Pan American Health Organization
World Health Organization
REGIONAL OFFICE FOR THE Americas

55th DIRECTING COUNCIL

68th SESSION OF THE REGIONAL COMMITTEE OF WHO FOR THE AMERICAS

Washington, D.C., USA, 26-30 September 2016

Provisional Agenda Item 4.2

CD55/6
27 June 2016
Original: English

INTERIM ASSESSMENT OF THE IMPLEMENTATION OF THE PAHO BUDGET POLICY

Introduction

1. The 28th Pan American Sanitary Conference, in Resolution CSP28.R10 (2012), adopted the new PAHO Budget Policy (Document CSP28/7) to become effective with the 2014-2015 Program and Budget. The new PAHO Budget Policy defined and introduced an updated model to allocate the Regular Budget among the functional levels of the Organization and to individual countries.

2. Resolution CSP28.R10 requested the Director, among other things, to present to the Directing Council or to the Pan American Sanitary Conference an interim assessment of implementation of the PAHO Budget Policy at the conclusion of the first biennium. The assessment should aim to highlight possible challenges and/or success factors to further improve the PAHO Budget Policy. This document presents the results of that interim assessment.

Background

3. An evaluation of the previous PAHO Budget Policy (2006-2011, extended through 2013) determined that although the policy was correctly applied, there were challenges ensuring adequate budgetary levels for all countries and for the regional entities. This was attributed to the Country Budget Allocation (CBA) model that used mathematical methods such as *population smoothing* and *progressivity,* which resulted in a significant redistribution of resources among countries. While some countries benefitted significantly from the particular allocation of resources, others with a relatively better health status, as measured by the Health Needs Index *expanded* (HNI*e*), saw their budgets reduced, in some cases to levels insufficient to support a minimum presence.

4. The current policy was built on the fundamental principles of the previous policy but with adjustments and new elements to address inherent weaknesses. Specifically, in the revised CBA model, changes were made in allocation concepts, as well as in the

underlying criteria in the formula. These adjustments strove to maintain and improve upon fairness, transparency, and equity in the distribution of resources, while ensuring that the policy was realistic and practical.

5. The new PAHO Budget Policy has addressed only the allocation of the Regular Budget to entities across the three levels of the Organization. The policy has not addressed the allocation of externally mobilized resources, such as Voluntary Contributions and Other Sources, which make up nearly half of the total Program and Budget. Voluntary Contributions and Other Sources were deemed to fall outside the absolute control of an internal budget policy and Member States.

6. Nevertheless, the Organization must mobilize resources from additional sources to fully finance its Program and Budget. Compared with other regions of the world, the predominance of middle-income countries makes the Americas less attractive for many international donors. This reality places a greater level of stress on PAHO's core budget for ensuring that all programs and offices at all levels are adequately funded.

Resource Allocation Criteria in the Current PAHO Budget Policy

7. According to the PAHO Budget Policy, the Organization's scope of work is reflected in its Program and Budget through three interrelated perspectives: programmatic categories, functional levels, and organizational levels. The programmatic categories constitute the highest-level programmatic classification and reflect the response to global and regional health needs. These categories (1 through 6) are derived from the WHO General Program of Work and adapted for regional specificities in the PAHO Strategic Plan. The distribution of resources among programmatic categories is determined by Member States through their approval of the Program and Budget.

8. The functional levels represent the scope of technical cooperation activities that the Organization undertakes in support of its mandates. There are four functional levels: regional, subregional, country, and intercountry. The PAHO Budget Policy allocates a minimum of 40% of the Regular Budget to the country level, 18% to the intercountry level, 7% to the subregional level, and 35% to the regional level. The subregional, country, and intercountry levels together receive 65% of the Regular Budget allocation, which is referred to as direct technical support to countries.

9. The organizational levels are entities that constitute the organizational structure of PAHO. These levels are responsible for delivering results and for accountability. Organizational and functional levels are interrelated; functional levels and entities are part of the organizational structure.

10. The Budget Policy divides allocations to countries into three components: core or needs-based, results-based, and country variable allocations. The core component is 90% of the country allocation; the results-based and variable components are 5% each of the country allocation. The core component is allocated to individual countries using the expanded health needs index (HNIe) as a composite.

