draw up a framework document for country guidance on national strategy development, as part of an overall package of tools for health system strengthening coordinated by WHO headquarters.

31. The European health policy will have attainment of the Millennium Development Goals (MDGs) as a central priority. Renewed, updated and strengthened policies and strategies on the health of women, mothers, children and adolescents will support all countries in the European Region in reaching MDGs 3, 4 and 5, especially those in central Asia and the Caucasus, where attainment of the international development goals is most threatened. However, the health of mothers and children in vulnerable population groups (such as migrants and Roma) is at risk in all countries in the WHO European Region and requires tailored support. Although good progress is being made towards MDG 3 in the Region, gender inequities still impede women's access to and use of resources, as is shown by their lower salaries, higher rates of unemployment, and lower participation in the labour market and decision-making bodies across Europe. Gender inequities are also responsible for a lack of improvement in indicators for other MDGs, particularly MDGs 4 and 5. WHO will support national investments in policies, programmes and access to quality services for making pregnancy safer and for sexual and reproductive health. Such investments need to recognize that gender inequities have a strong bearing on the health and rights of women.

32. The European health policy will inspire Member States to recognize that, while ageing is an inevitable biological process, how women and men approach it and what consequences it has are socially governed and can be changed. Social determinants in old age include in particular wealth, income and poverty, work history and experience, patterns of dependency, social vulnerability to illness and disability, isolation and a lack of social support.

33. In line with the new vision, the proposed programme budget levels for both SO 4 and SO 7 in 2012–2013 allow significant space for growth (for details of the regional budget overview, see paragraphs 89–93 below). However, actual funding of SO 4 still remains a challenge at all levels of WHO, including the European Region (in 2008–2009, the actual funding was 48.3% of the approved budget). Lack of funding may result in difficulties with meeting commitments to Member States.

Communicable diseases, health security and the environment (SOs 1, 2, 5, 8 and the food safety component of SO9)

SO 1: To reduce the health, social and economic burden of communicable diseases

SO 2: To combat HIV/AIDS, tuberculosis and malaria

SO 5: To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact

SO 8: To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health

SO 9: To improve nutrition, food safety and food security, throughout the life-course, and in support of public health and sustainable development

Promoting the International Health Regulations; strengthening emergency and disaster preparedness and response; contributing to a unified European notification/surveillance system; with a specific focus on tuberculosis and in particular on multidrug-resistant (MDR) tuberculosis, antimicrobial resistance (AMR)/health care-associated infections, poliomyelitis eradication and measles/rubella elimination. Implementing the Parma Declaration and Action Plan and creating a new institutional framework in the area of environment and health and climate change.

34. All WHO's 53 Member States in the European Region are committed to implementing the International Health Regulations (IHR), which also encompass communicable diseases. Regional activities will focus on strengthening relevant functions of the public health system related to communicable disease prevention and control (e.g. early warning, surveillance, control measures, strategies and responses). Member States will be given technical assistance with implementing, by June 2012, national IHR action plans for the development and maintenance of core capacities with regard to the Regulations. WHO will continue to facilitate exchanges of information and experience among Member States, make regularly available to national IHR focal points information related to public health events of potential international concern, and facilitate the compliance of States Parties with their obligations.

35. With regard to influenza pandemic preparedness, the Regional Office will continue to support Member States in their efforts to ensure continuous revision of national plans, focusing on their multidisciplinary and multisectoral components and on operational aspects related to their implementation. The evolution of the recent pandemic (H1N1) 2009, as well as of other emerging influenza viruses, will be monitored and the lessons learnt will be used to adjust preparedness and response activities at regional and national levels.

36. In addition to achieving MDGs 4 and 6, all 53 Member States of the European Region have committed themselves to the regional elimination of measles, rubella and malaria, and to maintaining the elimination of poliomyelitis as part of the global goal of eradicating that disease. These regional goals will require renewed political commitment and resources in order to maintain high routine immunization coverage and vaccine quality and safety, as well as investments in surveillance. Making progress towards the goals for HIV/AIDS, tuberculosis and malaria in the Region will require refinement of guidelines, policies, strategies and other tools for prevention and for treatment and care of patients, as well as innovative approaches to more effectively reach poor and vulnerable populations.

37. Additional resources and efforts will be directed towards the monitoring and control of AMR, through a concerted public health response using a multidisciplinary approach. A wide range of areas, including patient safety, infection control practice, surveillance of health care-associated infections and AMR, and the prescription and use of antibiotics in humans and livestock, will be addressed. The Regional Office will develop a comprehensive regional strategy and support Member States in preparing national policies and implementing strategies on infection control and use of medicines.

38. The Regional Office will continue to support national tuberculosis control plans based on the Berlin Declaration and the WHO Plan to Stop Tuberculosis in 18 High-Priority Countries. In this connection, continued support will emphasize MDR and extensively drug-resistant (XDR) tuberculosis and co-infection with HIV. Regional strategic and policy guidance will continue to be provided by the Technical Advisory Group for Tuberculosis.

39. The Regional Office will focus on strengthening and expanding national and regional systems for communicable disease surveillance, on programme monitoring and on evaluating the impact of efforts to monitor and control new pathogens and drug resistance. In pursuing these goals, greater emphasis will be placed on leveraging the global and regional resources available through new and existing strategic partnerships with European institutions, particularly with national public health institutes and the European Centre for Disease Prevention and Control (ECDC). These efforts will be supported by mobilizing the additional technical expertise and knowledge available at national level, through better use of WHO collaborating centres, country experts and institutional twinning programmes. Increased attention will also be focused on further developing the health intelligence function, in order to collect, analyse and disseminate information about epidemiological situations, health threats and health system responses to communicable diseases, and to conduct the operational research necessary to inform WHO's policy advice and policy-making by the Member States.

40. The Regional Office will continue its technical efforts to strengthen health security in close collaboration with technical experts across all SOs, with emphasis on strengthening national capacities to prevent, mitigate and respond to the health consequences of crises through an "all hazard/whole health" approach. It will support Member States in the planning of preparedness for health systems crises, and it will provide technical support to build national emergency preparedness programmes for disaster risk reduction, including safer health facilities, as well as expert advice and capacity-building on "public health and emergency management" and emergency preparedness of hospitals.

41. In the event of a serious health crisis or a humanitarian emergency affecting Member States in the European Region, the Regional Office's response will be mainly implemented through its direct country presence and supported by WHO headquarters. All humanitarian action will be closely coordinated with other United Nations agencies and partner nongovernmental organizations, in line with WHO's designated role as health cluster lead agency in the broader context of the United Nations humanitarian reform process. In a response situation, the Office will support its Member States' national health systems' capacities, focusing on the WHO core functions in emergencies.

