THE WORLD BANK GROUP ARCHIVES

ORAL HISTORY PROGRAM

Transcript of interview with

BERNHARD H. LIESE

April 9 and 17, 2008
Washington, D.C.

By: Charles Ziegler
ZIEGLER: Today is April 9, 2008. My name is Charles Ziegler, a consultant with the World Bank Group Oral History Program. I have with me here today in the Archives of the World Bank Group Dr. Bernhard H. Liese. Dr. Liese joined the Bank in 1976 as an assistant for public health in the office of the Vice President, Operations Policy. In 1980 he became deputy chief of the Population, Health, and Nutrition Department. In 1985 he moved on to become operations adviser and principal tropical disease specialist in that same department. From 1990 to 2000 Dr. Liese was director of the Joint Health Services Department, which he made into one of the leading such entities in the United States, launching many innovative programs. In 2000 Dr. Liese became senior adviser on human development in the Africa Region. He retired from the Bank in 2002, although he has continued his consulting activities.

Well, Dr. Liese, I’m very glad you could be here today for this interview. We’ll start by asking some simple background questions. When and where were you born?

LIESE: I was born on April 11th, actually, 1942, in Fassberg, which is a small place. And that is in the northern part of Germany, because my parents—at that time my father worked on research, something similar to what Wernher von Braun was doing.

ZIEGLER: Rocket research, in other words?

LIESE: Rocket research. Fassberg was a center for, basically, solid rocket systems and jet engines, and Peenemünde was the other one, so . . .

ZIEGLER: Please relate something of your early life and education.

LIESE: Three or four years after the war had come to an end, I went back to Bonn, which is the hometown of my family, and I went, basically, to school in Bonn.

ZIEGLER: Which became the capital of the Federal Republic.

LIESE: Which became the capital of the Federal Republic. My father’s family were all scientists. They came out of that corner: mathematicians, physicists. My father was a physicist. My mother’s family was business, a Bonn business family, so quite a cultural issue in terms of different outlook on life.

ZIEGLER: Yes, yes.
LIESE: But I basically grew up in Bonn. I went in Bonn to gymnasium, and then started at the university there.

ZIEGLER: In Bonn?

LIESE: In Bonn.

ZIEGLER: How did you become a World Bank staff member? You had some other work experiences before you came to the Bank.

LIESE: Oh, yeah. Oh, yeah. I initially did my medical degree, and then I did a doctorate in parasitology on malaria at the Institute of Parasitology in Bonn, which was run by Dr. Gerhard Piekarski, who at that time was the chairperson of the International Association of Parasitologists, so a very well-known and reputable kind of scientist.

I worked on malaria, but since I just had married and needed money, I switched over and did surgery because it paid better. So I worked for a while in surgery in a hospital not far away from Bonn—about 30 miles—doing a lot around accidents—traumatology.

One of these days my old professor, Piekarski, came and said, “Well, would you mind going abroad for a while?” Or something like that. And we had been looking at this earlier and had been in negotiations with the Friedrich Ebert Foundation, which had a project in Brazil on, basically, labor union development, which I was interested in. Luckily that fell through, and—but my professor then got me in contact with what was called at that time GAVI, German Technical Assistance—today it’s called GTZ, the organization, Deutsche Gesellschaft für Technische Zusammenarbeit—German Development Assistance—and I was offered a job in Cameroon, basically as the director of a nursing and midwifery school, and we agreed to do that.

I had some experience on that point because I was in charge of training activities at the hospital, and so we went and stayed for three and a half years—almost four years—in Cameroon.

It was highly interesting because I was sitting in a government line position; so, as they say in French, Chef de Service. What I didn’t know before, but learned very quickly, was that the director of the nursing and midwifery school, which was not only nurses, midwives, you know, diplôme d’état, but as well laboratory assistant, assistant de assainissement, hygiene assistants—there’s a whole spectrum of professions, allied professions, that this job was also that of the deputy medical provincial officer, by Cameroonian decree. So I was quite a bit involved in the functioning of health services in the province, the northwest province of Cameroon, 1.5 million people, which was highly interesting.

There were as well some Canadian technical assistance colleagues who worked the preventive services, but there was a tremendous learning experience because one saw the world differently; you know, how it looks if you sit really in a government line position in an LDC [less-developed country].
ZIEGLER: Which, often, Bank staff don’t get to do.

LIESE: Very rarely. Very rarely. These days there are more people coming from these positions to the Bank, but at that time it was not that often that you had people who had worked line positions.

It had its difficulties, though, I have to say, because one had always to hustle for money. One couldn’t transfer budgets from one line to another. One had to use all kinds of shortcuts; I had to maneuver to get through. My wife became involved with a political party, with the women’s branch that helped me a lot, and so on, so many of these—the realities of life, but it was highly interesting.

And the decision to go back home was taken simply because our eldest daughter needed to go to a decent school, to a gymnasium, and unlike in the U.K., where people are very comfortable to send people to boarding schools, that in Germany is almost hard to accept, so the decision was made: then if she needs to go to school, then we need to go back. That’s what we did, and I got offered a job in the Ministry of Health, and I got basically the policy desk in the Federal Ministry of Health in Bonn as the chief of that section, which was like going from—it was a total change of job because suddenly I was involved in legislation which had to deal with abortion rights, et cetera, and speechwriting for the minister. It was very interesting but as well very demanding, I have to say, and so different from what I had done before.

At that time I did remember that I had an offer for a scholarship from the German Research Foundation. It had to do with my doctoral thesis. When that had been completed, my professor had said, “Well, why don’t you stay in the research area and continue there?” And so that scholarship had been there, but I had not followed up on it. But I went to the German Research Foundation; I said whether that scholarship offer would still be around and whether it could maybe be re-packaged, because what I really would like to do is to do a master of public health because it would give me a better kind of foundation. And they said yes, so I went to the Harvard School of Public Health, where I was accepted, indeed did an M.P.H. at Harvard.

In order to get the permission from the German Federal Ministry of Health to go there, I had to do a number of studies while I was here in the States. One was on PSRO (Professional Standard Review Organization); other ones on HMOs [health maintenance organizations], the cancer treatment and cancer research area, et cetera.

And while I did these studies, which were highly interesting because it took me around the States, to different parts, I looked as well at the development assistance portfolio of the United States because I was interested in that. When I visited Washington, I went to the German Embassy—I was in Boston, but I was doing work here in Washington—and I said that I was interested in development. I had worked with some colleagues from the World Bank earlier in Cameroon, but the World Bank was something which was faint—right?

ZIEGLER: Faint, in not . . .
LIESE: I didn’t have a real comprehension. I had seen colleagues coming through—you know, consultants who appraised agricultural projects—but I didn’t have a real appreciation of the Bank. So, the attaché in the World Bank said, “Let me call the German Executive Director. I’ll arrange an appointment for you. You can get a better understanding of what the Bank is doing.” So he did, and I forgot who the Executive Director was [Claus Knetschke] because it didn’t last longer than ten minutes—the discussion—and he sent me to a German-Brazilian colleague . . .

ZIEGLER: If you tell me the year, I can find out.

LIESE: It must have been ’75. And then I went down to a colleague, which had become a friend by now, Caio [K.] Koch-Weser.

ZIEGLER: Who became quite senior in the Bank later on.

LIESE: Right. And Caio had just joined the Office of Environmental and Health Affairs with Jim [James A.] Lee, who was absent at the time that I was there.

ZIEGLER: Who was the Bank’s first environmental officer.

LIESE: Who was the Bank’s first environmental officer. So we chatted a bit about that, and Caio said, “By the way, we still need a public health physician in this unit. We have two economists, but no public health character around. There’s a Population Projects Department around with Kandiah Kanagaratnam—called K.K.—but no public health person around here.”

“Oh,” I said, “it would be interesting,” but I was employed by the Federal Ministry of Health.

He said, “Why don’t you send me a CV,” or something like this.

I said, “Sure. I will do that.” I did send that, and then a couple of months later on I went back to Germany because Harvard had finished. I’d started the job again in the ministry. I think it was five or six days after I’d started when an offer from the Bank arrived to come for an interview. It said I should come for the interview, but it had as well attached a potential salary, so the offer looked serious. So I went back to the States, went through the interview and accepted the job. And then, six weeks later, I moved over to the States, stayed with some friend initially, and started as assistant for public health in Jim Lee’s Office of Environmental and Health Affairs.

ZIEGLER: After several years of informal activity in the health sector, the Bank adopted a formal health policy in 1974 that limited its operations in this sector to the financing of health components of projects in other sectors. In 1975, a Bank health sector policy paper suggested that poor health facilities were impeding development in many countries and that the improvement of health conditions should become a major development objective. Subsequently, the Bank increased its activities in the health sector, and between 1976 and 1978 it supported
health components amounting to $405 million in 70 projects in 44 countries. This marks a significant and rapid increase in a major new area of Bank activity.

By 1976 you were, as you have just said, assistant for public health in the Office of the Vice President, Operations Policy. What was your role in this increased activity in the health sector? Now, this started before you came aboard, but it was ongoing when you came, so . . .

LIESE: When I came to the office, there were two colleagues, Caio Koch-Weser and Fred [Fredrick] Golladay. And Fred was the economist. And Fred had been, basically, the author of the previous 1975 health policy paper, which in a way was setting the stage for free-standing health lending but then was aborted at the end, it was said due to pressure by USAID [United States Agency for International Development], [Robert S.] McNamara caved in somewhere to U.S. pressure. That was—that was gossip or whatever, but that was the reason which was traded around, so there was a kind of disappointment.

And there are a number of water resource development projects which had schistosomiasis components, and Jim Lee was involved in some of these. Fred had been working on them as well, but the number of components was relatively limited. Well, the three of us got together and established what we called the "tickler system." We monitored all projects which could potentially have health impacts—right? And we called the project officers and talked with them. We split the work amongst the three of us. I have to say Fred did more the research part of it, but Caio and myself, we were the ones who did the operations work. And the result was an almost explosive demand for assistance from the Office of Environmental and Health Affairs.

ZIEGLER: So you weren’t viewed as interfering in the projects; quite the contrary.

LIESE: Quite the contrary. Quite the contrary. I could have worked full-time for the East Asia and Pacific Region Irrigation Division under Amnon Golan because we were appraising one project after the other one in the Philippines. I worked on Cameroon. I worked on Bolivia, and I then started on Brazil; Bob [Robert F.] Skillings was a programs division chief [Latin America and the Caribbean Region Programs Division 2A - Brazil], so there was a tremendous demand for basic health activities in integrated development programs—à la Cameroon ZAPI [Zones d'Actions Prioritaires Integreees]—in water resource development programs, small dams, medium-sized dams, big dams projects (Sobradinho in Brazil), in an agriculture development project which had health components, particularly the provision of health personnel. Also for the Brazil Northeast Regional Development Projects—Peter Greening was the chief—there was an enormous demand. So big was the demand that my wife actually complained that I was constantly on the road working with these folks.

ZIEGLER: So you would actually go out to the projects . . .

LIESE: To the projects. I was working on the projects, writing the section for the appraisal reports—right?—and the cost tables. It was a fantastic introduction to the Bank’s operational work. You couldn’t think of anything better. And I have to say the colleagues with whom I had
been working in East Asia—Amnon Golan and [Enzo George] Giglioli, some of these folks have been—or Eldon [E.] Senner in Latin America—absolutely superb because in no time did we get it, the bread and butter rules of the Bank, indoctrinated: what procurement is, how you deal with it, et cetera. You had people around you who really showed you. So I think Caio and myself learned the ropes very, very rapidly, very, very rapidly.

Since I was interested in the operational work, later on I had an enormous work program in terms of looking after different components, but it was highly interesting, highly interesting. And I believe that these components really had an impact because they provided health services as part of project activities and that they were only components is immaterial, in my view. So we went very, very heavily into the health sector, very heavily, but not in a controlling way, in an operations support way.

ZIEGLER: A supplementary way, in a sense?

LIESE: Yes. The result was that—and I mean Caio can speak to that—but a result was that one got an enormously broad support network in the Bank across the Regions. I worked the transmigration projects, and I worked in Papua New Guinea on road projects and so on. Across the Regions within two and a half or three years one knew a lot of people, a lot of people, and I worked with a lot of people. I worked in Afghanistan . . .

ZIEGLER: I’m sure that facilitated a lot of your work later also.

LIESE: Oh, yeah, because you could always call old friends. That is because the old boy network, which was an informal network in the Bank, is so important.

ZIEGLER: And, parenthetically, under current Bank personnel policies, this sort of thing is very hard to establish because of the shorter-term nature of most tenures in the Bank.

LIESE: Oh, very true, very true. I think the—I partly believe that this network of the old Bank had tremendous advantages. I fail to see today that this introduced a lot of rigidity. I have really not seen that. I felt that there was an enormous exchange of information on an informal level which guarantees a certain quality of work. You were really—I mean, there was no question that if the work was not up to snuff. You know Amnon Golan, right?

ZIEGLER: Yes.

LIESE: So if that was not first rate work, you got nowhere, so you better make sure that it was—any T’s crossed and, you know, that everything was . . .

ZIEGLER: I’s dotted?

