directing council

PAN AMERICAN HEALTH ORGANIZATION

XXIV Meeting

regional committee

WORLD HEALTH ORGANIZATION

XXVIII Meeting

México, D.F.
September-October 1976

Provisional Agenda Item 31

CD24/8 (Eng.)
2 August 1976
ORIGINAL: ENGLISH

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

The Interim Report of the Working Group (Document CE76/7) was presented to the 76th Meeting of the Executive Committee in June 1976. Following discussion of the Report, the Committee passed Resolution XXII, which transmitted the report to the Directing Council at its XXIV Meeting, together with the summary records of the discussion of the item by the Executive Committee. The Executive Committee urged the Director to take into account the recommendations of the report in the preparation of future programs and budgets of the Organization. The report, revised by the Working Group since the Meeting of the Executive Committee, is attached as Annex I. The summary records of the discussion of the item at the Executive Committee are attached as Annex II.

Annexes

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

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 Guzmán, former Assistant Director of PASB, and Dr. A. J. de Villiers, Director General of 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, pages 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 needs 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 bases for the development of the program of the Organization have 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). The Organization's program 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--was 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 utilize the services offered by the Organization accompanied this development. In consequence, the Organization 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 new 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, taking into consideration 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 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 that allocations for country projects remained at approximately the same level throughout. 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 therefore appear reasonable to conclude that a better rationalization of the use and allocation of already scarce resources is timely--as recognized by the Executive Committee--and that it is 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,

---

* Organizational study on: "The Planning for and Impact of Extrabudgetary Resources on WHO's Programme and Policy," OD-229, pp. 66-95, Annex 8.

** Working Guidelines for Country Health Programming. WHO CHP/DT, 5 July 1974.

and the Executive Committee with regard to the priorities for the Region (e.g., the Ten-Year Health Plan, the Sixth General Programme of Work of WHO) and by the priorities established at country level following on the introduction of country health programming.

No clearly expressed rules or criteria to be used in the selection of project activities or in 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 suggested--as will become clearer later--that some general principles must have been followed at least for the initial establishment of budgetary targets under the marginal budgeting procedure mentioned 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 Programme 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 global level, they also provide a sound basis for the selection of projects or activities at the regional and intercountry levels, and even at the country level. A brief outline of these criteria, as summarized 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:

(a) Relative importance and urgency of the health problem.

(b) Desire of a country to obtain technical services.

(c) Capacity of a country to benefit from technical cooperation projects with particular reference to their ability to carry on 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, which were determined arbitrarily at times but now, in collaboration with PAHO, increasingly identified by health sector analysis or country health programming. More advanced countries obviously should require less assistance.

The criteria outlined above, although qualitative, are nevertheless all still valid in today's context, and when used in conjunction with the priorities emanating from country health programming or at the intercountry and regional levels, according to the discussions by the Governing Bodies, such as the program criteria referred to in the Sixth General Programme of Work of WHO, 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.

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 also need to be considered. While the principle of "most for the most in need" may be universally acceptable, it implies a ranking of

countries according to need. However, it may be difficult to identify totally acceptable criteria for the equitable allocation of the PAHO/WHO regular budget for activities at the country level.

4. Examination of a Mathematical Formula for Use as a Possible Indicator

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 commonly used by agencies charged with responsibility to redistribute economic resources. As an example of such formulae the Working Group studied the formula used by the United Nations Development Program (UNDP), and developed several modifications in an attempt to make it more appropriate for possible use in relation to the health 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.

Having examined the UNDP formula, the Working Group felt that, being based largely on population and per capita GNP, it did not adequately reflect the health conditions and the health needs of the Member Countries and therefore searched for suitable health indicators which could be used to weight or modify the basic UNDP equation. 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 an appropriate "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 the inclusion of the "health needs" factor. Several calculations were made for which the relative importance of the basic elements was 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	
Bahamas	
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" indicators. It can be observed that a certain general comparability and conformity exists with regard to country allocations 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 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 appropriate units in a manner equitable or acceptable 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, the UNDP type of mathematical formula (developed for purposes of redistributing economic resources) is based in essence on information which is at best already 2-3 years old and is 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 with the dynamic, constantly changing health conditions, both within and between countries. This would be

unfortunate for a health organization that must retain sufficient flexibility to respond to the demands created by rapidly changing conditions, and that must at all times be prepared to meet the challenges 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 unsuitable 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, at best, be limited. They could perhaps provide general guidance 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. However, PAHO's main concern must be with health promotion based on technical cooperation and not on the redistribution of resources.