42. The Regional Office will continue to work on reducing or preventing the burden related to environmental risk factors by introducing, scaling up and sustaining existing and newly developed evidence-based policies and interventions, such as the implementation of measures to meet WHO's guidelines on air quality, noise, sanitation, chemical safety, drinking water, recreational water and occupational health and the development of plans to increase the adaptive capacities of health systems to climate change.

43. The capacity of countries to address emerging environmental issues, such as climate change, will be enhanced through greater engagement of the Regional Office in country-specific programmes and actions. Assisting Member States in developing and maintaining effective coordination mechanisms across sectors will remain a high priority, as will strengthening their capacity for collaboration with nongovernmental and civil society organizations.

44. The Regional Office will provide support to Member States in implementing the commitments made at the Fifth Ministerial Conference on Environment and Health (Parma, Italy, March 2010). This support will include the function of Secretariat for the European environment and health process and its European Environment and Health Ministerial Board.

45. A new area for WHO and a major environmental issue in the health sector is the impact of health services on the environment, such as their contribution to CO_2 emissions, energy efficiency, waste management, etc. The health sector is one of the largest global industries, as well as one of the largest employers, and it is an important actor with respect to sustainable development and the environment. The Regional Office will scale up its work on providing evidence and policy advice on "the greening of health services", in order to reduce costs and increase efficiency within the health sector.

46. The Regional Office provides a joint secretariat for the Protocol on Water and Health to the 1992 Convention on the Protection and Use of Transboundary Watercourses and International Lakes, together with the United Nations Economic Commission for Europe (UNECE), and for the Mediterranean Action Plan and Barcelona Convention for the Protection of the Marine Environment and the Coastal Region of the Mediterranean, together with the United Nations Environment Programme (UNEP). Partnerships with key regional actors such as the European Commission, the European Environment Agency, UNECE and UNEP will continue to be strengthened.

47. The proposed budget levels in 2012–2013 for SOs contributing to this area (SOs 1, 2, 5, 8 and parts of SO 9) will reflect the anticipated need to consolidate growth while acknowledging a changing mix of emphases. Aligning policy development and technical expertise across all locations will continue, creating synergies between different technical areas. Close links will be maintained or established with SOs 3, 6, 7 and 10.

Noncommunicable diseases, prevention and health promotion (SOs 3, 6 and 9)

SO 3: To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries and visual impairment

SO 6: To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex

SO 9: To improve nutrition, food safety and food security, throughout the life-course, and in support of public health and sustainable development

Implementing the integrated disease prevention and health promotion strategy (adopted by the Regional Committee at its fifty-sixth session). This will require renewed political commitment to existing and new policy and action plans (e.g. on food and nutrition, obesity, alcohol and tobacco) and health promotion.

48. The proposed programme budget for the Regional Office for Europe for 2012–2013 will see its most prominent change in SOs for combating noncommunicable diseases (NCDs), in

response to their very high disease burden in European Member States and in line with the new vision for the work of the Regional Office.

49. The commitment of Member States in the European Region has been expressed through their adoption of the regional NCD strategy in 2006 – Gaining health: the European strategy for the prevention and control of noncommunicable diseases (document EUR/RC56/8) – and the Action plan for the global strategy for the prevention and control of noncommunicable diseases (document A61/8) adopted by the Sixty-first World Health Assembly. It is expected that a European NCD action plan will be adopted by the Regional Committee in 2011. This will set the direction for work in the next biennium, particularly in the form of substantial support to Member States with developing comprehensive national policies addressing NCDs and the underlying social determinants. In this regard, disease prevention and health promotion will be especially important.

50. Addressing the multiple determinants of health requires promotion of integrated and intersectoral work across risk factors and diseases/conditions, as well as interventions and policies that are often outside the health sector, including fiscal policies and taxation, as well as policies on social support, agriculture, construction and urban planning, trade and industry, and education, and in other sectors. The Regional Office will keep advocating for the various sectors to be accountable for the impact of their policies on the health of all people and populations, and country-specific support will be provided to help strengthen the health system's capacity and role in the prevention and management of chronic diseases.

51. Addressing health inequities and the social determinants of health, as well as the special needs of vulnerable groups, remains a high priority and will be given further prominence in NCD prevention and control work.

52. Attention will be focused on the development and application of evidence-based guidance for effective and cost-effective interventions, including evaluations of economic impact and their use in country-led policy processes, integrated surveillance and monitoring systems, policy analysis and documentation of good practices, training of staff in integrated ways of working, and the development of platforms for learning and sharing experience.

53. At the population level, work will continue to address behaviour and lifestyles. Further progress will be made in tobacco control, as more countries are expected to implement fully the Framework Convention on Tobacco Control. Promoting healthy lifestyles and NCD prevention will be addressed through health systems interventions, both by integrating public health services more fully into primary health care and by implementing other population-based interventions. Addressing harmful effects of alcohol consumption will remain high on the agenda throughout the Region, not only as a major risk factor for NCDs, but also as an important determinant of violence and injuries. Use of psychoactive substances is more prevalent in the European Region than in the rest of the world, and the work in this area will be scaled up, particularly in the areas of prevention of overdose deaths, HIV and viral hepatitis. The technical work on prison health, in which the Regional Office has played the leading role in Europe, will remain an important component of addressing mental health, alcohol and drug use, and violence and injury prevention.

54. In the field of mental health, the emphasis will be on deinstitutionalization and the development of alternatives for social care homes; mental health and employment, with a focus on older people; and mental health policy and service development. Violence and injury prevention is a growing field of work where there is high demand for capacity-building activities at country level, particularly addressing road and traffic injuries and urban violence.

55. Management of chronic diseases, including cardiovascular diseases, cancer and diabetes, as well as of mental health and injuries, calls for a reconfiguration of health systems and the rethinking of care and social services in different settings (hospital care, home care, palliative care). Multiple and concomitant morbidities, and chronic diseases and conditions related to the ageing and longevity of the population in the Region, will be addressed through guidance in the area of patient management. The development of evidence-based approaches, including approaches for patient empowerment and the development of "expert patients", will be a centrepiece. This is an area of substantial interest for Member States and it will receive increased attention in 2012–2013 through the evaluation of various models and the provision of technical and policy advice.

