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Strategic budget space allocation

Report by the Director-General

The Director-General has the honour to transmit to the Executive Board at its 136th session the report submitted by the Chair of the Working Group on Strategic Budget Space Allocation (see Annex).¹

¹ See document EB136/3 for the report of the Programme, Budget and Administration Committee of the Executive Board on the Working Group's report.

ANNEX

REPORT OF THE WORKING GROUP ON STRATEGIC BUDGET SPACE ALLOCATION

BACKGROUND

1. The Working Group on Strategic Budget Space Allocation was established in line with the Executive Board's decision made during its 134th session. At the twentieth meeting of the Programme, Budget and Administration Committee, members of the Working Group presented the report contained in document EBPBAC20/5.
2. The Working Group presented its initial deliberations on scope, principles and criteria for a new strategic resource allocation methodology. It also presented proposed criteria for the four operational segments for the Committee's discussion and comments.
3. The Working Group recognized that the development of a new strategic resource allocation methodology in WHO is quite complex and interdependent with many other WHO reform initiatives that are currently under way, such as the work on bottom-up planning, costing of outputs and deliverables, the roles and functions of the three levels of the Organization, and the review of the financing of administrative and management costs.
4. The members of the Working Group highlighted the importance of ensuring that development of the strategic resource allocation methodology is informed by the work of these initiatives, and vice versa. They explained that the work needs to continue, given its complexity and the inter-linkages with a number of WHO initiatives that are under way.
5. Member States welcomed the report, including the road map, and expressed appreciation for the efforts of the Working Group. Member States also agreed to modify the title of the initiative from "strategic resource allocation" to "strategic budget space allocation".
6. The Executive Board, having considered the recommendation of the Programme, Budget and Administration Committee that the membership of the Working Group on Strategic Budget Space Allocation remain unchanged in order to facilitate the continuation of its work,
 - (1) decided on an exceptional basis to maintain the current membership of the Working Group on Strategic Budget Space Allocation, namely, Belgium, Cameroon, Egypt, Malaysia, Maldives and Mexico;
 - (2) requested that the Programme, Budget and Administration Committee report to the Executive Board at its 136th session, including on the outcome of the deliberations of the Working Group on Strategic Budget Space Allocation.
7. At the Sixty-seventh World Health Assembly in May 2014, Member States agreed that more analysis and in-depth discussion were needed, and endorsed the road map towards the development of

a proposed strategic budget space allocation methodology to be considered by the Executive Board in January 2015.¹

8. On 12 and 13 November 2014, the Working Group held its second face-to-face meeting with the objective of reaching an agreement on an approach to a strategic budget space allocation methodology, and of developing recommendations for the consideration of the Executive Board.

9. Feedback from discussions on strategic budget space allocation held during recent regional committees, and presentations by the Secretariat on planning, budgeting and financing, and the cost of administration and management, advised the deliberations of the Working Group over the course of the two-day meeting.

10. This report outlines the outcome of the Working Group's deliberations and elaborates on the methodology it is proposing for consideration by the Executive Board.

STRATEGIC BUDGET SPACE ALLOCATION METHODOLOGY

11. The Working Group's aim was to identify an objective and transparent approach to determining strategic budget space allocation based on guiding principles and the needs, priorities and results identified through the General Programme of Work, and bottom-up planning.

12. The Working Group reiterated its agreement with the current breakdown of the segments and the guiding principles previously set out for this process. It emphasized that the new strategic budget space allocation methodology must be informed by WHO reform initiatives that are currently under way, and vice versa, and therefore that the proposed methodology would be a prototype, to be evaluated and improved, as needed.

13. The Working Group highlighted that strategic budget space allocation should be flexible to allow for allocation and reallocation of budget space, and should be based on the best available data. It also recommended that the proportion of budget space allocation among the segments should be revisited in the future in the context of ongoing WHO reforms.

14. For the purpose of this exercise, the Working Group used the breakdown for the Programme budget 2014–2015 as background information for its discussions on each segment, as shown in Table 1 below.

