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Twenty-first Standing Committee of the Regional Committee for Europe
Subgroup on strategic resource allocation

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Report of the Subgroup on strategic resource allocation

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Background

1. The Sixty-sixth World Health Assembly requested that the Director-General propose, for consideration by the Sixty-seventh World Health Assembly and in consultation with Member States, a new strategic resource allocation methodology for WHO, starting with programme budget 2016–2017 (PB 2016–2017), using a robust, bottom-up planning process and realistic costing of outputs, based on clear roles and responsibilities across the three levels of WHO.

2. Further, the Sixty-sixth World Health Assembly requested that the Director-General submit regular reports on the financing and implementation of PB 2016–2017 as presented in World Health Assembly document A66/7 and on the outcomes of the financing dialogue, the strategic allocation of flexible funding and the results of the coordinated resource mobilization strategy through the Executive Board and its Programme, Budget and Administration Committee (PBAC) to the World Health Assembly.

3. It was also decided that the Director-General would establish a global working group chaired by the Chairperson of the PBAC to develop a process for resource allocation.[1]

4. At its May 2013 meeting, the Twentieth Standing Committee of the Regional Committee for Europe (SCRC) discussed the above issue and agreed that "while forming a regional standpoint on the strategic allocation of resources was very important, care must be taken to ensure that discussions at regional level remained in line with developments at global level; a spirit of global solidarity should be maintained".[2]

5. Keeping this global spirit in mind, the Twenty-first SCRC agreed to establish a subgroup to discuss strategic allocation of resources as a regional input into the global process and which would also consider issues of importance to the European Region within this corporate global context.

6. During meetings of the PBAC and the Executive Board in January 2014, it became clear that the global focus of the resource allocation work would be on allocating budgets rather than funds; therefore, the scope of the subgroup was reoriented accordingly.

7. Document EB134/10 set out four proposed budget segments:

   A. **individual country technical cooperation** based on an assessment of country priorities (bottom-up approach), national investment plans, alignment with country cooperation strategies and the priorities of the Twelfth General Programme of Work, and the comparative advantage of WHO;

   B. provision of **global and regional public goods**, including global/regional norms and standards, negotiated instruments, prequalification, guidelines, information on global health trends, and global/regional statutory strategies, plans and programmes, etc.;

   C. **administration and management** functions required to run the Organization, including stewardship, governance, common services and infrastructure (these functions are performed across all three levels of the Organization);

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[1] Proposed programme budget 2014–2015: Report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-sixth World Health Assembly. Geneva: World Health Organization; 2014 (document A66/7).

[2] Report of the fourth session: Twentieth Standing Committee of the Regional Committee for Europe. Copenhagen: WHO Regional Office for Europe; 2013 (document EUR/RC62/SC(4)/REP).

D. **response to emergency events** such as outbreak and crisis response (OCR). It should be noted that due to the nature of such events, the resource requirements cannot be fully known during the planning process.

8. The SCRC subgroup on strategic resource allocation has met twice to date. At its first meeting (Floriana, Malta, 15 December 2013), the terms of reference of the subgroup were further clarified and relevant financial and programmatic analysis was provided by the Secretariat in support of Member States' deliberations.

Second meeting of the SCRC subgroup on strategic resource allocation

9. At its second meeting (Geneva, Switzerland, 18 January 2014), the subgroup on strategic resource allocation:

- agreed to direct its deliberations to the subject of strategic **budget** allocation, in lieu of strategic **resource** allocation, in accordance with the discussion at the PBAC in the preceding days;
- received a brief from the Secretariat regarding some previous resource allocation mechanisms in WHO (see below);
- prepared draft guiding principles for strategic budget allocation for consideration by the SCRC (see below).

Highlights from previous resource allocation models used by WHO

Regular budget allocations to regions (1998)

10. "Regular budget allocations to regions" (resolution WHA51.31) authorized allocation of the regular budget – that is, assessed contributions (AC) – and **not** the budget in the sense of strategic resource allocation as discussed now; however, the techniques and principles used in 1998 could be of use in the current discussion.

11. The main principles of the formula were the following: (i) transparent; (ii) reasonably easy to understand; (iii) flexible to accommodate updating; and (iv) spreadsheet-based.

12. It was only applied to the regional portion of the regular budget (AC), while the headquarters share was taken out up-front. Hence, the scope was only redistribution among the regional offices.

13. The model took into account two indicators: the human development index (HDI) and immunization coverage (measured as three doses of combined diphtheria-pertussis-tetanus vaccine), weighted by adjusted population size (age-layered population structure (ALPS) method).

14. The reason immunization was chosen as a separate indicator was the fact that other well-known health indicators (such as maternal mortality rate, infant mortality rate, mortality rate of children under five years, low birth weight, etc.) correlate very strongly with HDI. The only important indicator was immunization, which had relatively weak correlation with HDI and hence made it a meaningful supplementary indicator adding a health service needs dimension to the resource allocation process.

15. Correction: a minimum country budget was set for small countries that would receive little or no funding because of population size and to limit country funding for high-income countries according to World Bank criteria.

