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INDEPENDENT EVALUATION GROUP

Approach Paper
IEG Evaluation of World Bank Group Support to Health Financing in Improving Health System Performance FY03-FY12

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Introduction

1. Improving health outcomes and protecting households against the financial consequences of ill-health are top priority efforts 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. Ill-health, however, can lead to financial hardship among low-income households who 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 needed and thus report worse health outcomes. Their ill-health can keep them trapped in poverty and negatively affect a country's growth prospects.

2. The global strategy for improving health outcomes has evolved from a disease-specific approach to strengthening health systems. In the early 2000s the adoption of the UN Millennium Development Goals (MDGs) led to the launch of several global health initiatives and a substantial increase in development assistance for disease-specific programs.[1] However, studies on the effectiveness of these initiatives raised concerns about the creation of parallel systems, fragmentation of donor programs across diseases, and countries' capacity to absorb rapidly increasing resources through specific programs (WHO 2008). Disease-specific interventions implemented in vertical silos were considered as unsustainable and the focus should be on health systems[2] (GFATM 2008, GAVI 2011).

3. There are diverse views as to what should constitute a "health systems approach" (Attachment E). The World Bank has embraced strengthening health systems in its operational work and this approach was articulated in the Health Nutrition and Population (HNP) Strategy 2007 "Healthy Development". According to the HNP strategy, "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". The HNP strategic objectives include preventing poverty due to illness by improving financial protection, and improving financial sustainability in the health sector and its contribution to sound macroeconomic and fiscal policy. The strategy focuses on results, and agreement with global partners on collaborative division of labor for the benefit of client countries. In this collaboration, the Bank sees its core mandate in health financing due

[1] Including the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the Roll Back Malaria Partnership, and the Global Alliance for Vaccines Initiative (GAVI).

[2] International initiatives have been launched to strengthen health systems, including the International Health Partnership (IHP+), the Implementation Research Platform, and the High-Level Taskforce on Innovative Financing for Health Systems.

to its multisectoral nature which spans across the public and private sector (World Bank 2007) (Attachment E).

4. Some aspects of health systems improvement have been evaluated by IEG. A 2004 health evaluation recommended a more selective engagement in global health programs focusing on where the Bank has a comparative advantage, and strengthening the links to country operations. IEG's 2005 evaluation on Bank support for HIV/AIDS projects found the Bank contributed to improved access and recommended investing in M&E, strengthening local capacity, and a selective and strategic approach. The 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. It found significant underperformance in the Africa portfolio, especially in HIV/AIDS projects. Findings also showed that excessive earmarking to communicable diseases can distort health systems; and that sector-wide approaches (SWAp) increase government leadership and donor coordination. IEG's 2011 GFATM Review found the Bank should have a more complete engagement strategy with the Global Fund, including on a country level (IEG 2011). IEG is currently reviewing the partnership between the World Bank and GAVI, and is finalizing a meta-review of impact evaluation on the determinants of maternal health outcomes (Attachment D).

5. A growing (but, up to now, unevaluated) part of the Bank's health system portfolio is supporting health financing reforms. These reforms are key to addressing the sustainability and fragmentation issues that challenge the ability of health systems to improve outcomes, especially among the poor. Health financing is about raising adequate funds from public and private sources and allocating these funds to health care providers through purchasing mechanisms such that services are provided efficiently, and through different forms of pooling of funds (e.g. in insurance, equity funds, and government budget) such that people from all income groups can use needed health services and are protected against the financial risk associated with having to pay for care (Gottret and others 2008). More than half of the Bank's health operations managed by HNP, Poverty Reduction and Economic Management (PREM) and Social Protection (SP) include health financing, whereas a decreasing share of projects includes components devoted to service delivery, medical products, and human resources (Attachment C figure 6). Similarly, the HNP anchor has invested in health financing, including through the Results-Based-Financing Initiative and the Universal Coverage Initiative which is conducting 25 country case studies.

6. The Independent Evaluation Group (IEG) will evaluate the effectiveness of World Bank Group (WBG) support to health financing in reducing fragmentation and improving health system performance measured by improved equity in access, quality, efficiency in health care delivery and financial protection. The evaluation will identify the evidence that the WBG supports priority challenges in health financing, the effectiveness of WBG support to health financing, and how WBG support to health financing was carried out on a country level. It will draw lessons to help inform the Bank Group's future approach to health financing activities.

