Interview

Ideas Versus Money: A Conversation With Jean-Louis Sarbib

A World Bank senior vice president explains how the Bank's combination of lending and knowledge makes it a valuable resource around the world.

by Philip Musgrove

PROLOGUE: As *Health Affairs* begins to devote more attention to health issues in low- and middle-income countries, it is natural to consult the experience and opinions of the major aid and development agencies. The World Bank is both the largest source of funds for health projects and a major repository of technical advice, especially on the economic aspects of health systems and programs, and has been involved with health issues since 1974. Jean-Louis Sarbib, since 2003 senior vice president for human development, which includes health, granted an extensive interview to explore what the World Bank has accomplished, what it has learned, and what it sees as the major challenges for progress in health and the relation of health to development. Sarbib was previously vice president of the Bank's Africa region (1996–2000), gaining experience with efforts to control onchocerciasis, malaria, and AIDS; and vice president for the Middle East and North Africa (2000–2003), where noncommunicable diseases are a growing concern. He trained at the École Nationale Supérieure des Mines in Paris before going on to the University of Pennsylvania for graduate studies in city and regional planning, and he has taught at the University of Pennsylvania and the University of North Carolina. He represents the Bank on a number of global initiatives: the Global Alliance for Vaccines and Immunization (GAVI); the Joint United Nations Programme on HIV/AIDS (UNAIDS) Committee of Cosponsoring Organizations; the Education for All–Fast Track Initiative (FTI); and the Health Metrics Network, among others. He serves on a number of boards of international organizations involved in human development.

Sarbib was interviewed by Philip Musgrove, a health economist who worked for the Bank from 1990 to 2002 and is one of the editors of the Disease Control Priorities Project, a joint venture of the Fogarty Center of the National Institutes of Health (NIH), the World Bank, and the World Health Organization, with financial support from the Bill and Melinda Gates Foundation. Later this year Musgrove is joining *Health Affairs* as a deputy editor with responsibility for global health issues.

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ABSTRACT: Philip Musgrove interviewed Jean-Louis Sarbib for *Health Affairs* on 23 May 2005 in a wide-ranging discussion of the Bank's experience with global health issues, including where the Bank has been most successful (disease control) or most frustrated (health systems). Since 1985 the World Bank has committed a total of $22.6 billion to health projects; it is the largest source of development assistance for health.

Phil Musgrove: To give you a quick background, *Health Affairs* has been around now for twenty-four years. It's heavily concentrated on the United States, and to the extent that it draws lessons from the rest of the world, those are primarily from other rich countries. The journal now has a grant from the Bill and Melinda Gates Foundation to expand coverage more for low- and middle-income countries—to go global. We thought one of the interesting first things to do would be to talk to the World Bank, since it is such a big player in this area.

Let's start off with the first of the questions we sent you earlier. The Bank's been in this business for a quarter-century now. I wonder, looking back over that quarter-century, what you think the Bank's contribution has been. Specifically, it's important for money, and it's important for ideas, whereas some outfits have only ideas and not much money, and others have perhaps more money than ideas. How do you characterize that balance?

Jean-Louis Sarbib: First, let me thank you for thinking of the World Bank to broaden the journal's horizons to the developing world. My recollection is that the Bank actually started in health around 1974, when [Robert] McNamara [president from 1968 to 1981] went to West Africa and saw the devastation of river blindness. He started pushing for the Bank to do something for the onchocerciasis control program [OCP]. So I think that it's about thirty years that we've been involved. But it wasn't until 1980, I believe, with the first *World Development Report on Poverty,* that the case was made that the Bank should look at spending in education and health not as consumption but as investment. I think that has led to the growth of the Bank's health portfolio.

As of December 2004, the last time we took a photograph of our health portfolio, we had 151 projects and $8.7 billion invested.

Musgrove: That's cumulative, or—?

Sarbib: Active projects, right now. That makes the World Bank today the biggest financier in health. We're doing this in a variety of country contexts, from poor countries of Africa, where we do both lending and technical assistance and support, to the rich oil-producing countries in the Persian Gulf, which are hiring the Bank to look at the efficiency of their hospital management—to look at potentially the best way to organize health insurance and to draw on good practices from other parts of the world.

