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FORMULATION OF THE PROGRAM AND BUDGET OF THE PAN AMERICAN HEALTH ORGANIZATION

Interim Report of the Working Group

The need for close cooperation between national health authorities and the Pan American Health Organization (PAHO) in the preparation of the program and budget of the Organization was emphasized in the discussions of the Executive Committee at its 74th Meeting held in Washington, D.C., in July 1975. Resolution XXXIX adopted by the Committee asked, in operative paragraph 3, "...the Director to appoint a committee for the purpose of recommending indicators to assist him in establishing provisional allocations of budgetary amounts for each country which will be commensurate with the technical assistance requirements for the projects requested by the Governments according to their own priorities and those established by the Organization."

In compliance with this resolution, the Director appointed a Working Group comprised of Dr. Alfredo Arreaza Guzman, former Assistant Director of PASB, and Dr. A. J. de Villiers, Director General, International Health Services of the Department of National Health and Welfare, Canada.

1. Method of Work of the Working Group

The Working Group reviewed the constitutional basis for PAHO's functions and activities, particularly with regard to the provision of technical assistance as part of the overall activities of the Organization, which in present day usage is better termed "technical cooperation" as discussed in OD.141, pp.1-5, and WHO OR.231, Appendix 1.

In addition, the Working Group reviewed all available documents relating to the allocation of resources to Member Countries under the various programs of technical cooperation; interviewed the officers involved in the preparation of the program and budget; examined the procedures followed by the Organization in the establishment of budget allocations for country programs, and studied the criteria or indicators used in the distribution of PAHO resources in accordance with the health requirements and the available resources of individual Member Countries.

As part of its basic approach to the study of the allocation of the Organization's resources, the Working Group, from the outset, considered that:

(a) It is essential that the greatest efforts involving technical cooperation be directed towards the Member Countries in greatest need. The extent, in monetary terms, to which this guideline could be applied is subject only to the need to maintain central technical services, support and administrative services and the priority program needs of groups of countries of the Region as a whole.

(b) It is important to preserve the concept of the unity of the Organization's technical cooperation programs with Member Countries regardless of whether the component parts are at Headquarters, area or country level.

2. The Development of the PAHO Program and the Current Status of Budget Allocations to Member Countries

The basis for the development of the program of the Organization has always been the provisions under the Pan American Sanitary Code and later the Constitution of the Pan American Health Organization as well as the decisions taken by the Pan American Sanitary Conference, the Directing Council, and the Executive Committee with regard to the various programs of work and the priorities established therein, such as those in the Ten-Year Health Plan for the Americas.

The program itself has gone through a number of important changes in relation to budgetary allocations. The early program emphasis under the Pan American Sanitary Code was on the prevention of the international spread of communicable infections, the corresponding need for standardization of the collection of morbidity and mortality statistics and the interchange of information between signatory governments.

Significant extension into technical cooperation occurred during and following the formative years of the World Health Organization (WHO). Such projects again focused mainly on certain regional priorities such as the communicable diseases (malaria, tuberculosis, yaws, venereal diseases), a few demonstration or local integrated health projects, and the provision of fellowships. Environmental sanitation projects were difficult to implement because of the almost complete lack of appropriate personnel in most countries. With a serious lack of the required health infrastructure at the national level, little was possible. Under these circumstances, it would appear that the choice of projects--and hence allocation of resources--were strongly influenced by the initiative of the Bureau staff.

The gradual strengthening of the economic status of some Member Countries, the increasing availability of local resources and the greater demand

by local populations for health services, brought about a better organization of country health services and the provision of a wider variety of special services. A growing interest, willingness and ability of some countries to use the services offered by the Organization accompanied this development. In consequence, the Bureau increasingly required and acquired a wider range of skills in order to serve Member Countries. Growth was essential, but it was difficult to change the projects that had been established initially. It appears that until recently--with little or no pressure for reorientation or any demand for more projects--there was a tendency for certain projects to continue without evaluation and/or change. This encouraged a system of marginal budgeting which allowed planning targets for the following year to be established on the basis of current year allocations, plus an allowance for cost increases. New projects at country level were budgeted on the same basis, together with the (unwritten) general principle that total country allocations should not be reduced at any time. Thus, real growth in the Organization's program depended upon increases in the total budget, with priorities for such growth areas being established jointly by the ministries of health and PAHO area and country staff.

