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Financial situation of the WHO Regional Office for Europe

This document contains an overview of how the WHO Regional Office for Europe has been implementing the approved programme budget 2012–2013 and describes the current challenges and their consequences for the operations of the Regional Office. The information provided in this document is intended to serve as background for the discussion of topics related to WHO reform at the Regional Committee session and to ensure that the WHO Regional Office for Europe is accountable to its governing bodies.

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Glossary of terms and abbreviations

Administrative support (AS). The resources generated through the levy of programme support costs (PSC). These funds can only be used for funding strategic objectives (SO) 12 and 13.

Allocated budget. The budget as revised by the WHO Director-General, subsequent to its approval by the World Health Assembly.

Approved budget. The budget as approved by the World Health Assembly when it adopts the appropriation resolution.

Assessed contributions (AC). Regular contributions made by all Member States, calculated on the basis of an assessment key determined by the United Nations. When the World Health Assembly adopts the appropriation resolution, it decides how AC funds should be used. For the current and past programme budgets, this has entailed allocation at the level of each strategic objective (SO), i.e. in 13 appropriation sections.

Base programmes (Base). That part of the Programme budget over which WHO has exclusive strategic and operation control.

Core Voluntary Contributions Account (CVCA). A mechanism to receive, allocate and manage resources that are provided to WHO from donors and which are flexible at the level of the Programme budget (across SOs 1–11) or within an SO.

Corporate resources. Resources which the Organization has a high level of flexibility to manage, including allocating and spending according to priorities and bridging financing gaps. Includes AC, AS, CVCA and POC funds.

European Observatory on Health Systems and Policies (OBS). A partnership that includes the governments of Austria, Belgium, Finland, Ireland, the Netherlands, Norway, Slovenia, Spain, Sweden and the United Kingdom; the Veneto Region of Italy; the French National Union of Health Insurance Funds; the World Health Organization; the European Commission; the European Investment Bank; the World Bank; the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine.

Other voluntary contributions (Other VC). Voluntary contributions other than CVCA and OBS.

Outbreak and crisis response (OCR). A segment of the Programme budget where the size and location of, inter alia, budget requirements are determined by external events. The OCR segment is only relevant to SO1 (epidemics) and SO5 (emergencies)

Post occupancy charge (POC). A mechanism introduced from 1 January 2010 to recover those costs most closely associated with the level of staffing of programmes and projects. Examples of such costs include: staff development and learning, information and communications technology infrastructure, human resources administration, United Nations common security charges, the Global Service Centre, and office accommodation. The post occupancy charge is included as a programme direct cost within all SOs.

Programme budget (PB). The biennial WHO Programme budget.

Programme support costs (PSC). A charge that is applied to activities financed from voluntary contributions, in accordance with the terms of resolution WHA34.17, to defray some of the costs the Organization incurs in delivering these activities.

Proposed programme budget. The budget as presented to the World Health Assembly prior to the start of the biennium. This budget's SO envelopes are often adjusted during the biennium, resulting in the so-called allocated budget.

Segment. The Programme budget is divided into three segments: Base, SPA and OCR.

Strategic objective (SO). A high level in the results structure. WHO's Medium-Term Strategic Plan 2008–2013 is organized according to 13 strategic objectives:

SO1: Communicable diseases
SO2: HIV/AIDS, tuberculosis and malaria
SO3: Chronic noncommunicable diseases
SO4: Child, adolescent, mother health and ageing
SO5: Emergencies and disasters
SO6: Risks factors for health
SO7: Social and economic determinants of health
SO8: Healthier environment
SO9: Nutrition and food safety
SO10: Health systems and services
SO11: Medical products and technologies
SO12: Leadership, governance and collaboration with Member States and partners
SO13: Administrative and managerial support

Special programmes and collaborative arrangements (SPA). Activities that are fully within WHO's results hierarchy and over which WHO has executive authority. However, the activities in this segment are undertaken in collaboration with partners and thus the magnitude of associated operations is determined by the special nature of the activity and the joint strategic decisions of the collaboration. WHO does not therefore have exclusive decision-making powers, e.g. in relation to budget levels. In the WHO Regional Office for Europe, the SPA segment primarily includes funds received from the Global Vaccine Initiative (GAVI), the Global Fund to Fight AIDS, Malaria and Tuberculosis, and the European Observatory on Health Systems and Policies (OBS).

Specified Voluntary Contributions (VCS). Funds that the contributor tightly earmarks with regard to on what and how they may be used.

