Management Response

The World Bank Group thanks the Independent Evaluation Group (IEG) for undertaking this evaluation. Management welcomes the opportunity to review and comment on IEG’s report on World Bank Group Support to Health Financing for Improving Health System Performance. This evaluation is timely as we embark on a One World Bank Group model encompassing the Global Practices and Cross Cutting Solution Areas and reevaluating our areas of strengths and space to enhance the performance in health financing. The IEG report generally provides a balanced commentary on most topics regarding the support of the World Bank Group to health financing and covers a wide terrain. Management also commends IEG for the way it engaged with management in a consultative process during the drafting of the report.

Broad Concurrence with Conclusions and Recommendations. Management broadly concurs with the conclusions and recommendations of this evaluation. Management welcomes IEG’s call for effective collaboration across the new Global Practices and IFC as well as the need for synergies in collaboration with external partners, as this will be critical in improving future World Bank Group support to health financing. IEG’s recommendation to develop a joint Bank and IFC approach to health financing is also timely and could not be over emphasized. The findings of the evaluation have broad relevance across the organization.

Comments Specific To World Bank Operations

General Comments

While the IEG report covers a significant amount of ground in terms of World Bank interventions on health financing, it could be more inclusive of the big picture in terms of the context in which interventions in health financing impact on our client countries. For example, management notes that in many emerging economies, while the private sector is not yet bigger than the public, the private sector is growing at a much faster rate. If that trend continues, over the period of a decade, the public sector’s weight will be reduced from perhaps half of the total to a small fraction of the total. Other players in global health have also grown and have a large weight relative to the direct role of the Bank in health financing.

The report covers the work of the World Bank Group only for the period of FY03–12. While it could be seen as beyond the scope of the report, it would be helpful to the reader to understand the larger historical perspective and note that the Bank’s health financing work has evolved over time (e.g., advocate for user fees in the 1980s, analytic work on voluntary insurance in the 1990s) to its current state. It could also
note that client demands have changed over the years (e.g., helping countries in Europe and Central Asia and Latin America and the Caribbean pivot away from tax-based health finance in the 1990s). More context could help explain the current state.

The report underemphasizes the Bank’s knowledge program role in supporting health financing, focusing mostly on lending. However, it could more explicitly recognize that much of Bank support to health financing reform is through technical assistance (often as an outcome of analytic and advisory activities, or AAA) rather than through lending. It may not have large monetary value (which is perhaps why work led by the Poverty Reduction and Economic Management Vice Presidency through development policy loans, or DPLs, comes across as so important in the overall support), but this does not make the technical assistance any less important to improving health system performance.

The report has an implicit focus on the Bank’s normative view of health financing. It indirectly suggests that one of the Bank’s strengths is its recognition of the many different ways to finance health and that there is not a “one-size-fits-all” prescription for clients. The report could benefit from recognizing this strength more explicitly.

RESULTS-BASED FINANCING

The portrayal of results-based financing (RBF) in the report could better reflect the reality of how Bank RBF projects in low- and middle-income countries operate. The country cases that were chosen are not the most representative. There are many RBF programs in the Health, Nutrition, and Population (HNP) portfolio that are more mature and have been under implementation for some time enabling a more in depth analysis of the impact over time. While the definition of RBF on page xv and paragraph 4.14 is accurate, in the rest of the report RBF is understood mostly as Pay-for-Performance (P4P), used in the OECD countries. The report often uses different yardsticks to evaluate the effectiveness and credibility of RBF. As many Bank-funded impact evaluations of RBF are still ongoing, the report prematurely draws several negative conclusions on RBF and minimizes positive findings.

The report describes RBF as a costly intervention and attention is drawn on financial sustainability. In most low-resource settings that the RBF operates in, key issues include poor utilization and low quality of services. Introducing RBF has resulted in large increases in service utilization and provision of quality interventions. By improving productivity and better leveraging the resources already invested, RBF payments form the incremental unit cost of providing the resultant service levels and quality standards. The small incentives used by Argentina’s Plan Nacer, one of the RBF programs discussed in the report, (2 to 4 percent of the provincial public health budget) have successfully leveraged the existing resources for health in the country. Impact evaluation results for the Nacer
Plan shows that the performance incentives are enormously cost-effective: the cost of a Disability Adjusted Life Year (DALY) saved was US$1,115, compared to a gross domestic product per capita of US$6,075. In Rwanda, facilities paid based on performance yielded better results in service provision and quality of care compared to facilities which received equivalent input-based budgets.

Government commitment is crucial for sustainability and is shown, among other things, by the financial contributions made by countries as diverse as Cameroon, Zimbabwe, and Armenia committing US$2 million, US$3 million and US$4 million, respectively, from their government budget to RBF. Further, RBF has supported the process of aligning and harmonizing donor inputs with government budgets. Burundi scaled up a virtual pooling system enabling the Government of Burundi, the Bank, and ten other development partners to jointly finance a comprehensive package of services. In Benin, a joint-basket fund supported by the Bank, GAVI and the Global Fund to Fight AIDS, Tuberculosis, and Malaria is managed by the Ministry of Health and used to pay for the RBF results in the health facilities in the country.