56. Counteracting obesity through improved nutrition and physical activity remains an important area of work in support of Member States. Nutrition covers not only the prevention of obesity but also micronutrient deficiencies, malnutrition, infant feeding and, notably in Europe, the double burden of malnutrition and obesity. Member States are increasingly asking for assistance and action in the area of nutrition policy, for instance on developing, implementing and evaluating national plans on nutrition and physical activity; on the links between nutrition and inequities; on surveillance of nutritional status; on the role of local governments and primary care; and on the identification and dissemination of best practices with regard to promoting healthy eating and physical activity in different settings, such as schools. There is also a need to continue with the intersectoral approaches initiated through the adoption of the Istanbul Charter, building partnerships and interaction with major stakeholders.

57. The core portfolio of the work on NCDs and health determinants is covered by SOs 3, 6 and 9. However, there are cross-links with other strategic objectives, notably SOs 1 and 2 (communicable diseases), SO 4 (life-course, children's and women's health, ageing), SO 5 (disaster preparedness and response), SO 7 (equity and human rights, social determinants) and SO 10 (health systems).

58. To meet the increasing challenges of the burden of NCD in the European Region, it is proposed that the budget level for SOs 3, 6, and 9 is increased in 2012–2013.

Health systems (SOs 10 and 11)

SO 10: To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research

SO 11: To ensure improved access to, quality and use of medical products and technologies

Continuing to implement the Tallinn Charter; strengthening health care systems and financing; strengthening public health systems and essential public health functions; strengthening human resources for health; examining health workforce requirements and developing training and continuing education capacity; ensuring the quality of health care delivery, and the safe and rational use of medicines; engaging patients; advising Member States undergoing major reforms; taking up new challenges, including e-health; and analysing the contributions of the health industry.

59. In line with the new vision of "Better health for Europe", work in this area will focus on public health, essential public health functions and public health training (promoting a critical mass of public health experts in the European Region), as well as on the social determinants of health and primary prevention. Particular attention will be paid to achieving better outcomes in the prevention and control of communicable diseases and NCDs by strengthening health

systems and facilitating the development of national health policies and intersectoral strategies (health in all policies).

60. The emphasis placed on health systems strengthening in the MTSP is consistent with the European Region's priorities, as most clearly demonstrated by its Member States through their endorsement of the Tallinn Charter on Health Systems, Health and Wealth in a resolution (EUR/RC58/R4) adopted by the Regional Committee for Europe in September 2008. The Charter committed the WHO Secretariat to provide direct country support to European Member States on health systems issues and to facilitate cross-country exchange and learning on system performance assessment measures and techniques. In addition, the effects of the global economic and financial crisis that began in 2009 are likely to be prolonged and felt for many years to come, as countries eventually have to reduce the growth of public expenditure in order to return to fiscal balance. This will increase the need for advice to countries on how to make their health systems more efficient, i.e. to be able to produce more health from available resources. This has implications for many aspects of health systems work, including financing policy, reorganizing service delivery, human resources policy, demonstrating the effects of preventive interventions, and monitoring and evaluation of system performance and the effects of reform measures.

61. The Regional Office's actions will continue to be focused primarily on direct support to countries for health system policy development, monitoring, and analysis. SOs 10 and 11 incorporate the four health system functions: delivery of both personal and public health services, creation of the necessary inputs (human resources, medical devices and medicines, and physical infrastructure), financing, and stewardship. Particular emphasis will be placed on achieving better results in the field of NCDs and MDR/XDR tuberculosis through strengthening of health systems.

62. The Regional Office will continue to support Member States in the fields of governance and stewardship, especially in developing and/or revising national health policies and strategies, and in documenting best practice in policy development and planning processes, with particular emphasis on MDGs 4, 5 and 6. This work will build on the principles of aid alignment as set out in the Paris Declaration, the Joint Assessment of National Strategies (JANS), the International Health Partnership Plus (IHP +), the joint funding platform of the Global Alliance for Vaccines and Immunisations (GAVI), the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the World Bank, and the United Nations reform in countries.

63. In its work on service delivery, the Regional Office will provide assistance to Member States in developing country-specific strategies and policies that have a sharper focus on public health, public health training and public health functions, primary prevention, and chronic disease in their health systems. Emphasis will placed on integrating services and improving the coherence between population-based public health and personal health services. Overall, a key aim will be to make systems more efficient at delivering quality services to the people who need them, as the prolonged impact of the crisis will require that systems provide more value for money.

64. The Regional Office also aims to support national policy development in order to improve the quality and availability of the critical inputs needed by health systems. High on the agenda will be support for ensuring the existence of a competent and productive health workforce, with the right mix of the skills needed to improve health outcomes. This will require work on medical and nurse education to promote evidence-based medicine, as well as support for monitoring and evaluating new workforce development programmes at country level in order to improve workforce retention, motivation and performance. Special emphasis will be placed on the issue of health worker migration in the European Region.

65. In the area of medicines, medical devices and technologies, including vaccines, the Regional Office will continue to support countries in strengthening their institutional capacity to manage the supply, regulation and use of medicines and medical products, in order to achieve equitable access to safe and efficacious products, and to ensure that these are appropriately used. Support to less affluent countries will focus primarily on increasing access to essential medicines, reducing out-of-pocket payments, and improving the regulation and quality of medical products on their markets. Specific efforts will be made to increase access to medicines to treat HIV/AIDS and tuberculosis. The more affluent countries are also faced with society's growing expectations of new technologies and the high costs associated with new medicines, vaccines and technologies (such as cancer drugs and H1N1 vaccine); they are therefore concentrating on increasing the efficiency of pharmaceutical spending; on making more use of health technology assessment for reimbursement decisions; on improving the way in which medical products are prescribed and used by health professionals and patients; and on stimulating research and development of medical products (diagnostics, medicines, vaccines) for "underserved" disease areas. The Regional Office will support Member States in their national policy-making and implementation in these areas through the timely provision of appropriate information, through stimulating networking among the countries and through specific technical assistance. Its efforts in strengthening this dimension of country health systems will be closely coordinated and developed with the disease-oriented programmes (with a special focus on HIV/AIDS, tuberculosis, the integrated management of childhood illness and NCDs).