LIESE: I’s dotted, yes.
ZIEGLER: The World Bank’s *Health Sector Policy Paper* of February 1980 notes that during this early period from 1975 through June 1978, the Bank provided technical and financial assistance to 44 countries for 70 health components of projects in other sectors. In addition, the Bank prepared seven health sector studies and conducted several population sector studies. This, I imagine, would have provided the Bank with a considerable body of experience in working with the health sector, as we’ve just talked about. You were in the office of the Vice President, Operations Policy for most of that period dealing with public health and thus would have had a good view of these activities. What, in your view, were the major lessons learned by the Bank in this early stage of involvement in the health sector?

LIESE: Well, I recall that Pieter [P.] Bottelier came one day and said about Indonesia, “It would be good if we would really understand a little bit more how the health sector functions.” There was no health sector study, so we did a health sector . . .

ZIEGLER: In Indonesia?

LIESE: In Indonesia. We did a health sector overview [Report No. 2379-IND, *Indonesia Health Sector Overview*, East Asia and Pacific Regional Office, February 20, 1979], hired a consultant who helped us, Manny [E.] Voulgaropoulos, who had been living there for several years. So we got a very good understanding of how the sector had evolved, what traditionally had been happening in the policy arena, what the institutional issues had been. Later on, when I worked in Indonesia to develop the first health project, this helped tremendously.

So one of the lessons was that in order to work with governments meaningfully in the medium term, one would have to have a very decent understanding of the sector, whether you call that a health sector strategy or whether you call that the health sector policies, but one needs to do one’s analytical homework before one really starts working on strategic issue or policy initiatives with government. That was something which came very clearly across.

John [R.] Evans, first director of the Population, Health and Nutrition Department, said later, “The component work is like sand castles which can be swept away,” which is wrong. The component work wasn’t like sand castles. What he, however, wanted to articulate, really, a little bit beyond the point, was that it would be very useful to have an underpinning to understand in what context these components occurred and in what context any kind of health activities had to be anchored.

ZIEGLER: Now, by demand, you mean from the borrowing countries?

LIESE: From the borrowing countries. I was unclear why the Bank was insisting on "only" components.

ZIEGLER: Well, that was an issue that I’m going to bring up in the next question, too. Basically, McNamara hesitated to involve the Bank in lending in the health sector, and his objection, from what I understand, was certainly—was not a question of suitability for the Bank
and not of policy for the borrowers, since he advocated health along with nutrition spending in speeches at Columbia University in 1970 and the Annual Meeting in 1972. What might have convinced him to get more involved in the health sector? I’m gathering that what you’re saying is the demand for this from the clients was probably part of the reason for this.

LIESE: I think there were two reasons: one, that the demand of the clients had been strong, because if you’re working in so many countries, the message came from all corners: “Why can’t we finance something in health?” And that’s—McNamara was a very, as you very well know, a very strong advocate of population control measures.

ZIEGLER: Notre Dame speech in . .

LIESE: Yeah, he was portrayed . .

ZIEGLER: . . the early ‘70s.

LIESE: And at that time, I think the pendulum started to swing from fertility reduction policies more toward the other side, because it was seen that in order to entice the mother to have fewer children, it might be useful to provide health service for the living children; in other words, what you expect the probability of survival for your individual children—whether you have five or three or seven—is.

So the importance of health status and health services provision as a major determinant of fertility emerged at this time. Before that, there was really—it was almost cut—right? Family planning was seen almost as a mechanistic process that people don’t multiply, full stop. But that mother’s education had something to do with survival of the child, et cetera, all the intricacies which really lead to a better fertility profile, that wasn’t much talked about. So the pendulum was swinging back again. And keep in mind that WHO [World Health Organization] jointly with UNICEF [United Nations Children’s Fund] had taken a very strong position on primary health care in 1978.

ZIEGLER: Which we’re going to get into, yes.

LIESE: Yeah. So the international environment changed, and I think McNamara—slow, slow, very slow—had to give in and accept the change. Fred Golladay and myself wrote the health policy paper [Golladay, Fredrick, and Bernhard Liese, Health Problems and Policies in the Developing Countries. World Bank Staff Working Paper No. 412. August 1980]. Fred was the major author and I was the reviewer, though I would say Fred did 60 percent and I did 40 percent. But that isn’t the point; the point was that we had to produce about 30 versions of that thing.

ZIEGLER: Different iterations before it was published?
LIESE: Yeah. And it was—it was such a forceps delivery, such a forceps delivery. It was not the writing. It was not the writing. It was the insecurity of the management to move that paper ahead. It was . . .

ZIEGER: What were the major points of controversy there, or hesitation, on management’s part?

LIESE: It’s still unclear to me. It was just the anxiety that it would be shot down again by senior management. Herman [G.] van der Tak was basically managing the program under Warren [C.] Baum’s office, and he gave a lot of good ideas, and then we incorporated them. We had the material from Alma-Ata, and we had very good contact with the WHO. So I think the case story hasn’t substantially changed, but the paper went through these iterations. I tell that because it is an interesting feature. And then we came to the end. We had almost 30 drafts we had gone through since we had first submitted it. The draft then went from Warren Baum to Ernie [Ernest] Stern. And I have to hand it to Ernie; it came back marked up left, right and center with mark ups—right? We called them “Stern-o-grams” at the time, but these were substantive, critical, really interesting comments. So we went back to Ernie, discussed it with him, made these changes, and Ernie said, “Now we can survive.”

I think it was the anxiety more of Warren Baum’s shop to move it ahead because, in terms of the internal politics of the Bank, there was a big Population Projects Department under Kanagaratnam which was basically staffed by demographers, and then there was a small nutrition advisory unit, which you might recall where Alan [D.] Berg and Emmerich [M.] Schebeck were working from, and they initially were sitting somewhere in Urban Projects or related to urban programs, urban projects. And the population group looked at health very cautiously because the emergence of a health sector, to a certain extent, if you looked at the external environment, was somehow a threat to their existence, because they were a fortress of what I would call traditional thinking. So the relationship between the Office of Environmental and Health Affairs and the Population Projects Department was obviously very tense.

It has to be said, however, that Dr. Kanagaratnam—K.K.—wasn’t this traditional kind of creature. He had a much more balanced view, and consequently I personally got along very well with K.K., very well. We actually became friends. And K.K. and myself went to Alma-Ata. It was a wonderful trip.

ZIEGLER: We’ll be getting into that also. Very interesting, I suspect.

LIESE: So—but it was there. It was there.

ZIEGLER: I didn’t want to—we kind of switched into this matter of McNamara involving the Bank in lending the health sector, and quite rightly, but I didn’t want to leave quite yet the question of major lessons learned. Was there anything else in terms of major lessons that you’d care to add . . .
LIESE: I think that’s it.

ZIEGLER: . . or you felt that that’s well covered? Okay.

The World Bank Annual Report of 1980 notes on page 71 that the Bank adopted in 1974 “a formal health policy that limited its operations in the sector to financing health components of projects in other sectors. That policy reflected the Bank’s concern about the feasibility of financing low-cost healthcare systems and its uncertainty about its proper role—how, in other words, its activities would relate to those of the World Health Organization.” How were these issues ultimately resolved? Now, you did mention interrelations with WHO and other such entities.

LIESE: Yeah.

ZIEGLER: And what was your role in establishing the relationships, also? We might as well continue that on.

LIESE: The—it was a kind of paradox relationship between the Bank and WHO, because our real only operational program with WHO—large-scale operational program—was the oncho program [Onchocerciasis Control Program]. When I came to the office, Jim Lee gave me this dossier and said, you know, “Look at this one. That’s the oncho program.” That was managed out of the Africa Region.

ZIEGLER: That’s the riverblindness program?

LIESE: The riverblindness program that McNamara had started. And that was a large partnership, with WHO as the executing agency.

The second area of importance in interacting with WHO was that Jim Lee had taken it upon himself to follow up on a program which was emerging at that time, which was a tropical diseases research and training program commonly referred to as TDR [Special Programme for Research and Training in Tropical Diseases], and there was a lot of discussion between UNDP [United Nations Development Programme], Jim Lee, the Bank, and WHO how that program could be structured. It finally was created in ’78, or ’77.

Then there was also a lot of discussion on diarrheal diseases, on a program of diarrheal diseases control. So Jim Lee and the office had actually done a lot of work with WHO. He has to be given credit for that. He knew a lot of people in WHO, and he was very active in the formative arrangements of some of the subsequent big special health programs. So the Bank was in with it.

There was anxiety on the part of WHO that the Bank would somehow take over its business. That anxiety had not been unfounded, as we have seen later. On the part of the Bank there was not really clarity of what its role would be. The notion that the Bank would be largely a source of health sector finance for the countries, that was not seen that clearly at the time. It was—sure,
that we would be financing projects, but that that would become such a massive infusion of money into the health sector, which later happened, that wasn’t foreseen. This had to do with the fact that in the late ‘70s many of the—if you look at Africa, the African countries were largely self-sufficient. The oil shock came a couple of years later.

**ZIEGLER:** Nineteen seventy-nine.

**LIESE:** Nineteen seventy-nine. Then, suddenly, the pendulum started to swing around. The need for massive inflows of resources, of financial resources as we saw it five years later, that wasn’t seen at that time. And the working relationship between WHO along many of these programs were actually very good, so—and I think there I did help because I’ve always had very good relationships with WHO, was sitting on all kinds of committees, working groups and so on, and tried to make it as easy as possible for WHO, so trying not to play the banker which had the money in the pocket.

**ZIEGLER:** In the 1970’s the concept of primary health care sponsored largely by the World Health Organization and the United Nations Children’s Fund, which we have already mentioned briefly, began to evolve. As I understand it, it was seen that the widespread provision of basic preventive and curative medical services is essential, but the concept of primary health care went on to tackle the broader causes of health problems, as well as administrative, political and other implementation problems. It is seen as an integrated approach to health that also encompasses food production, education, water and sanitation and emphasizes self-reliance and partnership between communities and government. Please discuss the evolution of the concept of primary health care and your role in this evolution.

**LIESE:** Primary health care emerged, basically, when Halfdan Mahler almost single-handedly decided that the World Health . . .

**ZIEGLER:** And he was head of . . .

**LIESE:** The WHO—that WHO should no longer be the technical advisory entity it had been for the previous decade. Dr. [Marcolino Gomes] Candau, who preceded Mahler, if I would build him a pedestal, one would write on it, "He created one of the foremost professionally competent organizations." You had people who knew everything about all diseases in Geneva and had certain regulatory functions, like international health regulations and so on.

Mahler changed the outlook of the organization completely. He basically moved it towards a social justice concept, where he looked in a very different direction. He gave it a developmental outlook. He gave it a new direction. WHO was a "technologically perfect organization," but now it had to adopt a developmental outlook. This perspective was not built on a market concept, as Mahler would say; it was built on basically equitable exercises to basic health services. And in order to do that, he brought in a lot of systems people, et cetera. So the organization doubled in size. WHO changed its focus dramatically, really, really dramatically, and this change of focus in the organization engendered a lot of resistance.

*Bernard H. Liese*

*April 9 and 17, 2008—Final Edited*
ZIEGLER: Within the organization, or externally?

LIESE: Within the organization and externally. Actually, UNICEF was brought in to help out. The joint UNICEF and WHO commission set up with WHO assistant director-general Kenneth Newell—a New Zealander—as the chairperson. They prepared the Alma-Ata conference. I personally have not been involved in the preparation of the Alma-Ata conference. I went to WHO for a couple of meetings, but I would say that my input was marginal on that point.

What I did, however, is I briefed the Bank, or our own office, on what was happening on the other side. Maybe my function was more to be a transmitter of information to the home front because initially the idea wasn’t really whether it was necessary for us to go to Alma-Ata—should we, should we not go to Russia. Actually, it was extraordinarily important to go there.

ZIEGLER: Well, that had to do—that’s an important aspect of this evolution of the concept of primary health care, correct?

Let me just put that in context for the purpose of this conversation. This was an international conference on primary health care convened by WHO in the capital of what is now Kazakhstan in September 1978, where the world’s nations agreed that health was far more than the absence of disease, that it was an inalienable right, that urgent action was needed to tackle health inequities between and within countries, and that primary care was the key to achieving health for all. The Declaration of Alma-Ata adopted at that conference stated in part, “A main social target of governments, international organizations, and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of the development in the spirit of social justice.”

Now, you were just saying how this head of the World Health Organization had changed the focus of the organization to social, the issue of social justice.

LIESE: Yes.

ZIEGLER: So, I wanted to put that in context for the continuation of this very good discussion on the evolution of primary health care, and now we can discuss the Alma-Ata conference.

LIESE: The Alma-Ata conference was very important because it became very clear that the concept of primary health was widely shared. Even in the U.S., where social justice wouldn’t be the primary driver of national politics—at least not as far as I have observed—the notion of primary health care went down initially rather well, and later on USAID financed something like 60 primary health care projects, evaluated them, and found that many of them didn’t work. That’s an issue, but initially it went down well, and—but it was very, very clear that this was a concept which was widely accepted, so in terms of looking at our clients, if we were active in the...
health sector and we wouldn’t have subscribed to the notion of primary health care, we would have been an outlier. We would have not been accepted.

It was very useful to be there during the conference. We had lots of discussions. K.K. met with many delegations, and it was a very nice environment. We made a statement, the topic of which was potential operational issues in primary health care, in which we pointed out that the institutional challenges of operationalizing primary health care would be the major issue, which turned out to be correct later on. And I think we said that based on the experience, (a) of Dr. Kanagaratnam had with the population project, and (b) what we in the health office had seen with our component work. So we felt that the critical issues in making actually health systems work were of an institutional nature rather than of a financial nature or a policy directive, et cetera, so we articulated that quite clearly in a statement to the conference. It might be in the conference proceedings.