World Health Assembly (WHA). The highest governing body of WHO.

Constituent parts of WHO

AFRO: WHO Regional Office for Africa

AMRO: WHO Regional Office for the Americas

EMRO: WHO Regional Office for the Eastern Mediterranean

EURO: WHO Regional Office for Europe

HQ: WHO headquarters

SEARO: WHO Regional Office for South-East Asia

WHO: World Health Organization. The term is used to cover the Member States and the Secretariat

WPRO: The WHO Regional Office for the Western Pacific

Introduction

1. This document aims to provide a brief overview of the financial situation of the WHO Regional Office for Europe. It serves two purposes: to provide background information for the discussion of topics related to WHO reform at the Regional Committee session and to ensure that the Regional Office is accountable to its governing bodies. The document identifies issues resulting from the current way of financing and the Region's challenges in resource mobilization.

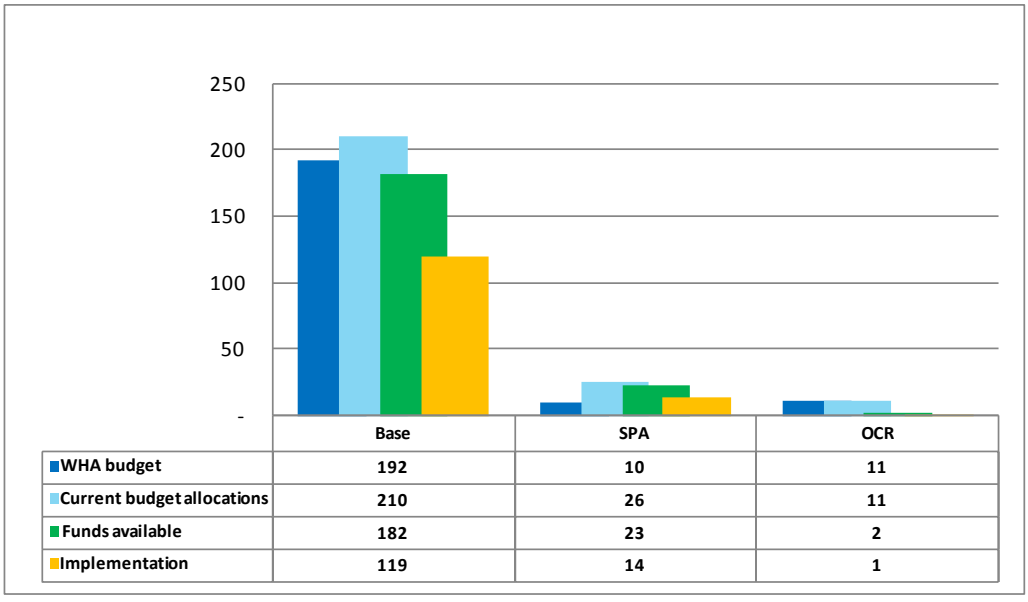
Resource situation and prospects

2. In the Programme budget 2012–2013 the Organization's budget is broken down into three segments: Base programmes (Base), Special programmes and collaborative arrangements (SPA), and Outbreak and crisis response (OCR). The programme consists of work towards 13 strategic objectives (SOs).

3. In the course of the current biennium, the Regional Office's approved budget has been increased by US$ 33 million, resulting in an allocated budget of US$ 247 million. As of May 2013, the Regional Office's approved budget was funded at 97%, while the allocated budget is currently funded at 84% (Fig. 1).

4. Base programmes (SOs 1, 2, 7, 8 and 12) have been increased by US$ 18 million compared to the approved budget. This increase was authorized by the Director-General and is due to a combination of programmatic and funding opportunities and some large single-country projects. At the start of the biennium, a budget correction between SO13 and SO12 also took place (SO12 was increased at the expense of SO13, but the combined budget of these two enabling SOs did not increase). The approved SPA segment was underbudgeted and has therefore been increased by US$ 15 million. Available funding and implementation in the SPA segment already exceed the approved budget. The OCR segment remains at its approved level.