66. The Office foresees maintaining a strong focus on health financing policy, particularly as countries go through fiscal adjustment in the aftermath of the economic crisis. This will require support to develop medium-term strategies for putting health systems on a sustainable financial footing. Emphasis will be placed on developing policy on health system financing, for both personal and population-based services. Work will consist primarily in providing technical leadership, support and capacity-strengthening in the area of health financing policy, and strengthening the information base on country health expenditures as a global public good to promote evidence-based policy-making. In those Member States where donor agencies and partners are active, the Regional Office will continue to support policy-makers in assessing the advice they receive and working closely with the partners to ensure a coherent approach. The crisis may also create demands for advice and support from countries that have not requested much direct support on health systems issues in the past, including several middle- and even currently high-income countries.

67. The Regional Office will give high priority to supporting Member States with overall national health policy development, to ensure coherence between reform measures and well-defined, measurable policy objectives as called for in the Tallinn Charter. The anticipated slow growth of public spending on health during this period will lead to increased emphasis being placed on improving the performance of health systems; hence support with developing tools and methods for performance assessment, including facilitating cross-country exchanges of experience, will be key roles for the Office. Extending the Regional Office's experience with country-based health policy advisers to a few more countries can be foreseen as a critical step in this regard. Beyond this, work on stewardship will place much greater emphasis on "making the concept real" by adapting and applying various dimensions of this concept (e.g. policy coordination, evidence-informed policy, etc.) in specific countries. Through a combination of in-depth support to selected countries, together with health policy analysis and performance assessment tools, as well as fostering of cross-country learning and exchanges of experience, the Office will provide Member States with concrete support to strengthen their health systems to deliver population health outcomes in a transparent and equitable manner.

68. The proposed budget level for SOs 10 and 11 in 2012–2013 will have considerable room for expansion (40%), allowing for the focus of attention to be broadened in line with the new vision, as well as for the commitments made in line with the Tallinn Charter to be followed up prior to reporting back to the Regional Committee in 2015.

Information, evidence, science, research and innovation for policy-making and technical programmes (SO 10)

SO 10: To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research

Promoting the use of modern information and communication technology; proactively reaching out to scientific, research and academic institutions to distil the results of evidence, highlighting the interface between science, research and policy; providing data, evidence and policy options, transferring good practice and providing opportunities for exchanges of experience; bridging the gap between science and policy; providing improved tools and instruments for policy-making, and exploring and using innovative communication and information tools to reach WHO's diverse stakeholders, such as decision-makers, professionals and the public, including vulnerable populations and young people.

69. By strengthening its Health Evidence Network, the Regional Office will continue to provide information for health policy that is both readily accessible and targeted at policy-makers. In addition, the Office will play a stronger role in research strategy and monitoring. This will include reconstitution of the European Advisory Committee on Health Research, phased development of a strategy on research for health for the Regional Office in line with the global strategy (and following the strategy developed by the Pan-American Health Organization), and institution of an ethics review protocol.

70. In the area of health information, the Regional Office will step up work to consolidate the broad range of information systems currently published on its web pages (such as the Health for All database), in order to identify the remaining gaps in the evidence for policy-making in an international comparative perspective, to improve the quality of data and documentation and to enhance accessibility and dissemination via up-to-date user interfaces and newly designed country profiles. This work will also draw on lessons learned from a comprehensive stock-taking within the framework of health systems performance assessment that is currently under way, following up on the mandate from the Tallinn Charter.

71. Moreover, this will be done in line with the priorities to be agreed under the renewed European health policy, keeping in mind the specific information needs for public health in Europe; these include monitoring ageing populations, chronic disease and the social determinants of health, such as differences in social protection systems between countries.

72. At the same time, the Regional Office will continue to provide technical support for the development and improvement of health information systems at country level. This will include support with implementing international standards such as the International Classification of Diseases and identifying and applying best practices on e-Health (i.e. information and communication technologies used in health systems) for better monitoring and integration of health information systems.

73. The Regional Office's mandate to collect health data and to monitor and report on the health situation and trends in the Region will increasingly be implemented in the form of joint data collection activities with other organizations. Major tools for dissemination will include updates of the *European health report* as well as reports on monitoring of progress towards the MDGs.

Governance including partnerships with Member States and other organizations (SO 12) and enabling and supportive functions (SO 13)

SO 12: To provide leadership, strengthen governance and foster partnerships and collaboration with countries, the United Nations system, and other stakeholders in order to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work

SO 13: To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively

A strengthened role for both the Regional Committee and the Standing Committee for the Regional Committee (SCRC); a strong Regional Office as a centre of technical excellence, with the geographically dispersed offices and country offices fully integrated; strengthened cooperation with partners who share the Regional Office's values, vision and objectives; a Regional Office that reaches out beyond policy-makers and public health experts to the general public through the media and new forms of communication. Leaner and more cost-effective provision of support for programme implementation.

74. In addition to advancing the global health agenda through WHO's leadership, the scope and purpose of SO 12 and SO 13 lie in assisting, underpinning and enabling work towards the other SOs to be delivered.

75. SO 12 is outward-looking in nature and covers issues of leadership, governance, WHO's presence in and support for countries, collaborative work with partners and effective alliances with sister agencies. Responding to the challenges linked to health governance in Europe has several strategic implications for the work of the WHO Regional Office for Europe.

76. As a reflection of the renewed importance placed on these issues, the Seventeenth SCRC decided at its second session in November 2009 to establish an ad hoc Working Group on Health Governance in the WHO European Region, with a mandate to make firm recommendations to the Regional Committee at its sixtieth session on ways in which health governance in the Region could be strengthened.

77. As seen from the Regional Director's perspective, the governance challenges facing WHO in the European Region can be grouped under four broad headings: WHO's role in international health work in Europe; the need for the Regional Office to strengthen its technical expertise and refocus its business model; the need for collaboration and partnership with other actors in international health; and the European contribution to global health.

78. These challenges in turn point to a set of new strategic priorities for the Regional Office, namely the need for Europe-wide consensus-building on a new health policy framework; the need for intensified collaboration with countries to strengthen strategic developments and capacity-building; more active partnerships with other stakeholders in the field of health; resource mobilization to ensure financial sustainability; and the formulation of an active communication strategy.

79. In order to support these strategic developments, it will also be of critical importance to amend some of WHO's internal governance and rules of procedure, which will an impact on the future roles and functions of the Regional Committee and the SCRC. A full report on all these aspects is contained in a separate paper entitled *Governance of the WHO Regional Office for Europe* (document EUR/RC60/11).