You asked about ideas versus money. I think it's very clear that both are needed. The balance between the two varies, essentially, depending on whether the countries have access to their own resources or to other non-Bank resources. But it is fair to say that the true comparative advantage of the Bank is its ability to provide both. As you well know, this is what makes the Bank a bit different from other organizations, in the sense that our presence everywhere in the world allows us to draw lessons and to share these lessons, this good practice, from one place to the next. The middle-income countries—Mexico, Argentina, Chile—which can very well find their own money, are some of our biggest borrowers precisely because they want to have not only the money but also the experience that comes with our presence in various parts of the world. Overall, the possibility for the Bank to help design evidence-based policies, because of its vast network and long experience, is key, and the combination of lending and knowledge is what makes it valuable.

Musgrove: This is a footnote, but isn't it the case that Chile is no longer borrowing from the Bank?

Sarbib: No, Chile is borrowing. These days Chile has about six projects in its Bank portfolio, in the area of higher education and in the

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social protection arena. So like many middle-income Latin American countries, Chile is borrowing mostly in the human development sectors.

Health And Economics

Musgrove: I should explain this next question. I ask it because I have taught health economics a number of times. I usually start a course by telling people to forget a fair amount of the ordinary microeconomics they know and start by seeing health as somewhat different from other sectors, not just like any other. Has the Bank's economic thinking evolved because it's gotten more involved in health issues? Could you say that there's a health-specific economic view, or not?

Sarbib: It depends. If you talk to health people, they will tell you, Yes, there is something very exceptional and very different about health. If you talk to most of our general economists, they will say that some of the guiding principles of economics—essentially the most efficient, more equitable use of scarce resources—should apply to health. Some of the uneven or unequal outcomes that we see in the field of health have to do with poor application of those principles.

Now, that being said, it's very clear that over the years the Bank has refined its analysis of the linkages between health and economic well-being, economic growth. The 1993 *World Development Report* is clearly the place where we tried to articulate that most clearly, and the concept of cost-effectiveness is in many ways the attempt to reconcile the specificity of health with the traditional methodology of economics.

Musgrove: I should add that I helped write that report. I'm a very interested party.

Sarbib: So you should know what I'm getting at; this report is credited with having convinced Bill Gates that it makes sense to invest his money in health. So, what you did at the time is having a huge impact, because the Gates Foundation today is probably second only to the Bank in the amount of money that it gives to health.

I think what's happened is that as the Bank got more involved in health projects, our analysis was mostly cost-benefit and cost-effectiveness, trying to look at the full streams of benefits—not only pecuniary, but also going beyond that.

The more we integrated health as part of the development strategies of the countries, the more we've begun to establish the relationship between investing in health and overall economic and social results. There are clearly some relationships between the health of the population and an attractive investment climate. For example, many companies that are thinking of investing in Africa today are put off by the HIV/AIDS pandemic. But you're an economist, so you know that the most difficult question for economists to answer is to compare investment between sectors. I still think that what we are doing is trying to grope for answers in this difficult area.

Increasingly, the Bank is going in a direction of a much more systematic effort at monitoring, evaluation, and assessing impact, so that we can see the results of various investments on both economic growth and its distributional impact. At some point, you may also be interested to talk to Paul Gertler, our new chief economist for the Human Development Network. Paul is really a guru on impact evaluation, and he can give you some real sense of what his work has been able to establish, in terms of the effectiveness of investing in health.

Musgrove: That would be very welcome. I'm familiar with the work he did on the Progresa program in Mexico.

Sarbib: Yes, indeed. I think what's happening, increasingly, with moving from project to program, is that the Bank has put health into an overall picture of public-sector management and of labor markets. I'm sure you're following the conversations that are taking place right now around human resources and health, on the need for investment and having the necessary room in the budget—what the economists call "fiscal space."

I've been trying to recognize the specificity of the health sector but also to apply general economic principles, because that's how we

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will make sure that ministers of finance—who, in the end, have to make difficult trade-offs in allocating resources—are sensitized and ready to accept the arguments made for the health sector.

Musgrove: When I worked for the Pan American Health Organization [1982–90], people there knew how to talk to ministers of health but not ministers of finance. The Bank clearly can get to ministers of finance with the arguments that might sway them.

Sarbib: I'm always prodding my health colleagues, saying, Well, if you want to make a case for the exceptionalism of health, or the exceptionalism of HIV, just make the case. It's very accepted within health circles that health is different, but the challenge is to have it accepted outside health circles, where the decisions are made in allocating resources.

"We have gone from the challenge of financing as the major bottleneck to the challenge of implementation. So the attention is turning to systems."