Scope of the Evaluation

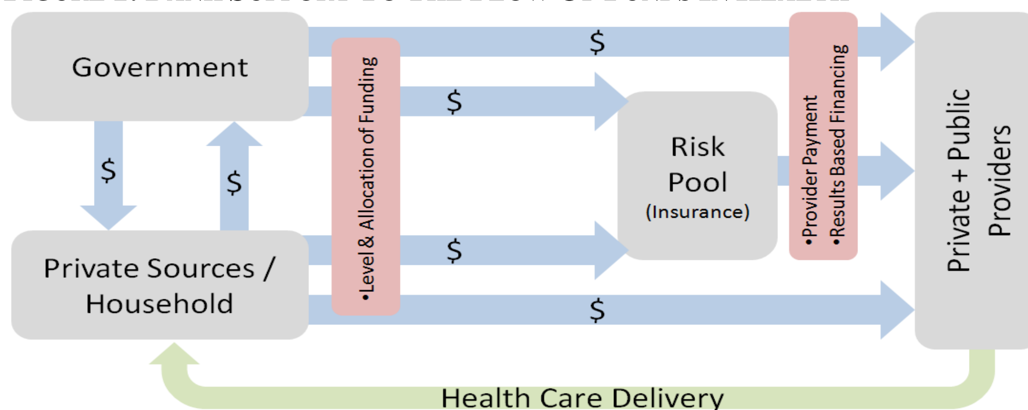
7. The evaluation will focus on health financing because it is an important and growing part of the Bank's HNP strategy and the WBG health portfolio and it has not yet been evaluated by

IEG. Health financing is also important to ensuring the sustainability, effectiveness and efficiency of other health interventions.

8. The Bank health portfolio has evolved as shown by an increase in PREM-led multi-sector development policy operations (DPO) which mainly support governance and health financing reforms (Attachment C). Similarly, an increasing share of IFC's health portfolio supports health financing activities. So far, IEG has not evaluated the effectiveness of Bank and IFC support to health financing, including the level of public and private health funding, insurance, financial risk protection, the allocation of funds through contracting with public and private providers, different provider payment methods and results-based financing linked to the fiscal transfer. Also, previous IEG health evaluations did not include PREM- and SP-managed operations with health components.

9. Focusing on health finance will enable IEG to evaluate WBG engagement on factors that affect system performance including equity in access, quality and efficiency in health care. Bank Group support to health financing includes technical advice and lending to the flow of funds in the health sector, including the level and allocation of health funds from households, private investors and public sources to insurers and health care providers, the way these funds are pooled, and how care is purchased and providers are paid by the government and insurers (figure 1). The Bank also provides technical advice to governments on the development and implementation of health financing strategies, legislation, regulations, policy formulation and information on the flow of funds. The effectiveness of these factors affects health care delivery and system performance. However, the evaluation will not examine lending to finance health care delivery including equipment, pharmaceuticals and construction of health facilities.

FIGURE 1: BANK SUPPORT TO THE FLOW OF FUNDS IN HEALTH



Source: IEG based on National Health Accounts Framework

10. The level of public health financing and the allocation of public funds within the health sector, affects the price patients will have to pay for health care services, their access to insurance and other types of fund pooling, the type of health care services they can afford, the quality and comprehensiveness of care they receive in health facilities, and how well patients are financially protected against the financial consequences of seeking health care services. The level of public spending for health can also crowd out private investors in areas that are competitive, and affect efficiency.

11. The Bank Group also provides technical and lending support to governments and insurers on how to contract and pay for care. This includes advice on contracting care from public and private providers and designing different methods of payments to providers including, results-based financing and capitation payment. The way providers are paid sets different financial incentives to providers and will affect their treatment behavior and their 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.

12. Depending on the context, health financing interventions can set adverse incentives that hamper system performance. For example, imperfect information can lead to adverse selection into insurance when individuals try to hide their "real" health status, leading to higher costs (Begg 2000). It can also set incentives for insured individuals to seek more care than needed – i.e. moral hazard - with consequences for the financial situation of the payer. Results based payment – such as fee for service – further incentivizes moral hazard behavior. The way health funds are allocated and providers are paid may also create different financial incentives for providers to change the number of services provided, manage costs, and improve quality of care; which may affect efficiency (Ellis and McGuire 1996).