80. Partnerships continue to be a main priority for the Regional Office. More emphasis will be placed on strengthening strategic partnerships with Member States and organizational partners who are either directly involved in health or whose activities indirectly impact public health in the Region. By improving strategic relations with partners, the Office aims to take a more prominent lead in dealing with public health issues and to coordinate activities more effectively with partners at both national and international levels, which will result in attainment of the highest possible level of health for all peoples in the Region and beyond. The Regional Office will also develop more strategic partnerships in the context of a European public health agenda that has been discussed and agreed with all partners. Formal agreements on the division of labour with key partners will be the cornerstone of this work, which will be guided by the outcomes and recommendations of the reviews of the work of the Regional Office's country offices. The partnership approach adopted in the previous decade will also guide work in 2012–2013.

81. Substantial progress has been made in strengthening the Regional Office's country presence and relations with national authorities in recent years, despite a tight resource envelope. The Regional Office's strategic partnerships with countries will be reviewed by a group of experts in 2010, with the objective of improving the Organization's performance and presence in countries. This review will yield recommendations on how to make best use of human and financial resources and will also identify remaining capacity gaps in order to allow for best use of available resources. The Regional Office will continue its work to establish well-founded country cooperation strategies with Member States, which will be based on and feed into other national and international planning instruments. To scale up its interactions with Member States without a country presence, the Regional Office will seek new and innovative ways of engagement.

82. The Regional Office will continue to establish institutionalized partnerships at regional level and to support country offices' capacity to be proactively engaged with partners and in health-related partnership initiatives at national level. A special focus will be on creating increased partnerships with the European Commission (the Directorate-General for Health and Consumers, as well as other directorates that have a direct or indirect impact on public health) and its agencies (particularly the European Centre for Disease Prevention and Control). An official agreement between the new European Commissioner for Health and Consumer Policy and the Regional Director to this effect will be signed at the Regional Committee session in September 2010. This agreement will establish closer and more effective links between the two organizations at strategic, political and technical levels in the context of both international and national processes, and it will give added value in the formulation, implementation and monitoring of national plans and strategies. (Further details are given in the paper entitled *Partnerships for health in the WHO European Region* (document EUR/RC60/12) and in the forthcoming draft agreement with the European Commission.)

83. The Regional Office will also make increased efforts to establish well-functioning information and communication systems and to build staff capacity in the area of partnerships. This will ensure the collection and analysis of relevant information, in order to adjust work with partners to the newly arising challenges and opportunities and to enable the Regional Office to be an organization that is flexible and able to adapt to changing needs and priorities.

84. In collaboration with WHO headquarters and in line with WHO policies, the Regional Office will also strengthen its role by creating and implementing Region-specific strategies for partners in the European Region, as well as for groups of partners such as nongovernmental organizations.

85. SO 13 is more inward-looking. Its purpose is to ensure continuous improvements in the provision of flexible, more efficient and cost-effective support to WHO's technical and policy work at regional and country level, thus supporting a responsive delivery of results. It comprises all areas of administration, including financial aspects, human resources management, and strategic and operational planning, monitoring and evaluation.

86. Efforts are being made to create a modern, leaner and more efficient management of the Regional Office, which is reflected in a halting of the growth in these SOs and in keeping the overall envelope for SOs 12 and 13 at under 30% of the total budget. Savings are expected to come from the following important areas.

- A new integrated Global Management System (GSM) was launched in the Regional Office in 2010. It is expected that after an initial adjustment period, internal efficiency gains can be realized from its introduction, especially in the areas of administration and finance.
- Administrative processes are being reviewed with the general aim of streamlining and reducing the associated costs.
- Running costs of country offices will be reduced.

87. While it is desirable to reduce general administrative expenditures overall, it is proposed to use part of those savings to strengthen analytical capacities and to provide more value-added services to technical units. The Regional Office's strategic and analytical capacity will need to further develop, especially after having implemented the Global Management System. Current efforts aimed at improving the performance of the Regional Office through a more strategic and responsible delivery of results will continue in 2012–2013, with more emphasis on qualitative technical monitoring, as well as on monitoring of measurable key corporate performance indicators, peer review assessments and critical evaluation of outcomes and work. This will place the Office in a better position to respond to changing or emerging needs, to correct performance challenges and to be more accountable to Member States.

88. Empowering staff through a modern and responsive human resources management strategy is essential. Consequently, efforts will be made to create and promote a stimulating and supportive environment for staff, while ensuring high performance and technical excellence. The overarching aim continues to be to ensure that Member States' needs and expectations are met by technically competent and managerially skilled WHO staff at all levels.

General considerations on the draft Proposed programme budget 2012–2013

Regional budget overview

89. Just as in the last biennium, the draft Proposed programme budget 2012–2013 is presented in three segments: base programmes, outbreak and crisis response (OCR) and partnerships (SPA). The Regional Office's envelope for the base programme segment is set at US$ 239 million, while the total budget (including OCR and SPA) is US$ 266 million.

90. Table 1 below is based on the global document (EUR/RC60/10) and makes comparisons using the resource validation mechanism[3] introduced in 2006. Based on Table 1, it can be seen that the Regional Office's currently proposed budget allocation share is 7%, which is at the very bottom of the validation range of 7–8.6%.

91. As is evident from Table 2, the Regional Office's proposed budget for base programmes in 2012–2013 represents a relatively modest increase of 26% when compared to 2008–2009 expenditures.

92. Both the past operations in 2008–2009 and the current situation in 2010–2011 point to the fact that some SOs (e.g. SO 8) already now have limited budget space for growth, despite being the priority areas of the new vision, while others have more significant room (Table 3).

93. The two complementary arguments above support the need for an increase in the level of the Regional Office's base programmes segment, to allow space for expansion in order to fulfil commitments in the new vision of "Better health for Europe".

