PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION

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## PROPOSED PROGRAM BUDGET 2008-2009:

## IMPACT OF A ZERO NOMINAL GROWTH REGULAR BUDGET

1. In March 2007, the first draft of the proposed Program Budget 2008-2009 was presented for discussion to the 1st Session of the Subcommittee on Program, Budget and Administration (SPBA). That first iteration of the budget proposal considered an assessment increase of 3.9%. The SPBA, in its guidance for further elaboration of the document, requested the Secretariat to prioritize among the 16 Strategic Objectives and to indicate the impact to the Organization if the assessment increase of 3.9% were not approved. The purpose of this brief document is to provide related information on these two points.

2. The proposed Program Budget 2008-2009 (*Official Document 327*) being submitted to the 140th Session of the Executive Committee totals US$ 623 million; $276 million refers to the regular budget and the remainder to voluntary contributions. The $276 million is $3.5 million less than the level of regular budget presented to the SPBA as a result of the reduction in the increase of the WHO regular budget share of the budget from 9.3% to 4.8% (the corresponding assessment increase is 4.0%) approved at the Sixtieth World Health Assembly. Thus, the regular budget portion of the current proposal includes $81.5 million from WHO approved at WHA60 and $194.5 million in PAHO regular budget funds; the latter represents an increase to PAHO Member States' assessments of 3.9%.

3. In addition to the distribution by the 16 Strategic Objectives and the nearly 100 Region-wide expected results, the PAHO budget is divided into three organizational levels: country, subregional, and regional. The Regional Program Budget Policy (approved by the 45th Directing Council in 2004) is designed, among other things, to shift resources among these three levels over three biennia: 2006-2007; 2008-2009; and 2010-2011. The country and subregional levels stand to grow during this period, while

the share of the regional level will be reduced. In the current proposal, the country and subregional levels would receive 78% of the budget increase (the country level alone will receive 64%), while the regional level would be allocated only 22%.

4. Furthermore, the budget is made up of two major cost components: fixed-term staff and programmatic activities. The proposed budget increase of $10.5 million (combined PAHO and WHO sources) does not fully cover the total expected cost increase for fixed-term staff of $14 million. Therefore, the regional level of the budget dedicated to programmatic activities will need to absorb the shortfall of $3.5 million ($14 million - $10.5 million) and be reduced by an additional $4.3 million (for a total of $7.8 million) to give way to the overall increase at country level as determined by the budget policy. This represents a reduction of 23% in this component and is the budget level reflected in OD-327. If the 3.9% assessment increase is not approved, the additional reduction of $3.6 million to the regional budget for programmatic activities will represent a total reduction of $11.4 million ($7.8 million + $3.6 million), or a reduction of 33% on average to this component.[1]

5. Given the dynamics explained above, the budget impact will be felt mostly at regional level, and indirectly at country level and subregional levels due to reduced regional support capacity.

6. Table 1 below summarizes the effect of the scenarios on the regular budget.

**Table 1. Effect of Different Scenarios on the Regular Budget**

| Scenario | PAHO assessment increase | Approved WHO assessment increase | Impact on regional activities |
|---|---|---|---|
| A (Zero real growth) | 11.3% | 4.0% | -8% |
| B (SPBA level) | 5.9% | 4.0% | -17% |
| C (Proposed EC level) | 3.9% | 4.0% | -23% |
| **D (Zero nominal growth)** | 0.0% | 4.0% | **-33%** |

7. In considering the impact to the Organization of a zero nominal growth (ZNG) regular budget (i.e., zero assessment increase), three areas are addressed: (1) programmatic prioritization; (2) areas of technical cooperation at risk, and (3) steps taken for increased efficiency.

[1] Given that some operating costs are fixed and must be maintained at current levels, some regional areas stand to be reduced by more than 33%.

