A Historical Perspective of WHO Budget and Resource Allocation

Over the past two decades, WHO undertook two major efforts in 1998 and 2006 to develop a resource allocation methodology. Prior to 1998, budget allocations were made on the basis of history and previous practice.

I. 1998 MODEL

1. In January 1998, the Executive Board considered a report of a special group it had established to review the Constitution as it pertains to regional arrangements.1 Among a large number of recommendations was a proposal to change the way in which allocations from regular budgets (now referred to as assessed contributions) to regions were to be determined.

2. The group expressed concern that because allocations had not been based on any objective criteria, the amounts had changed little over time. They were also concerned that the approach used to allocate the regular budget did not allow any flexibility to adapt to the evolving socio-economic and health statuses of Member States. The uneven economic development in different regions of WHO, in particular the dramatic deterioration in socioeconomic conditions in Africa and the birth of several new independent states in the eastern part of the European regions following the break-up of the Soviet Union, factored into the group’s recommendation for a new resource allocation methodology to equitably distribute programme resources to countries and to support countries in greatest need, based on objective criteria.

3. This work led to World Health Assembly endorsed2 Resolution WHA51.31 recommending that the allocation of regular budgets to regional, intercountry and country levels be, for the most part, guided by a model that:

   o draws upon UNDP’s Human Development Index, possibly adjusted for immunization coverage;
   
   o incorporates population statistics of countries calculated according to commonly accepted methods, such as “logarithmic smoothing”; and

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1 See EB 101/7 Corr.1

2 See Resolution WHA51.31
can be implemented gradually so that the reduction for any region would not exceed 3% per year and would be spread over a period of three bienniums.

4. The 1998 model was used to prepare the regular budget proposals for each of the three bienniums from 2000 to 2005. Percentage shares of the regular budget were allocated to each region based on the latest Human Development Index. Headquarters was allocated a fixed amount of the Programme Budget, determined separately from the regional allotment.

5. In implementing the 1998 model for the biennium 2000-2001, the Director-General adjusted the model to take into account immunization coverage. However, in light of fluctuations and uncertainties surrounding some immunization-coverage statistics, that variable was not used in the bienniums 2002-2003 or 2004-2005.

6. The maximum reduction foreseen in resolution WHA51.31 of 3% per annum per region was implemented in the first biennium, 2000-2001. Thereafter, the maximum reduction for any region was limited to 2% per year in the biennium 2002-2003, and to 1.5% per year in the biennium 2004-2005, in part to reflect the fact that regions were required to absorb cost increases in these biennia in addition to the decreases in regular budget allocations implemented through the application of the model. During these periods, least developed countries were not subject to any decrease.

7. The result in financial terms over the six-year period was an increase in the share of the African Region from about 28% of regular budget allocations in 1998-1999 to around 34% in 2004-2005. The share of the European Region increased from about 9% to 10% over the same period. The allocations of the remaining four regions were reduced in order to accommodate these increases.

8. The 1998 model was an instrument to allocate assessed contributions to regions and guided only the overall allocation to a region. It was not used to determine the individual allocation to countries within a region (although it was possible to generate such figures by the model). Those were based on judgements made by the Regional Director and the Director-General, and debates within regional committees. The Western Pacific Region, however, applied the model in part to assist it in its decisions on country allocation.

9. The two regions that received an increase in regular budget funds, namely African and European Regions, used them mostly to strengthen programmes in countries. The regions required to make regular budget reductions did so both in regional offices and in country programmes. At that time, extrabudgetary resources were generally tightly earmarked, so regions whose regular budget allocations had been reduced were sometimes obliged to make cuts in areas where no source of funding other than the regular budget was available.

10. The 1998 model did not meet the Organization’s goal to determine the optimal allocation of resources across its three levels. It excluded voluntary contributions the
amounts of which had outstripped those of assessed contributions, and its exclusive needs based formula did not provide evidence for the allocation of funds to the regional offices and headquarters. As a result, the World Health Assembly in 2004 requested that the Director-General develop guiding principles and criteria for the strategic allocation of resources across the Organization, in consultation with Member States and regions, and submit them to the Executive Board in January 2006.

