5. Factors in Successful Bank Group Support

<table>
<thead>
<tr>
<th>Highlights</th>
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<tbody>
<tr>
<td>❖ Government commitment to health financing reforms is influenced by political and fiscal constraints. The World Bank Group can reinforce commitment by building technical capacity but needs to be flexible and able to adjust to the local political and technical context.</td>
</tr>
<tr>
<td>❖ Bank analytical work has informed the international health financing dialogue and could be expanded to help institutionalize health financing reforms and build local capacity.</td>
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<tr>
<td>❖ To fully use its capabilities in health financing, the Bank Group should draw on the expertise from health staff jointly with public finance and fiscal experts and work across the new Global Practices.</td>
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<tr>
<td>❖ The Bank’s health financing portfolio is changing and focusing on one subintervention—performance-payment reforms, which is increasingly supported by results-based financing operations. Purchasing needs to be integrated with other health financing functions and public finance to be sustainable as outlined in the 2007 strategy for Health, Nutrition, and Population.</td>
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<tr>
<td>❖ This evaluation may be missing some successful Bank engagement in health financing because of weak monitoring and evaluation (M&amp;E) in health projects. Learning from the Bank’s rich country experience is constrained by weak M&amp;E in health projects.</td>
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The common success factors seen in the previous chapters that would make for good engagement in revenue collection, risk pooling, and purchasing include:

- Government commitment and technical and information capacity;
- Depth and relevance in analytical work;
- Capabilities and collaboration;
- Integration of all health financing functions; and
- Sound monitoring and evaluation (M&E).

Chapter 5 discusses how these factors cut across the three pillars of health financing and influence the effectiveness of Bank Group support and the implementation of the Bank’s Health, Nutrition, and Population (HNP) strategy. Chapter 2 showed that in governments that are committed to improving health outcomes and increasing support to the sector, efficient and equitable revenue instruments need to be used, taking into account the overall public finance context. Similarly, to address the many challenges in risk pooling described in chapter 3, strong institutions, management, and technical capacity are needed as well as information capacity to manage pooled funds. Bank analytical work helps inform governments in these health financing decisions. As seen in chapter 4, purchasing depends on integration with risk pooling to address financial barriers and thus revenue collection and with public finance. Purchasing depends heavily on information systems, M&E, technical capacity to analyze performance and define payments, and government commitment to
in institutional reforms to allow providers to respond to financial incentives. The Bank’s 2007 HNP strategy—chapter 1—sees health financing as a comparative advantage for the Bank because of its analytical capacity and multisector nature. Chapter 5 also contains lessons learned from the country case studies conducted for the evaluation (appendix E).

**Government Commitment, Technical and Information Capacity, and Flexibility**

Whether Bank support to health financing reforms is sustained depends on government commitments to allocate revenues to health, execute health budgets, address inequity in health financing, and introduce institutional reforms, including passing legislation, changing provider autonomy to allow responses to financial incentives, addressing fragmentation, and linking health financing to broader public sector reforms. Governments are also required to invest in information to document the flow of funds in the sector, build technical capacity to analyze information collected on finances and performance, and address adverse effects.

Mounting political commitment by governments has ensured important health financing reforms in countries such as Afghanistan—where nongovernmental organizations (NGOs) were contracted by the government—and Ghana, Rwanda, and Turkey, which introduced impressive health financing reforms. Yet insufficient financial commitment has limited reform sustainability. Ghana has too little fiscal space to subsidize insurance coverage for the poor, leading the health insurer to use a 1.7 percent poverty rate rather than the true rate of 30 percent. Weak technical and information capacities in Tunisia stymie coverage for the poor under the Free Medical Assistance Program (IEG 2014).

Government commitment is also affected by political, not just financial and technical constraints. In Bolivia, Bank lending and analytical work guided much of the policy discussion in health financing reform. However, since the government changed in 2006, the Bank has not been considered a technical partner in health financing. Similarly, in Egypt the Bank was engaged through lending and analytical support in consolidating insurance reform and the family health model, which was widely considered coherent and innovative. But discord within the government over the reform led to implementation difficulties, and the Bank has since found it hard to reengage. In Rwanda, Bank support was conducted through policy dialogue and general budget support, which addressed a wide spectrum of health financing reforms. But in 2009, the government decided under its division of labor policy that the Bank should redirect funds to other sectors. The Bank has since been absent from the health financing policy dialogue there. Although the Bank provided extensive
technical assistance to drafting the health financing policy in Rwanda, after the
Bank’s health financing team left, momentum drained and the draft policy has yet to
be finalized (IHP+ 2012). In Kenya, by contrast, the relationship with the
government has improved markedly since 2009. The Bank is now engaged in an
array of health financing activities, including analytical work on the level and
allocation of fund, and the government has provided additional $50 million in FY
13–14 to compensate providers for free maternity care. The International Finance
Corporation (IFC) has convened the stakeholder dialogue and supports
management reforms in the public health insurer. In addition, the Bank financial
collaboration with health facilities has contributed to improved reporting and
accounting of revenues in Kenya.