Evaluation Questions

13. The purpose of this evaluation is to identify relevant lessons from World Bank Group support to health financing interventions. The overarching evaluation question is: "What has been the effectiveness of Bank Group support to health financing in improving health system performance in different contexts?"Bank Group support to improving system performance will be evaluated for its attention to equity in access, quality, efficiency in health care delivery and financial protection. Findings will help to identify lessons of success, and inform future Bank Group work and the upcoming 5-year update of the Bank's HNP Strategy (2007).

14. The results chain links health financing interventions, supported by the Bank and the IFC, to expected outputs and outcomes (table 1). The Bank provides lending and technical support to governments to change the public funding and the allocation of funds within the health sector. A change in funding affects the quantity of health staff, medical products, and health infrastructure and the price the public sector pays for these factors. Bank support to public funding may also crowd out or stimulate private sector investment. A better allocation of public funding is expected to improve the availability and quality of public and private sector care, and to decrease user fees that providers charge to patients, which will allow more low-income individuals to seek care. Fewer households will report catastrophic health expenditures or, will be impoverished due to health care payments and individuals are expected to report better health outcomes.

15. Bank and IFC support to develop and strengthen pooling mechanisms (including health insurance and equity fund) affect who is insured and how much patients pay for care. Better functioning insurers have higher population enrollment including in the informal sector, and have the capacity to contract with quality providers in the public and private sector, and analyze provider performance based on claims data transferred by providers. Insured individuals have lower out-of-pocket payments when using care, and they seek care with better quality providers when they need care. Thus, financial access to care improves for the insured.

16. The Bank also provides lending and technical support to governments to change the way health care providers are paid. Instead of paying providers a line-item budget based on the number of beds and staff, providers are paid based on their results such as the number of services or the quality of services provided, or a capitation amount based on the population size in the catchment area. Providers are expected to react to the financial incentives set by the payment and change the way they treat patients, and the quantity of services provided. Providers who are paid a capitation amount will have to manage their own budget and use their resources more efficiently. They might reduce costs for some input factors such as staff to spend more on others such as medical products. As a result, quality and efficiency of care is expected to improve, and more patients will be seeking care, if they can afford it.

TABLE 1: RESULTS CHAIN FOR HEALTH FINANCING EVALUATION

<table>
<tr><th>Interventions</th><th>Expected Outputs</th><th>Intermediate Outcomes</th><th>Final Outcomes</th></tr>
<tr><td>Level and allocation of health funds</td><td>• Improved availability and allocation of funds to purchase health services
• Reduced fragmentation of funding
• Improved availability of better trained health workers, medical products, and infrastructure through public and private sector
• Change in health worker behavior</td><td rowspan="3">Equity in Access:
Improved equity in insurance enrollment, health financing and service use in private and public health facilities

Quality:
Improved quality of care (e.g. treatment compliance, stock-out rates, infection rates)

Efficiency:
Improved efficiency in provision of care (e.g. number of staff/patient, occupancy rates, average lengths of stay etc)</td><td rowspan="3">Reduction in share of individuals falling into poverty due to ill-health

Reduction of population reporting catastrophic health expenditures

Improved population health</td></tr>
<tr><td>Pooling of funds and risks</td><td>• Integration of vertical programs
• Improved availability of insurance
• More low-income households are insured
• More insurers with computerized systems
• Insurers conduct provider performance analysis</td></tr>
<tr><td>Purchasing care</td><td>• Providers respond to financial incentives and adjust behavior and input factors, including the number of staff and treatment
• Better equipped facilities
• More private health facilities contract with public sector
• More treatment for which incentives paid</td></tr>
</table>

Source: IEG based on World Bank documents. World Bank (2007), Gottret and others (2008).

17. The four evaluation questions on Bank Group support to health financing are:

(1) What has been the impact of Bank support to the level and allocation of public health spending on equity in health financing and service use?

(2) What has been the effectiveness of Bank and IFC support to the pooling of health funds in (i) increasing the share of population insured across income groups, (ii) quality and efficiency of care among contracted providers, and (iii) equity in financing and in service use for individuals?

(3) What has been the impact of Bank support to purchasing through results-based financing and other payment reforms on (i) equity in health care service use, and (ii) efficiency and quality of care as identified in projects?