11. The PAHO Budget Policy was applied in the formulation and implementation of the 2014-2015 Program and Budget and in the formulation of the 2016-2017 Program and Budget. To implement, monitor, and evaluate the Budget Policy, a series of mechanisms have been put in place to ensure that funding supports the organizational levels and programs in an efficient, equitable, and effective manner. Annual reviews of all the Organization's biennial workplans are conducted to make proactive adjustments to program implementation and to address emerging or changing priorities of the Organization.

Interim Assessment of the PAHO Budget Policy for 2014-2015

12. The interim assessment of the PAHO Budget Policy is based upon the US$ 279.1 million[1] appropriated for the 2014-2015 biennium, less the $5.0 million earmarked for retirees' health insurance, leaving $274.1 million to be allocated as per the Budget Policy. WHO provided an additional $2.9 million, resulting in a total available Regular Budget for the 2014-2015 biennium of $277.0 million.

13. The results from the 2014-2015 end-of-biennium assessment show a high level of compliance with the PAHO Budget Policy in terms of the final allocation of the Regular Budget to functional levels (see table below). The $277.0 million of the Regular Budget available for the 2014-2015 biennium was allocated as follows: $113 million (41%) to the country level, $50.0 million (18%) to the intercountry level, $20.0 million (7%) to the subregional level, and $94.0 million (34%) to the regional level. The proportion of the budget allocated to the regional level was reduced by 1%, while that allocated to countries was increased by 1%, for a total of 41%.

Table. Comparison of the Budget Policy and Actual Allocations of the Regular Budget by Functional Level (US$ Millions)

Functional Level	Budget Policy Allocation	Budget Policy Percentage	Actual Allocation 2014-2015	Actual Allocation Percentage 2014-2015	Net Increase (Decrease)
Country	109.6	40%	113.0	41%	3.4
Intercountry	49.3	18%	50.0	18%	0.7
Subregional	19.2	7%	20.0	7%	0.8
Regional	95.9	35%	94.0	34%	(1.9)
Subtotal	**274.1**	100%	277.0	100%	2.9
Retirees' health insurance	5.0		5.0		0
Grand total	**279.1**		**282.0**		**2.9**

14. The allocations to individual countries, which represent 90% of the core component, were maintained as prescribed by the Budget Policy. Allocations to categories and program areas within a country are based on priorities and biennial work

[1] Unless otherwise indicated, all monetary figures in this report are expressed in United States dollars.

plans jointly agreed upon with national authorities. The proportion of the budget allocated to a given category and program area at the regional level may differ from that at the individual country level due to differences in prioritization. A minimum level of country presence was ensured by increasing the level of funding to countries, mainly from sources other than the Regular Budget, which no longer covers the needs of all countries. The territories of Aruba, Curaçao, and Sint Maarten have become Associate Members of the Pan American Health Organization since the Budget Policy was adopted in 2012, and they were included in the sharing of the 41% allocation to countries.

15. Funding levels for the key countries (Bolivia, Guatemala, Guyana, Haiti, Honduras, Nicaragua, Paraguay, and Suriname) were increased in the context of the key country cooperation strategy despite the progressive reduction of budget allocation that resulted from the application of the Budget Policy formula. The key countries received over $34.0 million, representing 31% of the total country allocation.

16. Funding for a results-based component—5% of the overall country allocation—was provided to support countries in attaining specific targets, to build upon positive and demonstrated progress, or to encourage interprogrammatic activities. Country variable allocations and accumulated savings were made available to support countries with unforeseen and one-time needs for priority programs. Key countries were considered first in the allocation of variable funds.

Observations Ahead of the 2016-2017 End-of-biennium Evaluation of the Budget Policy

17. The initial results of the interim assessment of the PAHO Budget Policy support the decision to continue its application for the 2016-2017 Program and Budget. A thorough evaluation of the PAHO Budget Policy is scheduled for 2018, following two biennia of its implementation, to ensure that it continues to respond to changing health needs and that it consistently allocates resources in an equitable manner.