Table 1. Programme budget 2014–2015 broken down by operational segment and level of Organization (%)

Based on planned costs

Operational segments	Headquarters	Regional offices	Country offices	Total
1. Country level technical cooperation	0	0	23	23
2. Provision of global and regional goods	20	13	0	33

¹ See document WHA67/2014/REC/3, summary record of third meeting of Committee A of the Sixty-seventh World Health Assembly, section 2.

3. Management and administration	11	6	5	22
4. Response to emergency events, such as outbreak and crisis response	1	1	20	22
Total	32	20	48	100

Scope

15. The strategic budget space allocation methodology is applied to allocate both assessed and voluntary contributions in an integrated manner and in support of the Organization's one work plan and one budget (programme budget).

Guiding principles

16. The following overarching principles guided the development of, and could continue to guide the implementation of, the new strategic budget space allocation methodology:

- ***based on needs and evidence***: strategic budget space allocation should support those countries in greatest need and should be based on the best available data, including research findings and scientifically validated data, as well as objectively measurable benchmarks;
- ***results-based management***: strategic budget space allocation should include robust bottom-up planning and realistic costing of outputs and deliverables, in alignment with priorities identified in the General Programme of Work and taking into consideration how and where best to allocate resources in order to achieve significant impact and value for investment;
- ***fairness and equity***: strategic budget space allocation among geographical or functional segments should be conducted in accordance with objective and generally accepted and consistently applied criteria;
- ***accountability and transparency***: these should be central to planning and strategic allocation of budget space and to reporting on the use of resources;
- ***clear roles and functions***: at all three levels of the Organization, these should support decisions on allocation of tasks and budget space and strengthen accountability;
- ***performance improvement***: this should be considered in budget space allocation to encourage delivery of results and achievement of outcomes.

Criteria by operational segment

17. The strategic budget space allocation methodology is divided into four operational segments.¹ Criteria and an approach for strategic budget space allocation were determined for each operational segment, and underpin the proposed methodology model.

¹ See document EB134/10.

Segment 1: Technical cooperation at country level

18. This segment relates to functions and activities at country level, where the benefits are experienced directly by individual countries. Activities could include building country capacity, providing technical support, conducting policy dialogue, adapting guidelines and strengthening systems to collect, analyse and disseminate data. Table 2 below provides the breakdown of activity and staff costs in the Programme budget 2014–2015 for segment 1.

Table 2. Segment 1: Programme budget 2014–2015 – breakdown of activity and staff costs (%)

Planned budget 2014–2015	
Activity costs	65
Staff costs	35

19. In order to determine budget space allocation for technical cooperation at the country level, two steps were suggested. The first step is to determine the aggregated budget space allocation at the regional level based on a methodology described in paragraphs 20–25 below, and the second step is to allocate budget space to support technical cooperation at the country level based on bottom-up planning and taking into account key criteria, as set out in paragraph 28 below.

20. A four-step process was used to determine the allocation at the regional level. This process consisted of (i) indicator scaling; (ii) grouping countries into deciles; (iii) generating country weightings; and (iv) generating regional allocations. A description of the methodology can be found in the Appendix.

21. The Working Group considered a number of models with different formulations of indicators, the advantages and disadvantages of each indicator, and model formulation. The indicators considered included:

- GDP per capita (PPP\$) (purchasing power parity);
- life expectancy;
- DPT3 (diphtheria, pertussis and tetanus vaccine) coverage;
- Births in the presence of skilled attendants;
- Total disability-adjusted life years (DALYs) per capita; DALYs due to communicable, maternal, perinatal and nutritional conditions per capita; DALYs due to noncommunicable diseases and injuries per capita;
- PPP\$ exchange rate relative to US\$ exchange rate;
- percentage of population living in urban areas; population density; road density;
- percentage of population who faced droughts, floods and extreme temperatures;
- implementation of International Health Regulations (2005); and

- Gini coefficient of income inequality.

