The XII Malente Symposium on

Health Care Systems at the Crossroads:

The Drager Foundation

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Health Care Reforms that Serve the Poor

by

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Introduction

1. Mr. Chairman, Dr. Bruntland, distinguished participants;
   - I am delighted to be here.
   - I welcome this opportunity to address the twelfth Malente Symposium of the Drager Foundation.

2. Countries throughout the world are trying to reform their health care systems.
   - Many of you may be advising and helping governments to do this. I am not going to talk about the technical aspects of health system reform today in which many of you are experts.
   - Instead I want to talk about making sure that health reform also contributes to the fight against poverty. The way that health reforms are designed and implemented can have an enormous impact on the poor.

3. I want to make three key points today:
   - There has been immense progress in improving the health and nutrition status of people throughout the world.
   - The poor have not benefited as much from this progress as higher income groups. The poor bear a disproportionate burden of ill health and mortality, much of which could be cost-effectively prevented or treated.
   - If we want our efforts in health reform to make a large impact on global health outcomes, reforms must focus on the health needs of the poor. If we fail in this, there is a risk that health reforms will yield only marginal gains in health, nutrition, and reproductive outcomes.

4. I would also like to share with you how the World Bank's thinking and approach to development and poverty reduction has been evolving, and summarize some of our activities in the area of health, nutrition and population.

5. Finally, I will appeal to our international partners, including bilateral donors such as Germany and the EU, to join us in the fight against poverty as we enter the 21st Century.

Remarkable Achievements in Health, Nutrition and Population

6. Recent achievements in health, nutrition, and reproduction are remarkable. There have been greater gains in life expectancy and greater decreases in birth rates throughout the world in the past 4 decades than during the entire previous 4 centuries. Let me cite a few concrete achievements:
• People all over the world live almost 25 years longer today than they would have lived at similar income levels in 1900;

• There have been huge gains in infant mortality: the proportion of children who die before reaching age five is now less than half the level it was in 1960;

• Contraceptive use in low- and middle-income countries rose from 10 percent of married couples in the mid-1960s, to 55 percent in 1990; and as a result of this and other factors,

• on average, women choose (and are able to act on this choice) to have 3 children each, down from 5 in 1960.

7. Enormous progress has also been made in understanding the causes of diseases, and in developing effective preventive and curative interventions such as immunization and antibiotics. For example:

• In 1996, two hundred years after vaccines were discovered by the English physician Edward Jenner, 44 low- and middle-income countries already immunize 90 percent of all children.

• Smallpox has been eradicated, saving 5 million lives each year. Other infectious illnesses could also be eliminated, or at least controlled at low levels, with proper policies. Measles is a good example – more than a million children die each year from measles; most of those deaths could be prevented.

• Polio no longer occurs in the Americas, China, and many other countries. Within the next few years it should be eradicated world wide.

8. Health outcomes are powerfully influenced by socio-economic factors. In our lifetime, economic growth and rising living standards have also brought health and nutrition gains. These broader causal factors are especially powerful determinants of health at low-income levels.

• With growth and development come improvements in all basic needs – better nutrition, better housing, better access to clean water, and better sanitation. The impact of these factors on health is huge: for example, poor nutrition has been estimated to account for half of all infant mortality and morbidity, directly and indirectly.

• There are several mechanisms through which economic growth has had an impact on nutrition: higher agricultural outputs per person; a greater ability to deal with local famines, and the introduction of a healthier and more varied diet.

• As a result of these and other factors, child malnutrition rates in developing countries are now 20 percent lower than they were 30 years ago.
9. Education – especially for girls and women -- also improves health.

- Data from thirteen African countries show that a 10 percent increase in female literacy rates reduced child mortality by 10 percent.

- Women who have completed primary school have less than half the number of children compared to women without any education.

- There are many reasons for this link between health and education. For example, educated people tend to adopt healthier lifestyles, and they are also much less likely to abuse tobacco, alcohol, and illicit drugs.

10. Other public policies, outside the realm of the health sector, have also enhanced health by promoting healthy environments and lifestyles, and regulating dangerous and unhealthy activities by individuals and organizations. For example, successful public policies have helped:

- Lower the health problems related to road accidents by enforcing stricter drunk driving laws in Hungary,

- Decrease diarrhea through improved water and sanitation systems in Turkey, and

- Decrease the health consequences of tobacco, alcohol, and illicit drug abuse in Indonesia.

