1. Bank Group Support to Health Financing

**Highlights**

- The way that health services are financed affects human welfare because it influences how health systems perform in improving health outcomes, and more directly, it affects the income and consumption of the poor.
- Health financing affects health outcomes and poverty through three main functions: revenues collected for health, risk pooling, and purchasing.
- Almost half of the World Bank’s health operations support countries in improving the way these three functions perform. The topic is nascent at the International Finance Corporation. Most Bank projects support revenues collected from public sources, but this support has declined over time, whereas Bank support to purchasing has increased substantially.
- Evaluating Bank Group support is timely because of its relevance to the institution’s newly articulated poverty goals and its ability to inform the post–Millennium Development Goals 2015 agenda. Also, health finance is a central part of the health strategy implemented by the new Global Practices.

The way health systems are financed can directly affect growth and human welfare (Box 1.1). Ill health can lead to financial hardship among low-income households that have to pay fees for health services: they may have to sell assets and incur debts to pay for care, and may fall into poverty or deeper into poverty. As a result, the poor often forgo care when it is needed and report worse health outcomes. Their ill health can keep them trapped in poverty and negatively affect a country’s growth prospects.

Improving health outcomes and protecting households against the financial consequences of ill health are top priorities to reduce poverty and sustain growth. Continuous growth depends on a healthy and productive labor force. Good health helps to increase education and the level of human capital. A healthy population also has a fiscal impact as it frees up government resources that can be used for alternative investments. These health outcomes are determined both by household behavior and by the level and quality of health care services.

How revenues for health are raised, managed, and then allocated to health care providers may also create different financial incentives for insurers, providers, and consumers, which will affect their behavior and use of resources for service delivery. This affects the type of care patients receive, including the quantity and quality of services and efficiency in service delivery.
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Box 1.1. What Constitutes a Health System?

There are diverse views as to what should constitute a health system. To date, 41 different conceptual frameworks have been developed to describe health systems, offering diverse perspectives in terms of focus, scope, taxonomy, linguistics, usability, and other features (Hoffman et al. 2012). Common elements are found across the different definitions. These include the need to support health system performance measured by improved equity in access, quality, and efficiency of care, independent of the patients’ diseases.

The World Bank has embraced strengthening health systems in its operational work. This approach was articulated in the 2007 Health Nutrition and Population Strategy (World Bank 2007). It says, “Health systems encompass all country activities, organizations, governance arrangements, and resources (public and private) dedicated primarily to improving, maintaining, or restoring the health of individuals and populations and preventing households from falling into poverty (or becoming further impoverished) as a result of illness.”

As countries become richer, they make tremendous progress in achieving better health outcomes. Yet substantial inequities in health remain across population groups because health systems in low-income settings often fail to respond to the needs of the population. A major problem is that poor individuals often do not receive needed care because they cannot afford to pay user fees charged by health care providers (Gottret et al. 2008). In addition, patient surveys and citizen scorecards point to public dissatisfaction with low-quality care, informal payments charged by providers to patients, absentee health workers, and unavailability of pharmaceuticals in underfunded health facilities (WHO 2000).

Countries are responding to these challenges by ensuring that the way they finance health care is efficient and equitable. The World Bank Group has supported these efforts through a combination of financial assistance, policy advice, and technical assistance. This is the first evaluation by the Independent Evaluation Group (IEG) of the World Bank Group’s support to clients seeking to design their health financing functions. The evaluation is timely because of both its relevance to the Bank’s newly articulated poverty goals and the need to inform the post–Millennium Development Goals 2015 agenda. Also, health finance is a central part of the health strategy to be implemented by the Bank’s new Global Practices.

Health Financing Influences Health System Performance

Health financing systems consists of three main functions: raising revenues to finance health, pooling health funds and risks, and purchasing health care (Figure 1.1). These functions are designed differently across countries, and no single health financing model is supported by the Bank Group. Instead, the World Bank and the International Finance Corporation (IFC) have taken a flexible approach toward
advise and support to health financing functions through tailored interventions, depending on country context.

