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REVIEW OF THE PROPOSED PROGRAMME BUDGET FOR 1978 AND 1979 (FINANCIAL YEAR 1979)

Allocation of Resources between Regions

In view of questions raised by some members of the Executive Board on the considerations taken into account by the Director-General in proposing allocations between regions of the WHO regular budget and of resources made available to the Regional Directors' Development Programmes as a result of economies and reorientations of programmes in accordance with the programme budget policy and strategy approved by resolution WHA30.30, a working paper[1] on "Allocation of Resources between Regions", which was submitted to the Executive Board at its fifty-fifth session, is attached hereto for the information of the Board at its sixty-first session.

[1] Document EB55/WP/11.

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ANNEX

WORLD HEALTH ORGANIZATION
ORGANISATION MONDIALE DE LA SANTÉ

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EXECUTIVE BOARD

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PROPOSED PROGRAMME BUDGET FOR 1976 AND 1977

(Allocation of resources between regions)

SUMMARY

In the past, the WHO allocation of resources between regions has been determined by a variety of complex considerations and in accordance with the policy guidance of the Executive Board and the World Health Assembly. Although it would be desirable to allocate resources on the basis of a mathematical model, using criteria as objective and quantitative as possible, agreement on such parameters is very difficult to reach. WHO has undertaken a number of new activities to obtain better information for many purposes, including more rational allocation of resources between regions. Sudden reallocation of resources between regions would be a painful decision. In the absence of more specific guidance from the Board and the Assembly, the Director-General has sought to effect necessary reallocations by means of selective application of increases in available resources, without reducing the current level of allocation to any one region. This report, in response to the request of the Board, reviews the historical pattern of regional allocations, relevant considerations and criteria, and current developments affecting the allocation of resources between regions in WHO.

1. Background

1.1 The subject of allocation of WHO resources between regions has been discussed by the Executive Board and the World Health Assembly on several occasions, in connexion with regionalization of the WHO organizational structure, and review of the annual programme and budget estimates, particularly with respect to technical assistance to countries.

1.2 At the request of the Executive Board, the Director-General submitted to the thirteenth session of the Board a "Study of the Guiding Principles Governing the Determination of Regional Allocations".[1] The contents of the study are summarized below, and some of the main principles and considerations are reproduced in Annex I and Annex II of the present report.

1.3 During the fifty-third session of the Executive Board, the question was raised to what extent WHO allocation of regular budget funds was, or could be, related to regional needs. It was decided to put the subject of allocation of resources between regions on the provisional agenda of the fifty-fifth session of the Executive Board, and the Director-General agreed to provide the Board with a working document on the historical trends of the allocations of resources to regions, indicating possible criteria for consideration by the Board.

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[1] Off. Rec. Wld Hlth Org., No. 52, Annex 4.

2. The Study of Guiding Principles[2]

2.1 The "Study of Guiding Principles Governing the Determination of Regional Allocations" considered in general terms various international, regional and national factors affecting the determination of allocations between regions of the resources available to the World Health Organization. The study referred to guiding principles established by the second session of the Executive Board to be taken into consideration in the allocation of funds for advisory and demonstration services to governments. These principles, which are valid today, are summarized in Annex I of the present report.

2.2 The study also referred to the guiding principle of "concentration and coordination of effort" in the health field, derived from resolutions of the United Nations General Assembly and Economic and Social Council (ECOSOC), and to the problem of influence of extra-budgetary resources on the WHO regular budget, the difficulty of timing bilateral, multilateral, WHO and national assistance, differences in the political, economic and social factors through which the felt needs of different regions or countries are expressed, and the complexity of the sum of national considerations which affect allocation of resources between regions.

2.3 Finally, the study contained an assessment of special factors limiting the use of objective criteria for allocating available health resources to regions, countries and projects. The closing sections of the study, including a summary of regional and national considerations, assessment of special factors and conclusion are reproduced in Annex II of the present report.