Fig. 1. Approved and allocated Programme budget, available resources and implementation by segment, May 2013 (US$ millions)

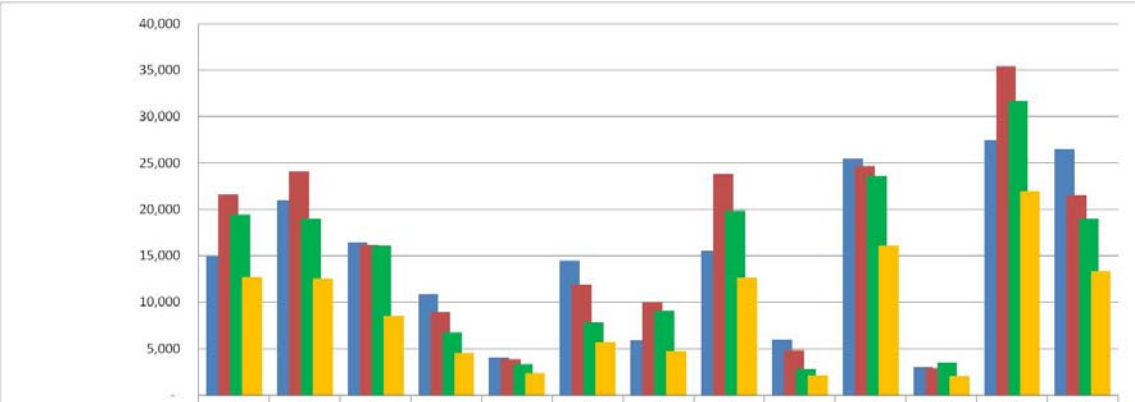


	Base	SPA	OCR
WHA budget	192	10	11
Current budget allocations	210	26	11
Funds available	182	23	2
Implementation	119	14	1

5. While SOs 1, 7, 8 and 11 have more than 100% of their approved budgets funded, SOs 4, 6 and 9 remain the least funded SOs in the Region, with SO9 having less than 50% of the approved budget funded (Fig.2). These underfunded SOs continue to have the lowest rate of implementation of the approved budget throughout the biennium, while SO6 has the highest rate of implementation of available funds, followed by SO9.

6. Despite the overall high percentage of funding of the approved budget for the European Region, there continue to be underfunded areas, which could jeopardize achievement of expected results as stipulated in the Programme budget.

Fig. 2. Base programme budget, available resources and implementation by strategic objective, May 2013 (US$ thousands)



	1	2	3	4	5	6	7	8	9	10	11	12	13
WHA budget	15,000	21,000	16,500	10,900	4,000	14,500	5,900	15,500	6,000	25,500	3,000	27,500	26,500
Current budget allocations	21,622	24,101	16,200	8,967	3,858	11,935	9,995	23,758	4,877	24,672	2,882	35,441	21,546
Funds available	19,462	18,946	16,073	6,754	3,299	7,788	9,099	19,885	2,837	23,617	3,494	31,699	18,993
Implementation	12,737	12,579	8,538	4,493	2,328	5,743	4,761	12,664	2,083	16,119	2,012	21,960	13,392

7. In May 2013, overall projected available resources stood at US$ 221.8 million for all budget segments, compared to US$ 228.6 million at the equivalent point in the 2010–2011 biennium. While in 2012–2013 the Regional Office has received approximately US$ 5 million more funds in the core voluntary contributions account (CVCA) than in 2010–2011, the level of other voluntary contributions in May 2013 was US$ 8.4 million lower than at the same time last biennium. The largest drop is seen in SO5 (US$ 5.5 million), which is related to the OCR segment of the Programme budget: the relatively stable situation in terms of disasters and outbreaks in the Region is reflected in the low resources of this segment, which is a positive development. In total, a decrease in voluntary contributions of US$ 4.7 million is projected for this biennium.

Overview of financial implementation

Implementation by Programme budget segment

8. In May 2013, the overall rate of implementation of the approved Programme budget was 63%, with 66% implementation of available funds (Fig. 1).

9. Base programmes were 95% funded and the Regional Office has implemented 62% of the approved budget. Comparing these data to the same time last biennium (Table 1), it is evident that fundraising and implementation are better aligned to the budget approved by the World Health Assembly.

Table 1. Regional Office for Europe Base programmes, approved budget and implementation, May 2011 and May 2013 (US$ millions)

	WHA budget	Funds available	Implementation	Funds avail as % of WHA budget	% Imp of % Imp of Funds WHA budget	available
2010–2011	239.0	177.1	112.6	74%	47%	64%
2012–2013	191.8	181.9	119.4	95%	62%	66%
Difference						
2012–2013/2010–2011	-20%	+3%	+6%			

10. For the SPA segment, implementation of the approved budget was 135% in May 2013, reflecting the fact that this segment was originally underbudgeted and that a US$ 15 million increase of the approved budget took place in this segment.