ZIEGLER: I want to stop just right there because we have to change the tape. Sorry.

[End Tape 1, Side A]  
[Begin Tape 1, Side B]  

ZIEGLER: We were talking about the Declaration of Alma-Ata and its importance in the evolution of the concept of primary health care. Please continue.

LIESE: The conference was actually in that sense very important because it showed to the two of us very clearly—and we related that to senior management—that we either be part of primary health care or we would not be not active in the health sector. Since we were at the time not active in the health sector, Alma-Ata very clearly was the major driver to get us moving with the health sector.

ZIEGLER: Which we talked about earlier, the 1980 paper.

LIESE: The 1980 paper. We started work immediately. We had already started the preparation of the paper, but then we pushed it ahead.

The issues which emerged with primary health care later on had more to do with the operational issues, the notion that you had this "low-cost kind of animal," the village health worker, which could do everything . . .

ZIEGLER: The barefoot doctors in China, yes.

LIESE: The barefoot doctor. These concepts turned out to be rather illusions. What—nowhere in the primary health care paper was said that China had the barefoot doctors, but parallel to it, it had a system of anti-epidemic stations based on a very, very well-organized functioning public health system which dealt with the big diseases and epidemics, like schistosomiasis, et cetera. It was somehow put aside on the primary health care discussion because the focus was on social
justice issues, so some of these things later on popped up. But Alma-Ata had an enormous impact on the Bank, no doubt about that.

ZIEGLER: The effect was also more widespread than just the Bank, of course.

LIESE: Oh, yeah. It changed.

ZIEGLER: It had to do internationally.

LIESE: Internationally it changed the field. But just to give an anecdote of how McNamara looked at it, we had a discussion with McNamara when we came back, he and myself, and he said, “Well, yeah, primary health care is very important, very important, and we support that.” Mahler had in the same context coined the notion “health for all,” and McNamara, bright as he is, said immediately, “Well, what he really wanted to say is not ‘health for all’; it’s ‘different diseases for all by the year 2000.’” So you saw this inquisitive kind of analytic mind of McNamara looking at the sector. We had actually to chuckle. He was so correct.

ZIEGLER: In July 1979—this is after the Alma-Ata conference—the Executive Directors reviewed the Bank’s experience in financing health components and approved a proposal to expand its program to provide, in addition to financing such components, direct lending for health projects. The Executive Directors agreed that emphasis should be placed on providing primary health care to treat common, simple ailments, on preventive care instead of curative medicine, on low-cost technologies in place of sophisticated hospitals and equipment, and on community participation in health care systems. This obviously is the direction urged by the Alma-Ata Declaration. Did it prove controversial at the Board level?

LIESE: No, no, on the contrary. I mean, there wasn’t a single voice that said something negative. It sailed through wonderfully.

ZIEGLER: Which is not always the case in these matters, but that’s . . .

LIESE: No, I mean, there was no opposition. There were questions, but it sailed through wonderfully, as it had been something which was overdue.

ZIEGLER: You were the co-author of an August 1980 staff working paper No. 412, Health Issues and Policies in the Developing Countries: A Background Study for World Development Report 1980. On page 30, the paper states: “The primary health care movement has developed a broad professional and bureaucratic constituency for accessible low-cost health care. The resistance to simplifying health care technologies seen earlier among the health professions and health bureaucracies has been neutralized and, in some instances, reversed. Moreover, the very vigorous support of WHO and UNICEF has given the movement professional legitimacy. The major accomplishment to date has been to influence the politics of health in the direction of greater social justice, rather than merely to produce a call for greater budget allocations of additional external assistance to the sector. However, the task of translating the principles of
primary health care into workable programs of training and service delivery has only begun. Almost no effort has been spent on developing strategic programs for implementing desirable change.”

Earlier, of course, we’ve touched on the question of the evolution of primary health care and the concept thereof. On a more specific level, what has happened since 1980 to develop what your paper called “the strategic programs for implementing desirable change”?

LIESE: Well, it became very clear that when one started to look at "local health services," that the idea was well articulated but how to operationalize that idea was quite a different story, and we had made that point earlier. Paul Isenman asked us to write the background paper for the WDR [World Development Report] 1980. The World Development Report addressed poverty every decade. We made the case very clearly that the major contribution of the Bank in the area of primary health care would not be primarily the funding of it. It was an important element, but the institutional knowledge, how one could operationalize primary health care in terms of institutional actors, management processes, quality controls, supervision, et cetera—what you call public administration—that on some of these issues the Bank could actually be helpful. It turned out later that this actually is one of the major contributions of the Bank in a sector like health.

At the same time, in the United States here, a school of thought emerged under the Rockefeller Foundation with Ken [Kenneth S.] Warren, whom I knew very well at the time, as the director of the Health Section of the Rockefeller Foundation, who advocated an approach which was called "selective primary health care." He wrote a paper with Julia Walsh which is still one of the seminal papers in the health sector. He basically said, “It is almost impossible to focus on a horizontal health system and improve that gradually everywhere. You need to focus on something which is measurable, which is doable, which is feasible,” and so he looked at selective areas of the health sector, particular disease control programs, and said, “Why don’t you move these ones ahead first? They will basically empower the health system.” That philosophy has caught on and still exists. It’s only in the last year that the pendulum is swinging back more towards the notion of health systems development. The recent policy paper of the Bank looks more at health systems development [Healthy Development: The World Bank Strategy for Health, Nutrition, and Population Results. April 24, 2007].

What subsequently happened was that for almost three decades “selective approaches,” particular disease control programs, have been taking off rapidly. They have been extraordinarily successful, but the accusation has been that they are vertical, that they are sitting in the overall health system like a “foreign body,” which is not entirely correct. So the notion about vertical and horizontal, between integrated and vertical, has been assuming an importance which it really doesn’t deserve because what we are talking about are really categorical interventions, which in some areas are integrated; in other situations they are not integrated.

In the Bank, we were sitting somewhere on the fence on this discussion. We were sitting between WHO and the Rockefeller Foundation. And what was our role? Our role was basically
to keep the communication open on both sides. And actually, more and more people then looked toward the Bank as if we would have something to offer, which we didn’t have at that time—I mean in terms of articulated knowledge based on real experience.

ZIEGLER: To cope with the expanded activities in the health sector, a new Population, Health, and Nutrition Department was established in October 1979 in the Central Projects Staff by combining the staff working in the fields of health, nutrition, and family planning. You became the deputy chief of one of the divisions in that department. What was your role in its establishment? And I’m talking about it—I’m talking about bureaucratically, rather than health policy as such.

LIESE: Well, we were—had been sitting around the table and trying to figure out how to go ahead. Since I was the one from the health sector, I was basically negotiating with the Population Projects Department how a health department or unit could be established, and then the staffing. We then selected a director, John Evans, who came from Canada, a wonderful man, intelligent and a highly charming personality. He came from an academic background, and that wasn’t—the Bank wasn’t really his area, so he stayed only for a year and a half or two years. He didn’t stay very long around here. The relationship between senior management didn’t actually work all that well, but very nice man, very competent man.

And then, initially, the decisions were made, you know, who would be taking over what division, and obviously the allocation of responsibility difficult. The old Population Projects Department had to be accommodated, and it was Ishrat [Z.] Husain and Hal [Harold W.] Messenger who became the division chiefs. I became the deputy division chief under Ishrat; these were huge divisions. We had West Africa, East Asia, Latin America in our division—half the world—and Ishrat and myself split it. I did Latin America because she didn’t speak Spanish or Portuguese. I did Latin America and East Asia largely, and Ishrat did West Africa, so we . . .

The initial marching orders from John Evans were to do sector work, do sector work, do sector work. Don’t do components anymore. Stop all component work.

ZIEGLER: Which had been initially very popular, from what you told me earlier on.

LIESE: Right, right, and he really ruled that should be stopped. I believe this was a remarkable mistake which he made because by doing so, we lost some of the contacts which we had. The Population Department wasn’t very popular in the Region. The population projects were not seen positively; they were seen as imposed. So he, John Evans, basically tried to stop the working relationship which we had due to components, which several of us felt was not particularly wise. Nobody disputed the need to do proper sector work, but we could have played on two pianos simultaneously operationally.

Then we made a major effort to start the first project, which was in Tunisia, actually a lot of discussion about it, how it should be done, and I thought at the time if we moved that slowly on a single project, we will never get anything done.
I worked actually on a component, on a health component in Brazil, the Northwest Regional Development Project, the famous . . .

ZIEGLER: Which I think we’re going to get into a little bit later, yes.

LIESE: And so I said to Bob Skillings, “Well, Bob, why don’t we make a project out of the component? Why doesn’t the department have a project? We have a $25 million component, or we have a $25 million or $80 million project, so whatever.”

Bob Skillings said, “Go ahead, make a project out of it, only package it properly. You have relatively little time, however, to do so, because it needs to go into the overall package to the Board.” So we developed the project.

My point is that we could have used many of these component undertakings to really develop project pipelines—which we later on did—but I believe in the initial development of the Population, Health, and Nutrition Department I believe there was a lack of operational leadership. I have to say that frankly, although I dearly appreciate John Evans, but he didn’t provide this kind of leadership drive. Operations were not his cup of tea. And it was when John Evans had left, it was John D. North, who came from Operations, who basically brought that dimension. Then things moved ahead.

John Evans, however, did a number of things which I think were extraordinarily helpful for the Bank. He established excellent relationships with WHO, particularly with respect to the TDR program—tropical disease research—in which we were a non-paying co-sponsor.

ZIEGLER: That’s the German effort that you mentioned earlier on, am I right?

LIESE: No. This is the WHO-UNDP-World Bank program on training and research in tropical diseases, one of the WHO flagship programs.

ZIEGGER: Okay.

LIESE: We were a co-sponsor. Jim Lee started that, and John followed it up, and I dealt with it later on for years and years as the Bank representative. But John insisted with Ernie Stern that the Bank should make a financial contribution, and he really muscled it through against a lot of opposition. He has to be given credit for that. It was quite an achievement. I mention that because in many of these respects John Evans was excellent, only he should have had a deputy who knew the Bank’s machinery.

ZIEGLER: And he was more of an academic sort, as you say.

LIESE: Right, right.
ZIEGLER: According to the World Bank Annual Report of 1980, the new Population, Health, and Nutrition Department was to start slowly, beginning with one health project in FY ’81 and a gradual expansion thereafter. However, by 1982 the World Bank had become the world’s largest lender for health projects in developing countries. What accounts for the rapid growth for Bank lending in the health sector, given the Bank’s initial reluctance to lend to that sector?

LIESE: It was simply the tremendous demand, and we became the largest lender simply because there were so few other ones which were lending money to the health sector, so you have to see that in perspective. The largest lender is actually almost an overstatement because, as I said, by default we became the largest lender. But we then developed rapidly a number of projects. There was demand. You could go wherever you wanted. There was demand.

ZIEGLER: You were the task manager for a number of World Bank projects in the health sector. Were there any particular experiences and lessons learned that you would like to place on the record?

LIESE: Well, the most important issue which I take away from years of work on the projects, which I really loved dearly, was there ain’t no success if you don’t have a decent local constituency for the program. In other words, there must be people who want it to succeed locally. You need a political constituency. You cannot from the top, from the solid pedestal of ignorance, dictate policies, which in other languages are called politics. The health sector is a living organism, and in that sense—and it’s culture-specific. It’s driven by the cultures and values, the political climate in a country, so you need to have to consider that. That has been one of the big shortcomings, in my view, of the Bank, that we felt that this was immaterial because we had a technological approach or an economically well-founded perspective on something. Well, it doesn’t work that way. Why do we have guns in the United States? It makes no sense to a German. And why are there no speed limits on the Autobahn in Germany? It makes no sense to an American, but these are the facts.

So the importance of creating these constituencies were often underestimated. They were particularly quite often underestimated in the population projects portfolio. In countries where they had a huge constituency, a local constituency like Indonesia, they worked. In other countries like in India, this was a different story. Or Jamaica.

ZIEGLER: What accounts for the difference there between, say, Indonesia on one hand, and India and Jamaica on the other?

LIESE: The idea of family planning was a marginal idea accepted by only part of the polity; you found these issues over and over. That’s one.

The second one is that I often felt that money alone is really not the solution. Let me give an example, because it is so classic. When we developed the Amazon Basin Malaria Control Program, $100-something million, the Brazilian government had these so-called “Polo funds”—Polonoreste and Poloamazoni—which were local development funds, tons of money sitting
unused. So, why, I asked Molart—hero of the National Planning Agency—I said, “Molart, why do you want the Bank to borrow over $100 million for this project?”

He said, “It’s very clear you need a stable entity which obliges us to perform; in other words, we need to de-politicize the development process.” Funds for malaria will be used by one particular portfolio with one particular institution, SUCAM [Superintendencia de Companhas de Saúde Pública - Superintendency for Public Health Campaigns]. So the Bank acts almost like an insurance mechanism for the national program. Very important.

The sad part is that the institutional issues are often overlooked. Attention to the institutional issues in implementation are paramount because institutional issues, particularly in the health sector, often are really micro-political issues. One better understands them and tries to maneuver around them because otherwise they can become very big impediments in terms of implementation, resulting in poor-performing projects.