**Programmatic Prioritization**

8. As requested by the SPBA, the Bureau has undergone a first round of programmatic prioritization and this is reflected in the proposed budget levels of the 16 Strategic Objectives (SOs) in comparison with the version of the document presented to the SPBA in March. The prioritization exercise called for a measure of the relevance to PAHO of each of the Strategic Objectives based on a set of criteria.

9. The set of criteria that was used for the exercise is as follows:

(a) Alignment with the Health Agenda for the Americas or other regional mandates;

(b) Alignment with the Millennium Development Goals;

(c) Potential of PAHO to improve health outcomes in the Region;

(d) Ability to provide specific support to special population groups and/or key countries;

(e) Relationship to global health security;

(f) Low accessibility of other sources of funding to countries;

(g) Difficulty in replacing PAHO's current technical cooperation by other partners;

(h) High implementation rate;

(i) Cost-effectiveness of current technical cooperation, especially impact at country level;

(j) Interprogrammability.

10. The assignment of different weights to each of the criteria was considered but not pursued in order to reduce the level of subjectivity in the exercise.

11. The top five Strategic Objectives ranked by this exercise, in order of priority, were: SO4, SO1, SO13, SO2, and SO3. The lowest three SOs ranked by the exercise, were: SO10, SO6, and SO9.

12. In such an exercise, some strategic technical areas, despite their well-established contribution and historical funding, may fall under low or mid-ranked Strategic Objectives. However, the proposed shifts in budget levels among the Strategic Objectives do reflect the results of this first attempt to apply programmatic prioritization.

13. In a restricted budgetary environment, there are certain types of activities that, by their very nature, affect the whole of the Organization. In determining these areas, all managers at the regional level were asked to analyze their programs and identify those areas that would be further at risk given a ZNG scenario, which would in fact result in an

additional reduction of $3.6 million and a total reduction of 33% in the budget for regional activities.

14. Table 2 below shows the ratio of the regional level budget between fixed-term staff and programmatic activities for each of the scenarios. Scenario D (ZNG) results in a decrease to the budget for regional activities from 26.8% to 23.1%, or a further reduction of $3.6 million.

**Table 2. Comparison of Budget Cost Components**

| Scenario | Regional Level Fixed-term staff | Regional Level Program Activities | Regional Level Total |
|---|---|---|---|
| A (Zero real growth) | 79.4% | 20.6% | 100.0% |
| B (SPBA level) | 80.7% | 19.3% | 100.0% |
| C (Proposed EC level) | 81.8% | 18.2% | 100.0% |
| **D (Zero nominal growth)** | 84.0% | 16.0% | 100.0% |

15. Below is a summary of the responses from the managers regarding activities that would be at increased risk given a further reduction of $3.6 million:

**Normative and Technical Cooperation Areas at Risk**

***Common Areas at Risk:***

(a) Normative functions, particularly those directed at consensus-building through regional consultations and at monitoring implementation of previously agreed upon mandates (i.e., tobacco; International Health Regulations 2005; influenza pandemic preparedness; emergency operating center; introduction of new vaccines; universal access to antiretroviral (ARV) therapy; intellectual property rights and access to medicines; sharing of viruses).

(b) Areas lacking in voluntary contribution support, such as health technologies, radiology, health services and others that depend heavily on regular budget funds will need to become less proactive and more reactive, responding directly to country demands instead of developing regional strategies.

(c) Forced to focus on priority and impact countries only.

(d) Regional commitments and support to key countries when voluntary contributions are not available.

(e) Training, networking and capacity-building activities, particularly in support of country-level activities because of travel costs.

(f) Inability to implement projects funded with voluntary contributions, which could result in not meeting expected results, donor partner's requirements, and ultimately affect PAHO's ability to mobilize new resources.

(g) Activities aimed at identifying and applying for voluntary contributions.

16. In addition to some of the common areas that would be at risk, there are some specific areas within the Organization that may be more at risk than others by a reduction in regular budget funds:

***Specific Areas at Risk:***

(a) Appropriate and timely support to countries to implement the International Health Regulations 2005 and continued support for preparedness and monitoring of avian flu and pandemic influenza.