The data provided in Table 1 pertain to the percentages of PAHO/WHO regular funds budgeted for various types of projects for the years 1970 to 1974, inclusive, and clearly show the stable nature of the budgetary allocations. The allocations for country projects remained at approximately the same level. It is interesting to note in Table 2 that the amount expended on country projects was generally higher than the amount budgeted by an average of 1.5 per cent for the years under discussion.

Another development of note is the increasing difficulty experienced by the Organization in attempting to meet the rising expectations and the increasing demands for services by Member Countries with the currently available resources. Inflationary cost increases have virtually wiped out increases for program expansion. In response, the Organization has increased its efforts to obtain extrabudgetary resources as well as to promote and to emphasize the need for country health programming with its inherent requirements for a clear definition of country priorities--in the realization that such programming is an essential prerequisite for the optimal use of the scarce resources available.

It would appear reasonable to conclude therefore that a better rationalization of the use and allocation of already scarce resources was timely--as recognized by the Executive Committee--and that it was necessary to review the criteria or indicators used for such allocation, particularly in terms of technical cooperation with Member Countries.

3. The Development of Guidelines and Criteria for Program and Budget Allocations

General guidance for program and budget development is provided by the decisions of the Pan American Sanitary Conference, the Directing Council, and

the Executive Committee with regard to the priorities for the Region (e.g., the Ten-Year Health Plan, the Sixth General Program of Work of WHO) and by the priorities established at country level following on the introduction of country programming. No clearly expressed rules or criteria to be used in the selection of project activities or the resultant establishment of budget allocations to individual countries could be found in the PAHO documentation examined by the Working Group. Nevertheless, the overall evidence indicated--as will become clearer later--that some guidelines must have been used at least for the initial establishment of budgetary targets under the marginal budgeting procedure discussed above, as well as for the (re)allocation of funds for new projects within those targets. It was necessary, therefore, to attempt to trace and identify such guidelines and to place them into better perspective for use in the future.

The First General Program of Work for a specific period developed by WHO for the years 1952-1955 (WHO OR.32, Annex 10, pp. 57-58) discussed in some detail a number of criteria for the selection or rejection of activities. Although these criteria were developed primarily for application at the central level, they also provide a sound basis for the selection of projects of activities at the regional and intercountry levels and even at the country level. A brief outline of these criteria, as adapted by the Working Group, follows:

(a) Regional or intercountry feasibility and acceptability; with the emphasis on intercountry acceptability; availability of techniques considered to be sound; and active participation in the activities by Member Countries, except under emergency conditions.

(b) Possibility of demonstrating results and of the project being successful within a specified period of time.

(c) Scope of the proposed field of action with emphasis on activities that are likely to benefit either directly or indirectly the largest possible number of people.

(d) Availability of qualified personnel to carry out the work.

(e) Prerequisites to action including: the necessary preliminary studies and preparation; full account of work already carried out in a particular field by other agencies; the possibilities of action or financing by other sources; whether PAHO is the agency best suited to initiate or undertake proposed action; and the possibility of integrating the proposed action with other projects related in type.

(f) The maintenance and development of activities which can be performed only through an international health organization and which can be related to, and comprehensively defined as, international information, standardization and coordination.

(g) Financial feasibility.

To these criteria could be added a number of other WHO criteria that pertain more particularly to the country level, namely:

(i) Relative importance and urgency of the health problem;

(ii) Desire of a country to obtain technical assistance; and

(iii) Capacity of a country to implement technical cooperation projects with particular reference to their ability to carry on such activities themselves at the termination of a PAHO project.

These last three criteria, together with the availability of the technical knowledge to solve problems, appear to be those which were used most consistently in responding to the requests for technical cooperation received from Member Countries. In the past, on occasion, cognizance had to be taken of political realities and pressures. Most countries, however, tailored their requests according to their needs. More advanced countries obviously required less assistance.

The criteria outlined above, although qualitative, are nevertheless still all valid in today's context, and when used in conjunction with the priorities emanating from country programming or at the intercountry and regional levels, according to the discussions by the Governing Bodies, should provide a realistic basis for the development of the totality of the Organization's program and budget. An essential and integral part of this process is the active participation of both the Member Countries and the Organization itself. There remains, however, the rationalization of the application of the principle of "most for the most in need" and the determination of the proportion of the overall PAHO/WHO regular budget to be allocated to technical cooperation at the country level.