A more detailed explanation of the methodology, including advantages and disadvantages of the indicators and the composite models formulated, can be found in the Appendix.

22. Table 3 below provides a snapshot of the percentage allocations by region for each composite model the Working Group considered.

Table 3. Segment 1: percentage allocations by region for each composite model considered (%)

WHO region	Planned budget 2014–2015	Average from 2006 validation mechanism	Composite model 1(B) ¹	Composite model 2(S) ²	Composite model 3(T) ³	Composite model 4 (U) ⁴	Composite model 5(V) ⁵
Africa	43.00	47.67	42.53	45.00	45.70	44.31	44.87
The Americas	8.00	10.24	11.15	13.35	12.48	10.78	10.16
Eastern Mediterranean	15.00	10.45	13.96	10.97	10.22	11.67	13.69
Europe	5.00	11.86	10.81	13.61	14.91	16.67	12.51
South-East Asia	16.00	10.44	12.74	7.89	7.74	8.61	10.84
Western Pacific	14.00	9.34	8.81	9.91	8.95	7.96	7.92

1 Indicators considered: GDP per capita PPP\$; life expectancy; births in the presence of skilled attendants; DPT3 vaccine coverage
2 Indicators considered: GDP per capita PPP\$; births in the presence of skilled attendants; DPT3 vaccine coverage; total DALYs; price level; population density; Gini coefficient
3 Indicators considered: GDP per capita PPP\$; births in the presence of skilled attendants; DPT3 vaccine coverage; DALYs due to communicable, maternal, perinatal and nutritional conditions; DALYs due to noncommunicable diseases and injuries; price level; population density; Gini coefficient
4 Indicators considered: GDP per capita PPP\$; births in the presence of skilled attendants; DPT3 vaccine coverage; total DALYs; price level; population density
5 Indicators considered: GDP per capita PPP\$; births in the presence of skilled attendants; DPT3 vaccine coverage; total DALYs; population density

23. After discussing the merits of each of the indicators, the Working Group considered a number of composite models made up of several of these indicators. It subsequently identified a composite model that included those indicators with the most stable, statistically robust and broadly available data as the best fit for segment 1.

24. The Working Group members were in favour of composite model 5 on the basis of data availability and the stability of its indicators, which are GDP per capita PPP\$; births in the presence of skilled attendants; DPT3 vaccine coverage; total DALYs; and population density. A few members indicated their preference for other composite models, such as model 1 (B), which has fewer indicators and provides a more proportionate distribution of budget space allocation across regions.

25. The Working Group proposes a transition period for the implementation of the proposed model by limiting the shift in the budget space allocation to no more than 2% per biennium, using the Programme budget 2014–2015 regional budget space allocations for segment 1 as the starting point. This will help the regions adjust over a period of time to a new level of budget space allocation.

26. The key factors the Working Group considered in its deliberations on strategic budget space allocation were the availability of quality data, and the recognition that countries differ with respect to their individual contexts, levels of development, resource capacity, and health needs.

27. The Working Group acknowledged the need to demonstrate performance improvements in the use of resources over time, but recognized the challenges some regions face in demonstrating quality of services when they are still struggling with the quantity of services delivered or available. It was suggested that the regions share best practices in performance improvement in order to demonstrate that resources are well spent, and that the outcomes and programmes justify the costs. Therefore, the strategic budget space allocation should be considered both at the global level among major offices and within the regions.

28. To further allocate budget space from the regional level to support technical cooperation at the country level, it is recommended to take into account:

- the needs and priorities of the individual country as part of bottom-up planning;
- alignment with the country cooperation strategy and national investment plan;
- the comparative advantage of WHO; and
- alignment with the priorities identified in the General Programme of Work.

Segment 2: Provision of global and regional goods

29. This segment covers the functions and programmes performed by WHO at headquarters and in the regional offices, as stated in Article 2 of the Constitution of the World Health Organization, for the benefit of all Member States and in support of the entire Organization. Examples of deliverables include WHO's norms, standards, policies, guidelines, analysis, and management and dissemination of health information.