Whatever the program/budget allocations arrived at for individual Member Countries, the rationale used for determining the figures involved should be clearly understood and should not be open to the interpretation that amounts allocated belong to them, or that unexpended portions could be redirected by countries individually for purposes other than the agreed program.

Technical cooperation programs should be clearly formulated in relation to the demonstrated health needs of a country--defined on the basis of country health programming--and should always aim at national self reliance. In this direction the Organization should strive also to improve the ability of countries to benefit from programs of technical cooperation. Essential to the latter would be the development of an adequate infrastructure and the most efficient use possible of allocated resources.

Tentative Recommendations

Based on the above considerations and the discussions at the 76th Executive Committee Meeting of Resolution XXXIX of the 74th Meeting of the Executive Committee, the Working Group suggests 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 demonstrated needs and 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 Programme of Work for a Specific Period and other relevant decisions adopted by WHO).

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 benefit from and to 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.

In concluding, the Working Group emphasizes that this initial report does not constitute an exhaustive study of the problem, but hopes that it will provide an adequate basis for continuing further discussions.

The Working Group is also convinced that both the Executive Committee and the Directing Council could make real contributions in further 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

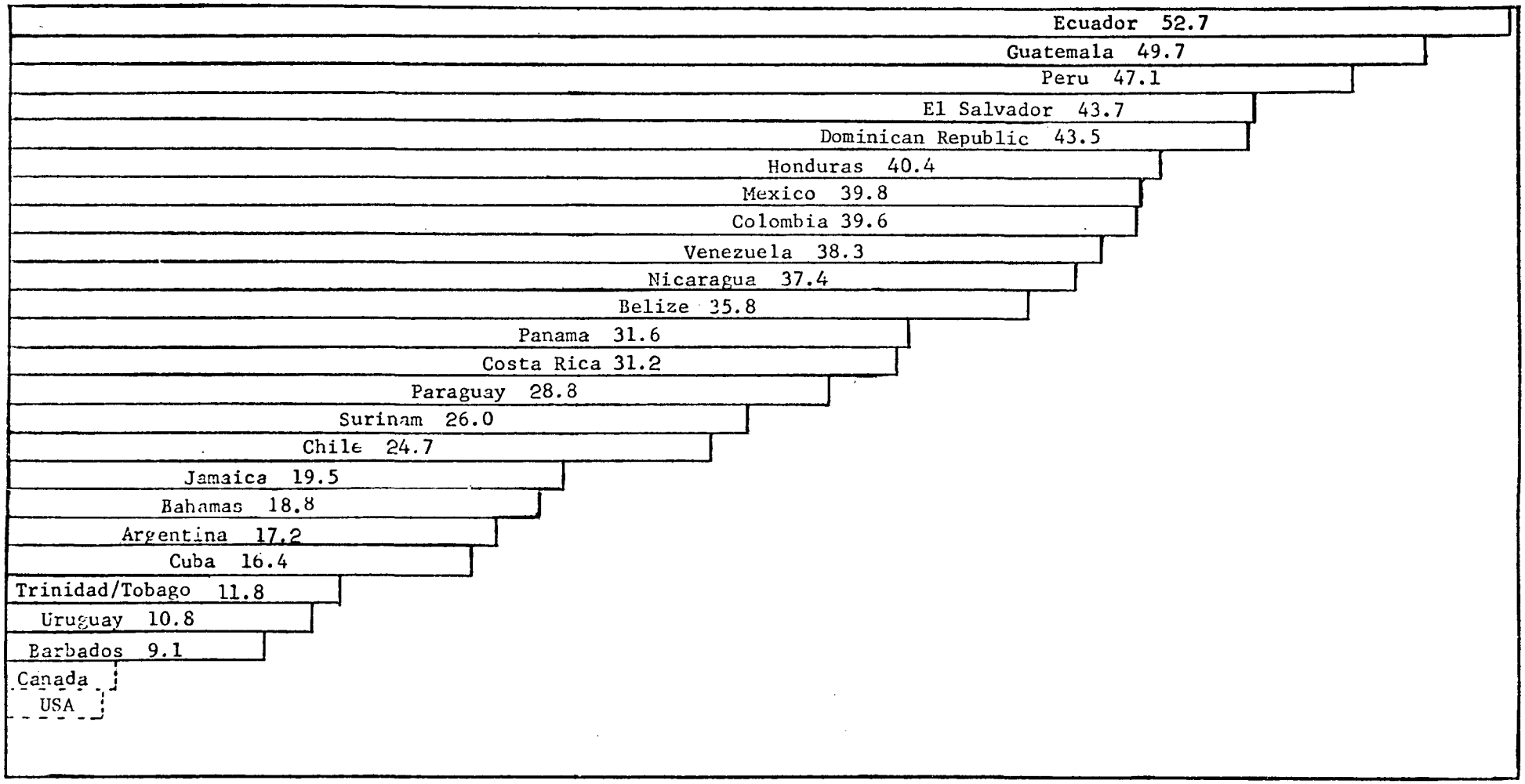

TABLE 1

PERCENTAGE 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
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
Total All Projects	100.0	100.0	100.0	100.0	100.0	100.0

TABLE 2

PERCENTAGE 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
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
Total All Projects	100.0	100.0	100.0	100.0	100.0	100.0

TABLE 3

TARGET FIGURES BASED ON POPULATION/GNP AND HEALTH

	(1)	(2)	(3)	(4)	(5)	(6)