(b) Field visits to ensure control and enforce the changes introduced in the decentralized and delegated administrative processes.

(c) Implementation of the human resource strategy including the UN contract reform and the commitment to the staff development needs after conversion to a competency based workforce and the SARA process for realignment with the organization priorities set up by Member States.

(d) Reliability of IT support and infrastructure in general, including a reduction of IT assessments in country offices.

(e) Engagement in the WHO Global Management System project.

(f) Adequate funding for the Master Capital Investment Plan.

(g) Seed money to support the introduction of new vaccines.

(h) Implementing processes defined for institutional strengthening.

(i) Timely implementation of International Public Sector Accounting Standards (IPSAS) by January 2010.

(j) Implementation of the knowledge management and sharing strategy harnessing the information communication technologies to advance as a knowledge based and learning organization.

(k) Development of a policy for health research in the Organization.

(l) Ability to expand universal coverage and reach MDG 4.

(m) Activities related to the implementation of the new WHO child growth standards and the Latin American Network of Breast Milk Banks.

(n) Production of the bi-monthly EPI Newsletter that reaches some 20,000 readers world-wide.

(o) The International Clinical Trials Register Platform.

(p) Education, advocacy, and institutional memory activities of the Ethics Review Committee.

17. Although this is not meant to be an exhaustive list, it does represent the types of activities that will be at an increased risk in the event of reduced regular budget funding.

**Steps Taken for Increased Functionality and Efficiency**

18. In recent years, in view of declining regular budget levels in real terms, the Bureau has undertaken several measures to rationalize the use of its limited resources. Many of these cost-reducing steps, as well as other managerial decisions, have resulted in streamlined operations and increased functionality and efficiency. Some of these measures include:

(a) Dissolution of the Pan American Institute for Food Safety and Zoonoses (INPPAZ), and transfer of the food safety program to the Pan American Foot-and-Mouth Disease Center (PANAFTOSA);

(b) Decentralization and merging of the Maternal and Child Health Unit with the Latin American Center for Perinatology and Human Development (CLAP) in Montevideo, Uruguay;

(c) Decentralization and merging of the Basic Sanitation Unit with the Pan American Center for Sanitary Engineering and Environmental Sciences (CEPIS) in Lima, Peru;

(d) Transfer of the CEPIS laboratory function to government authorities;

(e) Decentralization and merging of the Veterinary Public Health Unit with the Pan American Foot-and-Mouth Disease Center in Rio de Janeiro, Brazil;

(f) Increase in delegation of authority to country office managers and simplification, automation, and decentralization of administrative processes;

(g) Transfer of the oversight function of the Letter of Agreement process to the Program/Project Support Unit to better align the use of technical cooperation instruments with the Organization's priorities;

(h) Decentralization of several regional posts to the field and reorganization of subregional and intercountry posts:

(i) Increased levels of voluntary contributions from WHO and progress toward conversion from short-term project approach to long-term program support contributions by PAHO's major donor partners;

(j) Suspension and reassessment of the Training Program in International Health (Residents);

(k) Closer alignment of the PAHO and WHO strategic planning process;

(l) Eleven roadmap initiatives carried out with own staff participation and contribution that have led to institutional transformation and the Strategic Assessment and Resource Alignment (SARA) process to better define functions and responsibilities of individual units;

(m) New technical cooperation planning instruments, such as Regional Public Health Plans and Country Cooperation Strategies, which have enabled the Bureau to strategically define and prioritize the response to the needs of Member States.

19. The Bureau is committed to continue the effort to be more effective within existing resources without compromising the quality and timeliness of its services. There is a continuous review for increased accountability and creativity to do business in new and diffent ways. However, there is a need to highlight the fact that this is becoming increasingly difficult as core regular budget resources continue diminishing in real terms while the Organization is required to maintain its mandated statutory and normative functions in an increasingly complex health scenario.

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