4. Application of the Principle "Most for the Most in Need"

While the principle of "most for the most in need" may be universally accepted, it implies a ranking of countries according to need, and it is difficult to identify totally acceptable criteria for the allocation of the PAHO/WHO regular budget for activities at the country level.

The discussions which took place during the 74th Meeting of the Executive Committee, leading to the approval of Resolution XXXIX, focused attention on the possible establishment of mathematical criteria or a formula for such use. Mathematical formulae are most easily applied by agencies charged with responsibility to redistribute economic resources. At best, such formulae tend to be rigid and do not readily take into account the dynamic, constantly changing conditions both within and between countries.

5. Examination of a Mathematical Formula for use as a Possible Indicator

The Working Group studied the formula developed by the United Nations Development Program (UNDP) and developed several modifications in an attempt to make it more appropriate to the conditions operative within Member Countries. The UNDP developed its formula to calculate targets--Indicative Planning Figures (IPF)--for the distribution of available economic resources among recipient countries. The major portion of the formula (92.5 per cent) is based on two factors, namely, population and per capita GNP. A small portion is based on certain supplementary social criteria. Some additional constraints are introduced to avoid serious discontinuities in assistance over time.

The values used by the UNDP for the period 1977-1981 for the countries in this Hemisphere are given in Table 3. When the UNDP formula is applied to that portion of the PAHO/WHO regular budget which is allocated to individual countries, the percentage allocations--with minor exceptions--are reasonably comparable to those in the present PAHO budget. The most important differences pertain to countries such as Brazil, where the budgeted allotment would be reduced by one-half, and others, such as Argentina, Colombia and Chile, which would receive substantial increases.

The Working Group felt, however, that the UNDP formula based largely on population and per capita GNP was not adequate to reflect the health conditions and health needs of the Member Countries and searched for significant health indicators which could be used to weight or modify the basic UNDP approach. Among the indicators considered were:

- life expectancy at birth
- infant mortality
- proportion of deaths in children under five years of age
- per capita calorie consumption
- per capita protein intake.

Life expectancy at birth was thought to be the single most useful indicator to reflect the health status of a population, but reliable data are not available for most countries. Similarly, the data are not complete

enough for most of the other indicators listed. The most reliable information available relates to the proportion of deaths for children under five years of age, as compared with the general death rate. Since deaths in this age group would markedly influence life expectancy in any case, and because such deaths would largely reflect an aggregate of adverse health factors, such as poor sanitary conditions, unsafe water supply, the prevalence of communicable diseases and poor nutrition status, it was considered to be a suitable "health needs" indicator and was selected for further examination.

The UNDP method was re-examined and modified on the basis of a population of at least 2 million, a per capita GNP of $700, and to include the "health needs" factor. Several calculations were made for which the relative importance of the basic elements were varied for purposes of illustration. The most recent data available, mostly for 1973 (comparable to those published in Table 12 of Health Conditions in the Americas 1969-1972) were utilized for the illustrative calculations.

The countries were arranged in ascending order of the proportion of under-five years mortality (see Figure 1), and divided into four groups. The groups, in ascending order, are as follows:

Group 1	Group 2
Barbados	Chile
Uruguay	Surinam
Trinidad and Tobago	Paraguay
Guyana*	Costa Rica
Cuba	Panama
Argentina	
Jamaica	

Group 3	Group 4
Belize	Dominican Republic
Nicaragua	El Salvador
Venezuela	Peru
Colombia	Guatemala
Mexico	Ecuador
Honduras	Haiti*
Bolivia*	
Brazil*	

*estimated

In distributing the points to be assigned to each country on the basis of this index of health needs, weights were assigned as follows:

Each country in Group 1	1
Each country in Group 2	2
Each country in Group 3	3
Each country in Group 4	4

The percentage distribution, calculated on the basis of the 1975 PAHO/WHO regular budget allocations to country projects, is given in Table 3 for the adapted UNDP criteria and two combinations of the UNDP and "health needs" indicator. It can be observed that a certain general comparability and conformity exists with regard to existing practices as represented by the planning figures for 1975 expressed in percentages in column 6. However, when applying the desired percentages, e.g., from column 5, to the total amount allocated to country projects for 1976, as shown in Table 4, a number of significant differences become apparent. The most important of these relate to the drastically lowered amounts--in real budgetary terms--for countries such as Belize, Costa Rica, Jamaica and Trinidad and Tobago.