2.4 After reviewing the "Study of Guiding Principles Governing the Determination of Regional Allocations", and "realizing it would be impracticable to establish firm criteria governing such allocations", the Executive Board requested the Director-General, in his determination of allocation of resources between regions, "to continue to bear in mind the principles already outlined by the Executive Board, with due regard to those international, regional and national considerations that may be relevant for individual regions".[3]

3. Historical trend of regional allocations

3.1 Pursuant to Articles 44 and 45 of the Constitution of WHO,[4] the First World Health Assembly in July 1948 instructed the Executive Board in resolution WHA1.72 to establish six regional organizations.[5] Accordingly, regional organizations were established in 1949 for South-East Asia, for the Eastern Mediterranean, and by agreement with the Pan American Sanitary Organization, for the Americas. For political, legal and technical reasons, regional organizations were established at later dates, for the Western Pacific and for Africa in 1951, and for Europe in 1952. The reasons for and implications of decentralization, including regional allocation of resources, were reviewed in the Executive Board's "Organizational Study on Regionalization" in 1953.[6]

3.2 The decade of the 1960s saw rapid growth in allocation of WHO resources to regional levels, as well as changes in the proportional allocations between regions:

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[2] Off. Rec. Wld Hlth Org., No. 52, Annex 4.

[3] Handbook of Resolutions and Decisions, Vol. I, p. 198, resolution EB13.R23.

[4] Basic Documents, 23rd ed., pp. 11, 12.

[5] Handbook of Resolutions and Decisions, Vol. I, p. 315.

[6] Off. Rec. Wld Hlth Org., No. 46, p. 157.

3.2.1 Regional allocations in 1960, 1965 and 1970

Region	1960		1965		1970	
	$	%	$	%	$	%
AFRO	1 062	14.8	5 349	24.8	10 932	26.5
AMRO	1 354	18.9	3 309	15.3	6 631	16.1
EMRO	1 289	18.0	3 700	17.2	7 711	18.7
EURO	1 251	17.5	2 544	11.8	3 753	9.1
SEARO	1 190	16.6	3 710	17.2	6 794	16.4
WPRO	1 013	14.2	2 963	13.7	5 448	13.2
Total	$ 7 159	100%	$ 21 575	100%	$ 41 269	100%

Average (compound) annual growth rate: 1960-1965 +25% per annum
1965-1970 +14% per annum

3.3 The relative growth of allocations to the African region was particularly striking, reflecting the stress placed by successive World Health Assemblies on the legitimate claim of newly independent African countries to a proportionately greater assistance from WHO than other regions. The rapid growth in the number of WHO Member States between 1955 and 1965, particularly in the African Region, is shown below:

3.3.1 WHO Member States from 1955 to 1975

Region	1955	1960	1965	1970	1975
AFRO	2	17	28	30	33
AMRO	21	22	24	26	27
EMRO	12	15	17	19	23
EURO	30	31	33	33	34
SEARO	7	7	9	8	10
WPRO	9	10	11	12	13
Total	81	102	122	128	140
Increase		+21	+20	+6	+12

3.4 In 1961, the Fourteenth World Health Assembly initiated a series of activities in favour of the newly independent and emerging States, most of which were subsequently identified as the "least developed among developing countries". More than half of these countries were in the African Region. In 1962, the Fifteenth World Health Assembly, in resolution WHA15.22 authorized the Director-General "to implement an accelerated programme for assisting those States, concentrating on: (a) national health planning and related training; (b) expanding and accelerating medical education and training of national staff; and (c) providing operational assistance . . .".[7]

3.5 In 1967, the Twentieth World Health Assembly, realizing that the requirements of some developing countries exceeded their resources, requested the Director-General in resolution WHA20.50[8] to develop measures for special assistance to developing countries, and

[7] Handbook of Resolutions and Decisions, Vol. I, p. 9.
[8] Handbook of Resolutions and Decisions, Vol. I, p. 10.

in 1968, the Twenty-first World Health Assembly in resolution WHA21.47[9] endorsed the Report of the Director-General[10] outlining new features in the traditional forms of assistance, including increased participation by WHO in local costs in order to alleviate the financial burden on developing countries.