18. For each of these interventions, the following sub-evaluation questions will be examined:

- Did WBG support to health financing interventions lead to an alignment of incentives with outcomes for health providers in the public and private sector?
- How did WBG support to health financing address regulatory and management reforms and how did this affect the effectiveness of health financing?
- Did WBG projects help strengthening targeting mechanisms and increased coverage of the poor through health financing?
- To what extent has WBG support to health financing interventions had an impact on (i) decreasing catastrophic health spending for patients, and (ii) reducing the proportion of households who fall into poverty due to out-of-pocket payments?

(4) How was Bank and IFC support to health financing carried out on a country level?

19. The following sub-questions will be assessed:

- To what extent was the combination of WBG support to health financing a coherent and comprehensive engagement?
- How did the Bank and IFC partner with other donors and did this lead to reduced donor fragmentation?
- Did WBG support contribute to the empowerment of citizens and civil society in the health sector, and how did this affect equity in access, efficiency and quality of care?
- What has been the value added by the Bank Group to health financing, and what lessons emerge for future assistance?

20. The evaluation will not cover areas that have been evaluated in recent or ongoing IEG evaluations, but it will draw from the findings of these evaluations. The evaluation will not examine Bank Group support to health in projects managed by the water and sanitation and transport sectors (IEG 2009). It will not cover the Global Programs, Financial Intermediary Funds, and Trust Funds apart from the Results Based Financing Trust Fund which supports health financing reforms financed under IDA. The evaluation will not assess WBG support to Public-Private Partnerships (PPP) in health. An ongoing IEG evaluation already examines WBG support to countries in applying PPPs across all sectors, including health, and the use of PPPs as an instrument to crowd in private capital and efficiency.

21. The Bank's and IFC's work on health financing is highly relevant to internal and external stakeholders. The Bank and IFC management and staff are the main audience. External stakeholders include client countries, the international health community including multilateral and bilateral donor organizations, and health policy researchers.

Data and Methods

22. Data sources include the international literature on health financing; the Bank lending portfolio in health approved during fiscal years (FY) 2003-12, managed by HNP and the Social Protection departments and the PREM network; IFC advisory services and investments to health approved during FY09-12; 16 in-depth country case studies, of which about 6 are field-based; Project Performance Assessment Reports (PPARs) on health in Argentina, Bangladesh, Brazil, Indonesia, and Macedonia, existing impact evaluations on health financing interventions, Bank economic sector work (ESW), and key informant interviews.

23. The descriptive review of the health lending portfolio and analytical work managed by HNP, SP, PREM and IFC will show (Attachment C):

- how the Bank and IFC lending on health had evolved over time (before and after 2007 HNP strategy), with regards to volume, countries, lending instruments, objectives, interventions, target groups and areas, and results framework;
- how Bank and IFC analytical work on health financing has evolved over time, including ESW and impact evaluations on health financing conducted by the Bank; and
- how health lending support was carried out in multisectoral collaboration within the Bank Group, and how this has leveraged the private sector

24. Bank and IFC health financing projects are identified for additional analysis. The focus is on project impact on equity in financing and service use, quality and efficiency of care, and how Bank Group support to health financing was carried out in a changing multi-donor context including in collaboration through special initiatives such as the MDG initiative launched in 2008 in the Africa Region, and the Health in Africa (HiA) initiative (Brad Herbert Associates 2012). The analysis will use project results framework as reported in ICR reviews of closed projects, impact evaluations and other analysis conducted under the project. Most Bank Group operations were not implemented with a rigorous impact evaluation and many projects do not include data collections that can be used for rigorous analysis. This requires greater reliance on qualitative data collected in supervision reports and structured interviews. Findings will be portrayed against international evidence.

25. The evaluation will take country-specific challenges into account by including a sample of about 6 field-based and 10 desk-based country case studies (CCS). The WBG is typically one player among others in health financing reforms. A country study protocol with about 50 questions is developed and pilot-tested to collect relevant information in different country contexts. The CCS protocol will first assemble evidence on the impacts of any reform, and then assemble evidence on the Bank's role in the broader reform process. The study protocol will show how the WBG has supported health financing interventions in different countries, and how WBG support to health financing interventions has affected equity in access, efficiency, and quality of care, taking into account the different contexts and confounding factors. As with any policy intervention,

establishing a counterfactual to attribute outcomes to WBG interventions is a challenge. The pilot protocol will be field-tested and adjusted if necessary to ensure that the appropriate contextual questions are asked to facilitate qualitative assessments regarding attribution. There may also be "natural experiments" within countries where variations in WBG interventions may reveal additional information but we do not know now how much of this type of analysis will be possible.