Table 1. Proposed programme budget 2012–2013 for base programmes by major office with comparison to the averages, and minimum and maximum range of the resource validation mechanism (EB117/17)

Strategic Objective	AFRO	AMRO	SEARO	EURO	EMRO	WPRO	HQ	Total	% of total	HQ % of total
1	155.2	24.0	76.0	21.3	88.1	52.0	160.4	577.0	17%	28%
2	208.2	40.4	90.0	25.5	32.9	55.5	95.5	548.1	16%	17%
3	21.9	11.2	18.1	18.0	22.6	18.0	35.9	145.6	4%	25%
4	107.7	25.4	36.0	12.9	36.1	18.0	48.9	285.0	8%	17%
5	31.5	13.5	14.0	5.8	10.3	6.4	19.5	101.0	3%	19%
6	23.9	13.9	17.5	17.0	22.1	18.0	38.3	150.7	4%	25%
7	13.0	7.4	4.5	7.7	12.9	2.0	12.8	60.4	2%	21%
8	16.3	10.4	12.5	19.0	14.1	11.0	25.9	109.2	3%	24%
9	31.7	12.6	11.0	6.0	8.4	10.0	20.0	99.6	3%	20%
10	123.0	33.2	44.0	30.8	57.3	39.0	77.6	405.0	12%	19%
11	23.2	7.7	10.0	5.0	16.1	14.0	73.1	149.1	4%	49%
Subtotal SO 1–11	***755.8***	***199.7***	***333.6***	***169.0***	***320.9***	***243.9***	***607.9***	***2 630.8***	***76%***	***23%***
12	50.2	15.7	16.5	31.7	26.3	17.1	132.2	289.7	8%	46%
13	119.7	29.6	43.5	38.3	44.0	31.6	202.5	509.1	15%	40%
Subtotal SO 12–13	***169.9***	***45.3***	***60.0***	***70.0***	***70.3***	***48.7***	***334.7***	***798.8***	***23%***	***42%***
Grand total	**925.7**	**245.0**	**393.6**	**239.0**	**391.1**	**292.6**	**942.6**	**3 429.6**	**99%**	**27%**
% of total by office	**27.0%**	**7.1%**	**11.5%**	**7.0%**	**11.4%**	**8.5%**	**27.5%**	**100.0%**		
Validation range	24.9 – 30.4%	7.0 – 8.6%	9.8 – 11.9%	7.0 – 8.6%	9.0 – 11.1%	7.0 – 8.6%	25.2 – 30.8%			

[3] See document EB117/17. The validation mechanism is used to appraise and analyse the outcome of the MTSP and its associated programme budgets. It validates the results-based resource requirement. While it is an important and transparent point of reference, it does not determine actual resource allocations. It has three components: a fixed component comprising normative and statutory functions carried out at different levels of the Organization; an engagement component reflecting regional functions whose cost varies in relation to the number of countries served; and a needs-based component reflecting relative health and socioeconomic status together with a population factor. This component constitutes the larger part of the total resource envelope.

Table 2.Summary by segment and major office (US$ millions)

Major office	Expenditure 2008–2009 for base programmes	Approved PB2010–2011		Proposed Programme budget 2012–2013					
		All segments	Base, inc. SO12 and 13	Base, inc. SO12 & 13*	% of total (validation)	% change over 2008–2009 expenditures	SPA**	OCR**	Total
AFRO	555	1 263	926	926	27%	67%	402	81	1 409
AMRO	130	256	245	245	7%	89%	6	7	257
SEARO	272	545	394	394	11%	45%	80	32	505
EURO	189	262	239	239	7%	26%	16	11	266
EMRO	212	515	391	391	11%	85%	163	171	725
WPRO	204	310	293	293	9%	44%	11	13	316
HQ	977	1 389	881	943	27%	-4%	246	148	1 336
Total	**2 539**	**4 540**	**3 368**	**3 430**	**100%**	**35%**	**922**	**462**	**4 815**

* Base budget set at approved 2010–2011 for Regions and a 4% reduction in HQ compared to actual expenditure for 2008–2009 in order to move towards 30/70.

** SPA/OCR budgets set at the level of actual expenditures in 2008–2009

Table 3. Trends in expenditures by SO in the WHO European Region for the past three biennia and comparison to the Programme Budgets of 2010–2011 and 2012–2013 (all budget segments)

EURO Programme Budget – All budget segments											Comparison PB 12–13 to implementation 08–09	% Change in Budget 10–11 to 12–13
	Expenditures						Budget					
SO	2004–2005		2006–2007		2008–2009**		2010–2011		2012–2013		% change	10–11 to 12–13
1	14 020	8.8%	26 190	14%	26 095	12.8%	26 393	10%	27 771	10.4%	6.4%	5.2%
2	19 085	11.9%	25 560	13%	23 057	11.3%	25 473	10%	25 473	9.6%	10.5%	0.0%
3	8 049	5.0%	5 400	3%	8 053	4.0%	14 674	6%	18 000	6.8%	123.5%	22.7%
4	4 470	2.8%	5 280	3%	6 973	3.4%	12 937	5%	12 937	4.9%	85.5%	0.0%
5	8 439	5.3%	11 380	6%	10 609	5.2%	17 960	7%	15 753	5.9%	48.5%	-12.3%
6	6 568	4.1%	4 270	2%	9 559	4.7%	9 713	4%	17 000	6.4%	77.8%	75.0%
7	1 076	0.7%	3 130	2%	4 165	2.0%	6 944	3%	7 709	2.9%	85.1%	11.0%
8	16 377	10.2%	14 780	8%	16 988	8.3%	17 220	7%	19 000	7.1%	11.8%	10.3%
9	1 950	1.2%	3 950	2%	2 840	1.4%	5 501	2%	5 975	2.2%	110.4%	8.6%
10	35 197	22.0%	31 070	16%	29 533	14.5%	45 182	17%	41 381	15.6%	40.1%	-8.4%
11	3 222	2.0%	2 540	1%	3 635	1.8%	5 952	2%	5 000	1.9%	37.5%	-16.0%
12	16 915	10.6%	25 100	13%	24 903	12.2%	34 698	13%	31 698	11.9%	27.3%	-8.6%
13	24 631	15.4%	33 440	17%	37 065	18.2%	39 262	15%	38 262	14.4%	3.2%	-2.5%
TOTAL	**160 000**	**100.0%**	**192 090**	**100%**	**203 476**	**100.0%**	**261 909**	**100%**	**265 959**	100.0%	30.7%	1.5%

Financing mechanisms – issues and challenges

94. The budget of the WHO Regional Office for Europe, like WHO's global programme budget, is funded from a large number of individual sources. They can be categorized into five types:

(i) Assessed contributions (AC) from all Member States

(ii) Special account for servicing costs (AS): mostly originating from programme support costs and intended for use only in SOs 12 and 13

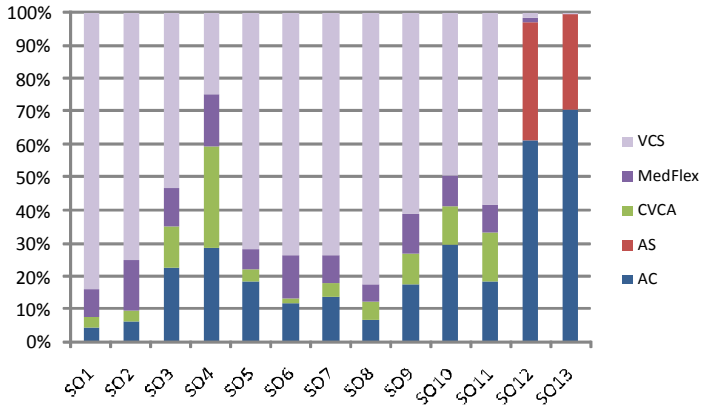
(iii) Core voluntary contributions account (CVCA): Official development assistance (ODA) funds provided by donors, flexible at programme or SO level and intended for use in base programmes and technical SOs 1–11 and for support of ODA-eligible countries

(iv) Medium-flexible voluntary contributions: funds provided by donors, flexible at the level of OWERs, Organization-wide programme, or major office

(v) Specified voluntary contributions (VCS): mostly tightly earmarked as result of detailed negotiations between technical programmes and donors.