30. Table 4 below provides the breakdown of activity and staff costs in the Programme budget 2014–2015 for segment 2.

Table 4. Segment 2: Programme budget 2014–2015 – breakdown of activity and staff costs (%)

Planned budget 2014–2015	
Activity costs	38
Staff costs	62

31. The Working Group recognized that segment 2 is largely based on governing body resolutions and international commitments and priorities in international public health as outlined in the General Programme of Work, and in conformity with other WHO reform initiatives that are currently under way. Therefore, it is recommended that strategic budget space allocation follow current practice and be based on the assessment and identification of global and regional health needs and priorities, taking account of the following criteria:

- the priorities identified in the General Programme of Work;

- the needs and priorities of countries;
- resolutions adopted by WHO's governing bodies;
- the comparative advantage of WHO;
- the roles and functions of the three levels of the Organization (with consideration given to efficiency and effectiveness);
- realistic costing of outputs and deliverables; and
- a project management approach.

Segment 3: Administration and management

32. This segment relates to the functions required to run the Organization. Administration and management costs can be subsumed under two general categories:

- stewardship and governance: all the corporate services and enabling functions, comprising leadership, general management and governance; and
- infrastructure and administrative support: comprising the running costs of the premises, maintenance, information technology, security and other administration support services. Most of these costs are within category 6 of the Twelfth General Programme of Work, 2014–2019, but some fall within the technical categories 1 to 5.

33. Table 5 below provides the breakdown of activity and staff costs in the Programme budget 2014–2015 for segment 3.

Table 5. Segment 3: Programme budget 2014–2015 – breakdown of activity and staff costs (%)

Planned budget 2014–2015	
Activity costs	25
Staff costs	75

34. The Working Group recognized the high fixed-cost component associated with segment 3, notably for stewardship and governance (for example, the costs of governing body meetings and governance structures, or senior management staffing across the Organization). It also acknowledged that a great deal of work had been undertaken to streamline cost harmonization and cost efficiency with respect to the administration and management functions.

35. Therefore, the Working Group recommends that the current approach to budget space allocation for the administration and management functions be maintained until the WHO reform process is completed, with consideration given to dividing leadership and governance, and administration and management into subcategories within the segment.

36. In addition, cost efficiency measures should be built into the system as an ongoing practice and should be institutionalized across the Organization to ensure that WHO achieves and demonstrates a return on investment.

37. It is also proposed that regular reporting to the Programme, Budget and Administration Committee on cost-efficiency measures and savings be instituted.

Segment 4: Response to emergency events, such as outbreak and crisis response

38. This segment covers outbreak and crisis response and polio eradication. Owing to the nature of outbreak and crisis response, which is governed by acute events, the resource requirements are normally significant but difficult to predict during the budget planning process. Polio eradication is currently considered to be a programmatic emergency for global public health, and as such, there needs to be flexibility for budget increases at short notice in order to accommodate programmatic needs.

39. Table 6 below provides the breakdown of activity and staff costs in the Programme budget 2014–2015 for segment 4.

Table 6. Segment 4: Programme budget 2014–2015 – breakdown of activity and staff costs (%)

Planned budget 2014–2015	
Activity costs	78
Staff costs	22

40. The Working Group agreed that a methodology for polio eradication already exists through the Polio Eradication and Endgame Strategic Plan 2013–2018. Therefore, the Working Group did not recommend a new approach to budget space allocation for polio eradication.

41. It is proposed that the creation of a global revolving fund be explored to address health emergencies of international concern, while taking into consideration other existing financial mechanisms within the United Nations system. Regional emergency funds should also be in place to respond to emergencies within each region.

General recommendations:

42. Within the context of the development of a methodology for strategic budget space allocation, the Working Group discussed several issues related to WHO reform. As a result, the Working Group proposes the following recommendations for the Board's consideration.