Technical capacity facilitated understanding for health financing reforms. The
Bank’s HNP regional departments and the World Bank Institute (WBI) are building
local technical capacity that helps facilitate dialogue on key health financing issues
with governments. Country and donor representatives interviewed by the
Independent Evaluation Group (IEG) indicated that WBI courses have improved
their understanding of the technical and policy aspects of health financing reform.
For this evaluation, the IEG conducted an online survey among graduates of the
WBI flagship course. Almost three-quarters of the 109 participants who completed
the survey said they had a chance to implement what they had learned during the
course. More than 80 percent used the literature from the course in their work, and
more than half of them said the course had a positive impact on their collaboration
with Bank staff. The WBI should consider tracer surveys among future graduates to
ensure that its courses build technical capacity for health financing (appendix A).

In some countries, including Brazil, Bank support to building the institutional
foundations at municipality level contributed to the timely execution of the health
budget. Bank support to consumer information and information technology has
created transparency in insurance management in Vietnam and elsewhere. The Bank
could also help more countries institutionalize standardized methods commonly
used in Organisation for Economic Co-operation and Development countries, such
as National Health Accounts to track the flow of funds in the sector. Standardized
government M&E helped inform Public Expenditure Reviews (PERs) in several
countries, built local technical capacity, and created a better understanding for
health financing reforms.

In some cases, Bank support needs to be more flexible and adjust to the local
political and technical context. In a low-capacity environment like Afghanistan, the
Bank demonstrated such flexibility. Given the limited ability of the Ministry of
Health to provide or purchase services, the Bank supported contracting with NGOs
and provided large-scale assistance. Similarly, in Benin, Bank support to pooling and purchasing was calibrated to the local context. In Tanzania, however, other donors viewed Bank financing as inflexible as it proved hard to finance one of the nine option papers on fiscal space to feed into a larger health financing strategy paper. Beyond flexibility, in some countries including Egypt, the Bank would have been more useful had it possessed a better understanding of the political economy.

**Depth and Relevance of Analytical Work**

The Bank has a unique ability to connect operational work with research and evaluation to inform policy making through its knowledge products. It has provided analytical support to health financing reforms including those for fiscal space, PERs, insurance analysis, and impact evaluations on insurance and results-based financing. Through this work, the Bank maintained a policy dialogue with governments that contributed to informing health financing reforms in countries such as Afghanistan, Ghana, Mexico, Kenya, Poland, Rwanda, Turkey, and Vietnam—and elsewhere.

The Bank has launched a growing number of impact evaluations to examine the effect of health financing reforms. The World Bank Development Impact Evaluation database in the Development Economics Group had 178 health-related impact evaluations in 2013. Of these, 14 are on health financing and complete and available (appendix Table A.8). Most of them examine health insurance in China and Vietnam. Results-based financing has become the most frequently researched topic among the ongoing evaluations (appendix Figure B.4). None of these impact evaluations, however, includes a cost-benefit analysis. Another drawback is that the Development Impact Evaluation database is not comprehensive and may have missed some impact evaluations of Bank-supported reforms (e.g., impact evaluations financed under a Bank project or conducted by non-Bank researchers).

Through health financing workshops, the Bank promotes international dialogue. It also adds value by creating and maintaining the global health databases with health financing indicators. International health financing experts and stakeholders in client countries interviewed agree that the Bank adds value through its knowledge work on health financing, health financing analysis in PERs, poverty assessments, fiscal space analyses, and a growing body of impact evaluations. They consider these reports of high quality and very useful. However, the Bank does not have a central registry that would make these studies or workshops easily accessible.1
CHAPTER 5
FACTORS IN SUCCESSFUL BANK GROUP SUPPORT