26. The case country selection covers all regions of the Bank so that region-specific issues can be explored, but the selection is not representative of the regions. From the 79 countries that have received WBG support to at least one health financing intervention, 16 are selected based on the following factors related to the country context. First, all countries are selected that are members of a health system donor coordination platform. Among them are countries that report very high or low levels of out-of-pocket payments which provide indications on issues in financial protection. In addition, two countries are selected (Vietnam and Mexico) with decentralized health sectors to examine specific health financing and performance issues in a decentralized setting (Attachment C). The health financing intervention is the unit of analysis.

27. Country case studies will draw on various data. Data sources for desk-based CCS include the published literature, Bank and IFC project documents and supervision reports, and analytical work, and key-interviews with Bank staff. The team will try to enrich the desk-based studies by selecting consultants who are familiar with the country, but have not previously worked on a Bank or IFC supported project in this country. Key-informant interviews with Bank staff and staff from other organizations will be conducted. Field-based country case studies also draw from key-informant interviews with government and nongovernment representatives from the recipient countries and representatives of other development organizations. These interviews help to assess how Bank and IFC support to health financing was carried out on a country level. The number of field-based studies is limited to 6 studies due to budget constraints.

28. The multiple-country studies design will provide illustrative material to identify contextual factors in the causal link between health financing interventions and outcomes. Country case studies on health financing reforms do not have a counterfactual situation as this is the case in statistical analysis. Instead, the evaluation will conduct analytical generalization from the 16 country case studies to compare the empirical results of different features in the case studies across different countries and before and after reforms (Yin 2009). Countries are categorized into the three intervention groups described in Table 1. The analysis is conducted across countries in the same group. The country cases will explain why and how certain interventions may have worked (or not), by comparing WBG support to the interventions against the expected outcome as identified in Government strategies, WBG project and analytical documents, and in the literature.

29. The final report responds to the evaluation questions by triangulating results from different sources and analyses. A structured approach using mixed methods will be followed. The evaluation design matrix in Attachment B provides an overview.

Quality Assurance Process

30. Peer reviewers for the Approach Paper are Charles Griffin, Senior Advisor ECAVP; Philip O'Keefe, HD Lead Economist EASHS; Francois Diop, Chief of Party, USAID-financed health financing and governance project in Senegal and former Senior Health Economist, World Bank Africa Region; and Tim Evans, Dean of James P Grant School of Public Health, BRAC University, Bangladesh.

31. The draft evaluation report will undergo a thorough peer-review process with peer reviewers internal and external to the World Bank Group to ensure evaluation accuracy, credibility, and relevance. The peer-reviewers are Philip O'Keefe, HD Lead Economist EASHS; Francois Diop, Chief of Party, USAID-financed Health Financing and Governance Project in Senegal and former Senior Health Economist, World Bank Africa Region; Juan Pablo Uribe, CEO of the Fundacion de Santa Fe in Colombia and former Health Sector Manager East Asia Region World Bank; and Randall P. Ellis, Professor of Economics and Adjunct Professor Center for Health Economics Research and Evaluation at Boston University.

Expected Outputs, Dissemination, and Follow-Up

32. The primary output will be the report to the Committee on Development Effectiveness (CODE) containing the main findings and recommendations. Beyond this primary output, IEG will develop briefs, presentations, and other output formats as appropriate to reach key audience of the evaluation. Some additional analyses may be submitted to the IEG Working Paper Series for publication and disclosure. All other materials produced by the evaluation will be considered deliberative in nature and therefore not disclosed.

33. During the evaluation, the team is engaging with other IEG evaluation teams to complement and coordinate efforts. In addition, the evaluation team engages with the IFC health teams and Bank anchors, sector managers and staff in HNP, SP, PREM, DEC, and DIME to solicit feedback, facilitate policy/operational relevance, promote complementarities, and cultivate interest in the work. Meetings will be held with the major donors, including the United State Agency for International Development (USAID), Gates Foundation, other bilaterals, and GFATM, as well as with the World Health Organization.