Figure 1.1. Bank Group Support to Health Financing Influences Health System Outcomes

Revenues to finance health systems are raised from public, private, and external sources. Governments collect revenues through direct and indirect taxes to finance public spending, including that for health care. Some of these taxes can be earmarked for health. These domestic revenues for health are then transferred to the health sector in the form of internal transfers, subsidies, and grants to the budget of the Ministry of Health and to lower levels of government (e.g., regions, states, and municipalities), and as subsidies to public or social health insurance (SHI) to finance contribution payments for groups such as informal sector workers. Compulsory contributions to SHI are paid by employees, employers, and the self-employed. Private revenues for health include voluntary premiums paid by households to private insurance and to other prepayment mechanisms, and user payments made by patients (or out-of-pocket payments) directly to public and private providers. Some private providers and pharmacies only receive revenues from user payments. Additional revenues for health are transfers from external sources including bi- and multilateral donors and nongovernmental institutions (OECD et al. 2011).
Pooled financing is money raised through taxes or insurance contributions and premiums that individuals must pay whether or not they need care (Savedoff et al. 2012). Risk pooling is about how to pool financing to share the health risk among pool members. With the exception of user payments, all revenues for health are pooled and then transferred to providers. Depending on the country context, pools can take different forms including the central and local government budget, public and private health insurance, and community-based health insurance, among others. Participation in a pool is compulsory or voluntary. Compulsory pooling of public funds includes (i) automatic coverage of the population (e.g., national health services) and (ii) mandatory participation by law for all or a defined population group in social health insurance, which can be public or private health insurance. Voluntary pooling refers to coverage of individuals at their own discretion through private health insurance and community-based health insurance (Gottret and Schieber 2006; OECD et al. 2011).

Governments and health insurers purchase health care benefits on behalf of pool members from public and private providers and nongovernmental organizations (NGOs). Passive purchasing is when providers are simply reimbursed for medical services. Strategic purchasing requires countries to make decisions about how to pay providers and at what price, what benefit package should be purchased for whom, and from which provider. These decisions require information about the behavior of providers and consumers. They also need institutions to govern management in health facilities (Figueras et al. 2005; Gottret and Schieber 2006; Langenbrunner et al. 2009).

The way the three health financing functions are designed sets different financial incentives to the government, health insurers, providers, and consumers that will affect the attainment of health system outcomes. It will also influence how much of the health funds are spent on different forms of health care (to ensure service use relative to need); how equitable health revenues are collected from public and private sources and distributed (equity in finance); who is protected against the financial risk of having to pay for care (financial risk protection); and how effectively health care costs are managed (efficiency) (Hsiao 2007). The three main outcomes can be assessed by a set of indicators (Table 1.1).
What Has the World Bank Group Been Doing in Health Financing?

World Bank and IFC support to countries’ efforts to improve their health finance systems are guided by clearly articulated strategies. The Bank’s 2007 Health, Nutrition, and Population (HNP) strategy on healthy development sees health financing as a comparative advantage for the Bank because of “its multi-sector nature, its core mandate on sustainable financing, and its fiscal, general economic, and insurance analytical capacity, on regulation, and on demand-side interventions” (World Bank 2007, 51). The strategy aims to prevent poverty as the result of illness by improving financial protection, and strives to improve health outcomes, particularly for the poor and vulnerable. It also aims to improve financial sustainability in health and contribute to sound macroeconomic and fiscal policy, as well as governance, accountability, and transparency in health. The strategy focuses on results and agreements with global partners on a collaborative division of labor in client countries (World Bank 2007). Also, two World Development Reports have brought health financing on the international policy agenda (Box 1.2).