95. The largest parts of resources available for the Regional Office in 2008–2009 were VCS (financing 44% of the total expenditures), followed by AC (33%) and AS (10%). The two types of flexible voluntary resources (CVCA and Medium-flexible) are accounted for 6% and 7% respectively (Fig. 1). This funding pattern is similar to WHO's global funding pattern.

Fig. 1. 2008–2009 financing of expenditures by SO and type of fund in the WHO European Region



Assessed contributions

96. The major shift in AC allocation across SOs in the WHO European Region took place between 2006–2007 and 2008–2009, with 66% of ACs being allocated to SOs 12 and 13 in 2008–2009. This increase resulted in a decrease in AC allocation to many technical SOs. Fig. 2 shows the comparison of allocation of AC resources among major WHO offices, with the Regional Office for Europe having largest share of ACs tied to SOs 12 and 13. However, the total share of ACs is lowest for the WHO European Region as compared with other major WHO offices (Table 4), especially for locations with a similarly sized WHO programme budget. This historical variation and inequity in the relative share of ACs remain unresolved, and it requires further attention and remedy.

Fig. 2. Allocation of AC resources by major WHO office, 2008–2009

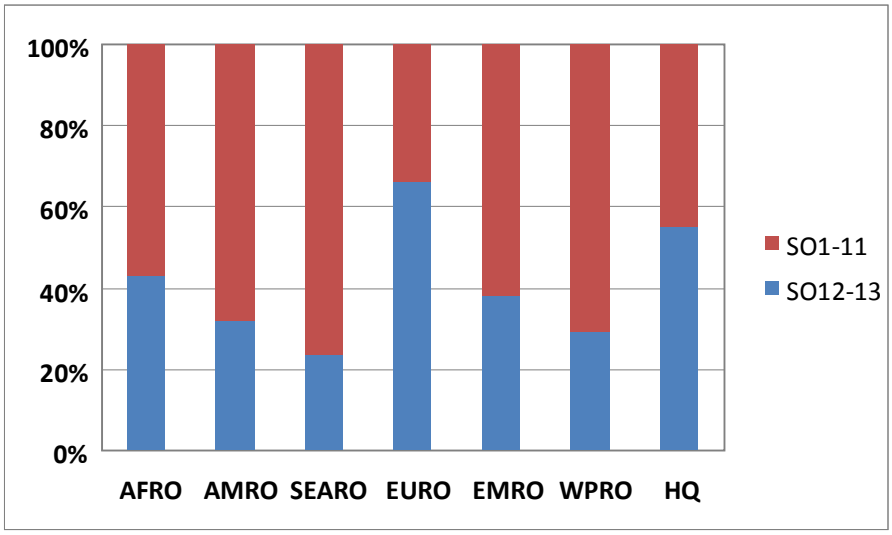


Table 4. Proposed programme budget 2012–2013 by major office for WHO programmes, with comparison of assessed contributions (US$ millions)

	Proposed programme budget 2012-13		Assessed contributions	
	WHO programmes		Total AC	% of total AC
AFRO	926	27.0%	213.3	22.2%
AMRO	245	7.1%	81.5	8.5%
SEARO	394	11.5%	103.9	10.8%
EURO	239	7.0%	63.3	6.6%
EMRO	391	11.4%	91.6	9.6%
WPRO	293	8.5%	80.2	8.4%
HQ	943	27.5%	325.0	33.9%

97. Despite the concept of a unified programme budget, assessed and voluntary contributions have up to now been managed as two separate budget elements. This has two consequences: (1) it limits the ability to make a managerial response to technical needs and the availability/non-availability of other funding; (2) it results in a significant increase of administrative work. Treating ACs as a resource rather than a budget would facilitate a much better alignment between priorities, budget, resources and implementation.

Resource mobilization strategy

98. The Regional Office will develop a resource mobilization strategy and action plan to secure an adequate resource base for effective implementation of the programme budget and the work plans for each SO. This strategy will be closely linked with WHO's Corporate Resource Mobilization Strategy.

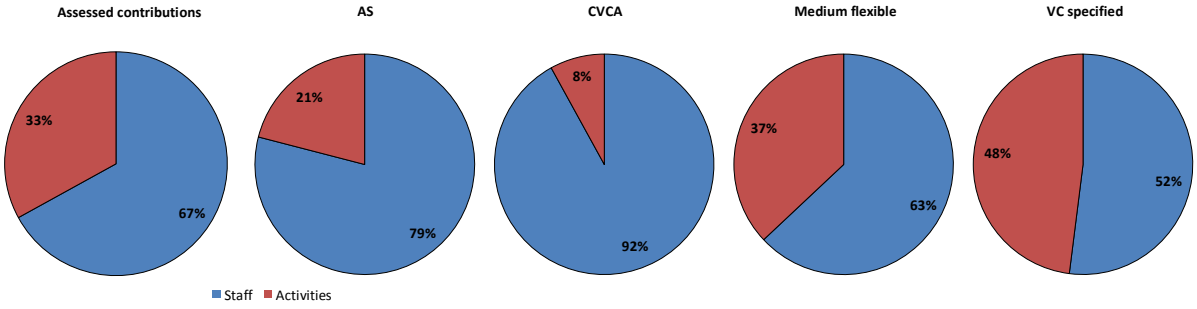
99. The regional resource mobilization strategy will be supported by careful monitoring of the funding gaps in the Region and countries, in order to identify the most urgent funding needs. Regular sharing of information with Member States about funding status and progress in the

implementation of work plans will allow countries to define the most appropriate mechanisms for supporting WHO's work in the Region.