3.6 By 1970, the proportional allocations between regions had stabilized and the annual increase for each region tended to be proportionate to the increase in the total allocation to all regions. The annual rate of growth of total allocations eased to between 7.7 and 14.1% per annum:

3.6.1 Regional Allocations 1970-1975 (in thousands of US dollars)

Region	1970 US $	1971 US $	1972 US $	1973 US $	1974 US $	1975 US $
Africa	10 932	12 122	13 972	15 091	16 870	18 130
Americas	6 631	7 359	8 318	8 834	9 888	10 772
South-East Asia	6 794	7 670	8 682	9 826	11 029	12 017
Europe	3 753	4 164	4 857	5 435	6 161	6 596
Eastern Mediterranean	7 711	8 541	9 774	9 965**	11 183	12 085
Western Pacific	5 448	6 052	6 773*	7 236*	8 049	9 089
Total	$ 41 269	$ 45 908	$ 52 376	$ 56 387	$ 63 180	$ 68 689

3.6.2 Proportional allocations between regions (in percentages)

Region	1970 %	1971 %	1972 %	1973 %	1974 %	1975 %
Africa	26.5	26.4	26.6	26.8	26.7	26.4
Americas	16.1	16.0	15.9	15.7	15.7	15.7
South-East Asia	16.4	16.7	16.6	17.4	17.5	17.5
Europe	9.1	9.1	9.3	9.6	9.7	9.6
Eastern Mediterranean	18.7	18.6	18.7	17.7	17.7	17.6
Western Pacific	13.2	13.2	12.9	12.8	12.7	13.2
Total	100.0	100.0	100.0	100.0	100.0	100.0

[9] Handbook of Resolutions and Decisions, Vol. I, p. 11.

[10] Off. Rec. Wld Hlth Org., No. 168, Annex II.

* Not including an additional allocation for China in 1972 $ 588 000 and 1973 $ 503 000.

** Takes account of a reduction of $ 452 000 for Bangladesh. The Eastern Mediterranean allocation would have been $ 10 417, representing an increase of 6.6 over the previous year. The corresponding increase for Bangladesh is to be found under South-East Asia. The South-East Asia allocation could have been $ 9 374, representing an increase of 8.10%.

3.6.3 Annual growth rates of regional allocations (in percentages)

Region	1970 %	1971 %	1972 %	1973 %	1974 %	1975 %
Africa	9.6	10.9	15.3	8.0	11.8	7.5
Americas	8.8	11.0	13.0	6.2	11.9	8.9
South-East Asia	10.8	12.9	13.2	13.2	12.2	9.0
Europe	7.5	11.0	16.6	11.9	13.4	7.1
Eastern Mediterranean	6.3	10.8	14.4	1.9**	12.2	8.1
Western Pacific	9.1	11.1	11.9*	6.8*	11.2	12.9
Total	9.0	11.2	14.1	7.7	12.0	8.7

4. Qualitative considerations underlying regional allocations

4.1 The rapid growth of regional allocations in the decade of the 1960s, and the stabilization of proportional allocations between regions resulted from a variety of considerations. In allocating regular budget funds to the regions, the Director-General had to take into consideration the constitutional functions of WHO, the policy guidance he received from the World Health Assembly and Executive Board, the recommendations of Regional Committees, the requests of and commitments to governments, as well as the complex historical, political and socio-economic situation existing in various regions and countries.

4.2 The pattern of allocations to regions is particularly influenced by WHO's role as an intergovernmental organization charged with the constitutional function "to assist Governments, upon request, in strengthening health services".[11] The Executive Board has made it clear that as a general principle "all countries . . . should participate in the work of the Organization", and "services shall be available to all Member States without discrimination".[12] WHO must respond to the right of all Members to have their requests for assistance at least taken into account.

4.3 WHO assistance to countries has to be provided in the context of WHO's function to help governments identify their health problems and needs so as to better mobilize their internal resources to meet them and make the best possible use of funds available from external sources. As an intergovernmental organization, WHO has an important role to play in the coordination of bilateral and multilateral assistance to countries. The ability of countries to attract bilateral assistance varies from region to region. Thus the allocation of WHO regular budget funds should be related to the availability and use of extra-budgetary resources, as well as to the existence or non-existence of alternative organizations for the promotion of health in different regions or countries.

4.4 One factor that has to be kept in mind is that regions differ in their potential to generate their own resources within the region. Some regions with affluent Members have abundant regional potential for mobilization of resources, and the Constitution of WHO offers

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* Not including an additional allocation for China in 1972 $ 588 000 and 1973 $ 503 000.