Where To Invest?

Musgrove: It's easy to exaggerate the exceptionalism of health. I've been dealing with public health people for twenty years, and they tend to overdo that. What's unusual about health is just that it's a peculiar asset, because you can't sell it, you can't give it away, you can't get many spare parts for it, and while your body is in the hospital, you can't go get a loaner body the way you can when your car is in the shop. The biology never goes away, but the economics has to be there, too.

What about the places to invest? There are at least two extreme directions to go. One is to say, Let's fight diseases one by one, or in small groups, and the other is to say, Let's work on the capacity of the whole health system. This is perhaps one of those debates where everybody's right but nobody ever quite knows how to convince the other side or how to get the right balance. Does the Bank have any specific views on that?

Sarbib: Well, we do have some thinking, and we do have, or we did have, some theology. The theology was that vertical programs are not good and that we should really go to health systems. At the same time as this theology was being expounded, we did become one of the major movers behind the OCP, which is a vertical program that did give results. The OCP was "horizontalized," if I can use this word, as its success spread. We understood that once we had trained community workers who could deliver the simple once-a-year pill, they could also do other things and deliver other health services with a modicum of training.

In many ways, I think what is happening today is that the Bank is becoming much more pragmatic and recognizes that when you have the challenge of the magnitude of HIV and AIDS or malaria in Africa, you need to address these challenges. With the increased funding that has come the various Bank interventions, from the Global Fund for AIDS, TB, and malaria, we are beginning to close the financing gap. It's not enough, but we've gone from $300 million available for HIV/AIDS ten years ago to $6 billion spent in 2004.

But what is happening is that this money is not being disbursed fast enough. We have gone from the challenge of financing as the major bottleneck to the challenge of implementation. So the attention is turning to systems. Systemic limitations are becoming evident with Roll Back Malaria, with Stop TB, with GAVI, with the Global Fund, UNAIDS. Each one of these vertical initiatives is realizing that it should also do something for systems, so the risk is that we're going to have a verticalization of systems, if you will. Hence, it's extremely important that we recognize and address the limitation created by underdeveloped health systems.

We recognize that the need for results is guiding the rich countries, where people want to say that we're giving money for this disease, or we're giving money for that disease. We need to make sure that these various disease-specific programs talk to each other and real-

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ize that in the end, the systems will have to deliver on malaria and TB and AIDS and vaccination programs.

Musgrove: Would you say that the same system underlies them all—

Sarbib: Absolutely, and so—

Musgrove: —if you carve the whole system up, then you don't have a system any more.

Sarbib: Right, exactly. So the idea is to recognize that each one of these vehicles can mobilize resources, some of which can be used for systems development. What we need to do is make sure the various initiatives talk to each other and build synergies. We're talking to our friends at the Gates Foundation in the context of the High-Level Forum on Health to see whether, together, we could not make sure that all these vertical programs talk to each other and really work much more in harmony to close the implementation gap, which is where the problem is today. I hope that the spotlight being shined today on the challenges of having the right human resources for health will really allow us to talk about these issues.

"To mobilize funding, you need to talk diseases, but to use this funding, you need to talk systems."

It's not an issue of either/or. We have to recognize the reality that to mobilize funding, you need to talk diseases, but to use this funding, you need to talk systems.

Musgrove: That's a neat way to put it.

Sarbib: That's really the way we need to square that particular circle.

Importance Of HIV/AIDS

Musgrove: You're already cutting deeply into some of the other areas I raised with you in advance, which is very convenient. You mentioned in passing how much extra spending has gone lately for AIDS, increasing fivefold.

Sarbib: Twentyfold, over ten years.

Musgrove: Back when the *World Development Report 1993* was put together, we were using the burden-of-disease calculations. That's where they were introduced to a lot of the world. I remember that we treated AIDS specially, because it seemed obvious that whatever the burden of disease was right then, it was a very poor measure of how dangerous this disease was. We will sometimes make these special arguments, although we didn't want to make a special argument for every special disease. How important would you say AIDS is in the Bank's current policy, and where do you think it's going?

Sarbib: I was in charge of the Africa region here at the Bank a few years back. With my co–vice president, Callisto Madavo, when we looked at HIV and AIDS, we said, In Africa this is a torpedo that is heading straight to the bow of whatever progress the ship is making. So let's just deal with HIV as the major developing challenge for the continent.