- The Secretariat continues to strengthen results-based planning and budgeting, including the improvement of transparency, efficiency, effectiveness and accountability.
- Governance reform is further advanced, in particular regarding the definition of the roles and functions of the three levels of the Organization, in order to better align the budget space allocation to roles and functions of the three levels of the Organization and to better respond to the priorities established in the programme budget.

43. The Secretariat better illustrates in the programme budget information that is factored into planning and budgeting processes, including resolutions and WHO's other global commitments.

Appendix

Methodology for budget space allocation for segment 1

This Appendix describes the methodology and the indicators used for developing the budget space allocation models for Segment 1. The mathematical methodology used to develop the models follows the four steps described below.

Step 1. Indicator scaling

The chosen indicators (described in the Table) were scaled for the purpose of comparison with one another.

Step 2. Determining the overall performance of each country

The mean of the scaled indicators was calculated for each country in order to determine the overall performance of each country for the chosen indicators.

Step 3. Generating country weightings

Countries were then ranked according to the mean value of the scaled indicators and grouped into deciles according to the chosen indicators.

Step 4. Grouping of countries and weighting

The relative weighting for each country was determined by multiplying the needs index for each decile (results of Step 3) by the country population scaling factor. The countries with the most need were in decile 1 and the countries with the least need were in decile 10. The 20% of countries with the least need (in deciles 9 and 10) were given a needs index of zero. For the remaining countries, the needs index function takes the form: Needs index = $1.3^{8-Decile}$

The population scaling factor for each country was the same adjusted log population squared (ALPS) function that was used in the 2006 validation mechanism. The purpose of the scaling function was to give a higher relative weighting to countries with a smaller population as compared to countries with a larger population, while taking into account overall differences in country populations.

The final part of step 4 was to aggregate the relative weights assigned to countries in each WHO region to arrive at regional allocations.

Key indicators considered

The Working Group requested the Secretariat to identify indicators for morbidity, cost of health services, access to health services, vulnerability to environmental and natural disasters and hazards, preparedness for health emergencies, and inequality and inequity. The indicators considered include:

- GDP per capita (PPP\$) (purchasing power parity);
- life expectancy;

- DPT3 (diphtheria, pertussis and tetanus vaccine) coverage;
- Births in the presence of skilled attendants;
- Total disability-adjusted life years (DALYs) per capita; DALYs due to communicable, maternal, perinatal and nutritional conditions per capita; DALYs due to noncommunicable diseases and injuries per capita;
- PPP\$ exchange rate relative to US\$ exchange rate;
- percentage of population living in urban areas; population density; road density;
- percentage of population who faced droughts, floods and extreme temperatures;
- implementation of International Health Regulations (2005) and
- Gini coefficient of income inequality.

The tables below are summary descriptions of the indicators considered by the Working Group, including the advantages and disadvantages of each indicator.

Indicators considered by the Working Group, including the advantages and disadvantages of each

Morbidity		
Potential indicators for substituting life expectancy	Advantages	Disadvantages
Total DALYs per capita	<ul style="list-style-type: none"> • Theoretically sound indicator capturing both morbidity and mortality 	<ul style="list-style-type: none"> • Only two data points available at country level: 2000 and 2012 • Limited variation in per capita DALYs across countries
DALYs due to communicable, maternal, perinatal and nutritional conditions per capita DALYs due to noncommunicable diseases and injuries per capita	<ul style="list-style-type: none"> • Theoretically sound indicators capturing both morbidity and mortality • Costs of dealing with DALYs due to communicable diseases and noncommunicable diseases could be different 	<ul style="list-style-type: none"> • Only two data points available at the country level – 2000 and 2012 • Limited variation in per capita DALYs across countries • Different countries' burden from DALYs due to communicable diseases and noncommunicable diseases is different, but the formulation places equal weight on both