** Takes account of a reduction of $ 452 000 for Bangladesh. The Eastern Mediterranean allocation would have been $ 10 417, representing an increase of 6.6 over the previous year. The corresponding increase for Bangladesh is to be found under South-East Asia. The South-East Asia allocation could have been $ 9374, representing an increase of 8.10%.

[11] Basic Documents, 23rd ed., p. 2, Constitution of WHO, Article 2(c).

[12] Off. Rec. Wld Hlth Org., No. 32, p. 55.

the opportunity to regional committees "to recommend additional regional appropriations by the Governments of the respective regions if the proportion of the central budget of the Organization allotted to that region is insufficient for the carrying-out of the regional functions".[13]

4.5 The Director-General also has to consider the stages of development of different countries, the readiness to absorb assistance, and the quality and probable effectiveness or impact of proposed health programmes at regional and country levels. In making resource allocations to regional and country priority health problems, the Director-General must consider a number of questions including whether the health problem is likely to be solved by the proposed approach, whether there is a strong rationale for WHO involvement, or whether other organizations could adequately deal with the problem.

4.6 A number of other regional and national considerations influencing the allocation of WHO regular budget resources between regions are contained in Annex II, taken from the Director-General's 1953 "Study of Guiding Principles Governing the Determination of Regional Allocations".

4.7 All in all, in view of the complexity of the matter and the great number of largely unquantifiable factors involved, it has been a matter of "feeling one's way" over the years in arriving at allocations of WHO resources between regions. The Executive Board has always had the opportunity to review and give its guidance to the Director-General as to the proportion of allocations between regions, or the most important criteria to be taken into consideration in determining regional allocations.

5. Quantitative criteria of need as a basis for regional allocations

5.1 During the fifty-third session of the Executive Board, a member commented that the allocation of WHO regular budget funds to one region appeared disproportionately low in relation to need, defined in terms of population size, level of health and available resources. This raised the question of whether it is possible objectively to quantify needs, and, if so, whether or to what extent the allocation of WHO resources between regions should be guided by these factors.

5.2 For purposes of resources allocation, it may be useful to group criteria of health need under three general headings:

1. level of health;
2. available resources;
3. socio-economic conditions.

5.3 On the occasion of the celebration of the twenty-fifth anniversary of the World Health Organization, in Geneva on 23 May 1973, the Secretary-General of the United Nations delivered a message via the Director-General of the United Nations Office at Geneva, urging WHO to adopt life expectancy as the leading statistical measure of health. WHO has never taken an official position on the ranking of statistical health indicators. Base-line indicators of the general level of health of a population might include:

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[13] Basic Documents, 23rd ed., p. 13, Constitution of WHO, Article 50(f).

(a) life expectancy at birth, and at selective ages;

(b) perinatal, neonatal and infant mortality rates;

(c) death/mortality crude totals, rates and according to disease and other specified causes;

(d) morbidity rates, total and according to diagnosed cause and severity;

(e) anthropological measurements of height, weight, fitness;

(f) nutritional status, diet and deficiency.

5.4 The definition of health need might also include an assessment of resources available within and from outside the region or country. It does not seem intuitively obvious whether a low ratio of national expenditure on health in relation to total resources available should be equated with a greater or lesser right to WHO assistance. Base-line indicators of health resources might include:

(a) health personnel, physicians, nurses and other categories per population;

(b) health centres, hospitals, institutions, bed ratio and utilization per population;

(c) per capita expenditure on health - public and private;

(d) government health budget versus GNP, GDP, and national budget;

(e) health care coverage by age, sex, income, occupation, location;

(f) medical schools and health training per population;

(g) resources for curative, preventive, environmental and supportive services;

(h) services available for disease groups, population groups;

(i) other external resources from bilateral or international sources.

5.5 Population size is perhaps the most critical general socio-economic indicator of need, since it defines the magnitude of health problems. If health levels and resources were equally distributed throughout the world, then sheer population size could be a rational basis for allocation. Base-line indicators of socio-economic conditions might include:

(a) total population structure by age, sex, occupation, and location;

(b) gross national product, domestic product, and income per capita;

(c) education facilities, enrolment ratios, and education levels;

(d) facilities for protected water supply, sanitation, housing, transportation and communications - urban, rural coverage;

(e) other health-related factors including: working conditions, nutrition, climate, pollution, nuisance and disease vectors, and basic natural resources.