We took AIDS out of the sole purview of the health family, where it had been. The first projects were essentially done as health projects, and we found that AIDS was also a big development challenge. That is how the Multicountry HIV/AIDS Program for Africa, MAP, was born.

I think the recognition was also there that the Bank could not do anything without the leadership of the countries. It took a very long time for the heads of state to recognize this, to see it the way we saw it: as a major threat to development. Addressing the issue of denial was absolutely fundamental. Today we have gone beyond denial in Africa, where it's hard to continue denying anything when you see southern Africa—when you see what goes on in Botswana, Swaziland, where I think 38 percent of the adult population is HIV-positive.

But there are other parts of the world where denial still exists. I think that the next wave of the epidemic is going to be in China, India, and Russia. I was in Russia not too long ago, and for the first time, because the private sector was pushing for better recognition of the threat posed by the epidemic, the deputy prime minister came and talked about the fact that there's a problem.

In many parts of the world where HIV/AIDS

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is coming up—whether it's China, India, or Russia—the dynamic of the epidemic is different. In Russia, as you well know, AIDS primarily affects injecting drug users, so it is very difficult for the government to talk about this. At the same time, we're beginning to see it bridging into the general population. AIDS is different, because we don't have a cure and because it is a disease that is spread through some very private kinds of behavior. At the same time, it is a disease whose consequences can be economically devastating.

I'm not saying that all of these countries with the incipient epidemic will go the way of Africa. But in Africa we see the impact on life expectancy. We see the impact on the teaching profession, we see the impact on the health system. We have invested about two and a half billion dollars in the fight against HIV. We invest $250–$300 million a year in Africa. And there have been some negative consequences to the single-minded focus on HIV. Because we also have limited resources and limited capacity, malaria has received less attention until recently, largely because of the focus on HIV. It's important to correct this, because you know as well as I do that malaria continues to be a big killer in Africa. If we don't do something on malaria, or help the countries do something on malaria, then the likelihood that we will meet the MDG [Millennium Development Goal] on child mortality is very remote.

"Because we have limited resources and limited capacity, malaria has received less attention until recently, largely because of the focus on HIV."

Other Disease Threats

Musgrove: What you've just been saying raises two questions that spin off from this very directly. On malaria: It's apparently getting a good deal worse because of resistance to the cheap drugs that have been used up until now. So I suppose that what might trigger much more attention to malaria is development of new drugs and the fact that they cost a good deal more—ten times as much. If artemisinin combination therapy [ACT] is the bargain that the Institute of Medicine is claiming that it is, that's what's going to have to provoke a shift for malaria. If it weren't for that—if chloroquine were still effective—malaria might go along at the same level almost forever. One question is whether you see that as something that is going to shift attention; a lot of money is at stake.

Sarbib: Well, in addition to the more parochial view of the claim on resources, I think you cannot ignore the fact that if people suffered from malaria in rich countries, the same thing would have happened that happened with HIV. I think we should not deny that the role of the activist HIV/AIDS community in the rich countries had a lot to do with bringing up the profile of HIV in the developing world. With malaria, the advocacy is not coming from within the rich world. It's coming from within the poor world. And the complication with the resistance to chloroquine and fansidar is creating a different environment. If the resistance spreads, then who knows where it's going to go. So I think you're right to say that the resistance is creating a new dimension.

I'm not an expert on this, but what I have learned from my colleagues who are (Soji Adeyi and others) is that we have also to be very careful about the introduction of the artemisinin. Because if it's not properly done, we can also create resistance to this new drug, in which case, then, we have nothing else in reserve. The current thinking is to actually do for ACT what was done with the insecticide for the OCP program; you remember that they were changing the insecticide regularly to prevent the development of resistance—to keep the flies off balance. If I understand, one of the ideas would be to change the combination in ACT, to keep the mosquitos off balance as well.

This is more of a WHO technical issue; the issue for us is how to respond to the challenge in Kenneth Arrow's book [*Saving Lives, Buying*

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Time, 2004], whether we should have a high-level subsidy for ACT that will be financed by the International Development Association. Is this a global public good if it works, or does it have the risk of becoming a global public bad if resistance to artemisinin develops through improper introduction of the medicine? We believe that the economics and the epidemiology have got to be brought together more closely than they have so far.

