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INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT

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Washington, D.C.

The seminar of the Executive Directors was convened at 2:37 p.m. in the Board Room, 1818 H Street, N.W., Washington, D.C., Mr. Lawrence Summers, Vice President and Chief Economist, presiding.

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P R O C E E D I N G S

MR. SUMMERS: Thank you all very much for coming to this seminar, the purpose of which is to discuss the Outline that will guide the preparation of the 1993 Development Report on Health.

Let me ask the team leader for that Report, Dean Jamison, to make a brief statement.

MR. JAMISON: Thanks, Larry.

Ladies and gentlemen, it is a pleasure for me to be here with you today to discuss our current thinking on the Outline for WDR '93 on health.

The last time that I came before the Board of the Bank was to present the Bank's first Health Project on China. That project was designed to help China's Government deal with problems resulting from China's success in reducing mortality and fertility. These successes of China in the Sixties and Seventies are now -- despite the mixed development experience of the Eighties -- successes that are increasingly share by many countries throughout the developing world.

In particular, much of the developing world must now, very much like China, address the problem of how to deal effectively, in very cost-constrained environments, with the rapidly increasing burdens of chronic disease, and in many

countries, AIDS, while simultaneously addressing the unfinished agenda associated with under-nutrition and communicable disease.

Rather than try to summarize how the Outline addresses these economically challenging issues, I would like to provide you with a sense of the process by which are preparing this year's WDR.

WDR preparation must balance three activities. One consists of background analysis and research, often resulting for past WDRs in a series of papers that were often valuable contributions in their own right.

The second activity involves interaction with technical people and policymakers, both inside and outside the Bank, to seek both their ideas for and their reactions concerning the arguments that are being developed for the Report.

And the third activity consists of the writing process itself undertaken by the core team in an extremely compressed period.

This year, our process shifts the balance of these activities somewhat away from preparation of background papers and toward a series of consultations to increase our opportunities for interaction with professionals from outside

the Bank. This consultation process is turning out, we believe, to be a particularly effective way of facilitating inputs from Part Two nationals. This consultations, on perhaps 15 separate subjects, are in part being financed from our own budget and in part through very helpful contributions from a number of governments, including Canada, Denmark, Norway, Switzerland, United Kingdom, and the U.S. Government.

We have now had the first several of them, and the indications are that this process of structured interaction with outside professionals is likely to prove very productive for us.

In closing I would like to highlight several of the main themes that we see emerging for this year's WDR. The first involves a reiteration of previous WDR messages concerning a strong win-win -- to use the phrasing from last year -- a win-win synergism among poverty alleviation, health improvements, and educational expansion.

Second, the range of institutional experiences with financing and delivery health services, including experiences from within the OECD countries, can be mined, we think, to draw clear lessons for effecting health status improvements while containing costs.

And finally, priorities both for national and

international action do emerge, I think, clearly from the analysis, and these are indicated in the Outline that was distributed to you.

Thank you, Mr. Chairman and members of the Board.

MR. SUMMERS: Thank you, Dean. We look forward to your comments.

Let me say that in addition to this discussion, Dean and the members of the team would be happy to meet with you to pursue in more detail any questions of detail about the Report that aren't likely to be of sufficiently general interest for this discussion.

Let me call first on Mr. Cosgrove.

MR. COSGROVE: Thank you, Larry.

I was interested to hear Dean Jamison's outline of the way in which your process is operating this year. I think the shift of emphasis toward direct consultations with people actually involved in this sector makes sense to me and sounds like a good change.

The topic of the Report this year is obviously important, and it seems to me that your Outline to date covers the most important aspects of the matter. I might just mention a few of those that occur to me as high priorities.

First is the recognition of the limitations of a free market approach to health care, and hence, of an appropriate role for government intervention.

Another one is the detailed attention that it gives to issues of health financing and equity. Third, the reiteration of the value of improved health in terms of humanitarian and economic conditions. Another is the focus on the effectiveness of health systems and of international assistance to the health sector. And the other one that I would mention is the emphasis on the costs of protection of domestic supplies and of health services and products.

On the basis of my reading, it seems as though we are headed toward another very worthwhile WDR.

I have several comments which I hope might be of help to the team in their further work on the Report. Let me run through those briefly.

As the Outline says, the health sector is clearly subject to market failures. The Outline leaves me rather uncertain about your assessment of the respective roles of the public and private sectors. In some places, for example, Section 1.5 in the Overview, it conveys the impression that the public sector should play a dominant role. And I have no doubt that will be essential in some cases, particularly in

the low-income countries. But in other sections of the Outline -- I would mention Section 6.3 -- you seem to be advocating a substantially larger role for the private sector.

Now, these may be matters of drafting that will be clarified in the fullness of the document proper, but perhaps Mr. Jamison might be able to assist me on this aspect and to observe your basic judgment in this question of which part of the economy is meant to do what.

It is pretty clear, of course, that the optimal balance of public and private sector provision and financing of health services will vary across countries; that striking the right balance will depend importantly on trade-offs between such factors as freedom of choice, cost containment and tolerance of waiting lists, as well as on levels of economic development. I think it would be very helpful if the paper could address those kinds of trade-offs explicitly, drawing on experience in member countries.

For example, it would be worth having some material on how effective governments have been in containing health costs while maintaining an adequate level of health services. Another issue might be at what level of economic development can the formal private sector begin to play a substantial role, thereby relieving pressures on government finances.

One topic that the Outline does not explicitly discuss is primary health care, particularly as a strategy to achieve greater coverage of remote and underserved areas. In fact, I had the impression -- and I may be wrong -- that there is almost a conscious decision to avoid use of this term, "primary health care." But the concept has dominated much of the discussion on health and development to date, and most countries support primary health care in policy and practice to varying degrees.

Given your Report's stated purpose, namely, to stimulate an informed discussion of government policies to improve health, I think it could make a valuable contribution by reviewing and, if necessary, redefining this concept of primary health care by perhaps dispelling romanticized notions of what it can do and placing it firmly in the context of an integrated health referral system.

Discussion of PHC would also provide scope for consideration of important issues currently not prominent in the Outline, such as community participation, community-village health workers, health education and promotion, and integration of health interventions.

So I think there is a little bit of useful material that could be worked there.

Part III of your Outline on Policy Reform is of obvious importance. The systemic policy recommendations, I think, are especially important in that section, and they appear sound. I do think the qualification at the end of the first sentence of the third point, namely, "appropriate to national circumstances," is quite important.

The program policy recommendations seem to me more eclectic, but they don't bother me particularly, although I do think I need some clarification of the meaning of the final section of point vi in that part of the paper.

Your section on AIDS could be worthwhile, especially the discussion of its current and likely social and economic impact, but I'd have to say I don't believe that it is the Bank's role, as the Outline indicates, to review options for reducing the spread of AIDS and for treating HIV-infected persons. I think that's one section of the Report that I would be prepared to see dispensed with. I think it is better done by other organizations.