**Enormous challenges remain in the Health Sector**

11. The list of past successes should not make us complacent. There are still enormous challenges facing us in the health sector.

- 7 and-a-half million infants die every year during the perinatal period and 2 million more children die each year from diseases from which immunization could have protected them

- 200 million children under the age of five are malnourished and

- 120 million couples have no access to modern contraception

12. One of the greatest health and development setbacks in the last decade is the huge increase in mortality due to AIDS. In many African countries, AIDS has erased all of the life expectancy gains from health and development programs of the past 30 years.
• There are more than 30 million people in developing countries living with HIV/AIDS;

• and 16,000 more become infected every day.

13. Poverty is at the root of many health problems. Three billion people in the world today are poor, trying to live on less than US2 dollars a day. Many live under appalling conditions, deprived of basic things that most of us take utterly for granted, and which affect their health:

• 1-and-a-half billion people have no access to clean water

• the homes of 2 billion people have no sewage system

• 130 million children are unable to go to school

14. Health, nutrition, and reproductive outcomes are significantly worse among the poor than among the rich.

• Old enemies still afflict the poor, including malnutrition, high fertility, communicable diseases, childhood illnesses, and debilitating and life-threatening maternal and perinatal conditions.

• Communicable diseases cause about 60 percent of deaths among the poorest 20 percent of the world’s population, compared with only 8 percent of deaths among the richest quintile.

• More than half of the disease burden in Sub-Saharan Africa and South Asia could be dealt with by adapting existing cost-effective interventions such as immunization, integrated management of childhood illness, family planning, maternal and perinatal health care, food fortification, targeted nutrition programs, and school health services.

15. As populations age, non-communicable conditions and injuries account for an increasing part of the burden of disease.

• Many of these conditions are expensive to treat, and so health care costs become increasingly unaffordable for the poor.

• Many of these conditions are quite well understood, and preventive actions or remedies are available.

• But, because of a lack of resources, these interventions are not available to the poor, and may not be available at all in poor countries.

16. The differences in health care resources available to rich and poor countries are staggering.
Health care is one of the largest sectors in the world economy. In 1994, Global spending on health was about US$2,330 billion.

Low- and middle-income countries account for only US$250 billion worldwide or 11 percent of global health spending.

Yet, 84 percent of the world's population live in these countries, and they suffer 93 percent of the world's disease burden.

The sheer size of the health sector, and the potential impact that some reallocation of this spending could have on the poor, make it critical to understand the economics and political economy of health financing.

At current rates of economic growth, health care expenditure will grow at US$9 billion a year in low- and middle-income countries.

In principle, this is enough money to pay for essential preventive and curative services for the 900 million poor people who still do not have adequate access to basic health services.

However, if the current unequal patterns of health care expenditure persist, many of these additional resources will go to people who already have access to health services, rather than to the poor.

Policy Options to Channel Scarce Resources to the Poor

In low-income countries, there is much that could be done to design policies and programs that would give the poor access to essential health, nutrition and population services in both the public and private sector.

There is good global experience and understanding of what needs to be done, and which health care services would do most to improve health outcomes.

But changing the composition of health care services and the allocation of public financing is not easy. There are strong vested interests and strong and powerful lobbies to protect those interests.

It is particularly difficult, for example, to reduce or even freeze the public subsidy to a large tertiary hospital that serves middle-income urban groups, in order to expand, say, nutrition or family planning services for poor rural communities.

It is difficult to reform health systems in such a way as to provide the poor with access to a basic set of health, nutrition and reproductive services. But it is an absolute priority – if we are to make real inroads against global poverty and disease.
20. Many developed and middle-income countries have found that one way to provide health care for the poor is to ensure that there is universal access to basic services. This "non-targeted approach" is politically easier, since everyone benefits. But it can be prohibitively expensive and wasteful. For example:

- Some low-income Middle-Eastern countries spend as much as 4 percent of GDP on publicly-funded food subsidies that have little impact on the nutrition of the poor; and
- in Brazil, there is universal access to health services, but the largest share of public spending on health benefits the better-off and not the poor.
- To be financially viable, in many low-income countries, the non-targeted approach has to be restricted to a very limited range of public health and food fortification programs, and a few essential health services.