ZIEGLER: Were there any individuals whose particular contributions in the evolution of the Bank’s health sector policy whom you’d care to mention? You mentioned Mr. Kanagaratnam and Mr. Evans. I don’t know if you want to elaborate on any of that.

LIESE: Yeah. I think Fred Golloday deserves a lot of credit because he has done a lot of homework, legwork on the policy paper, and then we hired somebody from CINDER [Centro de Investigaciones Multidisciplinarias en Desarrollo Rural], a research project in Colombia; Oscar Echeverri was actually the first rural health specialist. There were a number of other colleagues who really worked to operationalize things—Larry [Lawrence] Casazza.

ZIEGLER: Kanagaratnam was kind of a pioneer in a way in the population area in the Bank.

LIESE: Yeah, yeah. K.K. was a pioneer in that area, as was Alan Berg on the nutrition side.

ZIEGLER: Yes, yes. He had a seminal paper, did he not, oh, 25 years ago, I guess it is now?

LIESE: Yes, and then later on Frederick [T.] Sai came as population adviser, so we had a number of people who were really absolutely world class.

ZIEGLER: In February 1985 you became senior public health specialist in the Office of the Director of the Population, Health, and Nutrition Department. What were the circumstances of this change of assignment?

LIESE: Well, the—that was the time when the reorganization was coming, and the issue was we needed to somehow—as we were growing the portfolio, we needed to have somebody who could hold hands on the operational side; that is, backstopping younger colleagues. It is funny, but Jacques [F.] Baudouy, who has been the previous director of the Health Department in the anchor, when he came to the Bank he didn’t have much of an idea how projects were developed,
and so I was the one who worked with him through the first project, the Rwanda appraisal. I did basically the same thing which people from the Operations side had done when I was coming to the Bank: talk about procurement, finding out how things were done, how one would do an appraisal report, how one would get it through the system. So I did a lot of what I would call operations support, backstopping colleagues. And that was an interesting task, but not an easy task; it was a training task, like a coach.

ZIEGLER: Mentoring, we call it today.

LIESE: Mentoring, but it was as well very rewarding.

And then the other area—since I came from the tropical diseases side, I looked after the tropical disease portfolio, and I managed de facto the relationship with WHO. I was sitting on the task force which dealt with generic drugs for the pharmaceutical industry, the CDD [Control of Diarrhea and Respiratory Infections] Board; the ARI Board (acute respiratory infections), you know, these different programs. I spent a lot of time on the WHO relationship.

ZIEGLER: In your new position you were responsible for developing the Bank’s policies and operational programs in tropical and water-related diseases. Please give examples of some of this work. Now, what we were just talking about was the internal aspect. In this question I’m talking about the external.

LIESE: Yeah. So we had, for example, to develop guidelines for use of pesticides, to give one example. That I did jointly with a colleague who developed the first series of guidelines for development of pesticides, et cetera. So we did develop something which other outside people could refer to, which was published material, which was very helpful.

ZIEGLER: In speaking along these lines, in the late 1980s the World Bank made a loan to Brazil for the Amazon Basin Malaria Control Program to help the country to control a malaria epidemic in that area. DDT was approved for use in this project, and the use of DDT is, of course, a subject of considerable controversy even today. What is your take on that controversy?

LIESE: Well, it was an interesting controversy, but a tempest in a teapot because even today DDT is permitted as used selectively for public health purposes, and people have forgotten that what we call the environmental negative runoff from intra-domiciliary house spraying is minimal. It’s totally negligible. So we had actually a hundred tons of DDT in that malaria control program.

We discussed it with the Brazilian authorities. They had a task force to limit what the negative environmental impact would be, but DDT was used in Brazil and is still partially used. But, as could be predicted, the international NGOs [non-governmental organizations] were trying to attack us, so I had to really stand up there and defend this decision over and over again. And I’m glad that the Bank took this position because we had similar situations with malaria control in Madagascar, for example.
Today the pendulum is swinging back. WHO has just recommended DDT for . . .

ZIELER: Yes, I’ve read that the idea of the total ban on DDT is—there’s a lot of controversy about it. As you rightly said, the pendulum is swinging back. The people are saying, “A lot of people are dying of malaria, whereas if we used DDT, they wouldn’t have died of malaria.”

LIESE: Yeah, and the environmental—if there would be a serious environmental impact, that would be a different story, but the environmental impact came from the use of DDT for agriculture purposes. That’s a very different issue. For example, in India, where DDT was used by the Indian farmers for years and where there were still a lot of illegal sales to the agriculture sector, that would be a different issue. Then I could agree with the environmentalists that one would have to be very, very careful before one uses DDT. But in programs like Madagascar, where they had acute epidemics of people really dying rapidly, there was no alternative but to use DDT. That was the pesticide of choice.

ZIELER: And it worked?

LIESE: It worked. It surely works.

We have over the years been replacing DDT wherever we could with other pesticides, and initially with malathion—but that stinks—but the costs are higher and you see resistance building up quickly. So I think the role for DDT—I’m glad that DDT is finally rehabilitated in public health circles. It was not an easy stand to take, but . . .

ZIELER: But a scientifically correct one?

LIESE: Probably a scientifically correct one.

ZIELER: Regarding the same project, the New Scientist magazine for August 12, 1989, notes, “Bernard Liese with the World Bank points out that in Brazil no one understood the intricate factors contributing to the malaria epidemic in the Amazon until it had been going on for some time. Disorderly development with many families moving in each day by any possible means of transport made it difficult to evaluate what was going on. ‘Amazonia is really the Wild West, a frontier,’ he says.”

This sounds like a challenging situation. Could you please describe some of these challenges as they relate to your involvement in this project and the means by which you set out to address them? Now, DDT was, of course, one challenge, but clearly there were others here.

LIESE: I went to the initial mission with Bob Skillings in which we looked at what could be done in this area. You might recall that a road over a thousand kilometers long from Cuiaba to Porto Velho existed, which was one of the few north-south axes which traversed the Amazon. This road was largely unpaved, and it took about a week to go from pothole to pothole through
there between Cuiaba to Porto Velho. It hadn’t stopped farmers from the impoverished South to sell everything and move into Amazonia, so when we went through that road from pothole to pothole, there were lots of trucks and cars and people on that road, and they disappeared somewhere, almost mysteriously, into the forest.

What you saw there—which is called in Portuguese lineas, the little roads, feeder roads, branching off—first it was a kind of road, then it became a path, and then it disappeared. But then you saw somewhere people had built houses on stilts. They often didn’t have walls because there were no sawmills, so you couldn’t have boards—right? When you are flying over this area, you notice that the forest was invaded like the moths are eating on a cloth.

ZIEGLER: Just holes in the forest canopy where people had set up squatter settlements?

LIESE: Squatters, yeah. First they built the house, and then they moved in with the family—a platform on stilts, with a roof, is a better description—and they planted initially banana trees, and under the banana there’s a shade—as a shade tree, and then they planted coffee, because that was what they knew from the South.

It was very disorganized, totally disorganized. It was actually the Wild West. There were constant kind of robberies and shootings and—well, the biggest curse was malaria because the people from the South were never exposed to malaria, and suddenly they went into a malarious area. And it wasn’t only the children who died, like in Africa, where mainly children died because malaria immunity is well-established in this population. No, this was a non-immune population moving into this area, and so the fathers suddenly died, and there was a mother with three children, or three children alone because both parents had died; tragic situations, truly tragic situations. And in addition, there were some Indian reservations, and the settlers moved into these reservations.

But the settlers were one group of people. There was another group of people which was even more aggressive. These were the gold miners, garimperos, because there’s a lot of gold in this area, so they really—they were “washing” wherever they could find it. The biggest was Sierra Pelada, an enormous kind of operations, totally disorganized, no sign of government. The only person who was from government was the health worker from SUCAM, the disease control organization, so basically—well, SUCAM served as the only responsible state official in that area.

ZIEGLER: No police or . . .

LIESE: No police, nothing. Nothing. I’ve never seen such a mess, but it was one of the most fascinating work which I have been doing.

We went through these areas, but as we went back we said, “Something has to be done.” Well, the Brazilian government had decided to pave the BR-354 road between Cuiaba and Porto Velho. So they went ahead to do that, and we provided financial assistance for this road project.
And then we added on an agriculture support and settlement project—an agriculture project at first; later on, it was redesigned with a small settlement component, and the third part was a health project to deal with malaria control.

As you know, the Bank got a very checkered reputation in Brazil, largely because we went out beyond that portfolio of the three projects and engaged actively in settlement issues. That’s where the problem occurred. The road construction project didn’t do us any harm. The initial agriculture rehab project didn’t do much, but when we went into the settlement area, we went right into the middle of the controversies of who should be there and who should not be there.

ZIEGLER: That was one of my questions. In fact, my next question was going to be about how you would assess the Bank’s role in Brazil’s economic development in the period you were involved in these projects, and this directly refers to those controversies.

LIESE: Contrary to what the public opinion is, I think the Bank has done a very good job. If I imagine . . .

ZIEGLER: You’re speaking of Brazil, specifically?

LIESE: Brazil specifically, yeah. I only imagine what would have happened if the Bank would not have been there. The national authorities had great difficulties to control the situation; not that we were a police force, but at least we reported back what was happening. The Brazilian government then had the data to take a position, so I think the Bank played a catalytic role. It paid dearly for it. It paid dearly for it.

ZIEGLER: A lot of controversy over that.

LIESE: A lot of controversy over it, but several of us who worked on these projects—colleagues from various sectors—we all shared the same opinion, that it was good that the Bank went in. The only thing which we would not do again, we would not really deal with settlement issues per se. I think that was the area where we went into too much of a political controversy.

ZIEGLER: In the article in the New Scientist that I mentioned, it also quoted Bruce Rich, (who’s a well-known critic of the World Bank), the Environmental Defense Fund, as saying that the World Bank has loaned hundreds of million dollars to Brazil for development of the Amazon region and has “a direct responsibility for this disaster. For a country like Brazil, that’s a very expensive way of standing still.” Now, clearly, you and your colleagues would have disagreed with that assessment by Mr. Rich?

LIESE: Oh, yeah. Oh, yeah. As we were involved, as always, if you are in it, you are in it, so surely I think the Bank has to shoulder its responsibility, but I would say that on the whole, I would have been very much afraid if the Bank wouldn’t have been there. As you see, then, over the years, the situation stabilized. It stabilized. Now, there is no objective evidence which can be provided that we created a mess.
ZIEGLER: Concerning?

LIESE: Concerning whether that was a wise decision or not a wise decision.

ZIEGLER: Ah.

LIESE: I have the picture of the initial mission through the area, and I have really never seen something like this. Absolute chaos. Massive immigration, massive immigration. I think it would be criminal to have said, “Oh, we can’t do anything. That’s a Brazilian problem.” If you are a development organization, then we should be involved in the matter.

ZIEGLER: Well, we’ll be moving on to a different topic, so I think this would be a good place to end this first session of the interview and take it up next time. Thank you, Dr. Liese.

LIESE: Thank you very much.

[End Tape 1, Side B]
[End of session]
ZIEGLER: Today is April 17, 2008. My name is Charles Ziegler, a consultant with the World Bank Group Oral History Program. I have with me here today in the Archives of the World Bank Group Dr. Bernhard H. Liese, and we will be continuing his interview for the World Bank Group Oral History Program.

Bernard, last time we were discussing tropical diseases, and we’ll take up that subject at this point. You co-authored an article in the December 1993 issue of Finance and Development entitled, “Organizing Tropical Disease Control.” The article states, “Relatively few governments support major efforts to control tropical disease. The means, primarily drugs and insecticides, of treating and controlling most of these diseases do exist, yet despite a major expansion of primary healthcare in the 1980s, the burden of tropical diseases is increasing, and the prospects of controlling the major diseases—malaria and schistosomiasis—are worsening. The main area of controversy over the past ten years revolves around the question of whether programs should be ‘vertically’ organized or ‘horizontally’ integrated. In somewhat oversimplified terms, vertical is hierarchical, technology-based, and ‘categorical,’ that is, focused on specific diseases. In contrast, horizontal integration is intertwined with primary care, community-based, and close to the people.”

In the years since the article was written, what have you seen in terms of the question of vertical versus horizontal integration for tropical disease control? And I think we did previously touch on this issue of vertical versus horizontal but specifically here in terms of the tropical disease control.

LIESE: Well, the issue is still around. And it is—there is really no true technical issue behind vertical versus horizontal. This is almost a theological conversation about beliefs. Very often disease control programs are categorically organized; that means around areas of specialization. But they are decentralized for field operations. They’re centralized for support functions. Those are various ways in which these disease control programs are organized.

But behind that is the schism in public health between what you would call the true primary health care advocates and selective PHC advocates. The people believe that health systems are cultural expressions, which they actually are, that they have functions of social justice embedded in them, that the equity and quality issues are very much at the heart of a functioning health system, and that health infrastructure—that is, hospital systems, et cetera, et cetera—need to be systematically strengthened, and that this is the way to achieve better health.

On the other side of the spectrum are folks with a technological bias who say that health systems are largely a combination of disease control efforts. Yes, that hospitals need to be functioning—
they determine the legitimacy of a health system—but they look at it more from the technological end.