The section on the role of the international community will be of obvious interest. I think it should discuss failures as well as successes, because we can learn from both.

And finally, I have provided Dean Jamison already

with some more detailed comments on the Outline. I thought it might be worth mentioning two of these today because they have some general interest.

The first concerns family planning. I think its inclusion as a determinant of material and child health is important. And Section 3.3 would be strengthened by an examination of different countries' policies and approaches to family planning, including the degree of integration within the health system as opposed to stand-alone family planning systems.

It would also be interesting to refer to the literature emerging on the cost-effectiveness of programs which emphasize quality of services and expanded choices for clients, as opposed to more narrow authoritarian programs.

The second point is in the same chapter, Chapter 3, of the Outline. There, the restriction of environmental factors affecting health to those that are quantitatively significant is valid, but it could also be a little narrow by ignoring other actual and potential sources of environmental pollutants which can and do affect health. I have in mind things like industrial pollutants, agricultural pesticides, working conditions, road accidents, and so on. These are areas in which a number of countries are in the process of

developing policy and program responses, and they perhaps should be covered in the document, too.

I'll leave it at that. Thanks, Larry.

MR. SUMMERS: Thank you.

Mr. Sigrist?

MR. SIGRIST: Thank you, Mr. Chairman.

I would like to make first four general remarks and then proceed with a couple of specific comments and questions. I will first come to the general remarks.

We welcome the theme of the WDR '93 and the Report's suggested structure. We also support the view that purely market-oriented government policies often fail in the health sector.

Second, although there is a role for government intervention, we should ask ourselves what role a government can play in a sector that is highly influenced by individual behavior. Paragraph 3 briefly discusses some of the behavioral determinants; yet we have the impression that Chapter 8, on policy recommendations, does not fully take account of the importance of government policies that influence individual behavior. Rather, it seems as if the role of government is limited to provide curative and, as far as possible, preventive services to a population which is a

rather passive consumer of health services.

We therefore think that in addition to direct health interventions, which seem to be the main theme of the Report, more attention might be given to indirect government health interventions, with the objective to influence individual behavior toward a more proactive approach to individual prevention and health care. This might also prove to be more cost-effective.

This leads me to my third general remark. In order to operationalize this concept of indirect interventions, we would like to see that the Report give a more extensive coverage of the importance of investing in health education. This topic is touched upon shortly in Paragraph 3.1, yet we think that it could also be highlighted, for example, in the areas of sexual education for use in adults -- I am referring to Paragraph 3.3 -- in the context of both AIDS prevention and family planning; and also, in Paragraph 4, on disease control across the life cycle.

Paragraph 8.1, on the policy recommendations, should therefore also include a policy message on the importance of investing in health education.

My fourth remark is on the relationship between health policies and family planning. This basically reflects

the remark of Mr. Cosgrove. We would also like to see that the Report acknowledges the close interrelationship between these two subjects. Here again, education, in particular for females, plays a crucial role. We would like to suggest that the Report incorporates the main conclusions of the paper on effective family planning programs, which we discussed in the Committee of the Whole on May 11th of this year.

I now turn to specific comments and questions. First, on the main messages for health programs in Paragraph 8.1, the second point on AIDS. Does it not make sense to increase preventive action at an early stage instead of waiting until there are substantial burdens of AIDS in specific countries?

The second point, also referring to Paragraph 8.1-iv, the recommendation to reallocate international support away from service delivery surprised us, in the light of prevailing institutional weaknesses in many countries in the provision of services, and also in light of the importance of the delivery of preventive health services. Maybe staff could elaborate on that question.

The third comment or question, does the Report address the specific problems in transitional economies of the new member states? In the Overview on page 1, there is

only a specific question raised with regard to health that confront developing countries and the donor community. I think we should also cover specific health problems in transitional economies in the new member states.

Finally, I would like to support the two recommendations of Mr. Cosgrove to discuss the concept of primary health care, as well as the role of community participation. And last but not least, as a reminder of the discussion of the WDR '92, we think that since the Development Report is the most widely-read publication of the Bank, we would like to see that this year's Report also condition the traditional and more general introductory chapter on the developing countries' economic prospects.

Thank you.

MR. SUMMERS: Thank you.

Mr. Syed?

MR. SYED: Thank you, Mr. Chairman.

I welcome this opportunity to share some initial reactions and comments on this very thoughtful outline of WDR '83, investing in health.

I would like to commend the choice of this subject and also the themes that the staff have attempted to develop. The first four chapters, which are descriptive, look very

interesting to me. I look forward to reading them in draft form.

I like some of the features very much. For example, Chapter 3 looks at schooling and health, nutrition, diet, and food security. I would like the staff to make a searching analysis of what is currently being done and what needs to be done in these areas.

Like John Cosgrove, I would urge attention to primary health care, which will benefit the poor and the disadvantaged. I also concur with John's emphasis on family planning. And the previous speaker, Mr. Sigrist, mention in particular education of the female to which the Bank is giving great attention now.

Chapter 4, Mr. Chairman, which looks at diseases across the life cycle, and Section 1.2, which attempts to quantify the burden of disease in terms of years of damaged or lost lives -- it holds a tragic spectacle. I found the Outline very moving, and I would like to see more elaboration.

I have two criticisms concerning Section 4.3. First, the section proposes to discuss AIDS as a sexually-transmitted disease. I will refer to it further later. Section 4.3 could mention the aphragenic [phonetic] illnesses, unnecessary infections, et cetera. These are serious for

women during reproduction -- taking birth control, et cetera. They are also associated with injections.

The Outline for Chapter 5 proposes a Section 5.2 on improving health outcomes. The synopsis for the chapter proposes to discuss the right mix of public and private activities. The topics discussed in this section may be folded into Section 5.1, 5.3, 5.6, 6.1 and other sections.

As it is presented, this section seems to want to prescribe a certain level of style of public health interventions. Prescription is best left to other sections where policy recommendations are appropriate.

The prescriptive portion of the Report is concentrated in Chapters 6 through 8. The recommendations to me have too much the flavor of the doctor prescribing the remedy. I don't get a sense that the people are participating in deciding what health care they want through governments and privately. The sense I get is that specialists in the Bank want to train specialists in ministries of health, and they will set policies and spend the taxpayers' money.

I want to refer to Section 6.4 which refers to the vitally important area of autonomy and accountability. Autonomy means less control, and accountability means more control. The basic issue really is accountability, to whom

are health providers accountable. If accountability is clear, we can ignore autonomy, because management will be okay.

For example, if doctors in rural districts are effectively accountable to patients, maybe through the local councils, then forget autonomy. The system works.

When I see the words "autonomy" and "accountability," I suspect that this aspect may not have looked closely at the best way to make public servants accountable to the people they are to serve. This will often involve pulling activities out of centralized authorities and giving them to decentralized local bodies. I hope this area, how far the health services can be decentralized, will receive due attention.