16. Reallocation was to take place over three biennia, not exceeding 3% per year, starting from 2000.

17. The maximum reduction foreseen in paragraph 3(c) of resolution WHA51.31 was 3% per annum per region, but this was first implemented only in the 2000–2001 biennium. Thereafter, the maximum reduction for any region was limited to 2% per year in the 2002–2003 biennium and 1.5% per year in the 2004–2005 biennium. This decision was taken in part to reflect the fact that regions had to absorb biennial cost increases as well as decreases resulting from the use of the model.

Guiding principles for strategic resource allocations, including budget validation mechanism (2006)

18. The principles and mechanism were developed over 18 months, including reviews at various governing body meetings at global and regional levels; the resulting "Guiding principles for strategic resource allocations, including validation mechanism" (document EB117/17) was endorsed by the Executive Board in January 2006.

19. The document included guiding principles, which Member States may wish to review for their current applicability.

20. The validation mechanism was, as its name implies, intended to validate the outcome of results-based budgeting and planning process, not to determine up-front resource allocations across the Organization.

21. Three components were considered in the validation mechanism:

- fixed, 43% (including normative and statutory functions; headquarters, 28%, regions, 15%);
- engagement, 2% (variable, depending on the number of Member States in the region irrespective of socioeconomic development);
- needs-based, 55% (based on health and socioeconomic status by statistically smoothed population).

22. Emergency response was not included.

23. The headquarters allocation was contained entirely in the fixed component.

24. Two options were considered for the needs-based component: (i) using only life expectancy at birth and gross domestic product (GDP) per capita, adjusted for purchasing power parity (PPP); or (ii) adding an education indicator, in which case the HDI was recommended.

25. Two versions of statistical population smoothing were also considered.

26. Running the various scenarios (including or not including the education indicator; with more or less population smoothing) resulted in a range from 7.0% to 8.6% for the European Region.

27. The validation ranges were subsequently used extensively in discussions regarding both budget and funding allocations, although in practice the ranges were not adhered to in programme budgets from the period.

Shortcomings

28. The fixed component perhaps should not be fixed, given that this component can vary based on global needs and priorities.

29. The model entirely missed programmatic allocation and prioritization.

PAHO budget policy (2012)

30. The "PAHO budget policy" (document CSP28/7) was developed over two years, with extensive Member State consultations.

31. Three perspectives were used: (i) programmatic categories; (ii) functional levels (regional, subregional, intercountry, country); (iii) organizational levels (regional 53%, subregional 7%, country 40%).

32. Allocations across countries were divided into two parts: (i) core (with three components: floor, needs-based, results-based) and (ii) variable (a pool of flexible funds equalling 5% of the country allocation).

33. The country budget allocation (CBA) model balances socioeconomic conditions, health status, health inequalities, population size, country presence, and the achievement of results. The expanded health needs index (HNIe) is used, incorporating three broad dimensions of health and its determinants: life expectancy at birth; gross national income per capita, adjusted by PPP; and the Gini coefficient. The Gini coefficient captures the income distribution inequality factor, which is known to serve as a proxy for reflecting inequality in health.

34. A mathematical calculation plus statistical smoothing arrives at total AC allocations by country.

35. The policy is considered useful in the Region of the Americas and is viewed as fair and accepted by all concerned.

Shortcomings

36. The model does not account for the varying role at country level or for what is WHO's "value added" in country-specific situations.

37. It applies only to AC, without considering voluntary contributions (VC).

38. It is relatively rigid and applies to several biennia, effectively limiting flexibility in allocating AC to countries.

Guiding principles for strategic budget allocation

39. The subgroup agreed to develop proposed guiding principles at three layers to be considered in the development of the global resource allocation process, with a view to arriving at a pragmatic approach for PB 2016–2017. The first layer would provide overall guiding principles to the global process, the second layer would contain principles relevant for the

specific main budget segments for regional budget allocation (leaving each regional committee the responsibility of deciding on methodologies applicable to country budget allocations within each region), and the third layer would develop core principles or criteria to be applied in all regions for country budget allocation. The subgroup agreed to concentrate on the first two layers first and to discuss intraregional principles at a later stage.

40. All of the principles elaborated below are based on the following assumptions with regard to processes that are parallel to the work of the PBAC working group on strategic resource allocation:

- a robust, bottom-up planning process will take place, that will need to be reconciled with high-level strategic budget allocations;
- the costing of Secretariat outputs will be realized (in a standardized manner when possible);
- roles and responsibilities at the three levels of the Secretariat will be clearly defined as a prerequisite for developing PB 2016–2017.

41. The subgroup recommends that PBAC request an update from the Secretariat on the work being undertaken with respect to these assumptions, to be presented at the May 2014 meeting of the PBAC.

42. The subgroup expects that previous resolutions and other agreements with financial implications for the Secretariat will be incorporated into respective programme budgets.