The Bank has conducted an array of analytical work on health financing, including in sector analysis, PERs, and fiscal space studies. However, these reports do not necessarily examine the poverty and equity effect of health financing. The Bank could therefore deepen analysis on health financing in its poverty assessments. In 2007–2012, few poverty assessments with a health chapter looked beyond epidemiological changes to examine the poverty impact of health financing. Twenty of the 43 poverty assessments assess the country’s health financing situation (appendix Table A.5), but their approach varies greatly (Table 5.1). Ten included benefit incidence analysis, and five presented out-of-pocket spending as a share of total health expenditures. Few analyzed utilization combined with out-of-pocket spending. Health insurance enrollment among the poor is reported in 10 reports, but they did not analyze whether insurance improves utilization of care or protects the insured against catastrophic spending or falling into poverty. Two assessments reported on impoverishment from health shocks (Azerbaijan and Georgia) and compared household income before and after health payments.

Table 5.1. Poverty Assessments with Relevant Health Financing Analysis, 2007–2012

<table>
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<tr>
<th>Indicators used in poverty assessments</th>
<th>Country of poverty assessment</th>
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<tbody>
<tr>
<td>Benefit incidence analysis</td>
<td>Azerbaijan, Bangladesh, Chad, Ghana, Indonesia, Kenya, Nicaragua, Paraguay, Senegal, Zambia</td>
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<tr>
<td>OOP expenditure in health as percentage of total health expenditure</td>
<td>Azerbaijan; Georgia; Tajikistan; Uzbekistan; Venezuela, RB</td>
</tr>
<tr>
<td>OOP expenditure in health as percentage of total household expenditure</td>
<td>Azerbaijan, China, Georgia, Iraq, Nicaragua, Tajikistan, Uzbekistan</td>
</tr>
<tr>
<td>Percentage of lowest income quintile households participating in risk-pooling schemes</td>
<td>Argentina; China; Georgia; Ghana; Indonesia; Macedonia, FYR; Nicaragua; Paraguay; Russian Federation; Venezuela, RB</td>
</tr>
<tr>
<td>Percentage of households with catastrophic health expenditures</td>
<td>Azerbaijan, Georgia</td>
</tr>
<tr>
<td>Percentage of population falling below the poverty line because of illness</td>
<td>Azerbaijan, Georgia</td>
</tr>
<tr>
<td>Severity of poverty because of OOP expenditures</td>
<td>Azerbaijan, Georgia</td>
</tr>
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Note: For Kenya see www.worldbank.org/SDI; OOP = out-of-pocket user payments.

As in PERs, the Bank’s poverty assessments could usefully follow a common methodology to analyze the impact of health financing for households. This methodology could be developed based on the experience from the Azerbaijan and Georgia reports, and be integrated with the new Systematic Country Diagnostic framework which will focus on achieving the twin goals of reduced poverty and shared prosperity. Bank analytical work should be made easily accessible on the Internet.
Chapter 5
Factors in Successful Bank Group Support

Capabilities and Collaboration in Health Financing

Health financing requires a different skill set from that of the general health specialist. Since 2007, the number of Bank staff affiliated with the HNP sector has increased slightly. However, the share of economists among HNP staff remained at 19 percent, and the economist team became more junior as suggested by a decreasing number of lead economists working in HNP (from nine in 2007 to two in July 2013). The number of senior economists doubled from 14 to 29 in 2013. If the Bank is to be a major player in health financing, it has to staff accordingly.

The Bank’s comparative advantage lies in HNP’s ability to collaborate with the Public Sector and Macro and Fiscal Management teams and facilitate dialogue on health financing at all government levels, including the Ministry of Finance as outlined in the HNP strategy. To fully use its capabilities, the Bank Group could use a multisector team that draws on the expertise from Health and other sector experts and works across the new Global Practices and the IFC. Most IEG country cases found there was collaboration between the HNP hub and the Regions but limited cross-support from the Development Research Group or the Human Development chief economist, which is also confirmed in the HNP staff survey. Collaboration with the IFC was limited to the Health in Africa and India initiatives. Within the jointly established Health in Africa Initiative, an external mid-term review found that the Bank Group did not leverage synergies within the group and “operated without complementarity” (Brad Herbert Associates 2012). In several countries, including Argentina and more recently in Kenya, this collaboration has worked well and has improved results. Collaboration is essential in a broad-based systems approach to link health financing reforms (in purchasing, pooling, taxation, and user fees) to public sector reforms and lead the health financing dialogue at all government levels. However, the evaluation’s country case studies and the international health financing experts noted that the Bank does not often exert this leadership role.