Countries In Denial

Musgrove: Let me ask you one other short question related to what you were saying earlier about AIDS. You were talking about the difficulty of getting people to get over denial. What seems to happen is that countries where the epidemic hasn't really gotten rolling yet are giving themselves the luxury of the same long period of denial that African countries have gone through. Do you see any evidence of shortening that period, getting over the denial faster? Because that could make a very big difference in how the epidemic is treated. There's bound to be denial at first, but it's a difference if it lasts one year or it lasts five or ten. Do you know of any evidence of that happening in places like China, India, and Russia?

Sarbib: Well, I think that it's hard to know. In China, the fact that the premier went and shook hands with an AIDS patient on public television—I think it was about a year ago—was a recognition that HIV-positive people ought not be ostracized. You know, if the Chinese leadership decides that we're going to talk about it, there's the probability that this issue will come up.

At the Bangkok conference in 2004, Sonia Gandhi [now president of the Indian National Congress] came to talk about the epidemic. And there's movement in India, even though you've seen, as I have, the exchange between the Global Fund and the National AIDS Council of India as to whether India now has the largest HIV-positive population. There are still some real education issues there.

I think where I am probably most concerned about the denial is in Eastern Europe, because of the nature of the epidemic. The UNAIDS meeting of the Committee of the Cosponsoring Organizations [CCO] in Moscow served to bring the spotlight a bit on this. The day before the meeting, we had a private-sector sponsor event, which I mentioned earlier, attended by the deputy prime minister. At the end of the CCO meeting, we were told that the issue of AIDS was going to be put on the agenda of the Russian equivalent of the National Security Council, which is presided over by President Vladimir Putin. I can tell you that the Bank, at the very highest level, has really pushed in Russia, as we did in Africa, but there still has not been a response that is commensurate with the threat. What was really striking to me in the situation in the Russian Federation, in Eastern Europe, is the fact that it's very young people who are affected, between the ages of twelve and twenty. A lot of it is recreational drug use, which is creating the base, and then it's moving into the general population, and there's evidence that AIDS is already bridging through commercial sex workers.

Spending More Or Spending Better

Musgrove: The next question has to do with spending more versus spending better. A good deal of what you're saying already gives the clear answer that both seem to be needed. I mention this because of the WHO Commission on Macroeconomics and Health, which went very strongly in the direction of more spending as being essential. Perhaps that question is moot now, because, what you're saying means both more and better, particularly better allocation rather than more of the same.

Sarbib: There's also a question of how you ramp up. Because the challenge is that when you have heavy rainfall on soils that have been dry and scorched for a long time, a lot of this rain may very well run off and be wasted rather than being absorbed and making a positive difference. I don't want to make too much of absorptive capacity, because everybody says that capacity is something that you can work on; but what people very often forget is that even if you work on it, it's not going to be instantaneous. We have examples of programs

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where even with full funding, it took four or five years before you could see tangible results.

It's sadly true that with spending of four or five dollars per capita in Burkina Faso, you're not going to do what you need to do. But the question is whether you can go from five dollars to seventy-five dollars in the span of time that is implied by the advocates of "more right now," without worrying about the effectiveness of this spending, about its sustainability, and about getting the results that will convince the rich countries to continue to give.

All these things need to be put in some kind of alignment. Otherwise, in the debate about "more," it's very easy to get applause. I always have the very difficult job in the conferences I attend—to bring the voice of somebody who's been dealing with these issues for a long time. I have spent most of my twenty years at the Bank working on Africa, so I know these countries very well. You have people coming from very sophisticated institutions, making very generous statements. They get the applause, and then here comes this killjoy, saying, But it takes time—you've got to worry about the systems. Even though afterward the panelists will say, You're absolutely right, I don't think that there is enough of an advocacy for investing in the nonappealing things, such as systems, such as human resources. Advocating for more resources is key. But doing it without dealing with these issues will not do the trick.

User Fees

Musgrove: You could argue that being a killjoy is one of the most useful things the Bank can do. Economists get accused of it all the time; it's built into the job.

Let's move on to another question. Back in the 1980s the Bank generally argued in favor of user fees to help finance health care, sometimes based on the argument of containing costs and promoting more cost-effective care. In view of the experience with user fees over recent decades, what is the predominant Bank position on the subject now?

