THE WORLD BANK’S CONTRIBUTION TO TROPICAL MEDICINE: DIAGNOSIS AND PROGNOSIS

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The World Bank is 51 years old and its mandate is to contribute to economic growth and poverty alleviation. Of course, as most of you know, it started that work in the war torn countries of Europe following the Second World War. The first loan was to France in 1947 and remains the largest loan the World Bank has ever given. But today, the World Bank’s mandate is in the low and middle-income countries, often collectively called the developing countries.

The Bank is a big and complex organization (Figure 1). It has gone through some major reorganizations in the last year or two that have had a considerable bearing on its work in the Health Sector. This is the World Bank made simple, if such a thing is really possible. We have a Board of Governors that represents our owners. Our owners are every country in the world and the Board of Governors meets once a year (most recently in Hong Kong) with every share holder represented typically by its Minister of Finance or the Head of its central bank. Perhaps more important, are the executive directors representing all the share holders who live in Washington and meet twice a week. So, we have a very hands on governance structure. We have a new president, James D. Wolfensohn, an Australian masquerading as an American. He has been at the Bank for about two and a half years and he has brought many changes. Many of you will have followed his actions and pronouncements in the media. The main organization of the Bank (as it affects our work in the Health Sector) is the six Regional Vice-Presidencies and the five Networks. The Regional Vice-Presidencies are for Africa, East Asia and the Pacific, Europe and Central Asia, Latin America and the Caribbean, the Middle East and North Africa, and South Asia. Our operational work is done by those Regional Vice-Presidencies that reside mainly in Washington. It is from these Regional Vice-Presidencies that the operational work is actually designed and carried out. The cross-cutting structure in the new matrix management that we now have are the Networks. We have five sector-based or discipline-based networks of which the one of interest here today is the Human Development Network, comprising HNP (Health, Nutrition and Population), Education, and Social Protection. This Network, of which HNP is an important part, for the first time provides corporate cohesion for the previously fragmented work that the Bank did country by country in the Health Sector. It binds together our Health Sector work in 85 different countries around the world.

Coming now to the Banks’ work in HNP—what do we actually do? We do three things: We do analysis and research; we give policy advice and have policy dialogue with governments and others; and we give financial support. I deliberately list them in this order because many people thinking about the World Bank think of the financing. However, many of our clients are equally interested in the analytical work and policy advice. Indeed, for many of our middle-income clients, the financing is not the most important reason to have a relationship with the World Bank because the financing that we provide is a tiny fraction of indigenous health expenditures in those countries. Even in the low-income countries, the recipient governments and other stakeholders may place as much value in the policy dialogue and the analysis and research as they do in the actual flow of funds.

Now the World Bank was not always in the Health Sector. For the first three decades of its life it was essentially not in the Health Sector at all. The graph in Figure 2 shows that there has been an increase in cumulative financial commitments to the Health Sector now totaling $13.5 billion. The Bank’s work in the Health Sector really got under way in the early 1980s and it is since the late 1980s that the work has grown very greatly. Cumulatively, we have done Health Sector work in 89 countries through 225 projects. We are currently involved in about 85 countries.

It is interesting to put the growth and magnitude of our HNP work in the context of the other things for which the Bank provides money. Total new commitments by the World Bank in financial year 1996 divided by Sector are shown in Figure 3. The Southeastern quadrant, which is Human Development, was 24% of all World Bank commitments in that year. That is the sum of Social Protection, Education, and HNP. If we break out HNP alone, it was 11% of all Bank commitments in that year. Only three sectors were larger: agriculture at 14%, power at 13%, and transportation at 13%. Therefore, the Bank has come from essentially not being in health at all to health now being the fourth largest Sector supported by the bank, and we are often asked why that is. There is no exact answer to that question. However, I would mention one demand-side issue and three supply-side issues. The demand-side issue is very simple—we are asked, and we are asked with increasing frequency. Our client countries have the right and opportunity to seek Bank financial assistance for any Sector they desire. And increasingly our clients are asking for our involvement in the Health Sector. That is a strong motivating force. However, it would not have happened if there was not a strong responding or supply-side viewpoint within the World Bank—the belief that this was a good way for the Bank to develop. There are three origins to that new Bank conviction that HNP is an important Sector in which to be involved.

First, in all countries health expenditure is a large slice of GDP, whether it is 14% in the United States, or 3% in much of Africa, or 6% in India. It happens to be health, but it matters because it is a large chunk of GDP. If the public proportion of that expenditure is also substantial and increas-

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East Asia & Pacific
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Middle East & N. Africa
South Asia

5 Networks

Environmentally & Socially Sustainable Development
Finance, Private Sector & Infrastructure
Human Development
Poverty Reduction & Economic Management
Operational Core Services

HNP
Education
Social Protection

Figure 1. World Bank organizational matrix. HNP = Health, Nutrition and Population.

ing, as it is in many countries, then it has strong fiscal implications. So an institution like the World Bank becomes involved – because it is big, because it has fiscal implications, and because it is on the macroeconomic radar screen.

