World Bank Group Support to Health Financing
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<tr>
<td>HNP</td>
<td>Health, Nutrition, and Population</td>
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<tr>
<td>IEG</td>
<td>Independent Evaluation Group</td>
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<td>IFC</td>
<td>International Finance Corporation</td>
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<tr>
<td>M&amp;E</td>
<td>monitoring and evaluation</td>
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<td>RBF</td>
<td>results-based financing</td>
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All dollar amounts are in U.S. dollars unless otherwise indicated.
Acknowledgments

This evaluation is a product of the Independent Evaluation Group (IEG). The report was prepared by Pia Schneider with contributions from a team of evaluators and analysts. Management oversight was provided by Caroline Heider, Emmanuel Jimenez, and Mark Sundberg. Viktoriya Yevsyeyeva was responsible for all administrative aspects. Barbara Rice and Cheryl Toksoz provided editorial support.

Ann Flanagan conducted the analysis of the International Finance Corporation (IFC) portfolio and wrote Appendix D. Xue Li, Segen Moges, and Moritz Piatti conducted the World Bank portfolio analysis and reviewed the poverty assessments and impact evaluations. Key-informant interviews with international health financing experts were conducted by Pia Schneider and Judy Twigg.

The 16 country case studies were conducted by Manjiri Bhawalkar, Erik Bloom, Bjoern Eckman, Judy Gaubatz, Basil Kavalsky, Xue Li, Segen Moges, Moritz Piatti, Ana Milena Aguilar Rivera, Pia Schneider, Hjalte Sederlof, and Judy Twigg. Ann Flanagan provided private sector input to all country studies. The studies were peer reviewed by Cheryl Cashin and Nancy Pielemeier. Issue notes based on the country studies were prepared by Manjiri Bhawalkar, Cheryl Cashin, and Bjoern Eckman. The team is grateful for comments received from Robert K. Yin.

The evaluation greatly benefited from financial support from the Norwegian Agency for Development and Cooperation. Norwegian funds helped support consultants’ time and field visits for country case studies. The Norwegian support greatly enhanced the quality and depth of the data collection and evaluation analysis.

IEG management and colleagues provided helpful guidance and comments including Geeta Batra, Kenneth M. Chomitz, Marie Gaarder, Marvin Taylor-Dormond, Stoyan Tenev, and Nicholas York. Many World Bank and IFC managers and staff provided useful comments and support during the evaluation. The team is grateful for

the support received by the representatives of the governments of Benin, Cambodia, Ghana, Kenya, Mexico, Nicaragua, Rwanda, Tanzania, Turkey, and Vietnam where field-based country studies were conducted. We also thank the World Bank and IFC offices in these countries for mission support as well as donors who offered their time for interviews. The team is grateful for comments received from Jack Harlow and Bruce Ross-Larson.

Peer reviewers were Francois Diop (Abt Associates/U.S. Agency for International Development, Senegal), Randall P. Ellis (Boston University), Pablo Gottret (Social Protection, South Asia Region, World Bank), Joseph Kutzin (World Health Organization, Geneva), and Juan Pablo Uribe (Fundación Santa Fe de Bogotá, Colombia). The many thoughtful and thorough comments from reviewers improved the report and are much appreciated.
The way countries finance health care influences how well a health system performs and achieves its expected outcomes, including how equitable and efficient it is. Countries decide how to mobilize revenues from different sources for financing health care, how to pool revenues in public and private insurance and in a national health system with automatic coverage (risk pooling), and how to purchase care from health care providers.

The World Bank has implemented health financing activities in 68 countries during FY03–12. Health financing interventions are found in about 40 percent of the Bank’s Health, Nutrition, and Population portfolio. Most projects include interventions on revenue collection from public sources. Almost half of the projects support public health insurance and automatic coverage. More recently, results-based financing (RBF) operations became more prominent. The International Finance Corporation (IFC) delivered a small program in health financing.

This is the first evaluation by the Independent Evaluation Group of the World Bank Group’s support to countries trying to address health financing issues. While much remains to be learned about the health benefits, equity in service use and finance, and the financial protection value of health financing reforms supported by the Bank Group, this evaluation has been able to draw the following four major conclusions:

First, there have been some notable successes of Bank support to health financing. Bank support was more successful when the Health and Public Sector teams drew on a variety of skills across sectors and where government commitment to reforms was strong.

Second, Bank support has helped raise or protect public revenues for health. Equity in pooling increased where the Bank assisted governments in subsidizing compulsory contributions to various health insurance for low-income groups. However, increased pooling did not always lead to pro-poor spending, improved equity in service use, or greater financial protection. Support to reduce user payments was limited.