21. Targeted Approaches. Careful targeting can ensure that essential programs reach those who need them most. There are four ways to target health, nutrition, and reproductive services.

i. The first way is to identify the poor individuals or households most vulnerable to illness, malnutrition, and high fertility.

- Individual or household targeting can be done by applying a means test to identify the neediest. In Jordan and Tunisia, families below a certain income are issued a "health card". The health card allows them access to free or highly subsidized care in government health facilities.
- But in many of the world's lowest income countries like Bangladesh, India, and much of Sub-Saharan Africa, means tests are not administratively feasible. In rural areas, where a large part of people's incomes is from the food they grow or earned in the informal sector, it is difficult to assess such income.

ii. The second way is geographic targeting, where one identifies poor regions within a country or population groups that are particularly vulnerable to poverty

- Globally, nationally and locally, the poor often live in reasonably well-defined areas. Most of the world's poor live in South Asia, Sub-Saharan Africa, and a few countries in other regions. Poor regions, and sub-regions can be targeted.
- Within countries, it is often possible to select particular states, rural areas or urban areas where the poor live, or specific sub-groups within an area. For example, in Turkey a special emphasis has been placed on improving publicly run health services for the poor who live in the Eastern Provinces.
iii. **Third, one can target by emphasizing the health, nutrition, and reproductive problems of the poor.**

- For example, many of the most common conditions of the poor can be effectively addressed through immunization programs, targeted nutrition programs, family planning, maternal and perinatal health care, and school health services.

- In Sri Lanka, school health services have done much to improve the nutrition and health of poor children who benefit from de-worming and nutrition supplements.

- In Bangladesh, concerted efforts by the government to expand family planning services, maternal and perinatal health care have been highly effective in lowering mortality and morbidity among the poor.

iv. **The fourth way to target is to focus on the levels and types of service providers from whom the poor receive most of their care.**

- For example, in South Africa, a high priority has been given to funding special clinics that serve the poor in socially deprived areas.

- In India and other low-income countries with weak institutional capacity in the public sector, reforms are being tried to subsidize care by private clinics that are willing to treat the poor.

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**Trends in the World Bank's Thinking on Development and Work in Health, Nutrition, and Population**

22. Most of you probably know that the World Bank is deep into a process of taking stock of what we do, and how we do it, to try and make sure that everything we support is directly or indirectly linked to the goal of poverty reduction.

- Poverty has many dimensions – including low income, malnutrition, mortality, illiteracy, social exclusion, and vulnerability to economic downturns, unemployment, disease, etc.

- A sound and sustainable long-term poverty reduction strategy requires both good macroeconomic and trade policies, and a whole range of inter-related policies in the social and structural agenda.

- If countries are to break out of the vicious circle of poverty, high fertility, poor health and low economic growth, they need good policies on health, nutrition, and reproduction, and effective health services. But these program are effective only if the economy or society are functioning well.
• Under a “Comprehensive Development Framework” there is explicit recognition of the equal importance of both the economic and financial pre-requisites of development, and the social and structural areas.

23. During the past 25 years of our work in health, nutrition and reproduction, we have learned much in the World Bank, and become increasingly active in three main areas:

• The first area is policy dialogue and non-lending activities (some of which I will describe in a minute), in individual countries

• Second, hand in hand with policy dialogue and analysis, the World Bank of course makes substantial direct investments in health, nutrition, and population through our lending and grant programs, together with partner donors.

• Finally, the Bank contributes to generation and dissemination of global knowledge on health, nutrition, and population issues through regional and global studies, operational research and analysis, and sharing the lessons of our lending and other work across the globe.

So first, let me talk a little about Catalyzing Change at the Country Level

24. The country level is the main area for World Bank activities and support.

• In each individual client country, the Bank’s global experience, financial resources, and comprehensive engagement in development are brought together to try to catalyze changes that will reduce poverty.

• Through our financing (whether loans, credits, or grants), country-specific analysis, and policy dialogue, we try to promote systemic reforms that are needed and that will have a positive impact on the poor.

25. World Bank strategies for support to each country are now developed in close partnership with countries themselves – “putting countries in the driver seat”.

• Increasingly, this is done in ways that draw all segments of society into a broad discussion of development priorities.

• World Bank support needs to be selective across countries and across activities within countries. We need to be selective in supporting strategies that will be effective in reducing poverty.