Sarbib: I think the explanation in the *World Development Report 2004: Making Services Work for Poor People* is still the best thing that we have ever done on user fees. It's a very comprehensive answer. The applause-garnering line espoused in certain quarters of the development community is, "No user fees for anybody, anywhere, anytime." The question is, What do you do after you've said that? There are clearly situations where the abolition of all fees could make the poor worse off if the lost revenues—meager as they may be—are not made up from another source. The risk is to have rich people going and getting MRIs [magnetic resonance imaging scans] for free. Given the distribution of power in a society, the poor person—the poor woman who needs to get emergency care or even a simple shot somewhere in the community health center—will have to pay for it—maybe not officially, but under the table.

"A blanket policy of no user fees in health is something that needs to be thought through on a specific case-by-case basis, depending on the disease."

I think that the notion of equity is, in fact, about the distribution of power. An unthinking system, a free medical system, will be skewed, I'm willing to bet, toward the rich and toward those with easy access to power.

It's not something on which you ever get applause; it's very complicated to explain this thing. But you can see why we come to the conclusion that no user fees for primary education makes sense. But a blanket policy of no user fees in health is something that needs to be thought through on a specific case-by-case basis, depending on the disease, depending on the nature of the system, and guarding also against possible leakages of resources to the powerful and the rich. The Bank has actually pioneered approaches where poor people are given resources for accessing health services, and this has worked. The example of Mexico is a case in point here. The secret is to analyze each situation carefully and to develop a solution that fits the situation and allows poor

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people to have access to the services they need and to avoid having health expenditures push people into poverty.

Musgrove: You could add to that the argument that health and education are so different from each other, anything you can put in education can't just be picked up and carried over to health. I've been arguing that strongly for some years—that you should not even talk about "the social sectors," because they're so radically different from each other.

Sarbib: Well, one of the things where I see some similarity is when you look at the human resources dimension. You can think of what you need to do with teachers, and what you need to do with health workers, and they are, especially in poor countries, fairly similar, with both having a very big impact on the budget, a big impact on the civil service, on public-sector management in general. But when it comes to disease treatment, I agree with you that health and education are very different.

We've had the Fast Track Initiative [FTI] for universal primary school completion. Many people, including some of our colleagues in the international donor community, have been saying, Why don't you have an FTI for health? The only issue, in my view, for which we could have an equivalent is for human resources and health.

Involvement In Insurance

Musgrove: The biggest difference is that education is cumulative and health care is not. I'm glad to hear the Bank making this kind of distinction and not falling into simple-minded or, as you said, theological thinking, which is not very helpful.

Let's move on to another question. You mentioned earlier, just in passing, about dealing with insurance. My impression is that in recent years the Bank has gotten far more involved than it used to be in insurance questions, whether they be social security style or private insurance; and even in some projects, like one in Peru, basically helping the government to invent and implement a specific insurance—in this case, mother and child insurance. Is it possible at this point to draw some general lessons from experience with insurance schemes in the Bank?

Sarbib: I think it's too early to draw any definitive conclusions, other than that we need to branch out into the thinking that some of our colleagues have developed on pension systems. There is an interesting cross-fertilization going on now between the people working on pensions and the people working on health insurance. Some of the same ingredients need to be there: the connection with actuarial situations, the way in which you spread risk, and ensuring that there is solvency for the long term. Our pensions colleagues have developed a very useful model to try to see how different pension systems operate, and they're talking to the people in Jacques Baudouy's group to see how they can begin to cross-fertilize. There's also quite a bit of review work on our experience with community-based health insurance schemes.

Musgrove: David Dror and Alex Preker have released a publication about that, and there was a recent conference in April in Philadelphia, at the Wharton School, on why there isn't more private voluntary insurance. Why is the market not working better? It's an interesting question: People seem to be risk-averse, with good reason, because they often end up spending a lot out of pocket. And yet the market for private health insurance is negligible in those countries. But you don't think that there's enough experience yet really to conclude—

Sarbib: I think that what's happening is that you have a lot of different experiments in many different places and then somebody says, Well, let's take a look. I know that George Schieber and others have begun to be much more systematic in looking at what we know, in particular, about health insurance in poorer countries. And there is a great deal of dialogue—sometimes pretty intense dialogue—between those who think that poor countries are ready to introduce it now and those who say that this is not yet the case.

I think that you have identified an area where the Bank needs to do more, because in many ways we are probably uniquely placed to

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do this kind of thing, much more so than doing more scientific work on this disease or that.

Working With Other Organizations

Musgrove: It's a subject on which the WHO has no particular specialization.

Sarbib: That leads to one of your questions, which was about how we work with other organizations.