11. Detailed analysis of funding and implementation by SO shows the existence of "pockets of poverty" and highlights the need to improve the distribution of resources within the Organization, in order to address financial needs and performance equitably. Ideally, by May 2013, all SOs should be fully funded and should have implemented over 50% of their respective approved budgets. Three of the technical SOs in the Region (SOs 4, 6 and 9) stand out as having less than 80% of their approved budget funded (Fig. 2). Consequently, the rate of implementation of programmes in these SOs is also very low for this time in the biennium (approximately 40%), while their implementation of available resources is the highest among all SOs.

Implementation by staff costs and activities

12. Despite significant increases in staff unit costs,[1] projections indicate only 1% higher total staff costs by the end of 2012–2013 as compared to 2010–2011 (US$ 131.7 million compared to US$ 130.6 million). This was mainly achieved by an overall 15% decrease in staff numbers since September 2010 (from 596 in September 2010 to 509 in May 2013). Overall spending on staff costs in the Regional Office accounts for 63% of total expenditure for the biennium to date. The reduction in staffing is a reflection of ongoing efforts by the management to ensure the financial sustainability of the Office. Some of these savings, however, were achieved by delayed recruitments or non-replacement of some staff performing key functions; they therefore constitute only temporary savings and, without structural measures, the related costs will need to be met in the next biennium.

13. The Regional Office's human resources plan aims to address this issue for the 2014–2015 biennium and beyond. The new Human Resources Plan is expected to achieve three objectives: i) to adjust the skill-mix of the Office to the new priorities of the Organization as laid down in the Twelfth General Programme of Work, Program Budget 2014–2015, as well as resolutions of the WHO's governing bodies; ii) to put the Regional Office on a more sustainable financial path by reducing the overall salary component and iii) to strengthen technical capacity in the Regional Office through simultaneous reduction in administrative capacity and support functions.

[1] There was a 15% increase in salary costs in 2012–2013 compared to 2010–2011. This was not an increase in take-home pay but was due, among other factors, to hedging costs to avoid exchange rate fluctuations, inflation, and some salary-related charges such as the post occupancy charge (POC).

14. In addition to reducing staff, other cost-saving measures were introduced in the course of the biennium, such as reducing expenditure on travel.

15. By the end of the 2012–2013 biennium expenditure on activities is projected to amount to US$ 78.7 million, as opposed to US$ 86.9 million last biennium. The Regional Office is exploring ways of speeding up implementation, especially in the country programmes. The main reason for the slower than envisaged implementation is that many of the Regional Office's voluntary contributions only fund activity costs (see below, paragraph 17) and do not cover staffsalaries.

Financing mechanisms – issues and challenges

Carry-forward

16. Funds carried forward from one biennium to the next are essential to ensure continued implementation and to avoid excessive programme disruption. At the beginning of the current biennium, the Regional Office had fewer resources available than in 2010, mostly owing to decreased carry-forward into 2012. For the next biennium, according to our projections there will be a healthier carry-forward than into 2012–2013 (Table 2).

Table 2. Actual and projected resources and expenditures, 2010–2011 and 2012–2013 (US$ millions)

	2010–2011	**2012–2013**
Resources actual	**236.64**	
Resources projected		231.90
Expenditures actual	**217.48**	
Expenditures projected		210.42
Difference	**19.15**	**21.48**

Resource mobilization

Flexibility of funds

17. Currently, about half of the Regional Office's financial resources are fully flexible or highly flexible funds. The majority of those flexible funds come from assessed contributions (AC) (58%), the Core Voluntary Contributions Account (CVCA) (15%), and administrative support (AS) funds (14%); only 13% come from relatively flexible voluntary contributions. The other half of the Regional Office's financial resources consists of voluntary contributions that are highly specified for a project, a country, a disease or for a combination of these.

18. Moreover, the Regional Office's highly specified voluntary contributions often only cover activity costs and do not include other costs related to a project, such as salaries and running costs. These highly earmarked voluntary contributions therefore need to be supplemented with flexible funds, such as AC or CVCA. As a result, the latter core funds are almost entirely spent on staff costs (82% and 95%, respectively). Consequently, highly flexible funds end up being tied into existing structures, which make them less flexible and not available to support emerging priorities or to fill gaps.