To help countries improve their financial protection, the Bank in its HNP strategy commits to provide sound policy advice about the best use of external assistance for health; to remove user fees if the lost revenue can be replaced with alternative resources that reach facilities in a fiscally sustainable manner; and to support effective public financial management systems to document the flow of funds. The Bank also stands to help countries identify options to reduce fragmentation across insurance and public funds, and improve integration with regulatory frameworks for public–private collaboration. Extending risk pooling to the informal sector and the rural population, guided by solid evidence, is a key priority for HNP. The Bank
also commits to support countries in their monitoring and evaluation (M&E), to assess whether arrangements improve financial protection for everyone including for the poor and near-poor (World Bank 2007).

Box 1.2. Health Financing in World Development Reports

The World Bank’s 1993 World Development Report (WDR) on investing in health argued that countries could reduce their disease burden by, at a minimum, doubling their public spending on cost-effective public health interventions and that external assistance for health should be increased in low-income countries (World Bank 1993).

The 2004 WDR on making services work for poor people reasoned that to improve services for the poor, copayments made by patients needed to be retained locally and tied to the performance of providers. They also need to contribute to the income of providers rather than compensate for inadequate public funds. To provide income protection for the poor against the financial risk related to health, the WDR argued that governments should subsidize insurance enrollment or develop specific programs, adjusting subsidies between rich and poor regions in decentralized health systems (World Bank 2004).

The HNP strategy strives to improve the financial sustainability of the health sector by helping countries monitor indicators for fiscal sustainability, fiscal space, effects of health financing on labor markets, and country-competitiveness determinants. The Bank commits to help low-income countries address issues of financial sustainability by leveraging household financing to expand risk pooling, attending to volatility in external funding for health, and encouraging governments to adopt pro-poor fiscal policies. In middle-income countries, Bank support aims to help countries dealing with financial sustainability including systemic efficiency problems and the fiscal and labor implications of SHI (World Bank 2007).

IFC’s health strategy seeks to contribute to institutional capacity building in client countries. It aims to promote efficiency and innovation within health, while improving health security and expanding financial protection against the impoverishing effects of ill health (IFC 2002). In 2007 the IFC outlined a strategy for engaging in the health sector in Africa (IFC 2007). The 2007 strategy called for combined investment and Advisory Service operations, to assist governments with developing appropriate regulatory frameworks in order to support growth in the private health sector; to increase access to capital, promote quality standards for service delivery, and support risk pooling mechanisms (IFC 2007). Both strategies expected a growing portfolio to focus on private health insurance and to support supplementary insurance that covers services excluded from mandatory coverage.

The Bank and IFC do not have a joint strategic approach to health financing. There is no joint strategic direction about the mix of public and private insurance, which population groups they should insure, and how to prevent and address risk-
selection in multiple-insurance contexts. Nor have the two institutions decided on whether and how to separate the financing and the provision of care.

**How Has the World Bank Group Operationalized These Strategies?**

The Bank Group’s role in health must be seen in a context of the changing nature of international development assistance. Its share of total development assistance for health is small and has decreased since 1998 from almost 20 percent to about 6 percent in 2013 (appendix Figure B.3). The largest areas of growth in donor assistance have been in health related global programs (e.g., the GAVI Alliance; Global Fund to Fight AIDS, Tuberculosis, and Malaria; and U.S. President’s Emergency Plan for AIDS Relief) targeted to diseases but typically not addressing health finance and system requirements (IEG 2011a). Partly in response to this trend, in 2007, the Bank’s health strategy emphasized selectivity and a greater focus on the Bank’s comparative advantage. This evaluation conducted a detailed review of the World Bank and IFC support to health financing through lending, investment, policy dialogue, and analytical work. Bank operations were included if they supported any interventions that are part of the health financing functions (appendixes A, B, and C). Similarly, IFC operations are included if they support private or public health insurers or health maintenance organizations (HMOs) (appendix D).

Bank support to health financing is managed by the Health, Nutrition, and Population, Social Protection (SP), and Poverty Reduction and Economic Management (PREM) Sector Boards. In addition, the Regions and the HNP anchor produce a large number of knowledge products. Health financing is a relatively new topic for the IFC, which offers advisory services and investments including loans and equity to private, for-profit insurance companies.