I would like to suggest replacing Chapters 6 and 7 with a somewhat different and new Outline. In Chapter 6, public accountability and policy formulation; public education for health and how to involve people in the different levels -- central, state, local, hospital districts, et cetera -- issues with respect to private health care; insurance; cost containment; regulation of medicine.

In Chapter 7, public health management issues could include a) regulatory issues, which will involve framework

for participation by private sector and subnational governments; b) management issues; strategies for quality improvement and cost containment through competition involving the private sector; c) management issues; strategies for funding through privates, through various levels of government -- taxes, fees, local bond issues, insurance.

Finally, Mr. Chairman, I refer to Section 8.2, which will focus on AIDS. We have discussed this subject in the Board many times, and in some countries, it is now becoming a very serious problem both short-term and long-term, especially Africa.

There are two good reasons for the Report to be more balanced in its treatment of AIDS as both a sexually-transmitted disease and also a blood-transmitted disease. Number one, from the technical point, HIV is a virus carried in the blood just as is hepatitis B. A strong case can be made that much AIDS transmission in less-developed countries as in developed countries comes through blood -- contaminated needles for injections, contaminated blood, other skin-piercing medical procedures. Hepatitis B is widespread in many less-developed countries. This gives an indication of the potential for medical -- that is, injection -- transmission of HIV. Some lives may be saved by alerting

doctors, patients and nurses to be much more careful about injections and blood products, what should be recommended educationally, blood testing equipment, disposal needles.

Number two, finally, is political. I think political leaders in many countries have resisted taking a strong position on AIDS because of its association with immoral activities. National leaders do not want to admit that their nationals are as immoral or more immoral than those in other countries where AIDS is a problem. However, if AIDS is presented as a disease associated with modern medicine, then AIDS education can begin, and all aspects of the AIDS epidemic may be more openly discussed.

Thank you.

MR. SUMMERS: Thank you.

Mr. Li?

MR. LI: Thank you, Mr. Chairman.

I would like to commend the staff for this excellent and comprehensive Outline, and I would like to make four brief points.

First, I fully agree that the next issue of the WDR will reiterate WDR 1991's conclusion that in the health sector, the market itself cannot be expected to play a significant role alone. In this respect, governments can

play more important roles, particularly in formulating appropriate policies, establishing sound systems, and mobilizing adequate financing for investments in this sector.

This should be a starting point for the Bank to make any recommendations on development of the health sector in the member countries.

Secondly, with regard to Chapter 3.3, as just mentioned by previous speakers, I think the regulating of fertility should receive more emphasis in the Report. The control of high fertility will be a critical issue and one of the main tasks faced by many developing countries in improving their health systems. I hope that WDR 1993 will give developing countries some good advice.

Thirdly, in dealing with financing and delivery of health services in developing countries, more attention should be given to rural areas. In most developing countries, it is very hard for the governments to finance very basic health services, let along costly health systems, in these areas which are really densely populated. Therefore, I hope that WDR 1993 will provide some information on useful experiences -- for example, the effective use of indigenous traditional medicinal treatments, the effective training methods of health manpower and delivery of clinical services

to the rural areas. This will help the governments in developing countries provide basic health services and improve health outcomes for these areas at very low and affordable cost.

Finally, Mr. Chairman, regarding agenda for governments in the international community, I am glad that the Report will study aid flows for health to developing countries and make recommendations to improve donors' policies for the health sector.

The tentative conclusions in Part III indicate what governments should do to improve or maintain sound health systems. Actually, these conclusions point to the targets in the health sector for governments to reach in the future. But some of the targets may not be easily reached by developing countries due to the shortage of financial resources. I think that while the development of sound health systems will mainly depend on developing countries themselves, a substantial increase in aid flows from the international community will greatly facilitate the development of health systems in developing countries.

Thank you.

MR. SUMMERS: Thank you.

Mr. Akturk?

MR. AKTURK: Mr. Chairman, we welcome the selection of this topic, Investing in Health, for WDR 1993, since many important health issues still remain unsolved, not only in the developing world, but also in some of the most advanced countries, despite the latest technologies used and the great resources allocated to the health sector.

We also welcome the declaration in the Outline that the final Report will reiterate the conclusion of WDR 1991, that especially in health, the best government policies will not be market-oriented, and a dominant private sector role is unlikely to make sense for health.

We have some general remarks, Mr. Chairman.

There are several good reasons why the public sector plays a large role in providing medical goods and services. First of all, provision of affordable and high-quality medical treatment should be seen as a basic human right. This should be the basic approach for each country to start with and furthermore should be the subject of some form of social contract of a society. Therefore, financial and other barriers to obtaining medical care should be perceived as ? or at least, socially undesirable.

Second, there is a strong correlation between economic development, health and health care through utiliza-

tion. Investing heavily in people and their health not only makes sense in humanitarian terms, but also in pure economic terms. Health as one part of human capital is an important factor in further development of a country. It includes the planned productivity of working adults and the enrollment and performance of younger generations in education.

Third, it is well-recognized that the provision of medical services can generate externalities. Health care programs which generate large externalities include vaccination programs, the provision of clean drinking water, and awareness and control of contagious diseases, which are best forwarded by the governments.

However, the public sector, especially in developing countries, has to deal with severe budgetary constraints, which makes it difficult to argue for more public spending in the health sector. The Bank is one of the few institutions which would be able to press strongly for greater attention to the provision of funds for the health sector. That is why we expect help from this Report, and especially from Chapter 6, devoted to the discussion of practical issues in designing reforms, in finance and delivery of public health services from widely different starting points in various developing countries.

During the discussion of WDR 1991, our chair offered a proposal for better financing the investment in people -- namely, a viable and well-functioning tax system in developing countries. Since we agree that there is enough room in many of the developing countries for improvement of the tax system, Bank staff agreed that the WDR 1991 could help put more emphasis on the importance of tax reforms, but argued at the same time that it would be a serious mistake to suggest that whenever there is a need for public resources, the first resort should be through the tax system. Although we would agree that one has to look into all possibilities in order to utilize human resources in the most efficient way, we do hope that WDR 1993 will offer concrete solutions with regard to the important issue of financing efficient health systems in developing countries.

Finally, we would like to make a contribution to the content of the Report. Chapter 5, Section 5.6, on the instruments of government, states that "Governments can tax or regulate unhealthful substances, regulate the providers of services," and so on. We would like to add that governments can and should also provide specific rules and health standards for a safer working environment, as well as rules to protect consumers of many foods and medical products in

developing countries.

Thank you, Mr. Chairman.

MR. SUMMERS: Thank you very much.

Mrs. Jonsdottir?

MRS. JONSDOTTIR: Thank you, Mr. Chairman.

My chair very much welcomes this Outline for the 1993 World Development Report. We believe that it is important that the Bank, during a time when so many other issues take our attention, maintains a strong focus on basic human needs and poverty-related issues. Certainly, the health of the world's poor deserves our full attention.