11. The World Health Assembly requested that the guiding principles be based on objective criteria, applied to funds from all sources (assessed contributions and voluntary contributions), and that the principles of equity, efficiency and performance, and support to countries in greatest need, in particular least developed countries, be considered.  

II. 2006 MODEL

12. In January 2006, the Executive Board endorsed a new set of guiding principles and validation mechanisms for a results-based budget framework that included all sources of funds. The guiding principles were meant to move the Organization from a resource-based approach (where resources were allocated and then planned for) to a strengthened results-based management approach (where what should be done is first decided, then the implications and resource requirements to achieve results are determined). The guiding principles called for the allocation to a) have results determined after an Organization-wide planning process; b) be based on a bottom-up budgeting process; c) be rooted in the principles of equity and in support of countries in greatest need, giving due consideration to the definition of resource needs to reflect Organizational priorities; d) support the core functions and WHO’s comparative advantage; e) cover the full planning period of six years (2008-13); f) take into account the performance of specific programmes or offices; and g) used to appraise and justify the outcome of the planning process and results-based budgeting against a validation mechanism, which would provide indicative resource ranges for Headquarters and each region, including all sources of funds.

14. A mechanism was developed to validate the outcomes of the results-based budgeting and planning process. This mechanism was seen as an important and a transparent point of reference. It was intended to validate the results-based resource requirements for Headquarters and the regional offices as part of the development of the medium-term strategic plan and associated draft programme budgets, and not to be used to determine actual resource allocations.

15. The validation mechanism was based on the consideration of three components:

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3 Decision WHA57(10) 22 May 2004
4 See EB117/17
a. A fixed component of 43% (28% for Headquarters; 15% for regional offices) to finance normative and statutory functions that must be carried out at different levels of the Organization. Headquarters was covered entirely by the fixed component based on an analysis of the functions critical to achieving its strategic objectives most efficiently and effectively. This formula did not include emergency response.

b. An engagement component of 2% towards regional functions, the costs of which vary according to the number of countries served, including the organizational costs of engaging with all Member States in a given region, regardless of its relative health and socioeconomic status. Funding under this component also covered the costs of managerial and administrative functions that enable the effective delivery of WHO programmes at a regional level.

c. A needs-based component of 55% based on relative health and socioeconomic status along with a population factor. Formulae based on these factors were run to produce a number of allocation options for the regions and HQ. These options were used as reference points throughout the period of 2008-2013; however, they were not strictly followed.

16. The 2006 model fell short of expectations. A major weakness was that results-based planning, budgeting and resource allocation remained elusive due to inflexibilities inherent in the guiding principles and to the fact that much of the Organization’s resources are earmarked and unavailable to be applied to other programme areas in need. As a result, priorities were largely driven by available resources, outputs did not always reflect a clearly defined division of labour across the three levels of the Organization, and performance was not an explicit criterion in resource allocation. Consequently, the allocations in the last three programme budgets did not always follow the validation ranges.

17. These issues, coupled with the significant changes in the economic situation of many countries, the changes in capacities and health needs in many low- and middle-income countries, and the new developments in WHO financing (especially the approval of the budget in its totality, the introduction of a financing dialogue and coordinated resource mobilization) have led to the request by the World Health Assembly in May 2013 for a new approach to strategic resource allocation.

III. TRANSITIONAL PERIOD

18. In a move from the 2006 model, the Organization has been seeking an allocation model that adheres to a results-based approach guided by results of the WHO reform. In the 2010-2011 programme budget, budgets were allocated to the three levels of the Organization and to the country offices according to their expenditure pattern (as a proxy for implementation capacity) in the previous biennium, with adjustments made based on programme priorities. In subsequent years, the 2012-13 programme budget was again
based on past expenditure patterns (taking into consideration the reduction of budget by $900 million from the budget presented to EB to the one presented to WHA for approval), while the 2014-15 programme budget was based on an assessment of WHO’s funding, implementation capacity, and grounded on agreed-upon Organization-wide deliverables and programme shifts in health priorities. To date, budget space allocation has included a) the adoption of a new allocation approach based on an integrated budget (assessed contributions and voluntary contributions) approach; and, b) a new results-based framework for programme management.