	UNDP criteria only*	UNDP 75%, health 25% using ratios	UNDP 75%, health 25% using increments	UNDP 67%, health 33% using ratios	UNDP 67%, health 33% using increments	Distribution of 1975 PR & WR budget
Argentina	3.7	3.1	3.1	2.9	3.0	4.4
Bahamas	.2	.2	.6	.2	.7	0.4
Barbados	.4	.4	.7	.4	.8	1.2
Belize	.5	.5	1.5	.5	1.9	.9
Bolivia	4.7	4.8	4.7	4.8	4.7	3.3
Brazil	26.0	26.1	20.7	26.2	19.0	21.8
Chile	2.7	2.5	2.8	2.4	2.8	4.1
Colombia	13.1	13.2	11.0	13.2	10.3	5.3
Costa Rica	.5	.5	1.2	.5	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	2.3	3.4	2.9
Ecuador	4.4	4.7	4.8	4.9	4.9	3.8
El Salvador	2.8	3.0	3.6	3.1	3.9	5.1
Guatemala	2.7	2.9	3.5	3.0	3.8	3.8
Guyana	1.2	1.0	1.3	1.0	1.3	1.6
Haiti	5.3	5.8	5.5	6.0	5.6	3.9
Honduras	2.1	2.1	2.7	2.1	2.9	2.8
Jamaica	.5	.4	.7	.4	.8	3.1
Mexico	13.2	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	1.3	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	1.3	1.6
Trinidad & Tobago	.4	.3	.7	.3	.8	1.5
Uruguay	.7	.6	.9	.6	1.0	2.0
Venezuela	1.5	1.5	2.3	1.5	2.5	4.3

* 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	$ 366,029
Bahamas	58,561	85,407
Barbados	139,670	97,608
Belize	108,588	231,819
Bolivia	403,303	573,446
Brazil	2,409,236	2,318,185
Chile	431,480	341,627
Colombia	635,267	1,256,700
Costa Rica	364,299	170,814
Cuba	329,230	317,225
Dominican Republic	360,147	414,833
Ecuador	516,611	597,848
El Salvador	531,951	475,838
Guatemala	521,671	463,637
Guyana	232,113	158,613
Haiti	604,429	683,255
Honduras	334,966	353,828
Jamaica	313,725	97,608
Mexico	762,335	1,256,700
Nicaragua	235,143	256,220
Panama	306,306	158,613
Paraguay	276,208	256,220
Peru	529,945	622,250
Surinam	175,594	158,613
Trinidad and Tobago	247,291	97,608
Uruguay	274,308	122,010
Venezuela	541,452	305,024
TOTAL	$12,200,974	$12,237,578

*From OD 134

SUMMARY RECORDS OF THE DISCUSSION AT THE 76TH MEETING OF THE EXECUTIVE COMMITTEE ON THE FORMULATION OF THE PROGRAM AND BUDGET OF THE PAN AMERICAN HEALTH ORGANIZATION

Eleventh Plenary Session

The CHAIRMAN recalled that the Executive Committee at its 74th Meeting had asked 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. The Director had appointed as a two-man committee Dr. Arreaza Guzman, former Assistant Director of PASB, and Dr. de Villiers, Director-General, International Health Services, Department of National Health and Welfare, Canada.