18. Several changes in policy and procedures that may affect the Budget Policy have taken place since its implementation. These changes, which will be considered in the evaluation of the PAHO Budget Policy at the end of the 2016-2017 biennium, are described below:

a) The adoption by WHO in the 2014-2015 biennium of an integrated budget that no longer indicates the Regular Budget allocation to the Region of the Americas makes it impossible for PAHO to include this component in a disaggregated manner in the appropriation resolution used in the Budget Policy to allocate the Regular Budget.

b) The adoption by PAHO of an integrated budget starting with the 2016-2017 Program and Budget had the same effect. The approved budget, which is a result of bottom-up costing of outputs, indicates total resource requirements independent of the source of financing. Therefore, the approved budget no longer has the

Regular Budget appropriation, which the Budget Policy uses to allocate resources to countries and other levels of the Organization. Nevertheless, the underlying intent of the policy was to validate the results of the bottom-up process and to determine the estimated allocation of the integrated budget to organizational entities in the 2016-2017 biennium. The effect of broadening the policy to all sources of financing the Program and Budget may be analyzed in the 2016-2017 end-of-biennium evaluation of the Budget Policy.

c) The integrated budget facilitates strategic allocation of PAHO's most flexible funds to programs and offices based on funding gaps, emerging needs, and priorities. Assessed contributions from Member States are the main source of flexible funding, which does not have a prescribed usage. Other flexible funds include WHO assessed contributions, WHO Core Voluntary Contributions, and to a lesser extent, overhead earnings on voluntary contributions (Program Support Costs).

d) Further, a Strategic Plan Advisory Group of 12 Member States was established to refine the programmatic prioritization stratification methodology in Strategic Plan 2014-2019. That revised methodology will be presented to the Executive Committee and Directing Council for approval in 2016 to become applicable to the 2018-2019 Program and Budget. The revised prioritization methodology may be considered in the evaluation of the PAHO Budget Policy.

e) In 2015, WHO convened a Member State working group on Strategic Budget Space Allocation to develop a methodology to apportion budgets for technical cooperation among the six regions, based on the aggregated needs of countries of those regions. The approved methodology showed that the Americas Region was under-budgeted based on the measurement of relative need. The revised allocation formula will be implemented over a period of three biennia, resulting in a gradual increase of the WHO budget allocation to the Region of the Americas. Although PAHO and WHO allocation methodologies share several criteria, a more in-depth comparison can be done as part of the evaluation of the PAHO Budget Policy to determine if the formulae can be further aligned.

f) Three territories have been admitted as Associate Members of the Pan American Health Organization since the adoption of the new PAHO Budget Policy in 2012. In addition, many territories that were grouped into a single organizational entity under the policy have been established as individual budget holders as a result of the implementation of the Pan American Sanitary Bureau Management Information System (PMIS) and the processes it supports.

19. At the 10th Session of the Subcommittee on Program, Budget, and Administration of the Executive Committee in March 2016, Member States requested the Pan American Sanitary Bureau to include analyses of variations between the Budget Policy and actual allocations, funding allocations by functional level, the relationship between funding allocations and programmatic priorities, and changes in priorities for the 2016-2017 biennium, as well as an analysis of risks, in the application of the Budget Policy.

Variations in the Budget Policy and actual allocations and funding allocations by functional level are provided in the table above. There was little or no variation in the stratification of programmatic priorities from the PAHO Strategic Plan and the 2014-2015 Program and Budget compared to those identified in the 2016-2017 biennium. Priority program areas received adequate funding, some more than others, as shown in the end-of-biennium assessment of the 2014-2015 Program and Budget.

20. The integration of organizational and programmatic structures was a challenge. The 2014-2015 PAHO Program and Budget allocated the approved budget to categories and program areas. At the same time, the PAHO Budget Policy allocated the approved budget to functional levels and to individual countries. Country offices, in coordination with their national counterparts, determine the allocations to categories and program areas based on national needs and priorities. The Budget Policy does not prescribe country allocations by category and program area. There was therefore a risk of divergence or misalignment between the approved Program and Budget and the actual allocations to categories and program areas by organizational entities. This issue was addressed in the 2016-2017 Program and Budget by building the budget in accordance with a bottom-up approach to identifying priorities and estimating resource requirements. Country-level priorities were identified and resource requirements estimated jointly with national counterparts during the development of the 2016-2017 Program and Budget.

21. Overall, implementation of the new Budget Policy in 2014-2015 had the intended effects of allocating the greatest share of funding to countries for direct technical cooperation and giving priority to funding key countries with the highest need. Furthermore, the Budget Policy successfully ensured that all country offices could maintain the prescribed minimum presence and foster subregional support to countries as well as intercountry collaboration.

22. Based on this analysis, the Pan American Sanitary Bureau recommends that no changes be made to the Budget Policy until the evaluation is conducted at the end of the 2016-2017 biennium taking into consideration the impacts of changes to policies and practices that have taken place since the PAHO Budget Policy was approved in 2012.

Action by the Directing Council

23. The Directing Council is invited to note the report and make any recommendations it might consider pertinent.

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