34. Bank and IFC management and technical staff have welcomed this evaluation as a timely input to the update of the 2007 HNP Strategy which is scheduled to occur after the draft evaluation has been shared with Management. The IFC is currently drafting its private sector health strategy, and the evaluation may help informing its implementation.

35. An outreach plan will be developed once the evaluation is completed and publicly launched. IEG will publish the main findings within the Bank Group and externally through face-to-face meetings, seminars, brown bag lunches, and conferences. The evaluation will be disseminated at conferences at the World Bank Group, at relevant international events organized by evaluation and health networks, donors, and think-tanks and through presentations at professional conferences and outreach activities to increase awareness and use of findings.

Resources

36. The evaluation will be undertaken in FY13, with the CODE discussion expected to be scheduled in the second quarter of FY14.

37. The evaluation team will be led by Pia Schneider and will include Erik Bloom, Ann Flanagan (IFC), Moritz Piatti, Xue Li, and Ana Milena Aguilar Rivera. Short-term consultants will be hired to conduct case studies and PPARs, write background papers, and contribute selectively to the evaluation. The consultancy team includes Cheryl Cashin, Manjiri Bhawalkar, Judy Gaubatz, Segen Moges, Nancy Pielemeier, Hjalte Sederlof, and Judith Twigg.

38. The report will be prepared under the direction of Mark Sundberg, Sector Manager, and Emmanuel Jimenez, Director Public Sector, and will undergo the usual IEG quality assurance process, involving review by the Leadership Team and final clearance by the Director- General, Evaluation.

Attachment A: References

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Attachment B: Evaluation Design Matrix

Table 2. Evaluation Design Matrix

Evaluation Question	Sub-evaluation questions	Information and source required	Design strategy /Data analysis methods	Limitations
What has been the impact of Bank support to the level and allocation of public health spending on equity in health financing and service use?	Did WBG support to health financing interventions lead to an alignment of incentives for public and private sector health providers?	World Bank and IFC Portfolio analysis based on ICR review Country case studies, AAA analysis Key-informant interviews International literature on health financing	Systematic review of impact evaluations to identify effects Triangulate information using descriptive analysis. Identify nature of support by country context and trends. Comparative analysis of Bank Group support thorough lending and AAA against health financing issues identified in country case studies	Confounding factors affecting result including other donors working on health systems Projects with weak results framework may not report the relevant information Insufficient number of impact evaluations of Bank projects
What has been the effectiveness of Bank and IFC support to the pooling of health funds in (i) increasing the share of population insured across income groups, (ii) quality and efficiency of care among contracted providers, and (iii) equity in financing and in service use for individuals?	How did WBG support to health financing address regulatory and management reforms and what was the effectiveness of health financing?			
	Did WBG projects help strengthening targeting mechanisms and increased coverage of the poor through health financing?			
What has been the impact of Bank support to purchasing through results-based financing and other payment reforms on (i) equity in health care service use, and (ii) efficiency and quality of care as identified in projects?	To what extent has WBG support to health financing interventions had an impact on (i) decreasing catastrophic health spending for patients, and (ii) reducing the proportion of households who fall into poverty due to out-of-pocket payments?			

Evaluation Question	Sub-evaluation questions	Information and source required	Design strategy /Data analysis methods	Limitations
How was Bank and IFC support to health financing carried out on a country level?	To what extent was the combination of WBG support to health financing a coherent and comprehensive engagement?	Country case studies and key-informant interviews Portfolio analysis AAA review	Triangulate from all analytical outputs to conduct comparative analysis on the effectiveness of Bank support. Identify success factors and lessons.	Projects with weak results framework may not report the relevant information Insufficient number of impact evaluations of Bank projects Confounding factors
	How did the Bank and IFC partner with other donors and did this lead to reduced donor fragmentation?			
	Did WBG support contribute to the empowerment of citizens and civil society in the health sector, and how did this affect equity in access, efficiency and quality of care?			
	What has been the value added by the Bank Group to health financing, and what lessons emerge for future assistance?			