The report does not recognize the range of benefits that RBF provides. The report focuses on health financing, and portrays RBF merely as a provider payment mechanism. This is inaccurate because RBF is used as a platform to improve providers’ autonomy, strengthen monitoring, increase supervision, boost utilization and quality of care, and overall improve accountability and transparency in the health system. Impact evaluation studies (Basinga et al 2011; Gertler, Paul; Vermeersch, Christel. 2012) have demonstrated that paying for performance increased prenatal and postnatal care quality in addition to boosting service provision and that these effects translated into large and significant improvements in child health outcomes. The core concept of RBF is to promote a results-orientation by linking financing to desired outputs and encouraging entrepreneurial behavior by staff and managers. Further, unlike the typical provider payment methods (capitation, DRG1, case based), RBF payments do not reflect real service production costs, but aim at investing in front line services and modifying behavior, while leveraging existing resources in the health system. The IEG review, by focusing on a relatively narrow subset of country cases2 with an explicit health financing lens and drawing generic lessons, does not recognize the comprehensive nature of the RBF approach and what it has to offer. Moreover, the World Bank Group aims to

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1 DRG-Diagnostic Related Groups.
2 The 16 country cases in the IEG study that form the basis of the opinion on RBF include four countries where RBF is implemented with Bank support; out of which two countries (namely Benin and Kenya) were at the early stages of RBF implementation at the time of the study and two were more advanced (namely Rwanda and Afghanistan).
continue integrating RBF with the other health financing functions it is delivering to create a more comprehensive, systems approach.

EVIDENCE AND MONITORING AND EVALUATION

Finding evidence for IEG’s research questions is difficult. Most of the health financing reforms supported by the Bank are implemented nationwide, therefore making it difficult to use an experimental design (e.g., randomization) as an outcome identification strategy. Therefore, it should be recognized that the "limited evidence" of the Bank’s support to health financing reforms is also the result of the difficulties in producing rigorous impact evaluations that are implemented nationwide.

A more nuanced treatment of the monitoring and evaluation discussion would add value. Paragraph 5.23 states that “evaluation may be missing some successful Bank and IFC engagement in health financing because of weak M&E in health projects.” A more nuanced approach to this could be helpful. In cases where the Bank supported national reforms (e.g., through DPLs or AAA), there are no counterfactual or control groups to assess the impact. Analyses of the effects of health financing can be plagued by endogeneity (e.g., in the case of pooling, this could be the fact that insurance is a choice) that is difficult to overcome statistically and quantify without carefully designed impact evaluation and big data requirements. Evaluating these effects properly would require big financial investments by the Bank and, quite possibly, convincing clients to roll out health financing reforms in an “evaluable” way (e.g., phased or partial) — which may not be desirable for a number of reasons.

METHODODOLOGY

Health financing is one of several building blocks of a health system. The IEG conceptual framework for health financing would benefit from situating it as one of several "building blocks" of a health system (as the World Health Organization conceptualizes it). In several instances, there is a jump from health financing to health outcomes without putting other building blocks -- such as service delivery -- in complementary context.

MISSING PRODUCTS FROM THE WORLD BANK

Missing references to the Global Expert Team (GET) on Health Financing and Insurance. This was one of the few GETs in the Bank, and it would have been expected to help strengthen the Bank’s contributions in health financing and linkages across countries/regions. Its establishment attests to the priority given to
the Bank’s role in health financing. The evaluation did not mention this initiative, and did not comment on what mechanisms could have better ensured effective action in each health financing engagement.

**Narrow representation of lending and non-lending Health Financing tasks.** The report appears to have excluded projects where the Bank worked with clients to improve the allocative and technical efficiency of public expenditure, as most Sector-wide Approaches (SWAs) did explicitly (in South Asia, this would include the Bangladesh SWAp). In addition, the evaluation could have included operations which aimed to improve accountability of public expenditure and efficiency through contracting (such as the Uttar Pradesh Health Systems Strengthening Project) and as well as projects where the Bank supported efforts to pursue fiscal decentralization in health (as in the Sri Lanka Health Sector Development Project).

**COMMENTS SPECIFIC TO THE INTERNATIONAL FINANCE CORPORATION**

The International Finance Corporation’s (IFC) experience in the health financing space is relatively limited. Over the FY03-12 review period, IFC committed $161 million in this subsector, representing less than 1 percent of IFC total commitment volume across all sectors. According to IEG, the six investments and nine advisory services projects covered in the report already represent 100 percent of IFC interventions during the review period.

IFC was more optimistic in health financing when it formulated its health sector strategy in 2002. As indicated in IFC’s Management Response to a different but related IEG evaluation of the World Bank Group’s support to Health, Nutrition and Population in 2009, IFC learned that the business case for direct investment in stand-alone private health insurance does not exist to the extent IFC has envisaged it. Going forward, recognizing that in many emerging economies, the private sector is now growing at a much faster rate than the public sector, IFC anticipates greater opportunities for the World Bank Group to support private sector development in health financing.

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