We also find the proposed approach very interesting. Some people at times seem to think that the role of the state in the development process has been defined once and for all. The Outline certainly demonstrates that that is not the case, and it takes a very refreshing look at the balance between state intervention and private sector participation in this specific context.

We look forward to the outcome of this analysis.

In Sections 2 and 3 of Part I, the Outline deals with the health sector's relationship with economic and social parameters. My authorities find this perspective very promising.

I believe that a seminar like this allows for some more specific comments. I will thus share with you a few issues which we think might deserve further attention in the Report.

It is not quite clear whether the effects of structural adjustment programs on the health sector will be dealt with explicitly. It is well-known that many critics of the structural adjustment concept feel that health services are among the services often most negatively affected by adjustment measures. An analysis of how they have fared and what could be done to protect them in future adjustment programs would be welcome.

It might be useful if the Report to some extent took stock of how previous initiatives in the health sector have succeeded. I am thinking primarily of the Almaata [phonetic] Declaration on primary health care and the "Health for All by the Year 2000" strategy. These initiatives have contributed significantly to the formation of health policies over the last decade and should probably be revisited at this occasion.

The Outline analysis of behavioral and environmental determinants touches upon some very important issues. I would just like to add to the list the issue of health

problems related to urban development.

We also find it useful if the strategy section in Part II could highlight the need to prepare strategies for the various sectors which have a significant impact on health conditions.

It appears that institutional and organizational issues receive relatively little attention in Chapter 3 on policy reform. A more detailed discussion of appropriate institutional solutions for delivery of health services, including basic supplies, would be welcome.

We noted and welcome the attention given throughout the Outline to the influence of gender on health issues, but believe that it might be useful to have a separate analysis of the health problems faced by women.

On a final note, let me suggest that the Report, in light of the Bank's heightened concern for popular participation, take up the issues of decentralization and local participation in a separate section.

It appears that there will be plenty of opportunities to continue the exchange of ideas on these and other issues. We have noticed that the World Development Report team has invited an open dialogue with experts, borrowers, and aid agencies. My authorities very much welcome this

approach and expect that it will lead not only to an excellent Report, but also to renewed appreciation of the Bank's efforts in this field as well as its willingness to engage itself in a dialogue with concerned parties.

We look forward to these discussions and would like to encourage others to participate and support them.

Thank you, Mr. Chairman.

MR. SUMMERS: Thank you.

Mrs. Bloemenkamp?

MRS. BLOEMENKAMP: Thank you, Mr. Chairman.

First of all, I would like to welcome also this outline for the very important WDR on health. In our view, it provides sufficient opportunity to discuss the broad range of issues regarding this subject.

However, we would like to make some comments or suggestions concerning some specific issues which are in our view essential for the subject but didn't get enough attention or stress in the Outline presented to the Board today.

The first point regards the subject of health care and the policy around the world in general. It also struck us, like many others -- Mr. Cosgrove and Mr. Sigrist -- that the words, "primary health care," can only be found once in the document, and that is only in the discussion of facilities

and equipment.

In Part I, a separate review is warranted of policy approaches developed and applied so far, for example, since the Sixties. In this review, an important aspect should be the development of thinking on health systems into the direction of more attention to prevention and as to creative health care, more attention to primary health care as to hospitals and clinics.

Also, in the remainder of the document, systematic distinction between preventive and creative health care systems, including economic aspects, cost-benefit analysis, is in our view warranted.

Related to this, attention should be given to the need to adapt training and, through training, also mentalities in order to give more status and importance to primary health care. Whole generations of medical personnel also in developing countries have been educated with the idea that the most importance place for a doctor is to be in a hospital practicing creative care, and not in a village working on prevention.

My second point regards the paragraph on determinants of health. The Outline points out, rightly, that the macroeconomic level of a country is a very important factor,

but by no means the only determinant influencing the health situation. There are many others. Some of them are listed in this Outline as determinants; others are discussed under another heading in the Outline. What I would like to see is that the political priority a country gives to health policy is also one of the important determinants of health. This factor cannot be over-stressed. The kind of health care system which is provided, the extent health is supported by other sectors like agriculture, education, civil services, et cetera, is all of major influence to the health situation.

Furthermore, factors like income distribution, food security for everybody, health infrastructure spread, health activities aimed at country-specific illness problems, attention to prevention and education for the whole population, especially for women, are the basis for the relatively good results in countries like those mentioned in Paragraph 5.2 of the Outline -- the good results those countries have achieved and have achieved at low cost.

With respect to the importance of health care performance as a determinant of health, it should also be underlined that primary health care is not a phenomenon in itself, but that it can only function effectively where close cooperation is established between the health professionals

and their communities. Participation and support have been mentioned already by other speakers, and in whatever form -- for instance, involvement in planning and financing, share care for the environment, involvement of local communities and services in training people with regard to primary health care, et cetera, cannot be stressed enough.

My third point is very short. We regret that there is no indication in the document of the links between developing countries and industrialized countries in the field of health care. Attention should be given to links such as the production of pharmaceuticals in industrialized countries not always adapting to the needs of developing countries.

My fourth point is on terminologies. It is desirable to refine these terminologies on concepts like states, governments, and public sector. We think the concept of state had better be avoided in the Report. The Report's concept of governments is rightfully composed in central and local governments. The concept of private sector as opposed to public sector should more explicitly treat the role of the nonprofit sector, the potential role for women's organizations, farmers' organizations, cooperatives, trade unions, et cetera.

My fifth and final point is on the recommendations themselves. We feel that these recommendations should not be directed only to governments, but also to the nongovernmental sector and, last but not least, they should be directed not only to developing countries but also to the industrialized countries.

Thank you.

MR. SUMMERS: Thank you very much.

Let me call on Mr. Jamison to respond on what he sees as a few key points. Dean, I hope among whatever else you say that you will say something about the question of primary care, something about the question of family planning, something about the question of the respective role of government and market, and something about AIDS.

MR. JAMISON: Well, that's obviously a rich variety of suggestions, but there certainly are some common themes both in these and in some of the written comments and conversations I have had with members of your staff.

On the question of primary care, yes, I think we need to deal much more explicitly with that than we have, and I think that the suggestion of tracing the history of Almaata, the "Health for All" concepts, and the political importance of those concepts that Mrs. Bloemenkamp alluded to,

or part of what she alluded to on the political side, I think those are dominant features of what has been shaping thinking and, to some extent, action -- unfortunately, not flows of resources, in our estimation -- around health care, and we will return to that.

On the question of the role of government, the particular characteristics of the health care systems that make it arguably necessary for governments to play an important role, obviously there are several considerations that we will need to pay a lot of attention to. One is certainly the diversity among countries. Mr. Cosgrove alluded to different tastes, perhaps, for freedom of choice, different willingnesses to constrain costs through rationing, by waiting lists, and things of that sort. Clearly, countries will differ very much in how they are prepared to make those trade-offs. What we would like to do is to look at the fairly rich variety of experiences that I think we now have before us, including much more than previously, the OECD experiences, for lessons along these lines.