Between FY03 and FY12 the IFC made six investments, including two investments in private health insurance, two in Nigeria’s largest integrated HMO-provider network, and two in health-specific private equity funds, which have invested in insurance companies and HMOs. IFC also provided nine advisory services and funded two output-based aid operations to health financing (appendix Table D.1). Advisory services aim at generating knowledge and advising governments as well as private and public insurers (appendix D). Most IFC projects in health financing aim to improve the financial protection of underserved populations, expand access to private insurance covering the mandatory package, and improve access to care among the poor. The business case for direct investment in stand-alone private health insurance does not exist to the extent envisaged in the 2002 IFC health strategy. Thus, the operational execution of IFC’s strategy has emphasized
increasing health care access through direct investments in health care networks, centers of excellence, and wholesaling (see appendix D).

In the same period, the Bank provided 188 loans that included health financing interventions (appendixes A and C). These loans were implemented in 68 countries through development policy operations (56 percent) and investment loans1 (44 percent) (appendix B). The number of operations with health financing peaked in 2006 and then in 2010 when a large number of multisector development policy operations provided fast-disbursing financial support to ensure funding for social sectors during the economic crisis (Figure 1.2). About 40 percent of the Bank’s portfolio includes health financing. The share of health financing operations managed by HNP and the number of newly approved projects, have decreased as more health financing operations are implemented through development policy operations managed by PREM. Most health operations with health financing activities fund a variety of interventions, including infrastructure costs, but the actual lending amount for health financing activities is unknown.

Figure 1.2. Number of Bank Operations with Health Financing Activities by Sector Board

Most health financing projects support revenue collection from public sources (Figure 1.3). However, there has been a marked decline in this type of Bank support, whereas support to purchasing has increased substantially. Almost half of the projects support compulsory risk pooling, but few Bank operations focus on revenues from private sources, including user payments. The distribution of project interventions and objectives by Region and sector are presented in appendix B.
Most Bank projects in this evaluation aim to contribute to one of the four strategic objectives of the HNP strategy, namely, improving the health status of a population (Figure 1.4). Only a few health financing projects have a financial protection objective. Less than 20 percent of projects aim to improve equity in access, with access often defined as increased utilization or coverage of care. About one-fourth explicitly target the poor in their objectives (appendix B).  

**Figure 1.4. Objectives in HNP Health Financing Operations, FY03–12**

*Note: The IEG project portfolio review is based on 78 HNP operations with health financing interventions.*
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Bank lending operations are accompanied by a large body of analytical and advisory work, knowledge products, technical assistance, and training programs including the flagship course which is organized by the World Bank Institute (WBI). From 1997 to 2008 the WBI and its collaborating partners delivered 314 short-term training events on health sector reform and sustainable financing to 19,400 participants from 51 countries (Shaw and Samaha 2009). In FY03–12, the World Bank undertook analysis and promoted knowledge sharing on health financing reforms through 98 public expenditure reviews, at least 10 public expenditure tracking surveys, 20 poverty assessments, about 70 economic and sector work activities, 8 fiscal space studies, and a small but growing number of impact evaluations (appendices A and B). A large number of health financing workshops have been organized in the Regions, some of them in collaboration with the WBI and with initiatives such as the South–South Network and the Joint Learning Network. In addition, the HNP anchor supports health financing, including through the Results-Based Financing (RBF) initiative and the Universal Health Coverage initiative, which has conducted 25 country case studies. The Bank’s Development Research Group launched the ADePT health module software in 2011 which allows users to produce standard tables for health equity analysis.

Objective of the Evaluation

The evaluation’s objective is to examine the effectiveness of World Bank Group support to health financing in improving health system performance as measured by improved equity in service use, financial protection, and efficiency. The evaluation applies the health financing framework illustrated in Figure 1.1. The methodology is described in appendix A.