• Malawi provides a good example of how poor health and the lack of a healthy environment (especially sanitation, water, basic education, and adequate income) can be a central focus of the country strategy.
26. Specific analytic studies are also an important part of our work in the health sector.

- There have been a number of recent country-specific studies on the links between poverty, and health, nutrition and population issues.

- Two examples are an analysis of equity in health in Peru, and of the impact of the economic and social crisis on health status in Asia.

- These studies can be very revealing about the health, nutrition, and population issues and investment needs of the poor in specific client countries, and provide a firm basis for sensitive and sound policy and program development.

The second area I want to talk about is Financing through Loans, Credits, and Grants

27. Since the Bank’s first loan of US$2 million for family planning activities in Jamaica in 1970, activities in health, nutrition and population have grown to the point where the World Bank is now the largest single external financier in low- to middle-income countries.

28. In 1998, 7 percent of the total US$28.6 billion that the World Bank lent, was for health, nutrition, and population. Cumulative lending over the past 10 years, to the 10 largest borrowers in the health sector is almost $8 billion.

Details as follows

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<thead>
<tr>
<th>Country</th>
<th>Amount</th>
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<tbody>
<tr>
<td>India</td>
<td>2,777 million</td>
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<tr>
<td>Mexico</td>
<td>1,215 million</td>
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<tr>
<td>Brazil</td>
<td>935 million</td>
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<tr>
<td>Argentina</td>
<td>691 million</td>
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<tr>
<td>China</td>
<td>594 million</td>
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<td>Bangladesh</td>
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<td>Indonesia</td>
<td>445 million</td>
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<td>Russia</td>
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<td>Venezuela</td>
<td>248 million</td>
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<td>Nigeria</td>
<td>244 million</td>
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29. About 85 percent of the world’s poor live in these 10 countries.

- Much of this lending targets diseases of the poor, and improvements in basic health, nutrition and reproductive services used by the poor.

- Examples include: HIV/AIDS, malaria, and tuberculosis projects in India; population and reproductive health projects in Bangladesh; health care reform in Latin America; and nutrition projects in Sub-Saharan Africa.

30. But lending to the health sector is not the only lending which improves the health of the poor.

- Lending to all social services — including education, and social protection — has been rising, and reached nearly 20 percent of all new Bank lending in the last fiscal year.

- In addition, lending for agriculture, water and sanitation, environment, and rural and urban development also impact on health, nutrition, and population outcomes. These sectors collectively account for 20 to 25 percent of total Bank lending.

The Third Major area is the Bank’s contributions to generating and disseminating Global Knowledge

31. Many of the Bank’s policy studies in health, nutrition and population focus on the role of the state and non-government actors in addressing the needs of the poor, on the performance of health systems, and on sustainable financing. Some of you may be familiar with some of the studies, such as:

- The 1980 Health Sector Policy Paper, which was a first attempt to set out a solid rationale for Bank investment in health, expounding on the links between health, poverty, and family planning.

- The 1993 World Development Report: Investing in Health emphasized the need for governments to ensure access to cost-effective health services and sustainable financing, especially for the poor.

- The 1997 Sector Strategy for health emphasized the need to improve the health, nutrition, and population outcomes of the poor, and to protect populations from the impoverishing effects of illness, malnutrition, and high fertility, and

- The 1997 Report, Confronting AIDS, documents the impact of AIDS on poverty and makes the case that AIDS prevention is a core responsibility of governments.

32. The Bank has also published many books, technical notes, and working papers that deal with health, nutrition and population issues — nearly 200 so far, many of them
dealing with the health problems of the poor. A recent study looked specifically at how much of the global burden of disease is borne by the poor.

33. About US$20 million – or one quarter of the Bank’s Development Grant Facility is allocated annually to research or programs in the health, nutrition and population sector.

- Much of this is devoted to health problems of the poor, notably HIV/AIDS, Malaria, and Safe Motherhood

34. Something that is less well-known is that loans and credits from the World Bank provide by far the largest source of research funding for research and analysis of health, nutrition and reproductive issues in client countries.

- About 5 to 6 percent of total lending in the sector is devoted to country-specific research.
- This has provided research funding in recent years ranging from 50 to 75 million US dollars per year.

35. The Bank’s Economic Development Institute offers training and seminars on health issues for senior policymakers in client countries. The course on Health Sector Reform and Sustainable Financing focuses on the economic, political economy, and institutional issues that are central to health reforms, and that can help ensure that essential services reach the poor.