And after the Alma-Ata discussion, which we referred to earlier, these things really became two different schools of thought: the primary healthcare movement and what we call the selective private healthcare movement. And often the discussion is simplified around the notion vertical versus horizontal, which really doesn’t catch the issue. For the last, I would say, 25 years, the technological aspect of health service delivery has driven the field ahead.

ZIEGLER: Despite the Alma-Ata Declaration?

LIESE: Despite the Alma-Ata Declaration. Global health initiatives are today largely disease control programs—polio eradication. You have the malaria programs, which went up and down, and now up again. You have the programs of lymphatic filariasis control or elimination (that is elephantiasis, in more popular terms).

The vaccination, childhood vaccination programs have been solidly entrenched in the health systems. We started from measles campaign in West Africa, then we went to integrated disease—childhood disease control programs, EPI [expanded programs on immunization]. And now we are broadening the spectrum of vaccinations via GAVI [Global Alliance for Vaccinations and Immunization] and so on; I don’t want to go through them. But that side of the health system has very, very effectively maneuvered.

The other side of the spectrum, the support to general health services, has been a problem. It is fair to say that the Bank has had a major part in not helping this side of the spectrum.

ZIEGLER: The primary healthcare side?

LIESE: Yes, the primary healthcare side.

When the oil price issues hit in the ‘80s, the major preoccupation of the Bank, as you very well know, became to keep the balance sheet of the LDCs [less-developed countries], particularly in Africa, somewhat in the black. So we started with our structural adjustment loans. We initially really focused in terms of stabilizing the overall economy, and that makes sense. People did not really look at the implications; i.e., what this meant for the social sector.

ZIEGLER: Including in the Bank?

LIESE: The Bank was one of the main proponents of structural adjustment. Still, today, people are almost harshly in a denial state. The facts are undeniable. And that doesn’t mean that the structural adjustment operations didn’t have their positive side. Oh, no, only for the health sector per se they were not particularly helpful in many countries because we were slashing the public payroll, floating the exchange rate, et cetera. All the measures that the Washington Consensus
were applied, basically, uniformly to almost all countries. I’m exaggerating a bit, but that is a perception of the health sector.

This resulted in many countries in enormous difficulties to finance the health sector—for example, health manpower. I did a study four years ago in looking at Africa’s health manpower. I did a staff working paper as well [Liese, Bernhard and Gilles Dussault. *The State of the Health Workforce in Sub-Saharan Africa: Evidence of Crisis and Analysis of Contributing Factors*, Africa Region Human Development Working Papers Series. September 2004]. Kind of shocking to see the reduction in income. Cameroonian health workers lost around 70 percent of income over a period of 13 years. That includes, actually, the devaluation of the franc CFA [Communaute Financiere Africaine], which contributed to that. Well, that might be an extreme kind of case. But since I used to work in Cameroon running actually the health services, going back it broke my heart to see that many of the things which one had built up were simply falling apart.

**ZIEGLER:** You said devaluation contributed to that. What other factors would contribute to such a precipitous decline in income?

**LIESE:** Well, they basically froze all kinds of benefits, froze salary increases. They reduced—they literally reduced salary gradually in steps and steps. And so the total income calculated was reduced by almost two-thirds. Obviously, health providers—the ones which we had trained, nurses, *et cetera*—left the health sector. You had internal migration to other sectors. If you go to Yaounde to one of the larger hotels, the receptionist is most likely a nurse or somebody who comes from the health sector.

**ZIEGLER:** So some of them could have immigrated to Europe or the United States.

**LIESE:** Yes. I had one, you know, colleague here, Michael [N.] Azefor, who was part of that group. Cameroon might be a stark example, but in shades of gray we have seen that quite a bit. And investments in hospitals, for example, equally, the Bank hasn’t made many. Very few donors did. District hospitals, yes, a bit. But not many. And central hospitals, tertiary healthcare practice, practically no investment.

But if you go around and look at many of the big hospitals in African cities, you are shocked by the state of affairs. Tremendous issues of quality of care, you know, in terms of what actually could be done—structural ways in which services are provided, that the wards are, having proper patient records, *et cetera*, *et cetera*, all these qualitative measures—*I* think we could have done a lot about that. Instead, I think we focused on the so-called health sector reform. And my personal view is that this didn’t help to improve systems. Take user charges—you know, user fees—that’s fine, let’s make the user support the health system, but we didn’t think through this. We didn’t really look at the implications.

My personal view, which I’ve expressed many times, has been that the health sector reform movement was a fig leaf to hide the fact that at the end of the Cold War, official development
assistance for Africa dropped considerably. It dropped to about half the level it had been before. And so the countries had real difficulties to finance the services. There would have been ways to increase ODA [official development assistance], but we basically said, “Why don’t you reform your health services? Make them more efficient.” There were elements of that approach which were quite useful, but I have considerable hesitations to believe that the health sector reform movement was not merely a whitewash.

ZIEGLER: So this health sector reform movement wasn’t just the Bank.

LIESE: No.

ZIEGLER: I mean, it was much more broad.

LIESE: It was broad. The Bank was one of them, right.

ZIEGLER: Yes.

LIESE: I’ve been, as you know, traveling around quite a bit to the countries. Countries have always been looking at some of these health sector reform issues with an element of doubt. Certain elements were meaningful. If you look at user charges, for example, which could in particular cases be quite useful if they are properly managed and so on, but one has to look at the details before one deals with that.

I’ll give you an example. In Indonesia, a special program—Inpres Desa Tertingga—basically built health centers in rural areas, provided the money to staff that, et cetera. But there was a user charge for patients. And the patients which were not able to pay were exempted from the user charge. Now Indonesia has a system which actually could do that because they have a village classification system in which they pretty much know who is indigent. So that might be one of the countries where user charges actually work. The user charges were fixed at 500 rupiahs, if I recall correctly.

We looked at that several years later. It makes sense. It makes sense—right? Well, we found that the user charges had gone up in the meantime, 1,500, 2,000 rupiahs, collected from everybody. What was happening? Well, it turned out that the doctors at the health centers couldn’t retain the funds; they had to give it to the district officer—not the district health officer, the district officer, and that the district officer used for fixing roads, et cetera, because it was his only source of cash income. So what you had done effectively was levied an illness tax on the poorest of the poor. Just the opposite of what we actually wanted to do.

I’m saying that one has to look at some of these proposed measures; very carefully look to see what impact it actually might have had.

Now, these days the notion of health systems strengthening is back. You know, over the last couple of years with the new policy paper of the Bank we are back to systems thinking. We
have, basically, switched back to 25 years earlier. Today we acknowledge that there is a tremendous shortage of manpower, that this is a major issue which needs to be addressed. There is no question that the hospitals need to be rehabilitated and so on.

ZIEGLER: You were involved during this time in one of the most successful, long-term, multi-donor programs in the history of the World Bank, which succeeded in controlling riverblindness in West Africa. How did you come to be involved in this effort?

LIESE: Well, when I came to the Bank, Jim Lee, my boss at that time, gave me a dossier of backup material and said, “There is a problem; you might want to look at that. That’s something from the Africa Region, and Steve [Stephen M.] Denning deals with that. Just have a look.” He was obviously doubtful whether one could do anything.

Well, I looked at it, and I got marginally involved, and informed myself as well. I didn’t do much. Went sometimes to a meeting, followed up then.

Marc [L.] Bazin was then appointed by the Bank as the director of the program, and he actually organized OCP [Onchocerciasis Control Program]. And then, several years later—it was in the early ’80s—the program popped up because people said this is now definitely going to fail. We had re-invasion of the black flies, the flies which transmit the disease, and that meant that in areas where the spraying program for onchocerciasis had been successful, suddenly new flies popped up, and they were not local; they’re traveling 100, 150 kilometers. So the notion was that we will never be able to eliminate the fly population for ten years or so in these areas.

You’ll recall that the control technology was to interrupt transmission of the disease by killing the larvae of the black flies in the river, which are breeding in the highly-oxygenated water of rapids, and then to do that over a huge area. Well, if the flies always come back and re-infect these rapids, then that thing is going to fail. In addition, resistance to the only pesticide which was used, temephos, had emerged. And the feeling that this was a complete loser, this OCP project.

ZIEGLER: This point is around the early 1980s?

LIESE: Yes, the early 1980s. OCP had established an independent commission to make proposals. The report said that OCP probably has to enlarge the epidemiological area of control and so on. I don’t want to go into detail. And in the end, it was decided that there was no reason to give up, but that one had to enlarge the program. Furthermore, a decision was taken to prepare a long-term strategy for the program.

And I got involved, hands on, in the long-term strategy of the program. I actually did the costing, with a colleague of mine, and ever since until today I have been involved. And despite the fact that I’ve had various jobs in the Bank, I’ve always kept one foot in that program. I have to say I dearly love it because it is an extraordinarily successful program. But it is not the success only. OCP can provide a lot of lessons for how one operates an international disease control program.
ZIEGLER: Such as?

LIESE: The program survived when resistance emerged because it had wisely decided to investigate in operations research. Yes, there was only one pesticide available for operational use. But the program had gone ahead quite a while ago and tested other possibilities, so they could switch to a different pesticide.

Sorry, I said temephos before; Abate, it was the one for which resistance emerged. Abate. So temephos was suddenly available, et cetera.

There were different pesticides which could be tested. The program had the methodology in place to test them, which consisted—you will chuckle—in Bobo-Dioulasso airport, there were barrels, you know, 20 barrels with water. The choppers are flying over them, laying their beam over them with different pesticides. And then when they saw what the larvae kill rate was, they could then basically predict what you would see it in using it on the rapids, measuring how effective that would be.

OCP are equally invested in technology to check what the water level was. Formerly someone was running, measuring the water, but that’s difficult if you have thousands of rapids. OCP now has put in buoys, and they beam the water level to a satellite, and then the signal was picked up by the chopper and . . .

ZIEGLER: Somewhat high tech, in other words?

LIESE: High tech. The program has developed a combination of high tech and low tech, with fly catchers—people sitting with their bare legs on the river and, you know, waiting until a fly came and then catching it. But the most important one was that the program had always had this “let’s look at what else we could do” attitude. Let’s develop operations research. De facto, roughly 20 percent of program expenditures during these years were for operations research.

ZIEGLER: Which is fairly significant . .

LIESE: Very.

ZIEGLER: . . compared to what one would normally find.

LIESE: The earlier malaria eradication program basically spent nothing on operations research. It promptly failed. So when we were confronted with problems in OCP, there were possibilities to find ways around the problem. One very important lesson.

Secondly, the technical staff of the program were very, very competent people. OCP developed, for example, systems which were entirely new. Pesticide rotation schemes, which are now used in agriculture, but they came out of the OCP. They basically assumed that the pesticide
eventually becomes subject to resistance, but then after a while the resistance might fade away due to the change in fauna and flora, so maybe one can rotate pesticides, use them according to a particular pattern.

ZIEGLER: Because the fly population probably turns over quickly, the life span of the individual fly .

LIESE: Right, right .

ZIEGLER: . is fairly short.

LIESE: . right, short. So they tested out these pesticide rotation schemes and, lo and behold, it worked; a big step ahead in general resistance control.

So OCP did a long-term strategy and shared it with the donor community--Bilsel Alisbah was, at the time, the vice president responsible for OCP--but the donor community, which had been supporting the program, was still sitting on the fence. And Bilsel then said, “Why don’t we do a plan of operations as well? A long-term strategy and, in addition, a plan of operations.” So the Bank helped in terms of the political assessment to keep the donor coalition together, you know, sensing where the shoe pinches—right?

ZIEGLER: Yes.

Which were some of the agencies and donors who did participate?

LIESE: There were about initially 18 or so, including USAID, the Germans, the U.K. and France, all the large kind of donor nations were sitting around the table. That was really a collection of “Who is Who” in the field of health assistance.

I just want to make one more point on the program.

ZIEGLER: Yes, please.

LIESE: The aerial operation—spraying of the rivers—was done basically until the early ‘90s. And then ivermectin, a drug, became available, with which you could basically kill the microfilariae—the baby worms—which were responsible for the transmission, which was a major, major advancement. We still would like to kill the adult worms with a drug but we don’t have one. And suddenly the program was able to shift from what you would label as a high tech control, by chopper, to a community-based approach. I mean, you have never seen a shift from the left side of the spectrum to the right side of the spectrum by any comparable program.

ZIEGLER: From high tech to low tech, in other words.
LIESE: From high tech to low tech to behavioral and community-based distribution, which means that the communities organize it themselves. It didn’t cause trouble or anxiety amongst staff. It was something new, maybe a better idea to work with. One has to hand it to OCP staff colleagues because their reaction was strictly professional. They said, “If it works better, then let’s move in this direction.”

ZIEGLER: I believe it was indigenous people, local people, who were trained to distribute the drug. Am I correct?

LIESE: Yes. Actually, they were selected by the community. So one goes to a community, to the chief, and says, “This is the situation. Could we have a ‘palaver’ about it?” And then the chief of the village or the elders elect a community distributor, so that everybody gets the drug. The whole implementation mechanism is basically woven into the village.

ZIEGLER: Was it well received at the local level?

LIESE: Very well received.

ZIEGLER: So they understood the advantages?

LIESE: Oh, yes. Actually, the technology is now widely used for other disease control programs.