The data outlined above illustrate clearly some of the difficulties and particularly the rigidity and implied accuracy inherent in mathematically derived indicators, especially as they relate to their potential application to the health field. Questions can be raised with regard to whether it is indeed practically possible to arrive at the correct units in a manner equitable to all countries. In other words, while the mathematical accuracy of the equation and the calculations based on it can always be verified, it seems difficult to envisage a truly objective index--one that would be free from all suspicion, individual biases or arbitrary decisions.

Health status indices are of course fundamental to arriving at a true understanding of the health needs of a country. The best available data are, however, still largely unreliable. It is also the totality of all the health indices, used in conjunction with the totality of the socio-political and economic indices, that can best interpret the true health status of a people or the potential for its improvement.

Furthermore, mathematical formulae developed for purposes of redistributing economic resources are based in essence on information which is at best already 2-3 years old and are applied prospectively to 2-5 years ahead. If used in the health field, such mathematical formulae would tend to lock the health planner into a procedure that would be perpetually at least 3-4 years out of step. This would be inappropriate for a health organization that must retain sufficient flexibility to respond to the demands of rapidly changing conditions and that must at all times be prepared to meet the demands of the future.

Having in mind the various factors that must be considered, including the basic unreliability of the data, mathematical formulae would appear to be inapplicable to the types of problems the Organization has to solve and the kinds of programs it has to develop. Their usefulness in the allocation of PAHO's resources would, therefore, be limited and at best constitute a general guideline if applied to that portion of the Organization's technical cooperation program and budget relating to technical assistance, such as fellowships, training-educational materials and supplies and equipment used for demonstration purposes. Mathematical formulae could be useful also in allocating the extrabudgetary resources from, e.g., UNDP and UNICEF, required to supplement the already scarce resources available from PAHO for the purpose of providing direct technical assistance.*

It would be inappropriate to use mathematical formulae to merely increase country allocations for "book-keeping" purposes. Should, however, such "book-keeping" increases be desired, these could well be arrived at by apportioning the cost of, e.g., regional project field personnel and/or certain intercountry projects between countries on a pro rata basis. "Book-keeping on program and budget figures so arrived at, or by any other means, should be clearly understood by Member Countries and should not be open to the interpretation that amounts allocated to countries belong to them, or that unexpended portions could be redirected by countries individually to purposes which suit them best.

Tentative Recommendations

Based on the above discussions, and in compliance with the directives of Resolution XXXIX, the Working Group suggested that consideration be given to the following groups of indicators in the belief that these could best assist the Director in establishing provisional allocations of program/budgetary amounts for technical cooperation with Member Countries.

1. Requests from Member Countries with particular reference to the activities required, their relevance to the priorities established at country level by accepted country programming procedures, and the magnitude and type of their resource implications.

2. The priorities established by the decisions of the Pan American Sanitary Conference, Directing Council, and Executive Committee in keeping with the constitutional role of the Organization (including the Ten-Year Health Plan for the Americas, at the regional level, and the General Program of Work for a Specific Period and other relevant decisions adopted by WHO).

*PAHO's main impact should be on health promotion and not on the redistribution of resources.

3. Available information relating to the criteria used by WHO for the selection or rejection of specific activities, with particular emphasis on:

(a) The relative importance of a specific health problem;

(b) The demonstrated "absorption capacity" of a country to implement and continue selected activities;

(c) Regional, intercountry and country feasibility and acceptability of an activity;

(d) The likelihood that a specific activity will be successful; and,

(e) Financial feasibility, etc.

4. Indicators established as part of the Organization's long-term planning and evaluation procedures.

The Working Group emphasized that this "interim" report does not constitute an exhaustive study of the problem, but hoped that it would provide an adequate basis for further discussion. The Working Group was also convinced that the Executive Committee itself could make further real contributions in assisting the Director with the rationalization and development of the program and budget of the Organization.