36. Several international conferences and scientific meetings organized by the Bank and its partners in international health have addressed issues that impact the poor. One could mention:

- the 1990 World Summit on Children in New York that UNICEF led;
- the 1991 and 1998 meetings on Safe Motherhood in Washington;
- the 1994 International Conference on Population and Development in Cairo;
- the 1995 World Conference on Women in Beijing;
- the 1996 International Conference on Early Childhood Development in Atlanta; and
- Client countries are encouraged to participate in these conferences and scientific meetings as part of the effort to strengthen institutional capacity and to learn, plan and act together.
Finally, I would like to highlight our current and future priorities

37. We recently published a Bank Strategy Paper for the health, nutrition, and population sector. This sets out our plans and commitments in health, nutrition and population as we head into the 21st century. We aim to assist client countries:

- **to improve the health, nutrition, and population outcomes of the poor**, and to protect people from the impoverishing effects of illness, malnutrition, and high fertility.

- **to enhance the performance of health care systems** by promoting equitable access to preventive and curative health, nutrition, and population services, that are affordable, effective, well managed, of good quality, and responsive to clients.

- **and third, to secure sustainable health care financing** by mobilizing adequate levels of resources, establishing broad-based risk pooling mechanisms, and maintaining effective control over public and private expenditure.

38. As in all areas of development, the complexities of the health, nutrition and population sector mean that there cannot be rigid policy prescriptions. Policy advice and financial support must be carefully tailored to specific circumstances in each country.

39. In all of our activities, the Bank now stresses the principle that assistance should be based on the likely impact on poverty groups; and on results rather than on inputs and outputs. This is more easily said than done, but I can outline some examples where these principles are being applied in practice:

- Malaria, HIV/AIDS, tuberculosis, tobacco and maternal and child health are major public health problems in which we have developed new programs of action in partnership with other agencies;

- A new Bank strategy on population and reproductive health issues is in the final stages of development;

- A similar strategy is being developed for nutrition; and

- A major effort is being made to forge better partnerships between the public and private sector in meeting the health care needs of the poor.

**A Call for Partnerships**

40. This brings me to a message that some of you may have heard me deliver before. I am going to repeat it today, because it is so important, that it bears repeating often, and acting upon.
41. None of the international organizations can hope to face the challenges of development alone. The Bank is therefore seeking close partnerships with others in the fight against poverty. Our partners include:

- Governments – national, state, city and municipal, within each country
- Multilateral and bilateral agencies such as Germany and the European Union
- Civil society
- And the domestic and foreign private sector.

42. We are particularly delighted with the renewed partnership with the World Health Organization.

- We have already benefited from one visit by Dr. Bruntland and look forward to her participation in our conference on Human Development in March this year.

- Most of our senior staff in health, nutrition, and population visited the WHO headquarters in Geneva last fall and we look forward to deepening the initiatives that were discussed.

43. Other collaborative initiatives that the Bank feels privileged to be a partner in include:

- support for the International AIDS Vaccine Initiative, UNAIDS, and working with the private sector in a renewed search for an AIDS vaccine;

- a multi-organization initiative to combat river blindness;

- a partnership with the Norwegian, Dutch, and Swiss Governments to better understand the links between poverty and health; and

- support to the Global Forum on Health Research which provides a mechanism for focusing Research & Development resources more tightly on priority areas, including health policy research, low-cost management of non-communicable diseases, and slowing the spread of drug-resistant microbes.
Conclusions

44. In conclusion, I would like to stress three ways in which our thinking in the Bank departs from past approaches to health care reform:

- **What is new** is an attempt to view development efforts within a long-term holistic and strategic approach, where we fight against poverty on a broad front, addressing all the components of development.

- **What is new** is a renewed commitment to development in today’s global economy where overseas development aid is declining significantly;

- **What is new** is the conviction that the international financial architecture must reflect the interdependence between structural, social and human concerns, with the macroeconomic and financial considerations that have tended to dominate the development agenda.

45. A few weeks ago in the United States, we celebrated the birthday of Martin Luther King. His “dream” is well known. Our dream at the World Bank is of a *World Without Poverty*.

To achieve that dream, we ask you to work with us,

- To fight poverty with passion and professionalism for lasting results;

- To help people to help themselves and their environment by providing resources, sharing knowledge, building capacity, and forging partnerships.

46. Thank you.