Interesting. When the basic studies on community-based distribution—ComDT—were done by TDR—the tropical disease research program. We did studies in Africa and in India. It worked everywhere in Africa, but ComDT didn’t work in India due to a caste society and issues of responsibility. The issue in India was: who is responsible? It’s not my responsibility, the community felt; it’s the Ministry of Health. It was a culture element with them.

Maybe—and the last point on the oncho program is—well, two more points. The program always had a three- or four-day meeting every year with all the donors, which was highly technical. And a lot of people asked why we do that. But I believe it was very important because you involve the donor community into the real technical decision. And it was totally transparent. So there was no whitewashing on marketing. People said, “Well, call a spade a spade.” And so a culture was developed amongst the donor community which was one of trust; one should not underestimate that.

The donor community has stayed with that program for the last 30 years. And we were in December in Brussels, and we extended the program until 2015. We were thinking that a lot of donors would drop out and that we would have a shortage of funding. On the contrary, we asked for $50 million additional funding; we got $95 million additional funding. So I think maybe the human aspect of—it’s understood that that is a family and that family has certain responsibility and that there is complete clarity and visibility and transparency within that group, so people stick with it.
ZIEGLER: On what other constituent bodies of WHO-executed multi-donor projects did you represent the Bank, and of what did your duties consist on these constituent bodies?

LIESE: Well, the one where I represented the Bank for many, many years—I think 20 years—was the Tropical Diseases Research Programme—the UNDP-WHO-World Bank program in training and research for tropical diseases. That is a very important, has been a very important program in the health field because it basically has provided the research underpinning for many of the disease control operations.

ZIEGLER: What were the major challenges in managing and implementing multi-donor projects, and how did you address them? You’ve touched on this, certainly, in your discussion of the riverblindness, but perhaps just focus a bit on that specific issue.

LIESE: Yes, I did TDR—tropical disease research. I as well did acute respiratory infections. There were several other ones. And when HIV-AIDS started, I was responsible for that one, too. So I have done my share of sitting in board meetings of programs; quite a few, actually, over the years. Sometimes the issue has been to represent the interests of the Bank. I’ve had a very cordial relationship with WHO, despite the fact that we were not always of the same opinion. WHO was, for example, over the last decade very interested to mainstreaming TDR, which had been a separate program, into WHO. We were not.

ZIEGLER: TDR is . . . ?

LIESE: Special Programme for Research and Training in Tropical Diseases. To mainstream that program into a WHO division, basically. The program was not constructed that way. The program had its board. It had its donor community. The program had its statutory bodies. It has independent funding. And so it would have not have been a wise idea to make TDR a WHO unit. Why would you do that? Only for reasons of turf. So we had to quite clearly put the foot down and say that is not going to work. Keep TDR separate.

I actually chaired the only donors meeting which we ever had for TDR in Paris. And initially that donors meeting was opposed by the World Health Organization just for territorial reasons. [Dr.] David [L.] Heymann didn’t like it. And we walked away with literally doubling the budget of TDR. But so strong are the various turf issues, the we control or you control, because the Bank has been seen by WHO very much as a competitor. It has not been seen as a collaborator. Wrongly, actually. And so one had to maneuver a little bit on these accounts.

ZIEGLER: In July 1990, you became director of the Joint Health Services Department, which serves both the World Bank Group and the International Monetary Fund. How did that appointment come about? And to me this is particularly interesting because you were obviously involved in many operational aspects of health services, health delivery for member countries, and here your focus suddenly shifts to the internal aspects. So it would be interesting to hear how the shift came about, from your perspective.
LIESE: I worked under the onchocerciasis program very closely with Bilsel Alisbah, because he was in charge of OCP. And so it happened that Bilsel, who had also just taken over the Human Resources Vice Presidency, was confronted with an issue: the director of the Health Services Department, Michael [H. K.] Irwin, who came from UNDP, had somehow provided material for an unbelievable article which appeared in The Wall Street Journal.

ZIEGLER: I recall that very well.

LIESE: Yes. That was kind of shocking.

ZIEGLER: He was highly critical of many Bank practices, as I recall.

LIESE: Very, very critical. That was really a totally unfair, nonsensical article, but it did a lot of damage. He obviously disappeared. He actually disappeared. He wasn’t fired. He disappeared. And so Bilsel was left with the fact that he needed to have somebody to run that internal Health Services Department. The qualifications for that were—because it was a demoralized lot at the time—that one had reasonable managerial qualifications, that one was a loyal Bank person, and one would not write further articles—be “illiterate.”

[Laughter]

LIESE: So Bilsel came and asked whether I would be willing to do that for a couple of years.

ZIEGLER: And what was your perception of the atmosphere in the department on your arrival? You say it was demoralized. The staff was feeling pretty down about the whole Michael Irwin affair?

LIESE: Very much so, yes.

ZIEGLER: So it did have a real effect on the morale of the department.

LIESE: A very real effect on the morale of the department. There are many dysfunctional features of that.

And I went to Ernie Stern because there was an agreement which I had with Bilsel and senior management. I didn’t want to go permanently to a service department.

ZIEGLER: Which the Health Services Department is, of course.

LIESE: Right. And I said, “I’ll do that but I have one condition: that I can do 20 or 30 percent of my time still doing operational work, because these are the things which I know and which I like. And that’s why I’m here at the Bank.”
And Bilsel said, “That is fine. So two years, a maximum three years.”

ZIEGLER: Weren’t you kind of sticking your neck out? Because managing a department would seem to me to be a full-time job. I mean, you’re obviously a very talented individual, but even a person of your stature can be stretched, or over-stretched a bit, perhaps.

LIESE: Yes—no, I was very clear. That was somehow—I didn’t see myself as being corporate medical director, you know, for the next ten years, which actually happened . .

ZIEGLER: Yes.

LIESE: . . later on. So I had that agreement.

And I went up to Ernie Stern, and Ernie said, “Well, the department is treated almost like a soccer ball that is pushed around from one corner to another one,” which was true if you looked at the history. And there were very peculiar dysfunctional features in the department. How they had emerged, I do not know. The nurses had decided that they were so overworked that they had to take two-hour lunch breaks. Nobody in the Bank has a two-hour lunch break. And it was a very complicated kind of place.

ZIEGLER: The Health Services Department is unusual in the Bank in that it serves both the World Bank and the International Monetary Fund. What were the particular challenges of that arrangement, and how did you proceed to address them?

LIESE: That actually caused less problems than I ever thought—the dual ownership—because one had simply to talk with the folks over on the other side, which I did. And we established a very close relationship on the Fund side. So they left us a tremendous flexibility and were really an excellent customer, or client.

The challenge with the department was to make the department into something which would be functional. And that was actually a big challenge.

One opportunity would have been to, basically, re-staff the department and find new folks. I decided not to do that. I thought that it would be easier to work with the present staff which was there to—and provide a framework in which that staff could see itself functioning. And so we developed corporate objectives, goals, you know, visualization of sailing ahead of the crew, you know, and many of these things which you might have heard. And we involved quite a number of consultants, initially, to help us in retreats. So we did a lot of servicing ourselves. I think that paid off because de facto, except for one colleague years later, nobody left. And the department changed its perspective considerably. We built as well up the notion that we would be a service department, which tends to be forgotten sometimes. So, therefore, the customer is always, always right.
**ZIEGLER:** Indeed, that was going to be my next point, which is to discuss your client-oriented approach as it related to the Health Services Department.

**LIESE:** The Health Services Department is a service department. Physicians and nurses have always the tendency to become self-centered, to decide what is—because they tend to know, or believe they know, that they know what is right and that, therefore, the patient has to act in an almost slavish way: I tell you what to do, and you do it. That cannot be the attitude of the Health Services Department. It cannot. It would be deadly.

So the notion was to change it around almost like a hotel system, to make the customer comfortable. Look at what they want. Look at what they require. And then respond to that. So there were a lot of discussions with operational divisions in the Bank. And so we got accepted rather quickly.

**ZIEGLER:** It seems to me that the outsourcing mania of the past few years, the Health Services Department, given its function, should have been vulnerable to outsourcing. How is it that the department has remained intact?

**LIESE:** Well, the outsourcing issue became very, very, very prominent. There was a lot of pressure.

**ZIEGLER:** About when did that start?

**LIESE:** That started almost a year after I had taken over.

**ZIEGLER:** So about 1991?

**LIESE:** In ‘91 or ‘92 there was a lot of pressure to outsource. And we resisted that, not because we wanted to protect the jobs of the boys or the girls. And no, we went systematically around and looked at best practice in the sector in occupational health. That actually helped. We went everywhere, to Boeing, to Exxon, you know, to Philips in the Netherlands. We looked really around what was done. And then—we had relationships. We could marshal people in to help, if needed, to look at particular issues.

And secondly, it became very clear that you would have many more possibilities to maneuver around if you would have services in-house. People liked that, actually.

Then we looked at the cost implications, and calculated that and, lo and behold, it turned out that it would actually be cheaper, considerably cheaper.

And there was pressure. There were pressures from colleagues which principally were on the health side to outsource, in the same vein like, you know, sector reform—private sector. That’s the way it is. We resisted that. But it was sometimes a tough battle in the Bank. And it turned out—it turned out that it worked really quite well.
ZIEGLER: During your time in the Health Services Department, you implemented an increased communication program with staff of the Bank and the Fund. What were the improvements in the existing program’s communication that you sought to implement, and how did this program evolve over the nearly ten years that you were director of the department?

LIESE: We put a lot of effort on communication because you have to, using various media, not only one, so Health Beat and the travel web page was developed, et cetera, et cetera. So we used a lot of effort of communication, which paid off because it is exactly what you do in the private sector. You market your business, and then people relate to it. And as I said, multimedia, different venues, conferences, Health Beat, but maybe the most effective communication program for the department is actually not a media per se, like an article in a paper. But it was the fitness program.

ZIEGLER: Which we’ll get into.

LIESE: Yes. Because that really was associated with the department, and you recall that we grew it up systematically and marketed it as part of the department.

ZIEGLER: An article appears in September 1992 issue of The Bank’s World entitled, “The Issues of Work and Family - A Conversation with Dr. Bernhard Liese and Brian [Francis] Donnolley.” The introduction to the article states, “Perhaps no recent internal Bank initiative has interested staff as much as the Report of the Joint Working Group on the Work-Family Agenda for the World Bank. The report is the culmination of a one-year study by a working group comprising of members appointed by the Staff Association and the Office of the Vice President, Personnel and Administration. The World Bank Volunteer Services was also represented. Dr. Bernhard Liese, Director of Health Services, is the group’s chairman. Brian Donnolley, Personnel Services and Compensation Department, is the group’s secretary.” According to the article, the report proposed three clusters of recommendations that are directed at, one, creating a more flexible working environment; two, creating a more family-supportive environment; and, three, implementation and culture change. Viewed now retrospectively, what were the practical accomplishments of this working group?

LIESE: The compressed work week maybe is the most visible.

ZIEGLER: And I was the beneficiary of that, personally.

LIESE: Yes, it was an initiative of Bilsel’s, which originated, actually, in the Staff Association, if I recall. And Brian Donnolley, whom you know, had an almost encyclopedic knowledge of these issues. So he was an extraordinary help.
We went around and looked at, again, practices of other organizations, and we all were almost shocked to see how archaic we were in terms of dealing with our staff. And so the working group set out systematically to improve the working conditions of staff; the issue was not to increase the productivity. The goal was to improve the working conditions for the staff in their own right. There were many areas in which that could be done, and so we basically packaged it, the final report on the work and family agenda.

ZIEGLER: You were fairly certain that you wouldn’t result in a reduction of productivity, though, I’m sure.

LIESE: Yes. Because we had seen everywhere where we went that there was overbounding evidence, nationally and internationally, that these had made working conditions better. And it catered to the change in the work environment.

It went to the Bay Area in San Francisco because there were enormous traffic jams at that time, which are coming here to Washington now. Well, therefore on the West Coast the question of flexible work hours had to be explored because there wasn’t really any alternative—or working from home and possibilities of that nature.

We had here at the Bank specific areas which had to do with the nature of the G-4 [visa] status of the Bank which had to be dealt with as well. Employment! Because we don’t really look at spouses if they find a job, or you do not find a job. So you needed to deal with employment possibilities as well and facilitate that.

So we looked at the work life of Bank staff, particularly colleagues who came from abroad, their different needs. And we came up with this booklet, The Work and Family Agenda, which has quite a number of recommendations. Practically all the recommendations got accepted.

ZIEGLER: Now who would have been responsible for accepting them? Presumably Bilsel?

LIESE: Bilsel accepted them. And it was going to be a joint undertaking with the Staff Association.

The recommendation which was not accepted was the compressed work week. That was something people felt that was too radical. And then . . .

ZIEGLER: Although, eventually, that did get implemented.

LIESE: I’ll come to that in a minute. And the other recommendation had to do with phased retirement, that basically you could work on a part-time, phased-in retirement. And I, personally, think that still would have been a good thing to do in hindsight because that is what actually has happened—right?

ZIEGLER: You and I are examples of that.
LIESE: Exactly, exactly. So the compressed work week was something which people said, “Well, that works for Exxon, that works in the Federal government, but that can’t work in the Bank because people are here all the time. And if you do that, we will reduce productivity.” There was quite a disagreement about that. And we finally could persuade Bilsel that we would take ten departments and do a pilot study. That we got through.

So we did the pilot study. I have forgotten whether it was a year or nine months. But it was a considerable time for the proper evaluation. Boy, did we spend time on it. And the results were extraordinarily positive. So nothing of the concerns which were expressed earlier were valid; we could verify.