The Bank’s Health and Public Sector teams could enhance collaboration to fully embed health financing in broader public sector reforms. In Vietnam, health support has not been a significant part of overall public sector reform in the past, and a need to enhance coordination was emphasized in the IEG case study by the HNP and Poverty Reduction and Economic Management teams, with a view on macro-level issues of health financing reform such as fiscal space, costing of coverage, and affordability and sustainability of reforms. Similarly, in Benin reforms were intra-health focused without drawing enough on expertise on how to create fiscal space or considering longer-term implications of fiscal sustainability. In Tanzania the health team was involved in government-wide public financial management reform to track resource allocations to decentralized levels of government. Still, an attempt was made (without
success) to harmonize three independent reforms in this area. In Uzbekistan treasury reform supported by the Bank’s Public Sector team reintroduced rigidities in spending that reduced intended increases in autonomy and flexibility at health institutions. This created a contradiction between public financial management and health financing reforms—one that has yet to be resolved.

The international health financing experts raised concerns over the Bank’s dwindling capabilities in health financing. While the Bank has added value in the area of strong technical skills, the general impression is that it is not as deep as it used to be, following the departure of several more experienced health financing staff. Partner agencies reported they do not know who to contact on health financing at the Bank, and they raised concerns that recent senior retirees are not being replaced. There are also concerns that the Bank is losing its edge and a perception that it has become less serious about health financing. An example was that the Bank sent public health specialists to international costing meetings, where a health financing expert was expected. HNP staff interviewed by IEG echoed these anxieties and worried that this could affect the Bank’s future collaboration with other organizations. IEG’s country cases identified similar concerns. In several countries, including Ghana and Rwanda, the Bank did not maintain its health financing expertise even so governments embarked on substantive reforms.

Without doubt, the Bank’s capabilities affect partnerships with other bodies. At the country level as well as globally, the Bank works with other donors on health financing reforms.³ It often leads the donor collaboration agenda but not necessarily in health financing. Country-level engagements in health financing vary and are influenced by the perspectives of Bank staff, their available resources, and individual capabilities. In Nepal and Tanzania the Bank coordinated well with a multidonor sectorwide approach and basket funding arrangement, and has supported the health financing agenda as an active member of the technical working group of finance. Yet in some countries collaboration with Bank staff was described as informal, sporadic, and challenging, where staff are focused on disbursements instead of technical issues in health financing. In short, there is room to leverage synergies in collaboration between organizations so as to raise the quality of the health financing dialogue at the country level.

**Integrating All Health Financing Functions**

The evaluation showed that the Bank’s health financing portfolio is changing, and there is a growing focus on purchasing. Within purchasing most attention is given to one subintervention—performance- or results-based payment reform. This trend is
continuing. Since FY13, the Bank has approved 11 new RBF projects that are cofinanced by the Health Results Innovation Trust Fund. This is an impressive shift in the portfolio given that in previous years, HNP reported about six new health financing operations annually.

This shift in the Bank portfolio raises concerns that the Bank’s approach to health financing is driven by availability of trust funds; draws on an insufficient evidence base; and is not integrated with the other health financing functions and public finance. Payment reforms supported by the Bank’s RBF program tend to operate in parallel to health financing and public finance reforms (Ghana, Kenya, and Tanzania) and did not examine broader fiscal effects (Rwanda). Similarly, stakeholders interviewed by IEG in countries and among the international health financing experts indicated that the Bank focus in health financing seems to change with the viewpoints of the Bank’s leadership, with individual staff, and with the availability of donor funding to promote specific topics. For example, the Bank seemed only temporarily committed to support National Health Accounts as long as the external funding was provided. With the availability of funding from the Health Results Innovation Trust Fund, the Bank’s focus shifted to results-based payments in low-income countries. Because of these shifting areas of focus, the Bank is perceived as not properly linking health financing to poverty reduction.

IEG found that the Bank has integrated health financing reforms with public sector reforms in several countries, often in collaboration with Public Sector teams. Much of this support was provided through development policy operations. In Cambodia, cross-sector collaboration has been strong and effective, and the health economist in some instances took the lead in the overall policy dialogue with the government on public servant payment reform, for example. In Turkey health reform benefited from a dialogue between the public sector and health teams about the implications of insurance expansion for health spending, which were analyzed jointly. In Argentina, Bank support to the government’s budget helped protect pro-poor health spending. This was coordinated with the results-focused design of the Plan Nacer Program (Gertler et al. 2011). In several countries (e.g., Ghana and Serbia), the Bank provided support to public health insurers including to move to capitation payment and manage cost. In Bolivia, Cambodia, Turkey, and Uzbekistan, the Bank’s purchasing support could be considered a key entry point for other health financing reforms. The Bank can add value by stressing this comparative advantage via linking health financing with public finance and working across teams, as suggested in the 2007 HNP strategy.