I think the fundamental distinction that we are making at this point is around the role of the state in ensuring access and providing finance to help ensure access where we see a very central role for the state, and one that

markets are quite unlikely to solve, versus the provision of services, where competitive structures -- private profitmaking, private NGO, parts of the government competing -- are ways that we hope will, in different contexts, allow perhaps an easing of some of the trade-offs that Mr. Cosgrove pointed to. So there is that sharp distinction.

On family planning and the role particularly of birth spacing in affecting child mortality, perhaps other child outcomes and maternal outcomes, we certainly have in mind a very strong statement on that, and I think the further version of the Outline and the Report will reflect that. But unquestionably, it is centrally important, and we will, of course, be drawing quite closely on it, and we are working closely with Tom Merrick and his colleagues who are involved with the family planning paper.

Finally, on the question of AIDS, we are spending a lot of time on AIDS because it is for me, at least, and I think for all of us, a question of a good deal of uncertainty about just how much an emphasis -- it would be easy, I think, for AIDS and the discussion of AIDS to dominate discussion of a lot of other issues. On the other hand, perhaps it should. So we are thinking hard about it, and we'll keep you informed as we move forward.

MR. SUMMERS: Thank you very much, Dean.

Mr. Bourhane?

MR. BOURHANE: Thank you, Mr. Chairman.

We also welcome the discussion of this Outline. We found it comprehensive and interesting and is a serious attempt to address fundamental issues in health confronting LDCs and the needed involvement of the international community.

First, we agree that an all-out market-friendly approach would not be appropriate in the health sector, and we support government involvement in the health sector. We share the conclusion that "high levels of government involvement with health finance and public health investments are associated with favorable health outcomes and cost containment." We share also the view that enhanced competition in health services and better information systems will improve the effectiveness of the health system.

We are also concerned by the decline of donor support for the health sector in LDCs. We look forward in the final Report to specific measures aimed at increasing international aid for this important sector.

Second, we were surprised by the strong opposition advocated against policies designed to protect local phar-

maceutical industries and to publicly produce drugs and vaccines. We know that few multinationals dominate this industry, and it doesn't seem that market forces at this level play freely in the pricing of such products. We believe that strengthening regulations and building a national regulatory framework might not be sufficient.

We are of the view that providing populations with medicines of good quality and at affordable prices is the target we should aim at, and if locally produced drugs help achieve the target, we should look at this solution more fully and without prejudice.

Third, we strongly support the proposal that the international community shore up its support for research to develop new drugs and vaccines. We would like in this context to point out that this effort should also be aimed at two major diseases, that is, TB and malaria.

Indeed, as far as research is concerned, one is assured that for the AIDS epidemic, as it is a worldwide issue, funds will be available to researchers in developed countries for the development of new drugs and vaccines. This is in our view not the case for malaria, which is for the moment more devastating than any other illness in many of our countries, and we hope to see the Bank taking the lead in

this crucial area by helping those international and local organizations that are working to eradicate these illnesses.

Thank you.

MR. SUMMERS: Thank you.

Mr. Matambo?

MR. MATAMBO: Thank you very much, Mr. Chairman.

We, too, welcome the opportunity to discuss the Outline for the 1993 WDR on the important subject of investing in health.

On the basis of the Outline before us, our impression is that the forthcoming Report will be an appropriate follow-up to the three most recent Reports, i.e., the WDR 1990 on poverty, the WDR 1991 on the challenge of development, and the WDR 1992 on the environment and development. This, I believe, underscores the Bank's determination to pursue its core mission of reducing poverty in all its manifestations.

The strong links between poor health and low productivity, especially in developing countries, make it particularly desirable to have a detailed account of what is known as well as what is not known about the health sector, for the purpose of formulating appropriate prevention and health management policies. We hope the Report will endeavor to send a clear message for the need to prioritize health as

one of the cornerstones of human resource development and to translate such prioritization into action through national programs designed specifically to address poverty.

We note the intent to follow a practical approach in analyzing the problems of investing in health by focusing on the three aspects, i.e., determinants of health, improving health systems, and policy reform.

We go along with the proposed structure of the Report.

One observation, though, under Part I of the Report is that while there should be no difficulty in establishing the links between poverty, health and the environment, we believe that there may be a methodological problem in determining the complex link between health and income, especially in a free market economy.

For instance, while the availability of basic health facilities to a society can be seen as a function of that society's income, the access to such facilities by individuals is by and large influenced by the distribution of income.

We would therefore suggest that the pattern of income distribution deserves some consideration in the analysis of factors determining the quality of health in a

country.

With regard to Part II, which addresses the major point of investing in health systems, I look forward to detailed proposals in the draft Report when it comes later on. My initial reaction, however, is that this section of the Report should constitute the main body of investment issues in the health sector.

We also welcome the introduction of a chapter on the practical lessons from experience on how public and private actions can achieve key objectives in health policy. I should point out here that, like Mr. Cosgrove said earlier on, I also find that we still have to do a little bit more in terms of clarifying this balance between private action and public intervention.

The analysis of data on the contribution of public and private health care providers will be of particular interest to us.

In Chapter 6, on financing and delivering health services, we note that experience with previous reform efforts will be reviewed. In this connection, we would like the Report to review some aspects of recent Bank policy as it relates to lending to the health sector. In particular, we would be interested in some of the early results of the

policy of cost recovery on the delivery of health services in developing countries generally, but in those implementing adjustment programs in particular.

A word on improvement of information systems in the health sector. Medical statistics in developing countries, especially in the rural areas, are generally nonexistent, and where they exist, they are not reliable. The importance of the availability of reliable information cannot be overemphasized. We therefore hope that the Report will carry a message, a strong message, for the improvement of statistical data in the health sector, particularly, as I said, in the outlying areas.

Finally, Mr. Chairman, with regard to Part III of the Report, I only wish to emphasize at this stage the relevance of outlining an agenda for governments and the international community. We also look forward to innovative and bold proposals on the implications of the Report for health planning in developing countries as well as for the Bank's own lending policies for the health sector.

Thank you, Mr. Chairman.

MR. SUMMERS: Thank you.

Mr. Flano?

MR. FLANO: Thank you.

Together with other speakers today, we agree with the Outline. We think it is a very important paper, a very relevant paper, and a very timely one, and we have some comments that are the following.

First, of course, we agree with the fact that in general the best government policies will be market-oriented in health; they often will not work. That's a fact, and I think it is very important to make it relevant in the document.