Resource utilization

100. In 2008–2009, VCS accounted for 44% of the overall expenditures in Regional Office. However, the impact of earmarking was particularly felt in the technical SOs 1–11, because VCS financed about 60% of total expenditure for these. Only 52% of VCS were utilized to meet staff costs, while on average the latter constituted 57% of the total costs for SOs 1–11. This means that VCS created pressure on the scarcer flexible resources (AC, CVCA, Medium-flexible) to fund staff costs, as reflected in the higher percentage devoted to staff costs for these types of funds (Fig. 3). While the same problem is experienced across WHO, it appears more acute in the European Region, as illustrated by the fact that 92% of CVCA are used to finance staff costs, as compared to 60% for the Organization as a whole.

Fig. 3. Staff and activity financing by type of resources in 2008–2009 in the WHO European Region



Operational planning, monitoring and evaluation

101. An integral part of WHO's results-based managerial framework is regular progress monitoring and assessment, as a crucial element in a structured approach to accountability and commitment to achieving stated results. Performance monitoring and assessment outcomes are integrated at all levels, feeding the lessons learned into day-to-day management decisions and programmatic choices, as well as long-term knowledge-building and institutional learning. A prerequisite for successful implementation is solid operational planning that takes as its point of departure the needs and priorities identified by the Member States and the identification and selection of indicators to measure performance levels.

102. In 2008–2009, work began on carefully and systematically reviewing the set of indicators for all OWERs in the MTSP, with the aim of improving clarity and facilitating measurement and reporting. Most of the indicators were refined; some were replaced when they were considered unable to provide an adequate measurement of the result.

103. While the Organization is collectively accountable for achieving the OWERS, the contribution of each regional office to their achievement is expressed through regional expected results (RERs). RERs are achieved through the combined accomplishment of all country offices and the divisions at the Regional Office. RERs are operationalized through country-specific expected results and intercountry expected results in regional offices and their related products and services.

104. For the coming biennium 2012–2013, as previously mentioned, one of the key focuses for operational planning is better alignment with country priorities. To ensure that the strategic agendas of Member States systematically inform and drive the operational planning process across the Organization, an early full-scale exercise will be undertaken to map country priorities to the OWERs in the MTSP.

105. Countries whose priorities show a significant degree of focus on a given OWER will be identified and will form part of the 'targeted' countries for the relevant OWER indicator. This early exercise, followed by the elaboration of country-specific expected results, will ensure more effective country-focused programme development and management in 2012–2013. In the European Region, regular performance monitoring and assessment address the achievement of results as well as the delivery of products, services and related activities, and they involve the collection, analysis and recording of data in relation to country and regional results. To supplement and reinforce these exercises, the Regional Office intends in the coming biennium to undertake one to two internal programmatic evaluations/reviews focusing on relevance, efficiency and effectiveness and to commission two ex-post external evaluations of particular elements of its work, as a means of refining strategies and managerial and operational approaches.

Key actions to operationalize the vision: the budget and resource component of the Regional Office's new business plan

106. Making the new vision for the WHO Regional Office for Europe a reality requires that the budget and resource base is present or can be established to support the changes that it requires. Two key issues have continued to be brought up in the discussions of WHO's governing bodies: how to better align the agreed priorities with the monies available to finance them; and how to ensure greater predictability and stability of financing to promote more realistic planning and effective management?

107. The situation is complex and challenging with few immediate degrees of freedom, in particular as the current financial environment is not generally supportive of solving alignment problems through growth, for instance. However, challenges must be faced and dealt with effectively. As part of the new business plan for the Regional Office, an action plan to deal with these challenges has been developed in consultation with the SCRC. The action plan has four pillars, addressing four groups of challenges: room to manoeuvre, financial risk, resource management, and accountability and transparency (for details of the latter pillar, see paragraphs 15–17 above). Each of these pillars represents ranges of options and choices of entry points for action.

Create room to manoeuvre

108. The WHO Regional Office for Europe's biennial collaborative agreements with Member States, as well as the new vision of "Better health for Europe", call for increased activities in the areas of NCDs (SOs 3 and 6), improving health during key stages of life (SO 4) and social determinants of health (SO 7). However, funding has so far not been forthcoming for increased activities on these SOs. In 2008–2009, 85% of the financing for the Regional Office's technical health work, i.e. in SOs 1–11, came from voluntary contributions, with most of it being highly specified, mainly for SOs 1, 2, 8 and 10. This funding situation limits the Regional Office's ability to ensure better alignment with the needs of Member States and with the new vision.

109. There are two main ways of addressing these challenges: to increase the amount of flexible resources available, and to free up and/or shift assessed contributions from better resourced SOs or to reduce expenditures in SOs 12 and 13.

Reduce financial risks

110. WHO, including its Regional Office for Europe, has over the past biennia moved to a scenario where an increased proportion of expenditure goes on long-term staff commitments, while the funding received has a shorter time horizon and greater specificity. This poses a financing risk, i.e. when the specific funding ends or is shifted to other areas that require other forms of expertise, it takes considerably longer to adjust the staff costs. The result is increased pressure on assessed contributions and flexible corporate funding to cover staff salaries. This is particularly a challenge when there is an overall slow-down in growth of income. Currently, close to 60% of total costs in the technical health areas (SOs 1–11) is constituted by staff costs. Furthermore, about 90% of the international professional staff are employed on longer-term contracts.

111. Realizing that the Member States expect the highest level of technical advice and assistance from the Regional Office, there are three principal ways in which these challenges can be met: by adjusting the business model towards greater involvement of the expertise of partners and collaborators directly in the delivery of services and support; by ensuring a closer match between types of staff contract and the nature of the funding; and by improving internal efficiency and productivity, so that more is delivered with the same or less staff inputs.

Improve resource management

112. During 2008–2009 the Regional Office's activities were funded from more than 500 different sources, making it a complex and challenging task to ensure optimal management from pre-agreement negotiation to implementation and final reporting on the individual contributions. There is room for improvement at all stages of this process. Not all funding opportunities are necessarily explored, and donor agreements do not always have sufficient provisions to cover in particular all staff costs – a situation that can slow down implementation or put pressure on other sources of funding. In addition, as the costs of projects, and especially of staff, often have to be split over multiple sources of funding, administration is laborious and complicated, sometimes leading to unspent balances remaining on individual contributions, while the costs have actually been charged to other funds. The many different contributions frequently come with specific reporting requirements, adding to the burden of administering the grants and sometimes also adversely affecting the quality of the reports.