5.6 It is well recognized that existing data on health levels, resources and socio-economic needs are plagued with statistical inaccuracy, non-comparability, ambiguity and impermanence. None of the criteria ever proposed has succeeded in directly measuring quality of life or level of health. The definition of need is itself a subjective process, and it is not at all clear that criteria applicable to one population apply with equal force to all populations. The answer of the modern public health planner to the problem of allocation of resources would be to set up a mathematical model, using as objective, quantitative criteria as possible, but agreement on the parameters for such a model would be hard to reach. In practice, health priority decisions are cast in political, economic and social settings which constrain operation of "pure" mathematical models.

5.7 On the basis of indicators of the level of health such as life expectancy, or the availability of human resources, such as government expenditures on health, or the magnitude of the problem reflected in population size, some regions might be worse off than others. However, the Director-General has never received any specific instructions from the Executive Board or the World Health Assemblies on the extent to which allocations to regions should be guided by such factors. Under the circumstances, the only practical course would be to make use of the United Nations concept of "least developed among developing countries". In 1971, the General Assembly of the United Nations approved by Resolution 2768 (XXVI) a list of 25 "hard core" countries requiring preferential material, advisory and financial assistance. Of the 25 countries on the United Nations list, 13 are in the African Region, five are in the Eastern Mediterranean Region, four are in the South-East Asia Region, two are in the Western Pacific Region, and one is in the region of the Americas. Most of these countries have already received special WHO attention as "newly independent and emerging States", as described under 3.4 and 3.5 above.

5.8 The criteria used for identifying the United Nations list of least developed among developing countries includes low per capita income, predominance of subsistance agriculture, low level of industrialization, low level of education, shortage of skills, weak administrative and governmental organization, inadequate or rudimentary economic infrastructure, high transport costs, inadequate health services and, finally, smallness of size of most of these countries, with corresponding limits of their internal markets. As indicated in his report to the fifty-third session of the Executive Board on "Least Developed Among Developing Countries",[14] the Director-General considers that the 25 "hard core" countries are also the most deficient with regard to their health situation, but the health sector or some specific health problems in other countries may be of the same nature as in the "hard core" least developed countries. It was with WHO's special competence in the health sector in mind, including the need to identify least developed countries according to health criteria, that the Director-General and the Executive Board recommended, and the Twenty-seventh World Health Assembly approved, in resolution WHA27.34,[15] transformation of the Special Account for Accelerated Assistance to Newly Independent and Emerging States of the Voluntary Fund for Health Promotion into a "Special Account for Assistance to the Least Developed among Developing Countries", to receive contributions for the most deficient countries in terms of health.

5.9 Ideally, the allocation of WHO resources between regions should not be imposed by the central organs of the Organization but should, instead, be the natural result of the aggregation at the regional level of the priority needs of individual Members as identified through country health programming. As the Organization through country health programming becomes more responsive to the evolution of needs of individual countries, the allocation of resources between regions should become merely part of the problem of reallocating WHO's resources within the regions. Such a reallocation will, however, require the full participation of governments in the development of country health programming, health planning and evaluation methodologies and supporting information systems.

6. Current developments in WHO

6.1 The Organization is engaged in a number of activities designed to develop better information for decision purposes and to ensure that the programme of WHO is increasingly responsive to the health needs of all people.

6.1.1 Health statistics and statistical methodologies are under constant development by WHO to assist countries, and the Organization itself, to obtain more comprehensive, relevant and reliable information for health planning purposes.

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[14] Off. Rec. Wld Hlth Org., No. 217, Annex 7, pp. 47-52.

[15] Off. Rec. Wld Hlth Org., No. 217, p. 16.

6.1.2 Country health programming exercises are being undertaken to assist countries to identify national health programme priorities and make better use of health information systems in health planning. A by-product of these exercises is improved information for WHO on the health conditions and needs of countries, so that WHO may better plan its own programme of assistance in response to those needs.

6.1.3 Information systems development is being undertaken at all levels in WHO, from the field project and country WHO representatives level, through regional offices to Geneva headquarters, to ensure selective communication of relevant information for project management and programme planning and evaluation purposes.

6.1.4 Planning and evaluation methodologies are under further development, including the use of multidisciplinary and medium-term programme development teams, with a view to developing new strategies in furtherance of the priority objectives of WHO, in response to the needs of the health consumer, and with measurable impact on health conditions in all regions.