Third, the Bank has increased its focus on activity- or results-based payments supported by RBF projects. Little attention was paid to the impact on costs and broader effects on the public sector.
Fourth, an integrated approach that links health financing with public sector reforms is likely to be more effective than single-issue interventions because it builds the institutions that are needed for sustainability. This includes equitable revenue instruments, taking into account the overall public finance situation, moving toward compulsory pooling in insurance and national health systems, focusing on strategic purchasing, and giving attention to adverse effects in a broader public sector context. The linking of health financing to public finance requires strong collaboration across the Bank Group to facilitate the dialogue at all government levels.

The evaluation makes five main recommendations: support government commitment and build technical and information capacity; address health financing as a cross-cutting issue at the country level; focus on health financing as a core comparative advantage; integrate all health financing functions; and strengthen monitoring and evaluation in Bank and IFC projects.
Bank Group Support to Health Financing

Improving health outcomes and protecting households against the financial consequences of ill health are top priorities to reduce poverty and sustain growth. However, poor individuals often forgo care when it is needed because they cannot afford to pay user fees. They also report worse health outcomes, which can keep them trapped in poverty. How health care is financed thus influences who has to pay how much for care (financial risk protection), how much of the health funds are spent on different forms of health care, how equitably health revenues are collected from public and private sources and distributed (equity in finance), and how effectively health care costs are managed (efficiency).

The Bank Group’s role in health financing should be seen in a context of the changing nature of international development assistance. The Bank Group’s share of global development assistance for health is small and has decreased since 1998 from almost 20 percent to about 6 percent in 2013. 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. Because of the Bank’s involvement in both core economic as well as sector issues, health finance was seen as a principal focus area, a perception shared by other development partners.

This evaluation examines support from the World Bank and the International Finance Corporation (IFC) to health financing through lending, investment, policy
dialogue, and analytical work. Over FY03–12, the World Bank supported health financing reforms through 188 operations in 68 countries. Health financing interventions have been included in about 40 percent of the Bank’s Health, Nutrition, and Population (HNP) portfolio. This period saw a marked decline in Bank support to interventions related to public revenue collection for health, whereas support to purchasing care from providers increased substantially. The IFC delivered a small program in health financing with six investments and nine advisory services, and funded two output-based aid operations to health financing.

Accompanying Bank lending operations is a large body of analytical and advisory work, knowledge products, technical assistance, and training programs including the flagship course organized by the World Bank Institute.

The evaluation recognizes that reforms in health financing alone are insufficient and that additional investments are needed to ensure the supply of health care. But health financing decisions are necessary to influence the provision and use of health care and ensure financial protection.
Four evaluation questions are addressed:

• 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 health funds and 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?

Revenue Collection for Health

The main challenge for governments in financing their health care systems is raising revenues efficiently and equitably to provide individuals with essential health services and financial protection against unpredictable catastrophic financial losses caused by ill health. Where government revenue-raising capacity is weak, countries rely more on revenues from user fees, insurance payments, and development assistance. High user payments have raised concerns about the financial consequences for poor households and the negative effect on service use.

Two-thirds of the Bank’s health financing portfolio has interventions related to public revenue collection for health. Depending on the country context, the Bank advised governments to increase their budgets for health, protect health spending during the economic crisis, and introduce excise taxes to create fiscal space. In countries with social health insurance, the Bank supported improvements in tax collection administration and the payroll-tax take. It supported subsidies to finance contributions to risk pools for low-income groups and helped governments introduce explicit targeting of subsidies. In only a scattering of countries did the Bank help institutionalize monitoring and evaluation (M&E) to examine the level and flow of health funds to providers from public and private sources.

Health and Public Sector teams emphasized strong institutions and monitoring and evaluation through public expenditure reviews and tracking surveys. While this type of support has been decreasing over time, there are some notable successes. Several lower-income countries increased their health budgets based on Bank advice, although these increases were not always sustained. Bank advice also helped raise tobacco taxes in some middle-income countries. It also helped increase revenues for health by subsidizing contribution payments to various health insurers.

User payments are the most important revenue source for health sectors in low-income countries, and reducing these payments has fiscal and equity implications. Bank advice and a few operations have supported governments which have tried to lower user payments as a source of revenue, but evidence is limited that Bank support to reduce copayments for patients has improved service use and financial protection.

Pooling Health Funds and Risks

With the exception of user payments, all revenues for health are pooled in public and private health insurance and in central and local government budgets, and then transferred to providers. As countries grow economically, pooled health financing comes to dominate revenues from user fees. The objective of pooling of health funds and risk
is to ensure financial protection and equity in service use for members. But managing health revenues to ensure equitable and efficient pooling is a major challenge.