Attachment C: World Bank Group Engagement in Health

Identification of Lending Portfolio

1. For identification purposes the detailed Bank project theme report 2c.2.1 was downloaded and customized. All Bank projects were identified for inclusion in Business Warehouse on July 1st 2012 based on the following criteria:

- approval between FY03 – FY12
- Sector codes: Health (JA); Compulsory Health Finance (BK); Public Administration – Health (BQ); Non-compulsory Health Finance (FB)
- Theme codes: Health System Performance (67); Child Health (63); Other Communicable Diseases (64); Nutrition and Food Security (68); Population and Reproductive Health (69); HIV/AIDS (88); Non-Communicable Diseases (89); Malaria (92); Tuberculosis (93).
- for 'project count' type analyses project supplements were excluded
- for 'project funding' type analyses supplements were included
- Funding allocation estimates are based on the relative percentage shares attributed to the above mentioned sector/theme codes. For projects with multiple sector/theme codes, percentage shares are treated additively. As both sector and theme codes add up to 100%, the greater share of the two was used for computation.

2. Based on this selection process, 607 projects managed by different Sector Boards have funds allocated for health. Among them, 429 projects are managed by HNP, SP and the PREM network. All 429 projects were retained for additional review of their objectives and components as described in the project document to exclude the "false positive." This review led to 386 projects which were retained for the lending portfolio review (Table 3).

3. Two main limitations apply to this selection process. First, administrative data for a given project is recorded at a very early stage of preparation and the record is unlikely to be rectified even if significant changes take place. As a result, the database could exclude projects that later did include health-related activities or results. Second, the number of sector codes or themes that can be entered for a given project is limited to 5 each. Some projects, in particular policy loans, are likely to be multi-sectoral by design and may not have a health sector code or theme, even if they include health activities or could impact health outcomes. However, if health is 6th or higher order of priority, it is unlikely to play a major role in terms of activities or results.

4. The IFC investment portfolio was identified via the Management Information System (MIS), accessed on October 11th, 2012. The database encompasses all investments recorded in the 10 years leading up to FY 2013 and reflects net commitment amounts (original commitments less cancellations less transfers less sales). All projects with sector codes 'health' or 'pharmaceuticals' were selected. The IFC Advisory Services Project Database, maintained by the IFC Portfolio Management Unit, was accessed on October 15th. All products with sector codes of 'Health Care', 'Hospitals and Clinics', 'Pharmaceuticals and Medicines', 'Medical Laboratories', and 'Other Medical' were selected. Filtered out were products that were not identified as 'completed' or 'portfolio' and those, which were flagged

as not having an 'Early Review or Appraisal Document'. A limiting factor is that IFC products are sometimes coded as 'Other', and could thus have been wrongfully excluded. Advisory data is only available since 2005.

Table 3: Number of Projects with Health Managed by HNP, SP and PREM, by Regions, FY03-12

HNP	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	Total	*In %*
AFR	8	8	5	9	7	7	4	5	3	6	62	35%
LCR	7	5	4	3	2	5	5	6	6	1	44	25%
ECA	7	6	3	4	2	1	2		1		26	15%
SAR	4	3	4	1	4	1	3	1	1	2	25	14%
EAP	2	1	2	3		6		2	1	1	18	10%
MNA	1							2	1		4	2%
HNP Total	***29***	***23***	***18***	***20***	***15***	***20***	***14***	***16***	***13***	***10***	***178***	**100%**
SP												
AFR	2	1	3	2	2	2	3	3	2	3	23	37%
LCR	3	3	2	1	2	3	2	3	3	1	23	37%
ECA	3	1			1	1	3	1	2		12	19%
MNA		1								1	2	3%
SAR								1			1	2%
EAP			1								1	2%
SP Total	***8***	***6***	***6***	***3***	***5***	***6***	***8***	***8***	***7***	***5***	***62***	**100%**
PREM												
AFR	5	6	9	11	6	5	5	3	5	1	56	38%
ECA	2	3	5	3	6	3	2	7	5	5	41	28%
LCR	2	1	1	2		1	3	3	4	3	20	14%
EAP	1	2	2	2		2		3	2	2	16	11%
SAR	2	3	2	2	3						12	8%
MNA										1	1	1%
PREM Total	***12***	***15***	***19***	***20***	***15***	***11***	***10***	***16***	***16***	***12***	***146***	**100%**
HNP, SP, PREM	**49**	**44**	**43**	**43**	**35**	**37**	**32**	**40**	**36**	**27**	**386**	

Source: World Bank business warehouse.