The one concern, though, which turned up, which had to be dealt with, was that support staff could see that as an “entitlement” and that we were clearly advising managers that this is a “work accommodation” not an entitlement.

ZIEGLER: Now, you’re talking about the compressed work week?

LIESE: Compressed work week. And not an entitlement. And for support staff, that is a work accommodation and not an entitlement. And today you see that that part of it, in my view, hasn’t been systematically managed. You find problems in the support staff side. That’s what we had seen in other institutions. Where that was properly managed, the issue wasn’t there. But for the professional staff, we could find no downside to it.

ZIEGLER: How would one properly manage that, in your view?

LIESE: By basically insisting that people are there, you know, during particular times. Or there are agreements that somebody else covers.

It has been my observation that managers in the Bank don’t manage the support-level staff. But that wasn’t the issue which was at the table at the time. The issue on the table was: “Bank staff will work less. We can’t do it.” Jessica [P.] Einhorn was dead opposed to it, for example. And so we presented the results to the vice presidents, and it was turned down.

ZIEGLER: Even after the experimental pilot study?

LIESE: Turned down. And then we went—I convinced Bilsel (and then later on [S.] Shahid [Husain] came) that we should continue the pilot. And Bilsel said yes, and Shahid then agreed that it would continue.

So we did a second evaluation six months later or so. We went one-and-a-half years into it or almost two years. It showed exactly the same trends. And we went up then to Shahid, to the vice president. And Jessica went on a rampage. Sorry to say that because I shouldn’t say it. She was totally convinced that this was destroying the Bank. So we got stuck the second time. But
the notion was now that we had to continue the pilot for the units which were on the pilot. It would have really caused an uproar if we would have taken them off. So Shahid said continue. And then three months later or so when [World Bank President] Jim [James D.] Wolfensohn was in a good mood, Shahid and myself went to Jim, and then it was agreed upon. I mean this was really a forceps delivery. This was truly a forceps delivery.

ZIEGLER: Sometimes those result in birth defects. Not in this case, luckily.

LIESE: Yes. And later on it became a really popular part of the Bank’s culture.

ZIEGLER: Yes.

LIESE: People really appreciate it.

ZIEGLER: Now, I note that it wasn’t applied uniformly throughout the Bank. For instance, my understanding was that HSD [Health Services Department] itself did not adopt the compressed work week.

LIESE: Yes. We left it to the divisional managers to agree whether it could be adopted or not adopted. And some small departments, like HSD, had actually difficulties to do it. And we asked—in HSD I asked, as you recall, around whether we wanted to do it or whether we didn’t want to do it. And then the majority of folks said, “No, that’s not for us.” And so it happened.

ZIEGLER: One of the most popular programs sponsored by the Health Services Department is the corporate fitness program, which you mentioned briefly earlier. It had relatively modest beginnings in the mid-’70s, but is now, as I understand it, it is the largest in the U.S.A., with approximately 4,300 members. Please relate something of the initiatives that you undertook with this program and how it evolved during the time you were director of the Health Services Department. I can recall some articles in the Bank’s—in fact, in the 1970s, in *Bank Notes* showing some disused room in the old N Building being used at lunchtime for exercise purposes. I mean, this is just a bare floor with carpeting, and people in exercise gear just doing calisthenics and the like.

LIESE: We had three locations when I came. There were three little rooms and two people who had been hired from outside, part-time, to be something like fitness instructors, or whatever you call them. We had one in the I Building, one in the Main Complex, and one in the Africa [J] Building. Tiny little areas with a little bit of equipment. And then we had a group of volunteers who were very articulate, who were basically aerobics instructors. That was the fitness program. And it was characterized by a really aggressive attitude of some of these fitness instructors, who are now my friends, but one called me—I don’t—I will not repeat what she said. She regrets it these days. So they were managing the place. But it was really, truly dysfunctional.

The new MC Building was going up, and somewhere on the third floor below ground, in the garage area in the plans, there was an area in which a larger fitness center should be constructed.
But there was roughly only an area which was dedicated for them, no allocation or anything. It goes to the credit of Bilsel Alisbah, who really supported me there. We said, “Look, corporate fitness is something which is really coming up these days. That’s something which we need to provide. Why don’t we try to find a room, a space where we could anchor a corporate fitness center? A decent one.”

Well, we looked around and then, as you recall, we found some space near the Archives in the H Building. And there were some fitness instructors who were really quite competent in other areas. One of them, Clare, had developed quite some architectural knowledge. The idea was maybe one could hang really a fitness center into the two floors with three levels, and things like that. That was dreamt up internally. That wasn’t an architect from outside. Just scouting around.

Then I went to Harinder [S.] Kohli, who was, you know, in charge of the facilities at that time, and said that I’d be willing to trade this very wonderful space in the new MC Building if you give me that H Building area.

ZIEGLER: Now, this is around what year? The mid-‘90s?

LIESE: Oh, that was earlier, around ‘91 or ‘92. It was quite early. And Harinder, whom I knew very well personally, said, “Yes, I want that, if that is okay.” He said, in principle, “If Bilsel agrees, I can do that for you. It’s easier for us.”

I went to Bilsel and asked whether he would be willing to give us something like $1 million. Shocking. And we would repay once the fitness center was up. We would. So, basically, that he would, from the capital budget of the Bank, allocate about $1 million for the construction of a new fitness center. And Bilsel was a very strong supporter of that. Bilsel said, “Why don’t we do that? You can go ahead. But it has to be amortized later on and repaid on schedule.” So we then got an architect from GSD [General Services Department] and so on, and I went to the details. And the Fitness Center was built.

You cannot believe—you cannot believe the kind of aggression and accusation and anger which came from part of this fitness community. Bilsel got it often, but I got it all the time: “That is incredible. Why is it in the H Building? That is complete nonsense. That takes us ten minutes to go over there. You know we can never do that during the lunch break.”

ZIEGLER: For the record, this was in the basement of the H Building.

LIESE: In the basement of the H Building.

ZIEGLER: The first level down. Right around the corner from where I worked in the Archives. Exactly.
LIESE: Yes. And so Bilsel and I did walks, walks from the Africa [J] Building to exactly that area. Both of us. Believe it. And timed it. With green lights at the traffic or with red lights at the traffic lights.

ZIEGLER: So you crossed—for the record, you crossed two streets.

LIESE: We crossed two streets.

ZIEGLER: And then, actually, three if you’re going to go from, you cross 18th to 19th and then G Street, too.

LIESE: Yes, yes. And we came up with something like maximum three minutes or so. But look at it as to what extent we had to go to deal with this argument—right? Look at the vice president and the director of the service walking to check it out. There was a lot of hostility around that. Even with the elevators, that the elevators were too little and wasn’t fast enough. It showed a very unfriendly, unfriendly—it showed the underbelly of the institution and the thinking about of entitlement and egocentric thinking, really. And very, very surprising. I would have never expected that. But it was a big issue. Sometimes Staff Association got involved. But we muscled it through. Once the Center was open, all aggression collapsed because the center was beautiful. The hostility collapsed. All the hostility collapsed and there—people were saying, “Oh, wonderful!”

Some of the design issues had to do with colleagues, you know, Clare Fleming, and several of us, including myself, looked at the tapestry for the wall—there was a lot of volunteer work involved—and we came in at $890,000. But once this thing opened, it was wonderful. And it is wonderful.

And then we started to build up a really first rate facility, and I hired a contractor from outside who had been running facilities as an adviser. And I was very lucky to find a manager for the Fitness Center, Mike [Michael] James from Australia. He was recruited in Australia. And his relaxed Aussie attitude and his laid-back approach, it just fitted that outfit.

We started charging a decent membership fee, $10, initially. And we kept it for almost . . .

ZIEGLER: Ten dollars per month?

LIESE: Per month.

We let people screen membership cards at the entrance, so we could get decent statistics. And we built up the number of classes to 60 and membership to almost 4,000 people.

It still is wonderful. It has been enlarged recently, as you know. We took part of the remaining space after Archives moved out. I like to go to the Center. These are my most fond memories of the Bank, because many of the fitness instructors, that group became almost a family because it
was joyful and energetic. And I would have to say that I really liked to have worked with that group.

ZIEGLER: And the Fitness Center has been hugely popular with staff over the years also. I know that.

LIESE: Oh, yes, oh, yes.

ZIEGLER: In November 1994 the Health Services Department began an aggressive campaign to make mammography available to staff, bringing in the medical technologists, radiologists on contract and state-of-the-art equipment needed to implement the campaign. What led you to take this initiative, and did it prove to be successful over time?

LIESE: Well, we started in the department one area of work which hadn’t been there. Probably because I had seen it in many other programs, we started occupational health research. We wanted to have an idea of what was the state of health of the Bank staff, so we did a report on that, and we created a research capability. And it turned out that from all angles in which we looked at it, we had relatively high rates of breast cancer for our staff. Now these are difficult things to state, and we compared our staff to reference populations. It turned out in hindsight that we were slightly above it because later on Dr. Bernard Demure re-did the study. But it showed that we had a relatively high rate of breast cancer and we had a very low utilization of our staff on mammography service, preventative service.

So we decided that we would really systematically push mammography, and the easiest way to do that was to provide mammography services on the premises. The equipment wasn’t particularly expensive. We could contract the radiologist. So it was very convenient for folks to come. And it worked quite well.

You know that mammography services are no longer provided on the premises. That has to do with the change in the technology and the cost of the equipment. It would have become really extraordinarily expensive and complicated to run the new mammography machines here on the premises. One would have had a much larger group here to do that economically. That’s the reason why Bernard Demure reluctantly decided to stop the service four years ago. But initially that service helped us dramatically. It helped in establishing that mammography screening was absolutely important. We got firmly entrenched. We had as well communication sessions with breast cancer survivors, et cetera, et cetera. There was a lot of breast cancer around the Bank.

ZIEGLER: I recall reading that the Bank seemed to have a higher incidence of breast cancer than the general population.

LIESE: Yes, it did.

ZIEGLER: But this program, over time, an improvement in that trend was reflected as . . .
LIESE: Oh, yes, oh, yes, oh, yes.

ZIEGLER: . . a result of this program?

LIESE: Yes, later on we basically—the mammography rates of Bank staff, which were in the 90 percent. So almost everybody went.

ZIEGLER: During your time as director of the Health Services Department, the Bank undertook a significant process of decentralization. This is under Jim Wolfensohn, where things really moved out to the field. How did you address the challenges of providing services to staff in the various country offices?

LIESE: It was complicated. The staff in the different offices had basically to rely on their own health systems. But we then went out and negotiated in the context of some of the UN organizations, sometimes joint service agreements. We tried to provide as well reference physicians that people could go to.

The department took over as well the Medical Insurance Plan for our local staff abroad—the MIP—which was, basically, initially a medical assistance plan. It was not insurance. We rebuilt it into an insurance plan, which provided basically an almost equivalent insurance coverage than we had under Aetna or whatever in the Bank.

ZIEGLER: The Staff Association, through its Health Issues Working Group, has long had an interest in matters of health as they relate to staff. How would you characterize your working relationship with the Staff Association, and how did it evolve over time?

LIESE: I think the relationship with Staff Association on the whole was quite good over the years. They were very supportive in complicated areas. Sometimes there were challenges, but we sorted them out. And it’s best maybe characterized that we in the department always saw that the Staff Association was one of our major constituents, one of our major pillars on which we had to lean, and so we behaved accordingly.

Stress Among International Business Travelers." *Occupational and Environmental Medicine*, 1999;56(4):245-52]. Were there any other areas of study that deserve mention?

**LIESE:** We looked, obviously, at environmental health issues, to what air quality—we had a contractor and all this stuff.

**ZIEGLER:** I recall that, yes.

**LIESE:** Yes, the outcome was that we published quite a number of papers. We looked at the way in which we were sitting in front of the table because back pain, I think, still is the most common problem in the Bank. And we noticed wonderful situations, for example, women try to adjust their workstations. They complain loudly but they adjust their workstations so that they sit more comfortably. Men never say anything. They don’t complain, and they never adjust the workstation. So we had to laugh about some of these—about some of the outcomes of the study. It showed a very interesting spectrum. And then we added them. As you know, Danni [Danielle] Ali, who basically ran our Workstation Improvement Program. So we really provided decent data on how one would adjust workstations.

**ZIEGLER:** I guess that answers, at least in part, my next point, which was: did these studies lead directly to any changes in the working environment and conditions in the Bank through this?

**LIESE:** Yes, yes, in terms of the—equipment was—different equipment was purchased, et cetera. So there was some.

**ZIEGLER:** Okay. So there were .

**LIESE:** Oh, yes.

**ZIEGLER:** . far-reaching changes.

**LIESE:** Oh, yes, far-reaching changes in terms of—we discussed them with GSD, and the different height of the chairs, et cetera. So it was quite a bit.

But the most interesting study I have ever done, and I still believe that is one of the highlights of my professional life, was the study on business travel.

**ZIEGLER:** Business travel?

**LIESE:** Yes, because the Bank has this enormous—enormous number of business travels. And so we—since we were dealing with the Bank MIP in an advisory function, we said, “Couldn’t we look at the data in terms of utilization of particular services of our own Bank staff?” This, in itself, created tremendous difficulties because you had—you couldn’t look at individual records like that under the confidentiality agreements, would have been impossible. So we negotiated
with the insurance company that the data would be coded, became anonymous, would go through a third party, and then it could be analyzed. So you had, basically, numbers. You didn’t know who . . .