About 40 percent of the Bank’s health financing operations supports pooling of public funds through automatic coverage in national health systems or mandatory health insurance. The Bank also helped build institutional, management, and technical capacity to manage fund pooling at government units and in health insurance. Bank analytical work discussed the impact of risk pooling on adverse selection, service use, and financial protection and health outcomes in a few countries. Knowledge work informed governments about consolidating fragmented risk pools, mainly in middle-income countries. In some countries, the Bank could have taken a more active approach with the government to address weaknesses, including in targeting the poor. IFC-supported investments and advisory services include health insurance in India and a few African countries.

Reaching the poor requires commitment by governments. Equity in fund pooling improved where the Bank helped subsidize enrollment of the poor. But expanded coverage did not always lead to pro-poor spending, improved service use, or financial protection. The reasons for ineffective coverage include inadequate funding for services covered in the pool, insufficient information about benefits, and inadequate quality in service delivery. The Bank helped address fragmented pooling, but the topic remains an issue in several countries and can reduce efficiency. There is little evidence of the effect of IFC’s support to health financing on improved service use, equity, or financial protection because of the newness of the projects and scarcity of data.

### Purchasing

The public policy objective of purchasing is for providers to deliver quality care efficiently to individuals who need it. Formulating purchasing policy is challenged by the financial incentives of various provider payment methods and by the paucity of information on providers’ reactions to these methods. Payment incentives may encourage providers to change the number of services, manage costs, and improve quality of care, all of which can affect efficiency. Whether these incentives lead to the desired outcome depends on the institutional context for providers and how they react to them. Most countries have moved to paying providers based on their activities, which has led to increased service use and higher costs. A few Organisation for Economic Co-operation and Development countries have introduced performance-based payment to incentivize better quality and efficiency, though the evidence for better outcomes is slight. Transparent information and peer pressure may also affect provider behavior.

An increasing share of Bank health financing projects supports governments and insurers in purchasing. Some 60 percent of provider payment methods supported by the Bank include a performance- or results-based component, often on a piloted basis. Most are introduced in health systems with automatic coverage in low-income settings. These projects use the government as the purchaser. The majority of them run with the support of the Bank’s results-based financing (RBF) program to support policy and investment lending.

An RBF program typically supports a cash payment or non-monetary transfer made to a national or sub-national government, manager, provider, payer, or consumer of health services after predefined results have been attained.
and verified. Payment is conditional on undertaking measurable actions. RBF operations thus directly influence the provider payment method in a country. The Bank is conducting an increasing number of impact evaluations on provider payment reforms supported by RBF projects.

Bank support to purchasing has strengthened institutions, including management and information systems. Availability of care has increased where countries moved from line-item budgets to activity- or performance-based payments. Limited evidence suggests that higher public spending on health and performance-based payments have similar effects on service use. Performance payments mainly increased utilization of services that had higher unit payments and that providers could more easily control for; they had no impact on other rewarded services.

Where Bank support to purchasing was integrated with other health financing functions and linked to the public finance context rather than limited to narrowly defined payment methods, it has been relatively effective. This is because it addressed broader institutional reforms which in turn support sustainability. Bank RBF support to provider payments without measures to reduce user fees and
improve risk pooling is unlikely to improve equity in service use and financial protection. This points to the need to strengthen the linkage of RBF interventions to the overall financing of health systems.

Administrative costs and the financial implications for the payer are major sustainability concerns when introducing activity- and results-based payments, which the Bank did not sufficiently address. Adverse effects of payment reforms on sector efficiency were not examined in Bank analysis. The Bank did not examine spillover effects on public sector wages.

These factors have led to uncertainty over the financial sustainability of Bank support to results-based payments as shown in the country case studies. Most governments have not assumed financing responsibility in their recurrent budget for the cost of these programs, and even programs considered effective have not been taken over by governments.

Factors in Successful Bank Group Support

Common success factors include:

• Government commitment and technical and information capacity.
• Depth and relevance in analytical work.
• Capabilities and collaboration.
• Integration of all health financing functions.
• Sound monitoring and evaluation.

Mounting political commitment by governments has ensured important health financing reforms. The Bank has helped build technical and information capacity that is instrumental in implementing reforms. Yet insufficient financial commitment and capacity constraints are still limiting reform sustainability in low-income countries.

Bank analytical support to health financing and the policy dialogue with governments contribute to informing health financing reforms. Monitoring and evaluation of Bank support through the relevant health financing indicators is essential to analyze progress toward achieving strategic objectives.

The Bank’s 2007 health strategy sees health financing as having a comparative advantage for the Bank. Health financing requires a different skill set from that of the general health specialist. To fully use the Bank’s capabilities in health financing, collaboration across the new Global Practices and the IFC is needed. Synergies in collaboration with other organizations can be leveraged to raise the quality of the health financing dialogue.