Second, with regard to that, I think that one could say that there are two things with regard to the role of the state -- first, that for many years, I think the public sector will play a very important role in less-developed countries given the income distribution of these countries. In middle-income countries, for example, even though you have some good experiences with private sector health systems -- and good experiences, I mean -- you only get to 10, 15, 20 percent of the population, and you have 75 or 80 percent of the population that still depends on the public sector.

So I think that even though we agree, and I think it is important to see the interrelationships and the way that the private sector can work with the public sector, we have to have in mind that for many years in less-developed

countries, it will be a burden in the private sector to provide health care for the vast majority of the population.

Second, also with regard to the role of the state, with regard to subsidies, the question here is what is going to be subsidized -- the supply or the demand, or both -- and when, how, and in what way. I think that is very important, also, to see what are you going to subsidize.

Also, one should enhance the new role of the state in the sense that even though the state has to assure that 70 or 80 percent of the population gets what it needs through public health, it can do it in a decentralized way, using the private mechanisms, et cetera. And I think that the ministries of health should be more than ministries oriented to provide health services; they should be much more ministries that should provide guidelines, provide policy, regulate, et cetera, et cetera.

A second point is the linkages or cross-effects of the health sector; I think they deserve more attention and some more analysis in the paper. I especially refer to not only the macroeconomic aspects, which are obviously, but also, for example, social security -- what is the relationship between social security and health systems. I think that is a very important point for developing countries.

Third, with regard to human capital formation, health, et cetera, I think it is very relevant that a section is dedicated to examining the historical and long-term contribution of economic growth to health. But the Report should also clearly underscore and/or prove somehow that health expenses are essentially investment in human capital, and thus the existence of a vicious cycle between them.

I think that the concept of health as an investment in human capital, as has been said before in this paper, is a very, very crucial aspect of the Report that has to be like a motif, a central motif of the Report.

And with regard to that, also, I would stress the need, as an objective of the document or as a goal, the meaning of basic health access for all, and what is the floor for that. Recently, Mrs. Jonsdottir made what I think is a very good point. What has happened with the "Health for All by the Year 2000"? I think that that is very important. What is our aim? Are we looking for a floor of minimum health care for everybody, and what does it mean? Is it possible? How much does it cost? What are the alternatives? Can we make it, et cetera. I think that is a challenge, and it is important for the Bank to pose it, because it has a lot of financial implications, but it is also a challenge for the

countries in terms of providing basic health care for their populations. So I think that is another point.

Next, with regard to what Mr. Matambo recently said, I think on the statistical data and figures, it is not only important, on the one hand, that we make it consistent among countries, and second, we have to have a system -- and I think that we can improve a lot of the administering of the system with having good data, and I think that in many underdeveloped countries, that is lacking. And second, with regard to the same point, is the need for an effective project evaluation system in the health system. I think those are two points that should be enhanced, and some guidance should be given in the Report as to the way of operating the data and the project evaluation in the system.

Then, I have a point with regard to in developing countries, for political and other reasons, as I said, there is a conflicting set of indicators that are used to assist the country evolution in health. In this regard, I think we should stress the need to include at least a brief discussion of consensual and appropriate tendencies as well as cyclical parameters, and emphasize the need to develop a supportive statistical system.

Finally, another point that has also been stated in

this discussion is the concern about the relative contraction of international flows. Mr. Bourhane recently mentioned the problem of donor support. I think that strong and urgent, coordinated efforts by both donors and poor countries have to be applied to avert the trend that we believe is negative -- or, it is declining -- and grant relief to the present health and nutritional crises faced at present in some areas of the world.

In this context, this year, we would welcome a discussion on ways to strengthen the level and the desired composition of the assistance to the health sector as well as the allocation of it to its most affected users.

Finally, Mr. Chairman, I have two points. I think another point that is very important and that Mr. Bourhane just raised is about the local pharmaceutical industries. There have been a lot of conflicts in some Latin American countries, for example, with the making of the free trade agreement with the States, with regard to intellectual property, and that intellectual property has been referred many times to the pharmaceutical industry. I think that is a very, very important point for underdeveloped countries, not only in the provision of medicine at low cost, but what is means in the commercial relations, the trade relations, with

developing countries. I think that is a very important point that Mr. Bourhane just raised.

I think that the tax system also is a very important point to consider, and how we are going to finance this. I think one of the things that the Bank should focus on, being the World Bank, is what are the financial implications of what we are proposing and what are we going to tax, or where will we get the resources to improve the health situation of developing countries.

Those are in general my comments. I agree with many things that have been said, but those are the points that I wanted to stress.

Thank you, Mr. Chairman.

MR. SUMMERS: Thank you.

Mrs. Laury?

MRS. LAURY [INTERPRETED FROM FRENCH]: Thank you, Mr. Chairman.

We would like to welcome this document as well as the opportunity that has been given us this afternoon to discuss it.

First of all, as other speakers have already pointed out, we think it particularly important that the Report examine carefully the specificities of the health

sector per se. I am thinking of externalities and other factors that weigh on the sector, and to recognize up front what the limits are to the traditional approach of the health sector and what the services can be.

This is why we think it is particularly good that the intention is to stress the role of the public sector in offering health services.

We think also that it would be very good indeed to analyze very carefully the links that exist between the fight against poverty and the delivery of health services, as we hear is the intent of the Report. We think that is great.

We think also that, inasmuch as the policies that the World Bank has forged in order to fight against poverty would have a particular weight on the health sector, it is important that we point out what those policies are and what their impact is specifically on health.

We think also that a more general policy, a more generic policy of development of human resources, should be stressed. We know that the Report is going to look carefully, for instance, at the interfaces between health and education, health and population pressures, and that too is welcome.

But we would like to ask that more specific attention be paid to health and more strategic development

policies, more strategic, more targeted development policies. We know that since good emphasis is going to be placed on the delivery of health services in the countries, we think, too, as Mr. Flano just pointed out, that it would be useful to see how the quality of those health services are going to impact on the quality of human resource development. I think that that will be looked at, and we are pleased that that will be the case, but we just want to make sure that that analysis will be fully covered in the document.

A few last comments. On the competition that might exist between different services of health that are delivered, we think that it is perfectly justified and very important to insist on the way in which delivery of health care will impact on general public services as a whole in the country. But let us not assume as being self-evident that to introduce competition in the health sector will necessarily lead to a drop in the cost of health, because, I ask you -- it is a rhetorical question -- could we not in fact see quite the opposite take place as well?

So we would very much push for a strict and very rigorous case-by-case analysis of what has occurred in this field in the developing countries, so that we see whether injecting competition in the health services does indeed lead

to a drop in prices, a drop in costs in general.

We think also that it is important that the different health services be looked at as a whole to see how they can be rendered more efficient, and we are very pleased to see that in the final document, a number of recommendations are going to be developed.

Specifically, we would be pleased to see how the Bank intends to link the work that is carried out under this WDR to the development of its sectoral policies in health. We think that is something that should be looked at. Would it not be interesting to put forward a paper on the health sector as the Bank sees it?