Dr. DE VILLIERS (Special Working Group) said that the interim report was based on the discussions Dr. Arreaza and he had had over the past year. In preparing it, they had taken note of the constitutional role of the Organization, especially its coordinating role for and on behalf of the Region as a whole. Some of the newer concepts dealt with were country health programming, the importance of extrabudgetary resources and a concept of technical cooperation. It gave a brief historical development of the program and budget, reviewed the WHO criteria used for guiding the selection of program activities, including the relative importance or urgency of the health problem, the desire of a country to obtain technical services and the "absorptive capacity" to implement those programs, and examined the usefulness of the UNDP-type of mathematical formula for arriving at country allocations. It suggested that it was difficult to incorporate the health need factor in a manner likely to be acceptable to all and that, in general, such formulae would probably be unsuitable, or at best were limited to providing general guidance. It also contained some tentative recommendations.

Unfortunately, the report also showed that it had been prepared under severe time constraints which did not allow for a final revision or editing; nor had Dr. Arreaza had the opportunity to see it. Thus, a number of editorial errors had crept in. For any such deficiencies he alone was responsible, and he hoped that the next version, which would be presented to the next Directing Council, would not only contain Member's comments but would embody any corrections required. He emphasized once again that this report was not definitive, and did not represent an exhaustive study of the subject. Rather it constituted a discussion paper which he hoped would be useful in guiding the discussions at the current meeting.

Dr. DE CAIRES (United States of America) said that the thoughtful report submitted focused on questions of great concern. Dr. de Villiers had pointed out that the greatest good should go to those with the greatest need. While that principle was acceptable to all, it raised problems such as the ability of those with the greatest need to absorb effectively the assistance given,

whatever the source. It was important, therefore, that PAHO resources be used by the country involved to develop a program which would attract extrabudgetary funds; PAHO was not in a financial position to operate on its own.

Another point brought out in the report concerned the UNDP formula based on population and per capita GNP plus the health factor. In most cases there was no accurate up-to-date information on which to base the formula. Yet the report did not spell despair, but indicated broad guidelines which the Director might follow in distributing PAHO resources on an equitable basis to Member Countries. The problem was of a long-term nature, since what was timely one year might not be applicable the next.

Ms. McDONALD (Bahamas) termed the report valuable and provocative. She was critical of WHO's mathematical formula for distributing resources for being too rigid and failing to take account of constantly changing conditions. She was also doubtful about the UNDP formula, which was largely based upon population and per capita GNP. From personal experience within her own country, she felt that per capita income represented a misleading picture.

She pointed out that the mortality table on page 7 of the report neglected to cite the Bahamas which, according to the available figures, would come between Surinam and Paraguay.

Dr. ACUÑA (Director) (translated from Spanish) said that the document presented by Dr. de Villiers and Dr. Arreaza did not claim to provide a definitive solution to the problem of allocating WHO and PAHO resources to each of the countries of the Region. Nor was the problem a new one, since it had frequently been raised at meetings of the WHO and PAHO Governing Bodies. It sometimes happened that Governments requested technical cooperation programs that exceeded the budgetary appropriations. In some cases, those requirements could be met with general savings or funds for intercountry or regional projects, but the Organization was often forced to reply that it was currently unable to increase its cooperation. However, another important factor had also to be taken into account, namely the actual priorities of the Governments, as reflected in their national health policies and the projects under way. It was not unusual, when a request for an increased allocation was made, for no account to be taken of the fact that a technical cooperation program, whose effectiveness had not been evaluated, was under way in the country concerned. It would seem that the time had come for the countries to evaluate the impact of the technical cooperation provided by the Organization on the priority areas they had designated. He was pleased to note that one country, Peru, had already seriously addressed this issue, and had submitted an official request for evaluation with a view to shifting the emphasis of PAHO investments and programs to its priority health programs. Partial evaluations had also been made of technical cooperation programs in other countries, which indicated that the true significance of the assistance was recognized and that the resource allocation criteria used by international agencies were understood. As Dr. de Villiers had said, the document presented

did not claim to provide an exact formula for establishing those allocations: it was only intended to encourage the countries to find resource allocation formulae that would be not only more equitable but also, and especially, more efficient in promoting the countries' own programs. It was a matter of regret that the Chairman of the Executive Committee was not present; he was one of the instigators of the study being examined, since he had formally proposed it at the meeting of the Executive Committee in 1975.