The second reason is the role of the State. The Bank is attracted to sectors where the role of the State is undeniably large because the Bank deals with Governments. Sometimes we would say that the Bank deals with Governments unfortunately. It might be better to deal with someone else. But, nonetheless, the client, or the borrower, is the Government. That propels us towards sectors in which the role of the State cannot be wished away, even by the most Chicago-esque economist. Therefore, we are drawn into health care, into primary education, and into the environment (to give three examples) in which market failure is sufficient that the role of the State is essential.

The third reason is that the Bank is dominated by economists. Those economists share the views of economists around the world and subscribe to the current consensus that exists among economists. Part of that consensus is a belief in capital human formation. It is a belief that investment in people is a necessary, if not sufficient, condition for sustained economic growth. There is much evidence for that position.

Now where are we doing this? Currently 85 different countries, and that number is growing. Some countries, such as Brazil, are the countries that are borrowing from the International Bank for Reconstruction and Development (IBRD) for Health Sector work. They are the middle-income borrowers. A middle-income borrower is defined as a borrower whose gross national product (GNP) per capita is more than approximately $1,000 per year. Middle-income countries access our funds through the IBRD. These are comical-rate loans. They are low-end commercial-rate loans (attractive commercial-rates loans), but they are commercial loans nonetheless. From them, the Bank makes a surplus that pays my air ticket to come to Orlando for this conference. It also does many other things, including funding the Tropical Diseases Research Program at the World Health Organization (WHO).

Then there are those low-income countries with a GNP per capita less than $1,000 per year. They access Bank funds through the International Development Association (IDA), and this is very, very cheap money. The Bank hands out, shall we say to Tanzania, $50 million over five years for a health project. Tanzania repays nothing for the first 10 years, and then from year 10 to year 40 repays capital only at a 0% interest rate. I think if someone offered you that for your next large investment, you would take it. It is almost free money. If you apply any reasonable discount rate to the dis-
persement stream and the repayment stream and compare the present values, it is about 70% free money. It is more like a grant. It is more like going to USAID then it is like going to Chase Manhattan. Of course, it is particularly important for the infection and tropical diseases work that we are discussing at this meeting, and for the kind of priorities that the President referred to just a moment ago.

We also, as I mentioned, do research and have a grant program. The grant program behaves like a foundation. The grant program is running at about $20 million per year for the Health Sector, and funds a number of things that people in this room will be familiar with. It is a major funder (and has been for a decade or more) of the Tropical Diseases Research Program at WHO, the Human Reproduction Program at WHO, and other WHO-organized programs. We put money into UNAIDS, into various safe-motherhood and reproductive health initiatives, into the global micro-nutrient initiative, etc., etc. Our grant-giving activity is currently under revision such that the health proportion of total grant giving by the Bank may unfortunately decrease.

As a result of the fact that Bank lending in the Health Sector is about a decade old, it seemed timely about a year ago to stand back and consider what we were doing and why we were doing it. We spent the last year in self-scrutiny and in asking others how they feel about the work that we do. As a result of that, the Bank has produced a Sector Strategy Paper for Health, Nutrition and Population, which is the first Sector Strategy Paper that the Bank has had on any Sector. Documents like the World Development Report are sometimes mistaken for World Bank policy. They are actually not. They are a contribution to an ongoing intellectual debate world wide. Now, for the first time, we do have a Sector Strategy Paper, published in September 1997. If anyone would like one, they are more than welcome to write or call and we can mail one to you. The outcome of the Sector Strategy Paper was to arrive at three areas of focus, three primary objectives, for World Bank activity in the Health Sector over the coming few years. These are improving health nutrition and population outcomes for the poor, enhancing performance of health nutrition and population services both in the public and private sectors, and securing sustainable financing.

The project content, what do we actually do in these 85 countries, is very varied and changes with time. It is varied because our client countries range from upper middle income countries, such as Mexico, through to the lowest of the low income countries, such as some of those in sub-Saharan Africa.

In a simple way you can divide our projects into three clusters. The first is the disease focused cluster, perhaps of
particular interest to this Society, where World Bank financing is going for malaria control, for tuberculosis control, for integrated management for the sick child, for cataract blindness in India, and many other examples. We take on a conventional disease-focused intervention or set of interventions and are advised by the latest thinking from WHO, from the Centers for Disease Control and Prevention, and from members of this Society. We do not invent a good tuberculosis control program in China; we get the WHO tuberculosis program to work with the Chinese to design their project and we finance it and worry about some of the larger programmatic issues. This first category will continue; we will stay in the business of disease focused work.