An integrated approach that links health financing to multiple public sector reforms is likely to be more effective than single-issue interventions. This is the Bank’s and IFC’s comparative advantage as described in the 2007 health strategy. An integrated approach to health financing would entail efficient and equitable revenue instruments (tax and nontax) for health, taking into account the overall public finance situation. It also includes moving toward compulsory pooling, reducing fragmentation in pooling, and focusing on strategic purchasing. And it considers potential adverse effects in a public sector context. Linking health financing reforms to public sector reforms requires strong collaboration between the IFC and the Bank’s Health and Fiscal Management teams to help facilitate the dialogue on health financing at all government levels.
This evaluation may be missing some successful Bank and IFC engagement in health financing because of weak M&E in health projects. Although the HNP strategy stipulates that the Bank monitor how health financing affects equity in service use, risk pooling, and financial protection, this information is rarely collected in health financing operations.

Conclusions and Recommendations
The Bank’s 2007 health strategy remains valid to guide support to health financing reforms. However, the evaluation finds that key elements of the strategy have proven elusive (e.g., better integration and M&E). The reasons mainly revolve around capabilities and constraints to cross-sector collaboration, which are areas for further reflection for the Global Practices. Addressing these would allow the Bank Group to “punch at (or even above) its weight class” in an area where it has a comparative advantage.

The evaluation showed that the Bank and IFC do not have a joint strategic approach to health financing — there are no explicitly held positions 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. The Bank Group did not take an ideological stance in its work in health financing; rather, it worked flexibly in different country contexts. In line with the Bank’s health strategy, the Bank did promote a focus on improved results and performance in health facilities by helping governments and insurers change the way they pay providers.

The evaluation finds that evidence is thin on the effect of Bank and IFC operations and programs on ultimate outcomes, and much remains to be learned about the health benefits, equity in service use and finance, and the financial protection value of public spending, pooling, and purchasing supported by the Bank Group.

The four main conclusions of the evaluation are:

- There have been some notable successes of Bank support to all three health financing functions. These have occurred when Health and other Public Sector teams drew on a variety of skills across sectors and where government commitment to reforms was strong.

- Bank support has helped raise or protect public revenues for health against budget cuts during economic crisis. Equity in pooling increased where the Bank assisted governments in subsidizing compulsory contributions to various health insurance plans for low-income groups. However, increased pooling did not always lead to pro-poor spending, improved equity in service use, or greater financial protection. Support to reduce user payments was limited, and evidence is missing that it improved equity in service use and financial protection. This type of support often lacked the necessary fiscal and equity analysis.

- The Bank has been shifting its focus on health financing to performance- or results-based payments supported by RBF projects. Little attention was given to the impact on costs, broader public sector institutional reforms to allow providers to react to financial incentives and to demand-side barriers including user fees, and how to tackle these in a fiscally sustainable manner.

- An integrated approach that links health financing including RBF with public sector reforms is likely to be more effective than single-issue interventions in establishing the relevant institutions that are needed to sustain reforms.
The evaluation makes five recommendations to guide the Bank Group’s future work on health financing:

Support government commitment and build technical and information capacity to be able to inform health priorities and spending by:

• Supporting countries through capacity building in standardized monitoring of total health expenditures (e.g., National Health Accounts), with attention to serving the needs of the poor; and

• Expanding training in client countries in collaboration with local institutions to build knowledge and technical capacity through health financing learning platforms.

Address health financing as a cross-cutting issue at the country level by:

• Ensuring analysis of equity in health service use and finance, financial protection, and financial sustainability consistent with the aim of promoting Universal Health Care coverage.
Have Global Practices focus on health financing as a core comparative advantage of the Bank by:

• Building and expanding technical capacity among staff working on health financing in different Global Practices (including Health, Macro and Fiscal Management, Governance, Poverty, and Social Protection) to ensure that staff capacity is adequate to respond to country demand; and

• Having a clearly identified focal point on health financing for the World Bank Group.

Integrate all health financing functions by:

• Integrating results-based financing interventions with other health financing functions and the broader public finance context at the country level to address sustainability and prevent distortions; and

• Developing a joint strategic approach between IFC and the Bank and complementary implementation on the ground toward health insurance, including mandatory and voluntary coverage.

Strengthen M&E in Bank and IFC projects by:

• Improving appropriate M&E frameworks in Bank and IFC projects to put in place mechanisms to collect and monitor relevant indicators; and

• Monitoring distributional indicators, including on access and outcomes, consistent with benchmarking and tracking progress toward Universal Health Care coverage.
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The appendixes and Bibliography are available online at https://ieg.worldbankgroup.org/evaluations/wbg-support-health-financing.