Thank you.

MR. SUMMERS: Thank you.

Ms. Harris?

MS. HARRIS: Thank you.

We are very pleased with this Outline. Mr. Jamison described the process of consultation by which this WDR is being prepared. ODA in London has already been involved in this consultation process, and I would like to say that they are finding it an extremely valuable exercise, and they consider it is going to give them ample opportunity for detailed exchanges with Bank staff. We think it is an

excellent way of approaching this paper.

Could I just stress, therefore, very briefly, three points now. We like the fact that this paper is going to look particularly at the cost-effectiveness of health investments. We think that is very important. Even the most basic health care is expensive, so you have got to prioritize your scarce resources.

We like the way the paper is going to stress the importance of efficiencies, including allocative efficiencies. That has obviously got to make provision for ensuring that in allocating scarce health resources, the poor are fully taken into account.

The delivery of health care is also important. Management systems are crucial. We are going to be particularly interested to see what emerges in the section on improving budgetary management and administrative autonomy at the local level. I think Mr. Syed said something earlier about decentralization, and we think that is very important in the health care system.

The complex issue of government versus the private sector has already been rather fully discussed. Perhaps I could suggest just one other area where I think the government is going to continue to need to be involved, and that is in

the regulation and monitoring of agreed standards for health care provision.

Thank you, Mr. Chairman.

MR. SUMMERS: Thank you.

Mr. Sevigny?

MR. SEVIGNY: Thank you, Mr. Chairman.

We also found this to be an interesting and very useful overview. If I could just pick up on a couple of points which were raised having to do with primary health care. It might be useful to have a little clearer understanding of the data that we are going to be operating with -- I think this is the core of our concern -- before we build a fairly elaborate superstructure to look at the data we are looking at.

Specifically, I think it would be very useful if we could -- we talk a great deal about the efficiency and effectiveness of primary health care -- it would be very useful if we could get some indication throughout the document, or somewhere in the document specifically, of in various countries what the division is between health care spending on primary health care versus hospital-based care. And also, looking at it from the point of view of public policy, I think it would be very useful if we could take also a

breakdown in terms of international aid flows, and if we could get some sort of -- and maybe you can tell me whether that is possible -- but some sort of breakdown or indication of where international aid money is flowing and whether indeed it is flowing to benefit basic health care, which we all agree is probably more effective and efficient, or whether it is more in the curative end of the spectrum.

There are two other things which I think it would be useful to take up in the text of the Report. One would also be looking again at this dichotomy between hospital-based and primary health care, and looking at the crowding out problem that exists in a lot of different countries with recurrent costs. I think this is something that we are all familiar with anecdotally, where very expensive hospitals tend to crowd out recurrent costs for basic health care. But if we could have illustrative cases, perhaps, and maybe some sort of sense of best practices, how we could get around this problem or whether indeed we can get around this problem.

And a final point, just with an eye to the critics of this Report, I think it would be very useful to return again to the idea of what impact do structural adjustment policies have on social sector spending. Here, a case in point -- we have done some work on the social sector spending

as such, and I guess our impression is that the data is quite mixed in terms of how well health care education can be maintained. And I wonder if it is also possible to look at -- and this is a caveat which repeatedly comes in World Bank documents, in terms of central government versus municipal and state and local spending -- I wonder if we could get a better handle on that because it seems that we only tell half the story, and it is hard to reach a fairly robust conclusion on those kinds of questions.

If we could have any indication today as to what the state of data is that we are working with and specifically the division between basic health care and, say, hospital-based care, and what additional information we might have on this breakdown between central government and state and municipal, that would be very helpful.

Thank you.

MR. SUMMERS: Thank you.

Finally, the last speaker on our list today, Mr. Hosny.

MR. HOSNY: Thank you, Mr. Chairman.

Like previous speakers, we welcome the choice of "investing in health" as the topic for the 1993 WDR, as it deals with a specialized area of particular relevance to

human resource development and poverty alleviation in developing countries.

The responsibility for and methods of delivery of health services and the costs involved are pertinent to developing as well as to developed countries, and the general state of health, especially for present and future economically active relations, is one of the basic determinants of economic growth.

Therefore, we welcome the discussion of the proposed Outline, and in particular the acknowledgment in line 4 of the Overview about the reality of active government policies in sectors supportive of better health, both directly or indirectly.

This basic premise, however, should be interpreted with caution. As in the case of education, the distinction between government financing and government provision of services must be carefully drawn.

Mr. Chairman, although the Outline appears to be comprehensive, we wish to call particular attention Chapter 7, Paragraph 7.1, concerning health manpower development as it applies to developing countries. The missing item here is that of the "brain drain," which has not been touched on by previous speakers, and I would like to emphasize particularly

the kinds of policies that governments must pursue to deal with the incidence of migration of trained medical personnel to developed countries, which undermines the ability of developing countries to deliver adequate health services to their populations. In this respect, I believe that a cooperative effort involving both developing and industrialized countries and relevant international organizations is required to deal with the "brain drain" of medical personnel from developing countries.

Mr. Chairman, I had also in mind that more emphasis should be given to family planning, but Mr. Jamison's responses to the observations made by other colleagues reassured me that family planning will be adequately treated in the Report.

Finally, I join the previous comments with regard to the importance of primary and preventive health care, rural health services, and the availability of these services to women, particularly in rural and poor urban areas.

Thank you, Mr. Chairman.

MR. SUMMERS: Thank you, Mr. Hosny. You were not in fact the last speaker.

Mr. Aris?

MR. ARIS: Thank you, Mr. Chairman.

I think at this stage of the discussion, I shall be brief, because many of the points I had have already been raised by other speakers.

We would like, however, to see that the following sections or topics be reemphasized. One is the question of family planning, because we strongly feel that where there is a reduction in the death rate through health care, equal attention should also be given to the reduction in population growth through the decline in fertility.

Second is the need for proper definition of the role of both public and private sectors because we believe that the private sector has also a role to play in the area of health development in developing countries.

Third, like Mr. Cosgrove, we also feel that there should be some reference to the Bank's experience in health care, both cases of success as well as failure. We also feel strongly that the case of pharmaceutical firms in developing countries should be encouraged to develop.

And finally, one point which has not been raised is regarding what has been happening in the area of regional cooperation in health care, particularly in the area of medical research.

Thank you, Mr. Chairman.

MR. SUMMERS: Thank you.

Mr. Tricha?

MR. TRICHA: Thank you, Mr. Chairman.

We think the Report presented to us today is comprehensive and seems to address most of the health and health-related issues. Therefore, we can address its main thrust.

One important finding the Outline is suggesting is that, because of market failure, health services financing and delivery are first and foremost the responsibility of the government and the role of the public sector. This is an obvious conclusion that we agree on.

For a change, we see that the market cannot be the solution for everything. We will take this opportunity to remind that, as for health, there are a lot of other basic human needs, such as food, education, and housing where the market alone does not help, especially when trying to protect the poor.