Dr. ALFARO (Costa Rica) (translated from Spanish) praised the document prepared by the Working Group because, among its other merits, it showed how difficult it was to distribute the funds available in a logical and equitable way, a problem that all administrators of health services were well aware of. He agreed with Dr. de Caires that whatever the formula adopted it could benefit some countries and harm others. For example, as the Representative of the Bahamas had pointed out, the use of the criterion based on the child mortality rate could affect countries that had succeeded in rapidly lowering that rate since it did not necessarily mean a general improvement in public health conditions in the countries. No less objectionable were other criteria such as population, which would prejudice the underpopulated countries, or per capita income, perhaps the most controversial, since it was well-known that the gross income of the countries was not equitably distributed among their inhabitants. More important than the amount of the assistance was the capacity of the recipient country to make use of the funds it was allocated. Therefore the Executive Committee should leave the Bureau free to assign the resources, bearing in mind that the amount of the technical assistance provided would depend on the applications of the countries. PAHO could influence the political level by informing the authorities of the need to prepare national health programs. The principle according to which most of the resources should be allocated to the most needy was just, but it should be borne in mind that money was not everything and that, to handle it efficiently, the recipient country had to have a sound administrative structure. Otherwise, it would not solve its problems, and that assistance might even have a demoralizing effect if the country found it was incapable of making use of it.

Dr. DE CAIRES (United States of America) thought that, in subsequent work on the report, some mention should be made of the ability of a country to utilize effectively any aid obtained from PAHO. He also emphasized the importance of technical cooperation, with PAHO helping to attract outside funds.

He reminded the Committee that the Sixth Programme of Work of WHO listed the following five criteria, which might well be applied to PAHO: (1) identification of the problem arising in the program area; (2) status as a major underlying problem of public health; (3) a demonstrable potential for progress towards a solution; (4) a strong rationale for WHO involvement; and (5) the need for international collaboration.

He believed that it might be helpful to draw on the above criteria as well as the criteria outlined in PAHO's Ten-Year Health Plan in further work on the report under discussion.

Dr. DE VILLIERS (Special Working Group) expressed appreciation for the comments made, which would be properly reflected in the next draft. He also acknowledged the considerable assistance given to his committee by the PAHO staff, especially in the preparation of tabulations.

The CHAIRMAN thanked Dr. de Villiers for his report on a very difficult subject. Clearly the report would be a continuing one. He asked the Rapporteur to draft a resolution reflecting the opinion of the Executive Committee.

****

Thirteenth Plenary Session

The RAPPORTEUR read out the following draft resolution:

THE EXECUTIVE COMMITTEE,

Having examined the report on the formulation of the program and budget of the Pan American Health Organization submitted by the Director (Document CE76/7),

RESOLVES:

1. To note the report on the formulation of the program and budget of the Pan American Health Organization (Document CE76/7).

2. To thank both the Director and the Working Group for the report.

3. To transmit the report on the formulation of the program and budget (Document CE76/7) to the Directing Council at its XXIV Meeting, together with the précis minutes of the discussion of the item at the 76th Meeting of the Executive Committee, for information and for whatever action the Council may deem appropriate.

4. To urge the Director to take into account the recommendations of the report in the preparation of future programs and budgets of the Organization.

Dr. DE CAIRES (United States of America) felt that draft resolution PR/16 did not attribute sufficient importance to the subject, nor did it pay adequate tribute to the Director and to the Working Group he had appointed. Dr. de Villiers had stressed that he was presenting an interim report and that the process was continuous. In line with the Committee's discussion, the preamble might read as follows: "Bearing in mind the presentation to the Committee by a member of the Working Group appointed by the Director and recognizing that the study will be an ongoing process.."; and operative paragraph 2 might be changed to read "thank the Director and the Working Group for the excellent indepth preliminary report."

The CHAIRMAN (translated from Spanish) agreed that the efforts of the Director and of the Working Group should be recognized, as should be the provisional nature of the document presented. He submitted the draft resolution, together with the proposed amendments, to the Committee for consideration.

Decision: The draft resolution as amended was unanimously approved.