Musgrove: Right; I mention this for two reasons. One is because I spent a couple of years on loan from the Bank to the WHO, seeing a few things from the opposite side. The other is that there's a lot of discussion in Sebastian Mallaby's recent book, *The World's Banker,* about the Bank trying to work with other organizations, sometimes getting along well, sometimes facing a great deal of hostility. This is a more political question than the others; let me hear what you think of the Bank's experience has been, what has worked in these situations.

Sarbib: I think we really started with the onchocerciasis program, because there's where we really first worked with the private sector—with Merck, which donated the drug. Then, when the oncho program began to extend to the rest of Africa, we did it with a lot of NGOs [nongovernmental organizations]. Today, under MAP, we're funding almost 30,000 local civil society organizations to deal with prevention and care. So, I think there is a lot being done, realizing that we cannot work alone. We have reached out to the private sector, and we try to understand better the role of the private sector and, in particular, the role of the pharmaceutical industries. We have Andreas Seiter regularly here in Baudouy's department, somebody who can really consult with us and tell us how this industry thinks. And we have tried to work with the traditional partners—WHO, UNICEF—on issues of disease control for the WHO and with UNICEF on issues of vaccination and, increasingly, orphans and vulnerable children—in particular, links to HIV/AIDS, but not only that.

And now there are a whole bunch of newcomers who are big, impatient, and different. The Gates Foundation is probably the biggest one. We also have the UN Foundation. The latest arrival is the Ellison Institute, which is going to be set up, I believe, as a global institution at Harvard University. I must say that this has been a challenge on both sides to really learn the very, very different ways of going about things that these newcomers have brought. Working with the Gates Foundation is very different from working with Rockefeller or Ford. Gates' resources are, as you know, quite considerable, and they have a very clear sense of what they want to do. My view on Gates is that they have discovered that we could be a very good platform for them to enter the countries, they realize that we know a lot about countries, and they want to use that and to partner with us in trying things out.

The malaria action and control program in Africa is one such case. They said, We want to do this; we have the money. You, World Bank, get us in the door and make sure it works. That's the sort of relationship we have with them.

Musgrove: It sounds almost ideal, because they start off recognizing what you can provide, and you can see clearly what they can do.

Sarbib: Well, I think the relationship with Gates is a good one. It's still in its formative stages, so that Gates is still kind of bubbling with all kinds of ideas. One very interesting example of that relationship has been what we call the "buy-down." I'm sure you've heard about this. The idea is that the countries borrow from the Bank. In the case of TB, I think it was, in China, the Bank and Gates and the UN Foundation said, If you reach the objectives, we will essentially buy back the loan, so that the loan becomes a grant, but it becomes a grant only if the objectives have been reached. There was a similar arrangement for polio.

Musgrove: It's certainly a powerful incentive.

Sarbib: Yes, it's working. Where I have the most experience is that the Bank and Gates have been playing a major role of launching the GAVI program. There we have, I must say, a good symbiotic relationship.

Now, there are other NGOs that continue to be critical of the Bank. I think we're certainly being taken to task for not having done more on malaria, which I think we have ac-

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knowledged and tried to correct. There's a continued debate—sometimes in a fact-free zone—on user fees, and on the impact of the so-called ceilings that the Bank and Fund program are establishing. But I certainly don't have the sense that in the health system we've had the sort of fight that Mallaby describes concerning the environment. It's not been quite the same.

Musgrove: Well, I ask the question because Mallaby's book says very little about health, except for some discussion of AIDS, and there's a lot of concentration on the environment, which seems to raise a higher level of excitement or confusion. Maybe it's more conducive to fact-free zone issues.

Sarbib: But what I discovered when I dealt with some of these people—when I was in charge of the Chad oil pipeline project—was that some of the things they say are just plain wrong. I remember receiving a petition that claimed that a number of local organizations had been consulted, so we went and asked them, and they were very annoyed to see their names used when they had not been consulted.

Where I feel the strongest pressure on the international community is from the AIDS activists. I went for the first time to the AIDS event [the international conference] in Bangkok—17,000 people. I've never been to a place where there was so much pressure on the decisionmakers from people affected by their decision. That has a positive impact in reinforcing the sense of urgency, but also the risk that you make decisions because of this pressure, before you're quite ready to make them. There were a lot of scientific debates on antiretrovirals and things of that sort, on which I'm not qualified to have an opinion. Some of the people I spoke with—some of the scientists—were very worried that they were pushed into making statements long before they were ready to make them, on the basis of evidence.