Figure 1

PERCENTAGE OF DEATHS UNDER FIVE YEARS OF AGE

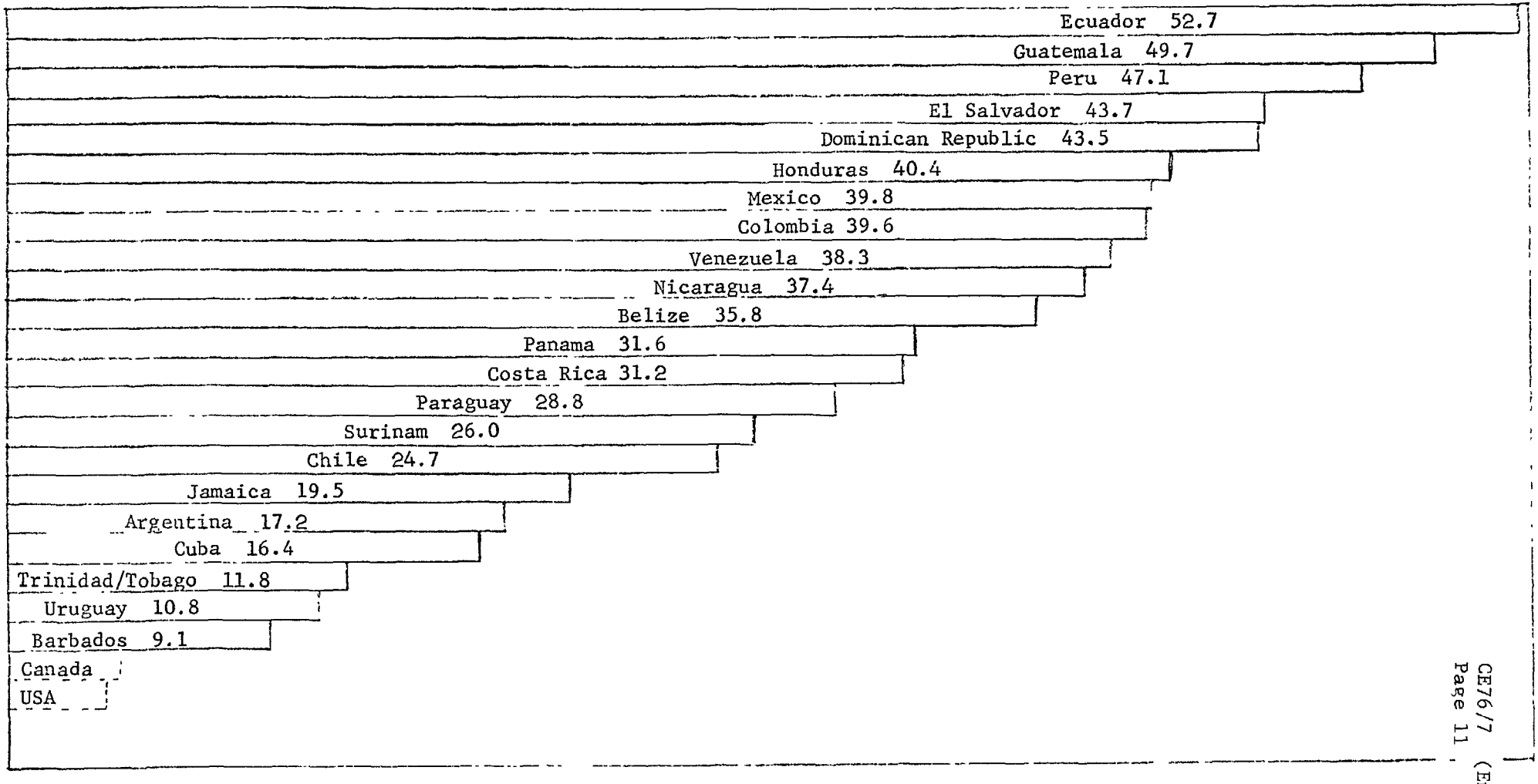

TABLE 1

PER CENT OF AMOUNTS BUDGETED ON PAHO/WHO
REGULAR FUNDS BY TYPE OF PROJECT
1970-1974

Type of Project	1970	1971	1972	1973	1974	Average Rate 1970-1974
Total All Projects	100.0	100.0	100.0	100.0	100.0	100.0
Country Projects	34.6	33.4	32.4	33.2	34.7	33.7
Area AMRO's	7.4	7.3	8.3	7.3	6.1	7.2
Other AMRO's	24.4	26.8	26.5	26.8	27.6	26.6
Area Offices	4.2	3.8	4.1	3.7	3.6	3.8
Headquarters	28.8	27.6	27.4	27.6	26.5	27.5
Increase to Assets	.6	1.0	1.3	1.4	1.5	1.2