6.2 It is to be expected that if the above-mentioned developments are successful, a more valid allocation of WHO resources should become possible in due course.

6.3 The problem of allocations between regions would be much simpler if it related to the allocation of rapidly growing, new developmental funds. But reallocation of stable budgetary resources from one region to another would be a painful decision. The present level of allocations to regions, and allocations within regions, substantially reflect planned commitments to governments, and sudden change would be detrimental to the relations between Members and the Organization as well as to the attainment of national health objectives in many countries. Consequently, the Director-General has endeavoured to effect the necessary reallocations by means of selective application of increases to regions, when such funds were available, without reducing the absolute level of allocation to any one region.

7. Conclusion

In the absence of more specific guidance from the Executive Board and World Health Assembly on how to go about allocating resources between regions, and notwithstanding the acknowledged limitations of existing health statistics, the Director-General has found it useful to include among other considerations quantitative indicators of health levels, resources and needs, to determine at least the direction which future proportional allocations should take, and to apply such considerations to allocation of increases in total available resources, without cutting back on the current allocation level of any region. The Director-General would welcome an exchange of views with members of the Executive Board on the general approach adopted and on the relative weight which should be given to various criteria of health and other considerations in arriving at resource allocations between regions.

ANNEX I

GUIDING PRINCIPLES FOR ALLOCATION OF FUNDS FOR SERVICES TO GOVERNMENTS

(Report of the second session of the Executive Board - November 1948)[16]

1. Allocation of funds.

1.1 As a guiding principle in the approval of programmes for the rendering of advisory and demonstration services to governments, the Board agreed that the following should be taken into consideration:

(a) decisions, plans or programmes of the World Health Assembly or Executive Board;

(b) decisions, plans or programmes of the United Nations or specialized agencies, if they relate to the subject of a request;

(c) the importance of the problem to the whole health programme of the requesting country (if no plan exists, assistance may be offered in developing a plan preliminary to further consideration);

(d) the ability of the country itself to provide the services required as measured by the availability of trained personnel, of means of training personnel or of foreign currency;

(e) the probability of achieving successful and useful results;

(f) recommendations of expert committees, to which problems may be referred;

(g) reasonable assurance of satisfactory cooperation on the part of the government throughout the programe . . .;

(h) reasonable assurance from the government, where appropriate, that the programme will be continued, especially that the government has, or will, establish a health organization with personnel and financial support adequate to continue the programme;

(i) the desirability of making every effort to assure equitable distribution, if the requests should exceed the available budget (this may be accomplished by progressively stricter application of the guiding principles).

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[16] Off. Rec. Wld Hlth Org., No. 14, p. 17.

ANNEX II

REGIONAL AND NATIONAL CONSIDERATIONS AND SPECIAL FACTORS INVOLVED IN THE ALLOCATION OF RESOURCES BETWEEN REGIONS

(From the Director-General's "Study of Guiding Principles Governing the Determination of Regional Allocations" - 23 December 1953)[17]

REGIONAL AND NATIONAL CONSIDERATIONS

Differences between regions

The point need not be laboured that there is much dissimilarity between regions and between their health problems. In some WHO regions, or parts of them formal organizations for the promotion of joint health programmes have existed for some years. In others, they are more recent; but in both cases they are important factors to be considered. While geographical differences are of some consequence, they are perhaps not so important, in programme planning and execution, as are the political, economic and social factors through which the felt needs of a region or a country are expressed. These differences in cultural patterns also affect the range and rate of acceptance of programmes designed to improve the total health of the people concerned. Under these circumstances, it is hardly possible to predict the optimum amount of assistance to be provided. It may be hoped that trial and error, slowly working up from experience in the field, through local governments and the secretariat to the Health Assembly, may in time provide some answers.

In addition to the differences in the regions themselves, the offices of WHO which serve the regions, have not developed uniformly in time or structure. In terms of allocation of resources, the time factor is more important than structure. The regional offices which were organized relatively late expect to be afforded opportunity to achieve as quickly as possible an organizational level appropriate to their tasks. A standard pattern of regional offices could be devised and resources allocated within the limits imposed by such a pattern. One effect of such a plan would be to impose a strangling rigidity on regional programmes.