When admitting that government and the public sector must be responsible for an effective national health system, one cannot but ask for more clarifications about the propositions made in this Outline for competition in the provision of health services, Section 1.5, page 3, and

Section 6.3, page 10, and for the removal of protection of domestic suppliers of health services and products, Section 7.2, page 12, and Section 8.1, page 13.

While the private sector may be encouraged to play a more active role in health, our opinion is that a government's involvement with health finance and public health investment implies with some flexibility that said government be able to full control this sector, including the cost, the provision and the delivery of health products and services.

Another important point is the fact that the Outline is not focusing enough on the global danger of disease spreading and the benefit for all of improving health and eradicating diseases, especially transmissible diseases. In this connection, the Outline notes in Section 8.3, page 14, that international aid flows for health have declined over the past decade and that global investments in research in products directed at developing countries are low, in Section 7.4, page 12.

We are deeply concerned, of course, by such trends, and we therefore urge the authors of the Outline to elaborate more extensively on the sections of page 3 of Part III dealing with the role of the international community in aid for health and support for biomedical and epidemiological

research.

Moreover, the Outline is hushing up the role of the United Nations agencies dealing with health issues -- WHO, UNICEF -- and we wonder why. We think that close cooperation and at least a summary of these international institutions' objectives and operations are warranted in the WDR.

Conversely, we think Section 4, pages 6 and 7, on disease control is a technical one and should be either abridged or dealt with by specialists.

Finally, one cannot but question some trade-offs which it is hinted to in the Outline between interventions at high cost and the extension of life that such interventions will allow -- Section 4.4, page 7, and Section 6.5, page 11 -- and between multiplication of the number of specialist practitioners and cost containment. While we agree that investment in health must be efficient, we believe that when life is at stake, such trade-offs become irrelevant.

Thank you, Mr. Chairman.

MR. SUMMERS: Thank you.

Mr. Jamison, do you have any responses you want to make?

MR. JAMISON: Yes, a few final, brief comments.

I think a theme of several of the comments around

the table this time concerned the international dimension of quite different facets of health care. Let me touch on several of those.

One is around international trade in pharmaceuticals and vaccines and medical supplies. A lot of concern, I think, was expressed about the question of creating a countervailing force to what is I think rightly perceived to be a great deal of concentration of power in many of the vendors and that protectionism of domestic suppliers might be an approach to that. We will certainly be looking at that. We will also be looking quite closely, I think, at alternatives to protectionism, such as the UNICEF and WHO essential drugs programs, which attempt to provide through concentration on the purchasing side a countervailing power, and in many cases, I think quite effectively, a countervailing power to that of market concentration on the supply side.

So I think while we will be very concerned with the problem, we won't necessarily conclude that protectionism is the right way to go.

Related to that, I think, is the issue of R and D. Mr. Bourhane talked about pharmaceutical development particularly for anti-malarials and anti-tuberculosis drugs. This is certainly something that I think is important for the

international community to be concerned with and will be dealing, I think, with that.

We haven't but I think need to look more at the international flows of staff and personnel, the migration issue that Mr. Hosny raised. These are clearly important issues. We have touched on them, and I think we will look more carefully.

A couple of other international issues. Mr. Tricha raised two. One is relations with the World Health Organization and UNICEF, their roles in this Report and in our discussion of the international community. We are working extremely closely with WHO -- perhaps I should have said that at the outset -- in the preparation of this Report; less so with UNICEF, but certainly to some extent with them as well. And that will certainly be part of the discussion of directions for the international community.

The question of how to organize and finance disease control efforts that extend across national boundaries -- the onchocerciasis control program in West Africa, I think, is a very good example of that -- is something that I think we do need to pay a good deal of attention to for a small but quite important number of infectious diseases.

So that the international dimension is one that we

will be paying a good deal of attention to.

Several speakers raised the issues around data availability and what we do and don't know in terms of our starting points. One of the things that I have been impressed with is how much we rely on a relatively small number of data sets -- for example, the World Fertility Surveys, the Demographic and Health Surveys -- for a great deal of the inferences we draw about actual levels and trends of fertility, mortality, and that those data sets focus very much on the child. We know nothing like as much about the adults. The need for comparable data around adults, similar data, particularly in the poorer parts of the world, are very much before us, and I think we will be touching on those questions.

Mr. Sevigny raised questions about patterns of aid flows going up, down, what kinds of things. We have commissioned a study -- it is surprising how little synthesized the data are on these, and we hope to be able to clarify that at least somewhat in the course of our efforts. Likewise, on total resource flows into health, one of the difficult issues again that was raised, is how much in the public sector comes from local governments and federal states. We are trying to sort that out, and again, I think we will have a crude but

reasonable analysis that goes well beyond what is now available. So data is an issue that we will be talking about and do think is important.

A final comment on the role of the state. I welcome very much the expression of support for our taking a view of the state that is more activist, more central, and we will be doing that, but I think we will be doing that very much mindful of the limitations that I think we have all seen in what the state can do. And I think the challenge in many ways before this Report is to talk about how -- given the experience of limited capacity for states to regulate effectively, much less to provide financial services or other services around the health sector -- how in the context of those constraints can one fully realize what is clearly a very central role for the state in taking advantage of what we all know to be possible in terms of greatly increasing health outcomes in poor countries at relatively low levels of expenditure.

MR. SUMMERS: Thank you very much, Dean.

Let me just thank you all for what has been an enormously valuable discussion from my point of view and from the point of view of the team that is writing this Report.

I take away several things. There are a large

number of specifics that have been taken away, but I take away your general support for the approach taken here and for the key role of the state in ensuring adequate health delivery.

I take away a need to relate our discussion to previous discussions and declarations regarding primary health care and to the emphasis on primary health care that has played a key role in discussions of these issues in the past.

I take away the importance of family planning as something that we must not lose sight of and in particular the broader question of women's health as something that has to be taken up not as a side issue, but as a central issue, in this Report.

I take away the need for this Report -- and I think this is something that the team has recognized -- to provide specific and explicit guidance on the respective roles of government and market; that the Bank is an economic institutions, and so our comparative advantage is not in epidemiology but is in economics, is in the design of incentive schemes that can best deliver results.

And I also take away that in discussing the respective roles of the government and the market, it is

critical that we not lose sight of institutions that exist between government and market, of nongovernmental organizations and their role, of issues relating to community-based care, of issues relating to decentralization and the autonomy of health care institutions; that it is too simple to just speak of what governments can do without giving guidance as to the level of governments.

And I finally take away support in most of the people who commented on it for the motivations that led to the decision to write a World Development Report on health; that there is a great deal that the international community can do that in relatively low-cost terms can contribute enormously to human welfare. And I take note especially of the plea that this Report conclude with a bold and hopeful agenda.

Thank you very much.

[Whereupon, at 4:12 p.m., the seminar concluded.]