This is the first time that IEG has evaluated the effectiveness of Bank and IFC support to health financing. IEG’s 2009 HNP evaluation analyzed IFC and Bank portfolio performance in achieving health outcomes for the poor, conducted analysis of communicable diseases, and examined health in transport and water and sanitation operations. This evaluation will not examine lending to finance health care delivery including human resources, equipment, pharmaceuticals, and construction of facilities, nor the procurement of these products. Some of these aspects of health systems improvements were evaluated previously (IEG 2009). Also, as procurement in the health sector is not part of health financing, it will not be addressed (IEG 2014). Social safety nets through conditional cash transfers were evaluated previously (IEG 2011b).
The evaluation recognizes that reforms in health financing only are not enough to improve quality of care, ensure utilization according to need, or remove barriers in the use of care, and that additional investments are needed to assure health care. However, financing reforms are necessary to influence the provision of health care. Other factors also influence the performance of health systems and outcomes, including economic growth, demographic and epidemiological changes, new medical technologies, and the environment. However, examining these factors is beyond the scope of this health-financing-focused evaluation.

The evaluation addresses four questions, each of which is the main topic of the next four chapters:

- What is the evidence that Bank Group support to revenue collection for health leads to improved equity in health financing and service use, financial protection, and efficiency?
- What is the evidence that Bank and IFC support to pooling of funds and health risks leads to improved equity in health financing and service use, financial protection, and efficiency?
- What is the evidence that Bank Group support to purchasing leads to improved equity in health financing and service use, financial protection, and efficiency?
- What are the factors in successful Bank Group support to health financing reforms?

The evaluation offers lessons to inform future lending and knowledge activities.

This evaluation covers FY03–12 and draws on several sources (appendix A). They include a review of 188 closed and ongoing Bank operations (appendixes B and C), a review of Bank impact evaluations, 43 poverty assessments, 8 IEG project performance reports, semi-structured key informant interviews with 25 international health financing experts, and an electronic survey of Bank staff working in HNP. All IFC health-related advisory services and investment operations were reviewed (appendix D). The evaluation team also carried out 16 new country case studies, summarized in appendix E. Country case studies review reimbursable advisory services where relevant.

Two caveats stand out. Evidence on the achievements of the Bank and IFC project portfolio has been difficult to obtain, mainly because project M&E frameworks do not collect the relevant indicators (appendix A). Further, limitations in project data severely constrain the ability to assess the contribution of Bank and IFC support to health financing (chapter 5).
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References


Investment lending to the public and private sector finances project costs such as goods, infrastructure, and consultancies. Development policy operations are nonearmarked loans, credits, or grants that support the country’s economic and sector policies and institutions; they finance transition costs, institutional strengthening, and consensus building on reforms. Using its RBF experience, the Bank introduced a new lending instrument, Program-for-Results financing, in January 2012, which supports government programs and links the disbursement of funds directly to the delivery of defined results, with a focus on strengthening institutions. The Bank has approved one health project under Program-for-Results financing, namely the Ethiopia Health Millennium Goals Program for Results (P123531), approved in February 2013. It is not included in this evaluation. Public Financial Management for Results Program in Mozambique (P124615) includes public financial management, health and education and is scheduled for approval in June 2014.

Health, Nutrition, and Population (HNP) operations tend to target the vulnerable in their objectives. But as these projects often include disease-specific components, “vulnerability” could be interpreted as vulnerable to higher infection risk and not necessarily vulnerable to weaker socioeconomic status.

The Bank’s business warehouse database does not have a special code to identify public expenditure tracking surveys.


For more information, visit http://www.rbfhealth.org/.


ADePT is a software platform that uses micro-level data from various types of surveys, such as household budget, demographic and health, and labor force, to automate economic analysis. The ADePT health module allows users to produce most tables that have become standard in applied health equity analysis with a very low margin of error, and covers inequalities and inequities in health and health care utilization, benefit incidence, financial protection, and equity in health financing.