National considerations

It is well accepted that national considerations, taken singly, cannot, in the last analysis, be permitted to influence materially the proportion of resources to be allocated to any particular region. Nevertheless, the sum of such considerations, together with international and regional findings, must be given due weight in relation to the sum of similar considerations in respect of the other regions.

It is the right and the responsibility of national governments to advance and justify their requests for a share of the resources of WHO. The adequacy of these justifications would provide one basis for the allocation of resources within regions and among regions. Regardless of whether or not detailed justifications should include factors which may be objectively measured, all justifications should be as comprehensive as possible. Among the reasons which should be presented in support of a request are the following:

(1) the health needs of the country and the relative importance of the problems requiring solution;

(2) the ability of the country to absorb assistance and sustain activities started with international assistance;

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[17] Off. Rec. Wld Hlth Org., No. 52, Annex 4, pp. 65-66 (from EB13/53).

Annex II

(3) the stage of development of national health services and the next logical step in their development;

(4) continuity of development in the health field, with due regard to the integration of national with international services;

(5) the evaluation of the results of previous efforts on the part of national as well as international agencies;

(6) the relative progress in the health field in terms of cultural background;

(7) interest of the government as expressed in terms of specific requests for international assistance;

(8) assistance requested and received from other sources.

The assessment of special factors

It has been suggested that certain reasons for justifying the use of resources are universally more important than others and that, in some way, they could be measured objectively and combined to provide a single factor which would be used to justify more precisely than is now the case, the allocations of the resources of WHO to regions and to countries within regions.

The resources which are available to a requesting country are tangible and to a certain degree measurable. Statistics are available, but probably in a varying degree of comprehensiveness and accuracy, on populations, national income, per capita national income, governmental expenditures, etc. However, raw data of this kind would need considerable refinement before it could be used to measure the relative abundance or scarcity of resources. For example, a figure indicating the average per capita income would not indicate how many persons receive much less than the average per capita income. Nor does national income necessarily measure national wealth, much of which might lie untapped for tax purposes. Nor are data available for comparing, between countries, the numbers of people who cannot be provided with health services from national resources.

No objective criteria exists by which the relative degrees of countries' technical development can be assessed. Per capita production or utilization of certain basic commodities such as iron and steel, salt, generated horse-power, etc., have been used to measure relative industrialization. These data might be used to discriminate between economically developed and underdeveloped countries, but they are hardly a useful means of comparing the health needs of economically underdeveloped regions or countries.

As already indicated, the equitable allocation of the Organization's resources is complicated by the diversity of the resources now available to countries which are entitled to receive them. The willingness of a country to accept such aid, the nature and extent of such aid to the many recipients are generally known, but the book-keeping required to make this information precise for purposes of strict comparability would be tremendous.

It may be argued that the extent of international assistance should bear some relation to the proportion of the revenues devoted by a particular government to health services within its own territory. In so far as it may be possible to apply such a criterion, the question arises as to what factors should be considered and what relative importance should be assigned to them. Some of the factors which might be considered are:

(a) the overall resources at the disposal of the national government;

(b) the extent to which the government has used or is willing to use such resources; and

(c) the proportion of the public revenues devoted to health services.

Whatever factors are considered and whatever importance may be assigned to one or other of the factors, it would seem impossible to apply the same scale to all countries, inasmuch as this could give rise to anomalies when related to the real needs of individual countries.

The problem of deciding on the relative importance of needs and the amounts to be provided for each is not unique to the World Health Organization.

In private business, management makes an enlightened guess as to which uses will return most profits. Even in this realm, where self-interest may be the exclusive factor and objective measures are applied, the results are far from certain. Likewise in the field of government expenditures, the head of an administrative service can only present his best estimate of the varying needs of his department and the legislators either reject or accept his proposals on the basis of what they consider is the general public good.

CONCLUSION

It would seem that no list of factors can, at this time, be devised which could be uniformly applied to measure, for all projects, all countries and all regions, the allocation of available resources. In the introduction to this study, it has been shown that certain guiding principles have been developed to enable the Organization to assess the relative importance and urgency of requests to share in scarce resources. These guiding principles are of a qualitative rather than quantitative nature. They have proved to be reasonably effective in practice and their application should become more efficient and acceptable as knowledge and experience is gained in their use.

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