Musgrove: Well, it's a very emotional subject. There are people who are saying, in effect, Settle this while I'm still alive and can benefit from it, which hasn't happened in the same degree even for other diseases.

Sarbib: Right, it's unique. It has really made me wonder, What would it look like if we had discussions on other economic policies that had an effect on the people in the room? It would be a very different dialogue altogether. There's something to be learned from involving the people who are affected by the policies much more strongly in their design.

> **"There's something to be learned from involving the people who are affected by the policies much more strongly in their design."**

Successes And Challenges

Musgrove: Where do you think the Bank has had its greatest success in health, and where do you think it's been hardest to do what the Bank is trying to do? It would be interesting to *Health Affairs* readers to hear about the extremes of success and difficulty.

Sarbib: I think that the example of success that we're very all happy to quote is the onchocerciasis program. There's really quite a story to tell, and in many ways it's a story that foretells the evolution of the partnership with the private sector, the NGOs, the involvement of communities. It also indicates that results in health take a long time. It's taken thirty years to get to where we are right now. It's taken sustainability, it's taken continuity, and it's taken high-level support.

Musgrove: Would you say that all those are prerequisites for achieving that kind of success again, that you need the ability to stay with it? Without this, you don't succeed?

Sarbib: I think that we see the same thing on HIV/AIDS. I think that the high-level support that we got from Jim Wolfensohn [the outgoing World Bank president] was absolutely essential in pushing this to high visibility. That's the Bank using its bully pulpit, using its multisectoral capacity to talk to ministers of finance to get it on the development agenda. Then the challenge is to have staying power, because the

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more successful we are at getting people in treatment, the longer we're going to have to stay involved. When I say "we," I mean the countries and the international community.

We also, I think, have increased the literacy of the debate on health and development—or the health literacy of the development debate—and we have a very good course that we do together with the World Bank Institute, the Flagship course on health reform.

Musgrove: I may add that I helped design that course and taught in it in several countries.

Sarbib: It's one of the most positive things we have. The book that Adam Wagstaff and Mariam Claeson wrote, *Rising to the Challenges: The Millennium Development Goals for Health,* is also a contributor to this overall higher health literacy in development. We've had some successes in a number of projects, with vaccination, with linking health and water, our education programs dealing with health issues, and with HIV in particular, at the early stage. Those are on the positive side.

I think where I am much more frustrated is the challenge of having the right people in health systems, in the right jobs with the right qualifications and the right incentives. This is where, I think, the Bank needs to make progress, because a lot of the sustainability of our successes will depend on whether or not we have health systems in countries that are well staffed, well financed, effective, and efficient.

Musgrove: And human resources are basic to that.

Sarbib: Absolutely. It's a no-brainer.

Changes On The Horizon

Musgrove: It's pretty hard to disagree. People are what make the system work, and it isn't just numbers of people, obviously. Let me go to the last question, then. Putting what you said together about successes and frustrations, do you foresee any substantial changes in Bank orientation or anything happening or coming over the horizon that's going to force some change? Or is the future likely to be more of the evolution that you've been describing so far?

Sarbib: I think that the tempo of change is going to accelerate. If you take the HIV pandemic, the fact that we have so many young people—probably the largest cohort ever to come into their sexually active lives—is creating an enormous challenge. Sixty percent of the population in most of the client countries of the Bank is under age twenty-four; that's an enormous wave of people. It's cause for hope, because if they're well educated and if they are able to understand risky behaviors, then we have a chance to stop the epidemic; but it can be a terrible, terrible tragedy if they're not. So the tempo is going to accelerate.

"What the Bank needs is to be much more specific in establishing the relationship between investing in health and in growth and development."

What the Bank needs is to be much more specific in establishing the relationship between investing in health and in growth and development. We need to make a lot more evidence-based policy recommendations, so that we can take the health issues, as they relate to development, out of the health family. Obviously, there is the scientific dimension, which needs to remain; but there is a development dimension that we need to broaden the audience for, making sure that the prime ministers and ministers of finance, and the public at large, understand the impact of better health.

Musgrove: So when you say, Take the health issues out of the health family, you mean, Let's not leave it exclusively to them: Let's get everybody involved.

Sarbib: That's a better way to put it. Health is too important to leave it to the health people.

Musgrove: Like war and the generals. Mr. Sarbib, thank you very much.

Sarbib: You're most welcome.

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