ZIEGLER: Not individuals.

LIESE: You could not figure out. That was an enormous difficulty. It took us almost a year to get agreement with all the authorities and the confidentiality agreements. But once that system was in place, we then could certainly work with this data. And then we looked at stress and the business traveler. And we noticed that the consultations for mental health dramatically increased with the number of travel days. We published that as a paper [Liese, B., K. A. Mundt, L. D. Dell, L. Nagy, B. Demure. “Medical Insurance Claims Associated With International Business Travel.” Occupational and Environmental Medicine, 1997; 54:499-503]. That is a paper which has received wide international attention. It is one of the few studies which demonstrated the risk of business travel. There were reports in all kinds of publications, The New York Times and all over the place it was.

ZIEGLER: And if anything, I would say travel stress has probably increased. I mean, just in my own personal life, I find air travel a lot more onerous these days than say 10, 15 years ago. After September 11th, things got dramatically worse.

LIESE: Much, much more. So I think it would be very interesting to redo this study and see the situation today. I think it is a very important study. I would love if the department would continue to work in this area.

We had then as well a big—a big meeting on stress and the business traveler with corporate directors of different companies and the airline occupational health directors. And what came out is that this is an issue which a lot of people have felt and know about, but which isn’t really systemically documented. I have to say that that was one of the highlights professionally.

ZIEGLER: You did not confine yourself to purely internal matters during your period as director of HSD. As you said, you wanted to spend roughly—what—30 percent of your time on operational matters.

LIESE: Later on that was 10 percent, you know, because I didn’t have the time any more.

ZIEGLER: In 1992 you represented the Bank at the Ministerial Conference on Malaria held in Amsterdam convened by the World Health Organization to define a new global strategy for malaria control and stimulate new efforts to control malaria around the world. What was your particular role in that conference?

LIESE: I had been working before I came to the department on Brazil, Indonesia and Madagascar, as we talked about earlier, in malaria control. And we had basically looked at malaria as an occupational disease and had proposed the notion that we should look at patterns of
disease transmission. So you could have coastal malaria. You could have malaria in areas where gold miners were. You could have malaria in rapidly-urbanizing populations, et cetera, et cetera.

That notion, which is basically a different epidemiological concept, owes its origin to Dr. Agostinho Cruz Marques of SUCAM and Dr. José A. Nájera of WHO, and the three of us looked at that. We decided to write a Staff Working Paper on patterns and policies in malaria control, and that was just ready a year before the conference. Lo and behold, it became the background paper on new approaches to malaria control, one of the background materials for the ministerial meeting on malaria.

And so I represented the Bank there. Obviously there was a great interest because in the years before I had been involved really a lot in malaria control. And it was a very successful meeting. It was a very, very important meeting.

ZIEGLER: The conference defined the four basic elements of the global strategy for malaria control as follows: early diagnosis and prompt treatment; implementation of selective, sustainable, preventative measures, including vector control; early detection, containment, and prevention of epidemics; and fostering regular assessment of affected countries’ malaria situation, especially the ecological, social, and economic determinant of the disease by strengthening local capacities for basic and applied research.

You coauthored a background paper for the conference which was published as *Malaria, New Patterns and Perspectives*, Technical Paper No. 183. I think this is the one you were just referring to.

LIESE: Yes.

ZIEGLER: I found two passages to be of particular interest: “At the beginning of the malaria eradication program, a major effort was made to train the personnel needed for the program. But as programs became staffed, and because malaria was expected to disappear soon, manpower resources, especially young professionals and technical staff, became increasingly scarce. It has been said that the global malaria eradication program did not eradicate malaria, but did eradicate malariologists. Moreover, training for eradication was definitely oriented toward the execution of the highly-standardized program, task, and operations. The training of malariologists did not give them epidemiological background needed to adapt to changing situations, to solve problems, to manage uncertainty, or to adapt or change control approaches and strategy.”

And you write further, “Funding for malaria control programs shrank when people began to recognize that malaria could not be eradicated, when the basic health services approach to developing a health infrastructure did not succeed, and when no successful models developed for incorporating malaria control into the primary healthcare strategy. Malaria and general public health services exhibited a nearly universal reluctance to define or to redefine their responsibilities towards the malaria problem.”
It sounds as if malaria control was in serious trouble. Did the global strategy for malaria control formulated at this conference improve the situation with regard to malaria control?

**LIESE:** Yes, it did, because it basically provided the official recognition that malaria control was in trouble. Before the conference there was a kind of laissez-faire attitude toward malaria control. Eradication had failed. We had integrated it into general health services. So why don’t we look the other way? But the data coming from every country in terms of prevalence was that malaria was going up, so you couldn’t look the other way. And that conference was, basically, the recognition we are in trouble. We have to do something about it. These are the dimensions along which we have to go. It did set the stage for the future of malaria control. It took another almost five years before the control activities started on a larger scale, almost until Ms. [Gro Harlem] Brundtland came to WHO and started the Rollback Malaria Program. She institutionalized things. So the follow-up of the conference was relatively slow. On a country-by-country basis, plans were made, but the international movement was slow. Five years later, it started to gain in momentum. But it was an important historical event.

**ZIEGLER:** Well, we’re now at the point in the interview where we can do some summing up, I think. From your perspective, what were the most important lessons learned, both from a personal and institutional point of view, during your career at the World Bank?

**LIESE:** Well, from an institutional point on the project side, on the lending side, I think one of the things which I’ve taken away is that the—in terms of interaction with different cultures, one has to develop a great sensitivity and tolerance. And the Lord has given us two ears; therefore, it is useful to listen. And he’s only given us one mouth to talk. So maybe one should use two ears more than the one mouth. I think it is very important in dealing with different cultures and different settings. That is, I think, an important kind of feature of how one should look at the development.

Related to that one is every activity, project, or whatever, what we get involved in needs a local sponsor. It needs a constituency, to use a political term. It needs people who are living there who want to do that. If you don’t have that, don’t try it. If it doesn’t fit the culture, it doesn’t move. We have seen that in project after project. So you have to have a constituency who really wants to do that.

**ZIEGLER:** You can’t impose what you think is a good project on an unwilling group, in other words.

**LIESE:** Right. You can. But it won’t work. The Bank has quite a few times tried to do that. We have often suggested solutions which appeared to be solutions but in reality they didn’t really conform to what local values and beliefs are. So I think one has to be humble about the development process. That is something which I took away from my years at the Bank.
On a personal basis, I think I have learned over time to—Mark Twain said once, “I was born modest, but it didn’t last long.” And I would have to say about myself: I was born modest; it didn’t last long. But I had to re-learn modesty at the Bank.

ZIEGLER: What do you think have remained the important themes and core activities of the Bank in the course of your career?

LIESE: Well, the focus on poverty which McNamara established I think is still the core of the Bank’s work; the lending activities and how we interpret that and how we address it changed over time. But the notion that we are in the “poverty business” has remained. Poverty is the umbrella; McNamara, basically, erected that umbrella with his Nairobi speech . .


LIESE: . . right, ’73. The operational response to poverty was integrated development, integrated rural development project infrastructure, agriculture development, irrigation, you know, the social sector development. But the definition of poverty has changed now. We defined poverty in monetary terms initially, very, very effectively. You know, “one dollar a day.” And then we re-defined it in terms of dealing with basic needs. And then we defined it in terms of sector reform. And then we defined it, suddenly, as a glass ceiling, listening to the people. So we have over the decades defined poverty in a different way as an institution. We could say we have advanced in our definition. I believe so, from a very restrictive definition. That has been the core of the Bank, and under this umbrella we have been doing our activity. And I think—I hope that that will prevail.

ZIEGLER: What are the values and objectives that you think are necessary to sustain the Bank in the future?

LIESE: I think this focus on poverty, it is a value which the Bank needs to continue. But if you look back on the Bank, at least when I came to it, how it has historically developed, you had a cadre of what you would call old colonials.

ZIEGLER: Well, there is an old joke that the Americans pay for the Bank, the Indians borrow from it, and the British run it.

LIESE: Right. Yes. The—now you look at—you might look at the term “colonial.” But I’m looking at the professional competence of these colleagues which were there. We had initially a lot of people who had an enormous degree of intellectual integrity and practical field knowledge combined with political savvy—what to do—because they had been sitting in positions where it was needed.

ZIEGLER: Yes.
LIESE: And that very much colored the culture of the Bank. The focus on professional competence, and with that professional integrity, that has been a core quality of the Bank. The—I’m afraid that with the focus on economics as a discipline, the multi-cultural kind of professional features of the Bank have been shrinking. They have not been disappearing, but they have been shrinking. And if one profession starts to dominate, like the physicians at WHO . . .

I hope that the value systems will be broad enough in the years to come to still maintain this focus on interdisciplinary professional excellence, combined with political savvy.

ZIEGLER: Yes.

[End Tape 1, Side B]
[Begin Tape 2, Side A]

ZIEGLER: Bernhard, what did you like most about your career in the Bank, and what did you like least?

LIESE: If you would ask me what I liked most about the Bank, I would have to say the people, the variety of people. It has been absolutely fabulous to work at this place because you have many friends and many colleagues who come from very different parts of the world, who speak a different language, think differently. And you can work collegiately under the same roof. And you learn something. And you become family friends. I have found that fascinating. I think it will be very, very hard to find an institution which is similar. So that’s the reason why I have really enjoyed working for the Bank. I wouldn’t trade it off for anything.

In addition, you had the fantastic opportunity to actually shape development on the country side, helping people to move ahead. So that is—I consider the project part of the Bank a wonderful opportunity as well.

The bureaucracy of the Bank, particularly on the financial legal side of the Bank, as a trust fund manager is something that I sometimes wonder about. The Bank has not been effective in minimizing—streamlining its own administrative functions, despite many attempts.

ZIEGLER: It’s difficult to do, I suspect.

LIESE: Yes, yes.

ZIEGLER: What do you consider to have been your greatest success, and what would you like to have done better?

LIESE: I thought the—to move the health policy discussion ahead when I came to the Bank so that we could actually start lending for health projects, I thought that was a major contribution.
And later on, shape the Health Services Department into a functional entity, to build an organization.

ZIEGLER: Well, that, just in my perception, that was a very—had a very profound impact on the culture of the institution, the internal culture.

LIESE: Yes.

ZIEGLER: Which is something that is often ignored, I think, in the history of the Bank. You know people—and they rightly focus on what the Bank does for the borrowing countries, and that, of course, is what it is here for, but that minimizes the—well, let’s put it this way, how the Bank is governed internally has a very powerful effect on how it interacts with its clients.

LIESE: Oh, yes.

ZIEGLER: And that—there is an importance, which I think is often minimized when looking at this history of the institution.

LIESE: One takes it for granted, yes. But I think the internal servicing is not an easy task. In fact, I found it very fascinating.

So these are the two areas where I think I made a contribution. And I think when we started the department, the Health Services Department, I should have, in hindsight, much more focused on the managerial issues. I was preoccupied at just getting projects moving around.

ZIEGLER: Now when you say managerial issues within the department, you mean . . .

LIESE: Not the Health Services Department; indeed, when we started the PHN department . .

ZIEGLER: Oh.

LIESE: . . and I was deputy division chief, I basically was moving project portfolios ahead. I think in hindsight that was actually—was actually not the job. I should have really systematically looked at how to build that institution, you know, to focus on the managerial side of it . .

ZIEGLER: Yes.

LIESE: . . which I didn’t because I liked the project side.

ZIEGLER: And yet, despite that, you did have a profound effect on the evolution of the health sector in the Bank and in terms of how the Bank operated in the health sector with regard to its borrowing countries.
LIESE: Yes.

ZIEGLER: Who were some of the notable personalities that you would care to mention that you encountered during your Bank career? I know you mentioned Bilsel. Was there any . . .

LIESE: Bilsel I’ve always admired for his diplomacy and competence and dedication. And I liked Shahid Husain as well.

ZIEGLER: Not everybody would say that.

LIESE: No, I know that, you know. He was sometimes not easy to work with, but I got along with him well in his own right.

Bob McNamara was a fantastic leader. And I have to say that the president, which is often underestimated, I feel, because he was so short here, Lew [Lewis T.] Preston. With Bilsel, we had quite a bit of contact with him and, boy, was he a competent manager in terms of understanding managerial dimensions that I really felt he was a very, very effective person. Later on Jim Wolfensohn came, who was with us in the Health Services Department, as you well know, always charming and supportive and helpful. And so there are—these were the upper lines.

And then one person which I have truly admired as well, Shengman.

ZIEGLER: Shengman Zhang, yes.

LIESE: He basically kept the Bank together, moved it ahead, pushed it. And obviously before that, but I had much less contact with him, was Ernie Stern. So there are really interesting people, and you could go on the division level or at the collegial level.

There’s a whole list of people who come to mind, you know, in our own area: Nancy Birdsall and Kanagaratnam. So it’s hard to figure them out.

ZIEGLER: Yes. Is there anything finally that we haven’t covered that you would like to discuss?

LIESE: No, not really. It has been fun. And thanks very much, Chuck.

ZIEGLER: Well, thank you for participating in the Oral History Program, Bernhard.

[End of session]
[End of interview]