43. The subgroup believes that the mechanism under consideration should apply first and foremost to budget allocation.

44. The subgroup acknowledges that efficiency and results-based criteria should be incorporated in allocation of budget and resources for future programme budgets, although this is not likely feasible for PB 2016–2017. Specifically, budget and resources should be directed to areas where performance is higher in terms of results obtained from given investments. This also relates to the issue of absorption capacity; that is, budgets should not be increased in areas for which the Secretariat does not have the capacity to implement.

45. A further criterion to be considered is the “value added” of the Secretariat in a given country; that is, with respect to the role it plays and the funds given by others in the health sector (and beyond) in achieving country-level health outcomes.

46. While recognizing “budget inertia” due to staff costs and other factors, future programme budgets should not be wholly based on historical budgets, but on priority-based bottom-up planning to meet country needs. It is acknowledged that implementation of such an approach may require more than one biennium.

47. The PBAC may wish to request the Secretariat to apply the agreed-upon criteria and priority-setting mechanism to the planning exercise for PB 2016–2017, for subsequent consideration by regional and global governing bodies.

48. The role of the regional committees is to assess the outcome of the regional bottom-up planning exercise, to ensure that it reconciles with the allocated budget envelope and that the objectives and results are consistent with the General Programme of Work and globally approved priorities. The regional committees must also be empowered to prioritize work at the regional level and to shift budgets to reflect these priorities (such as across categories and countries, etc.).

Overall guiding principles

49. In light of the above, the subgroup wishes to propose to the SCRC the following important principles and elements.

- Before determining allocations from within the four budget segments, the allocation among these segments needs to be reviewed. Historical expenditure figures should not be the sole basis for this exercise.
- The new allocation mechanism should further equity and fairness in meeting the public health needs of all Member States.
- Member States' involvement in the process should be consistent with their oversight role, avoid micromanagement and be in line with the ongoing reform of WHO.
- The new mechanism should be transparent and easily understandable with the possibility of being periodically updated, if needed.
- Any new mechanism should enable predictability in the allocation of budget and funding.
- Whether the new mechanism is used to develop an a priori allocation by major office, or a validation mechanism following results-based planning, it should be binding on the Secretariat.
- The allocation mechanism should apply to the entirety of the budget (AC and VC).
- If a formula-based mechanism is used, the data informing this mechanism should be regularly updated (for example, each biennium).
- There should be harmonization throughout all major offices in defining which functions and related costs are included in which of the four budget segments.

Additional recommendations

50. In addition to these principles the subgroup recommends the following.

- The allocation mechanism should define an allocation (or a range) by major office; it is unmanageable to use the same formula to determine individual country allocations.
- Budgets at the three levels of the Organization should be set in order to allow for appropriate functions to be performed at each level. In keeping with the broad reform strategy, headquarters' target share of the overall allocation should not exceed 30%.
- It is recognized that, whatever the allocation determined by the new mechanism, it may well be necessary to implement it gradually due to cost inertia (for example, fixed-term staff costs).

Important elements to be considered in the development of the main budget segments

Individual country technical cooperation

51. This segment should not be used to define individual country budgets, but rather to determine an overall indicative allocation for country-level work in an entire region.

52. Regional budget allocation criteria should include health, socioeconomic and population size considerations. The number of countries in the region should also be a factor.

53. Indicators describing the efficiency of health systems should be taken into account.

54. Important emerging health challenges should be reflected (such as extremely resistant and multidrug-resistant tuberculosis, antimicrobial resistance, noncommunicable diseases, ageing, dementia, etc.), which are not captured by or correlate with the HDI or traditional health indices.

55. Within-country inequalities need to be properly captured, possibly through weighting for the Gini coefficient or other proxy measure, since health inequities are not currently measured in a systematic fashion.

56. It should be noted that technical cooperation is not limited to developing countries or to countries with WHO country offices.

Provision of global and regional public goods

57. This component should be based on the roles and responsibilities matrix developed in 2013.

58. Detailed costing of these goods will be required if allocation in this segment is to be based on anything other than historical figures.

59. Although there is emphasis in the reform process on country-level cooperation, the public goods segment should be preserved, as this is a core WHO function, set out in its Constitution.

Administration and management

60. The administration and management (A&M) component should be divided across the three levels of the Organization.

61. Determining allocations by major office could be based on historical expenditures and/or linked to the sum of the needs-based + public goods components.

62. When determining A&M costs, benchmarking and best practices should be used and real salary costs should be considered.

63. Budget allocation to this segment should be based on standardized cost accounting. Functions included in this segment should be consistent across major offices and across categories.

64. The fixed costs of maintaining country offices with core staff need to be properly reflected. Additional staff in countries should be reflected in the technical cooperation segment.

Response to emergency events

65. This segment requires more specific definition. It should include unexpected OCR costs.

66. This segment should exclude routine preparedness, capacity-building for implementation of the *International Health Regulations (2005)*, running costs for the Global Outbreak Alert and Response Network (GOARN), operating costs for the Strategic Health Operations Centre (SHOC) room and similar costs, which should be included among the other three segments.

67. A global budget allocation for this segment could be estimated from average expenditures during the previous five biennia.

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