Table 2

PER CENT OF EXPENDITURES ON PAHO/WHO
REGULAR FUNDS BY TYPE OF PROJECT
1970-1974

Type of Project	1970	1971	1972	1973	1974	Average Rate 1970-1974
Total All Projects	100.0	100.0	100.0	100.0	100.0	100.0
Country Projects	35.2	34.5	33.4	35.9	36.7	35.2
Area AMRO's	6.9	7.4	7.5	7.4	6.0	7.0
Other AMRO's	22.4	24.7	26.3	24.8	25.1	24.8
Area Offices	5.2	4.3	4.2	4.2	4.6	4.5
Headquarters	29.6	28.1	27.3	26.3	26.9	27.5
Increase to Assets	.7	1.0	1.3	1.4	.7	1.0

Table 3

TARGET FIGURES BASED ON POPULATION/GNP AND HEALTH

	(1) UNDP criteria only*	(2) UNDP: 75% using ratios	(3) Health: 25% using increments	(4) UNDP: 67% using ratios	(5) Health: 33% using increments	(6) Distribution of 1975 PR and WR
Argentina	3.7	3.1	3.1	2.9	3.0	4.5
Barbados	.5	.4	.8	.4	.8	1.2
Belize	.6	.6	1.6	.6	1.9	.9
Bolivia	4.7	4.7	4.7	4.8	4.7	3.3
Brazil	26.0	26.1	20.6	26.1	18.8	21.8
Chile	2.7	2.5	2.8	2.4	2.8	4.2
Colombia	13.1	13.2	11.0	13.2	10.3	5.3
Costa Rica	.5	.5	1.1	.4	1.4	2.8
Cuba	3.1	2.6	2.7	2.5	2.6	2.6
Dominican Republic	2.0	2.2	3.0	2.2	3.4	3.0
Ecuador	4.3	4.7	4.8	4.9	5.0	3.8
El Salvador	2.8	3.0	3.6	3.1	3.9	5.1
Guatemala	2.6	2.9	3.6	3.0	3.8	3.8
Guyana	1.7	1.4	1.7	1.3	1.6	1.6
Haiti	5.3	5.8	5.5	5.9	5.6	3.9
Honduras	2.1	2.1	2.8	2.1	3.0	2.8
Jamaica	.5	.4	.7	.4	.8	3.2
Mexico	13.1	13.2	11.0	13.2	10.3	6.7
Nicaragua	.8	.8	1.8	.8	2.1	1.7
Panama	.5	.4	1.1	.4	1.4	2.4
Paraguay	1.6	1.5	2.0	1.4	2.1	2.6
Peru	4.6	5.0	5.0	5.2	5.1	3.4
Surinam	.5	.5	1.1	.4	1.4	1.6
Trinidad and Tobago	.4	.3	.7	.3	.8	1.5
Uruguay	.7	.6	.9	.5	1.0	2.0
Venezuela	1.5	1.5	2.3	1.5	2.5	4.4

*With slight adjustment described in text

Table 4

PLANNING FIGURES BASED ON POPULATION/GNP AND A HEALTH FACTOR COMPARED WITH WR AND PR FIGURES FOR 1976

Country	WR-PR Allocation 1976*	Allocation of WR-PR 1976 using % given in Table 3, Col. 5
Argentina	$ 557,145	$ 364,272
Barbados	139,670	97,139
Belize	108,588	230,706
Bolivia	403,303	570,693
Brazil	2,409,236	2,282,774
Chile	431,480	339,988
Colombia	635,267	1,250,668
Costa Rica	364,299	169,994
Cuba	329,230	315,703
Dominican Republic	360,147	412,842
Ecuador	516,611	607,121
El Salvador	531,951	473,554
Guatemala	521,671	461,412
Guyana	232,113	194,279
Haiti	604,429	679,975
Honduras	334,966	364,272
Jamaica	313,725	97,139
Mexico	762,335	1,250,668
Nicaragua	235,143	254,991
Panama	306,306	169,994
Paraguay	276,208	250,668
Peru	529,945	619,263
Surinam	175,594	169,994
Trinidad and Tobago	247,291	97,139
Uruguay	274,308	121,424
Venezuela	541,452	303,560
TOTAL	$12,142,413	$12,142,413

*From OD 134