Second is what I would call strengthening the fabric. Many of our projects are about strengthening the infrastructure that allows many things to be delivered. The training of primary health care workers, the construction and refurbishment of clinics and district hospitals, the setting up of arrangements for the purchase and distribution of essential drugs and so on; things that are to do with the fabric of the health system, which then allow for the delivery of a range of interventions once that fabric is sufficiently strong. Again, that work will continue with increasing emphasis on what the private sector is doing because we are mindful of the counterintuitive fact that the poorer the country the larger the relative size of the private health care sector in relation to the total health care sector. So private finance and private delivery is proportionally larger in poorer countries than in richer countries, and to neglect the private sector is to neglect where most people go when they feel ill and seek medical attention.

The third category of projects, which is growing strongly, is what I would call reforming the sector. These are projects in which we work with the government on some of the big issues that the OECD governments, including the United States, are currently grappling with. Issues of the structure of health services, the role of the public and private sectors as providers, the role of the public and private sectors as financiers of health care, and defining more exactly the appropriate role for the State in dealing with quality issues. These macro-policy issues faced by the health sector are increasingly becoming a focus of our work. One of our experiences from the last 10 years of work is that if you neglect those macro-policy issues you are in danger of getting nowhere in the medium term. You can create a successful project that 10 years down the road has unraveled and is hard to detect because the macro-policy environment was not sufficiently good to sustain it. A good example is immunization...
in Africa. Most African governments do not pay for their vaccines. They get other people to pay for them. How sustainable is that? There are major macro-policy issues around getting government commitment to the most cost-effective health interventions.

To do the work I have described and to do it better and more effectively than we have done it in the past, we need to have new collaborations and we need new instruments. First, I will discuss instruments. Our current primary instrument is the project. The project with its project cycle was invented in the 1950s and 1960s and is excellent for building roads and bridges and frankly awful for health projects or other social sector projects. It is a project cycle in which we work with a client to define in great detail what we are going to do, and we then agree on a loan based on that tight specification of all the detail in the project over a five- or six-year life. We then implement, religiously following the prescriptions in the original loan agreements, even though by year three or four they are looking rusty and inappropriate. It is a rigid instrument and very good for infrastructure projects; if you want to build a bridge, you decide in advance what kind of bridge and where you are going to build it, and you do not want to change your mind halfway through.

Health is not like that, as you all know. You want to start with a strategy, and then you do want to change your mind frequently, in response to the data that is coming to you about the effectiveness of what you are doing on a year-by-year basis. You change your mind for technical reasons, to do with what the mosquitoes are doing, or what the parasite is doing, or what the people are doing. But you also change your mind for political and economic reasons. Doctors will go on strike, ministers will be fired, governments will change. This is the political economy of health and health care reform, and one has to be mindful of it and work within those constraints.

We now have on the table two more flexible instruments that we hope to use increasingly. One is the learning and innovation loan (LIL), which was recently approved by our board and which we hope to use in the health vector a good deal, although we do not have any experience of having done so yet. Approval within six weeks (we hope), up to five million dollars, and it is to try things out. It is to experiment on a local scale, to pilot, to demonstrate, and to build in the monitoring and evaluation required to learn the lessons and to know whether we can scale up. These LILs could certainly apply to innovative approaches to disease control.

The second instrument is the adjustable program loan (APL), which is the long-term line of credit. For example, it might be to work on HIV in India for the next 15 years; not to have to redesign a project every five years but to have a strategy, agreed to with the government of India, and to have an amount of money agreed in principle (it could be a very large amount of money), and to let that money flow flexibly to the execution of that strategy with the details and the annual disbursements being worked out as we go along.

Now, I will discuss partnerships. The Bank has in the past sometimes fallen into the trap of believing that it is all-knowing across all sectors. We are learning that that is a mistake. We are learning that the Bank is not a repository of technical expertise across a wide range of subject matter in health, nutrition and population, and we are trying to get better at partnering with those who do have that expertise. Our relations with WHO have improved enormously within the last two years. The basis for that relationship is that they have the technical expertise and we do not, we have the money and they do not, and that is a good marriage. Also, partnerships with UNICEF, with bilateral agencies such as USAID, and with centers of expertise in the academic world and organizations such as this Society are of critical interest to the Bank. Collaborations with such organizations and the individuals who comprise them are essential for our work. We will seek to maintain a cutting-edge expertise in economics and finance as applied to the health sector, but clearly others will be in that field as well. However, across the main public health, medical, and biomedical subject matter of health, nutrition, and population, we will be looking outside and we will be looking to forge partnerships.