Price level		
Potential additional indicator	Advantages	Disadvantages
PPP\$ exchange rate relative to US\$ exchange rate	<ul style="list-style-type: none"> Theoretically sound indicator if budget allocated in US\$ but spent in local currency Available for 183 Member States for 2012 or 2013 	<ul style="list-style-type: none"> Based on PPP factors which are collected only periodically (in 2005, 2011). Current PPP\$ exchange rate based on 2005 factors Based on US\$ exchange rate, which can be quite volatile from year to year
Access to health services		
Potential additional indicators	Advantages	Disadvantages
Percentage of population living in urban areas	<ul style="list-style-type: none"> Available for 191 Member States, for 2013 	<ul style="list-style-type: none"> Relevance based on assumption that urban areas have good access
Population density	<ul style="list-style-type: none"> Available for 190 Member States for 2013 	<ul style="list-style-type: none"> Relevance based on assumption that high population density means good access
Road density	<ul style="list-style-type: none"> Theoretically sound indicator for geographical access in most countries Available for 183 Member States 	<ul style="list-style-type: none"> Some data quite old – only 50% of data points from 2010 onwards May not be particularly useful for countries composed of many islands
Vulnerability to environmental and natural disasters		
Potential additional indicator	Advantages	Disadvantages
Percentage of population who faced droughts, floods and extreme temperatures (average 1990-2009)	<ul style="list-style-type: none"> Theoretically sound indicator for assessing risk from the specified natural events Construction of indicator effectively eliminates potential for sudden change in value 	<ul style="list-style-type: none"> Data only available for 165 Member States, from 2009 Does not capture all environmental security risks, such as earthquakes.
Preparedness		
Potential additional indicator	Advantages	Disadvantages
Implementation of International Health Regulations (2005)	<ul style="list-style-type: none"> Covers multiple domains of country preparedness Linked to key WHO objective Data available from 2012 	<ul style="list-style-type: none"> Data only available for 139 Member States

Inequality and inequity		
Potential additional indicator	Advantages	Disadvantages
Gini coefficient of income inequality	<ul style="list-style-type: none"> Commonly used and theoretically sound indicator of general inequality and resulting inequities 	<ul style="list-style-type: none"> Data only available for 148 Member States Some data quite old – only 50% of data points from 2010 onwards

The 2006 validation mechanism used GDP per capita (purchasing power parity, PPP\$), and life expectancy. In this exercise, two additional indicators reflecting access to basic health services, DPT3 coverage and births in the presence of skilled attendants, were used to formulate a base model. Different composite models were formulated by either substituting or adding indicators to the base composite model.

The indicators were derived from reliable international databases such as the *World Development Indicators*, and were selected by the Working Group based on availability and completeness of data, and the reliability and robustness of the data. The resulting composite models considered were: 2(S), 3(T), 4(U) and 5(V).¹

The Working Group determined that the indicators used to formulate composite model 5(V) were best suited to allocating budget space.

A sensitivity analysis of the indicator weightings in composite model 5(V) was also carried out to assess the model's statistical robustness. This sensitivity analysis varied the weight given to each of the indicators in the model when taking the mean of the scaled indicators. In the main methodology described above, all the indicators were given equal weighting. The minimum relative weight given to each indicator in the sensitivity analysis was 10%. This resulted in 930 iterations, whose summary results are presented in the table below. These results show that the original results of Composite Model 5(V) are robust to indicator weighting.

Sensitivity analysis of the indicator weightings in composite model 5(V)

Region	Original composite model 5(V) allocation (%)	Sensitivity analysis (%)			
		Minimum	Maximum	Median	Mean
Africa	44.87	39.93	46.45	44.83	44.30
The Americas	10.16	9.30	11.52	10.15	10.17
Eastern Mediterranean	13.69	12.65	14.10	13.59	13.48
Europe	12.51	9.94	17.52	13.54	13.25
South-East Asia	10.84	9.21	12.75	10.69	10.77
Western Pacific	7.92	6.42	9.59	7.90	8.03

¹ See paragraph 22, Table 3 of the main report.