These findings suggest that the Bank could revisit its approach to performance- and results-based financing and integrate purchasing, including that in RBF projects,
with other health financing functions and public finance. The Bank could link provider payment methods with public reforms to help institutionalize these changes. It could also help governments disseminate information on provider performance that affects the reputation of health care providers and informs consumers (e.g., infection rates, cleanliness in health facilities). As performance- and results-based payments mainly benefit patients who seek care, payment reforms need to be linked to pooling so as to reduce demand-side barriers in accessing care.

In countries with social health insurance, such as Ghana, Kenya, and Tanzania, the Bank could explore working with the insurer to implement its results-based financing activities with ongoing insurance payment reforms, instead of implementing a parallel activity. This would help streamline financial incentives, reduce fragmentation, and build institutions that support sustainability.

**Monitoring and Evaluation in Health Financing Projects**

This evaluation may be missing some successful Bank and IFC engagement in health financing because of weak M&E in health projects (appendix Table B.8 and Table D.4). HNP is among the sectors with the lowest ratings for the quality of project M&E. Of the 34 closed HNP projects with an IEG project completion review included in this evaluation, 25 percent were rated substantial or high M&E performance in IEG project ratings, which is considerably below the Bank average of 32 percent. Reasons for weak M&E ratings in Bank projects include missing indicators, indicators that are too vaguely defined or not measurable, use of national data to evaluate a pilot program, and unreliable data. However, looking forward, HNP is substantially investing in impact evaluations, and most of them are evaluating RBF pilot programs (appendix figure B.8). It remains to be seen how the results from these evaluations will inform future program expansion and progress in health financing projects.

The HNP strategy stipulates that the Bank monitor how health financing affects equity in service use, risk pooling, and financial protection, but this information is rarely collected in health financing operations (Table 5.2). The majority of Bank projects that aim to improve access to care monitor changes in the utilization of services, though rarely across socioeconomic groups. Of the 12 HNP projects with equity objectives, the China Rural Health Project is the only one monitoring utilization patterns across income groups. Four of the 11 HNP projects with objectives to expand health insurance report enrollment, but only two—in Turkey and Vietnam—report enrollment among the poorest as stipulated in the HNP strategy results framework. Only three of the nine projects with financial protection objectives report on changes in catastrophic spending or the impact of out-of-pocket
spending on household incomes; even so, these are indicators identified in the 2007 HNP strategy results framework. Only seven of 19 HNP projects with poverty objectives monitor changes in utilization of care for the poor.

<table>
<thead>
<tr>
<th>Number of HNP Projects with Health Financing Objective</th>
<th>Relevant Health Financing Indicators</th>
<th>Bank Projects with Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equity in service use (12 of 78)</td>
<td>Utilization of care across socioeconomic groups; visit rate of top versus bottom quintile</td>
<td>China (P084437)</td>
</tr>
<tr>
<td>Expand risk pooling (11 of 78)</td>
<td>Percentage of lowest income quintile households in risk-pooling schemes (HNP strategy indicator)</td>
<td>Turkey (P074053); Vietnam (P079663)</td>
</tr>
<tr>
<td>Financial protection (9 of 78)</td>
<td>Percentage of households experiencing catastrophic health expenditures</td>
<td>Kyrgyz Republic (P084977); China (P084437); Vietnam (P082672)</td>
</tr>
<tr>
<td></td>
<td>Out-of-pocket expenses in health as a percentage of total household expenditure (HNP strategy indicator)</td>
<td>Kyrgyz Republic (P084977); China (P084437)</td>
</tr>
</tbody>
</table>


References


1 The Bank’s Business warehouse reporting does not capture reports that were prepared within a project or under a technical assistance code. It also does not identify technical assistance or workshops.

2 Most collaboration with the Bank’s Development Research Group was on impact evaluations (see Table A.8).
Collaboration is on strategic issues, operational and country-level support, analytical product development, and knowledge and capacity building through joint health financing workshops, conferences, and the World Bank Institute flagship course. Some organizations provide temporary funding through trust funds to advance initiatives managed by the Bank Group (e.g., National Health Accounts, Universal Health Coverage, Health in Africa, and RBF). The Bank’s collaboration with universities is limited, mainly involving universities in the United States.