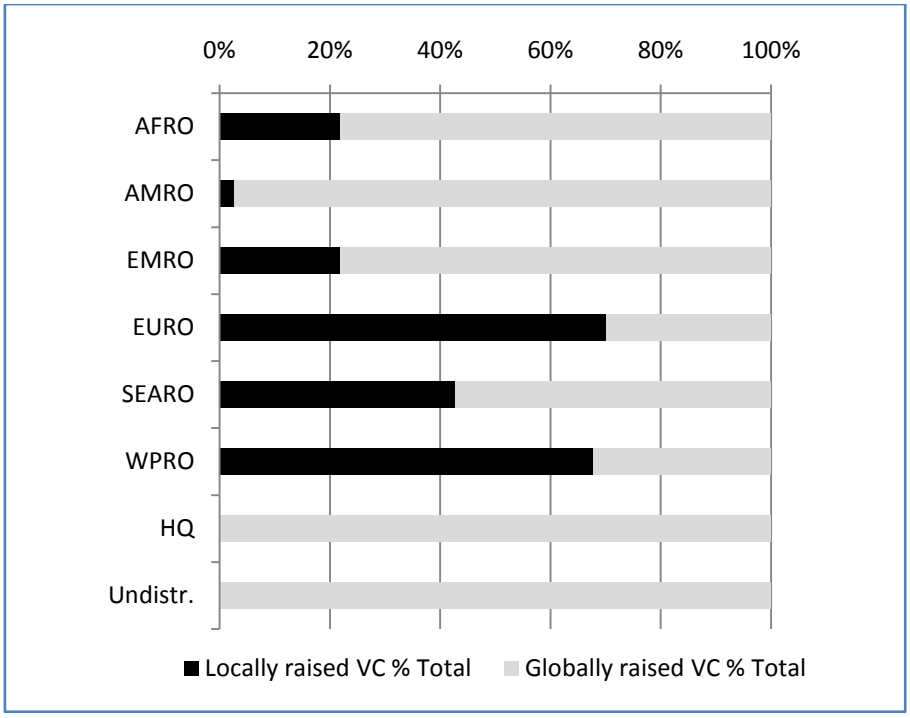
19. It is essential to further improve the quality and flexibility of funds, so that the Regional Office can properly address two key challenges: to fully align voluntary contributions with the

approved budget, and to adequately cover salary costs. The financing dialogue recently initiated at global level provides an excellent opportunity to address these challenges, and the Regional Office is actively contributing to this mechanism.

Large share of regionally raised funds

20. In WHO, voluntary contributions are either mobilized globally and distributed to major WHO offices through WHO headquarters, or mobilized locally through the Regional Office and country offices. In May 2013, 30% of the voluntary contributions available to the Regional Office were mobilized globally (excluding CVCA) (Fig.3).

Figure 3. Reliance on globally versus regionally mobilized resources by major office (May 2013)



21. Globally mobilized funds tend to be more flexible and are provided at higher thematic or programmatic levels. They are also more predictable, because a number of major donors are providing voluntary contributions on the basis of multiannual agreements; a limited number include a dedicated regional component. However, the amount of globally mobilized voluntary contributions distributed to the Region is not predictable and varies from biennium to biennium. A process for distribution of globally managed voluntary resources across the Organization and the active involvement of the major offices in global bilateral meetings with donors remain of key importance for increasing the predictability of voluntary contributions at all levels of the Organisation, including at regional and country levels. The Regional Office welcomes current efforts and is ready to help find the best solutions to tackling both these challenges.

22. Resources mobilized at regional and country levels originate from a wide range of sources that often have a specific mandate and/or provide earmarked and project-based funding with a relatively short time frame. These opportunities do not exist for all WHO's priorities, and some topics attract more interest and funds than others. Out of all regionally raised voluntary contributions, 44% are for SO 8 (Healthier environment) and SO 10 (Health systems and services). It is important to note that a large part of the voluntary contributions to SO 10 are for

the European Observatory on Health Systems and Policies, which comes within the SPA segment of the budget. Overall, regionally raised voluntary contributions are less predictable because they may be raised through calls for proposals, follow lengthy negotiation processes and/or are based on intensive searches for resource mobilization opportunities. The transaction costs related to these funds are relatively high.

Donor base

23. Approximately 80% of the Regional Office's voluntary contributions come from the ten top donors: Denmark, Germany, Italy, the Netherlands, the Russian Federation, Spain and the United States of America, as well as United Nations agencies and funds, the GAVI Alliance and the European Union. Some of these donors make substantial in-kind contributions.

24. The income of the Regional Office therefore comes from a relatively narrow donor base, and this fact constitutes an operational risk. The Regional Office is making efforts to identify additional funding sources in order to broaden the donor base, in line with global efforts and the conclusions of the first financing dialogue.