Evolution of World Bank and IFC Engagement in Health

5. The number of Bank operations with any health activity is shrinking and an increasing share of them is managed by PREM and Social Protection (figure 2). The annual number of newly approved operations with any health activity dropped from 75 in 2003 to 40 in 2012. The 178 projects managed by the HNP Sector Board provided $14 billion lending over 10 years. IBRD health lending peaked in 2010 during the financial crisis (figure 3).

Figure 2. Number of Projects with Health Managed by Sector Board and FY 2003-12 Approval

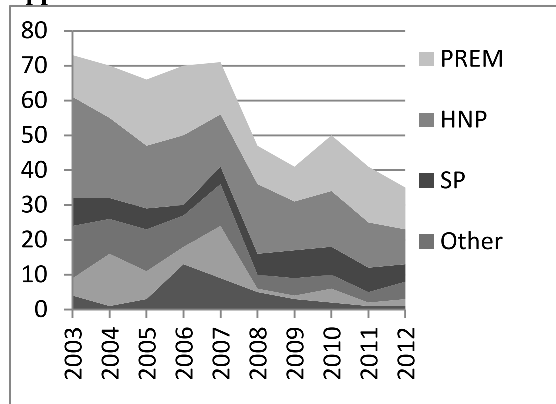
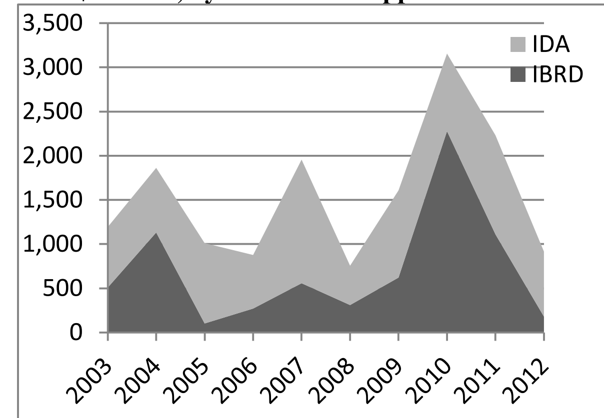


Figure 3. IDA and IBRD support managed by HNP, in US$ million, by FY 2003-12 Approval



Source: Business Warehouse.
Notes: See above for identification strategy of projects. Additional financing is not counted as a new project. HNP = health nutrition and population; SP= social protection; PREM= Poverty Reduction and Economic Management. World Bank support to HNP is the sum of total loan amounts managed by HNP sector board, including supplemental, regional, and Avian flu projects that are excluded from this evaluation.

6. The Africa region accounted for 35 percent of HNP projects followed by Latin America and the Caribbean (25 percent). PREM operations with health mostly went to the Europe and Central Asia region (38 percent); whereas 74 percent of Social Protection operations with health were equally distributed across the Africa and Latin America and Caribbean regions.

7. An increasing share of operations with health is implemented through policy lending. The share of development policy operations (DPO) managed by HNP, SP, and PREM increased from 33 percent of the health operations in 2003 to 48 percent in 2012. At the same time the share of investment lending dropped from 67 percent to 52 percent. DPOs are mainly managed by PREM. They finance governance interventions in health, such as regulations on health financing and service provision, decentralization of the health sector, health facility management reforms, private sector involvement, and monitoring and evaluation of health care performance to strengthen transparency and inform health policy.

8. The IFC is in the process of developing its own health strategy. Although the 2007 HNP Strategy applies to the World Bank Group, including the IFC, the strategy does not include any private sector goals. In 2009, the IFC together with the World Bank and the Gates Foundation launched the Health-in-Africa Initiative (HiA) to support countries with analytical work, country-level policy support and regional advocacy, and finance for private

businesses. A recent mid-term review assesses progress of the HiA initiative (Brad Herbert Associates 2012).

9. The IFC health portfolio has doubled since the 2009 IEG health evaluation while the technical focus remained largely unchanged. In FY03-12, IFC net commitments amounted to $1.6 billion implemented through 103 projects. Investment lending has increased over time and most of it went to the Middle East and North Africa, South Asia and East Asia (figure 4 and 5). Seventy percent of these projects were investments in private hospitals and 25 percent were investments in life science, lower cost generic drugs and technology innovations. About 54 IFC advisory services supported public-private partnerships (PPP) in hospitals and the outsourcing of specialty care to the private sector; half of these advisory services were in Africa, including one hospital PPP in Lesotho, implemented jointly with the World Bank.

Figure 4: IFC Net investment FY03-12, by Regions

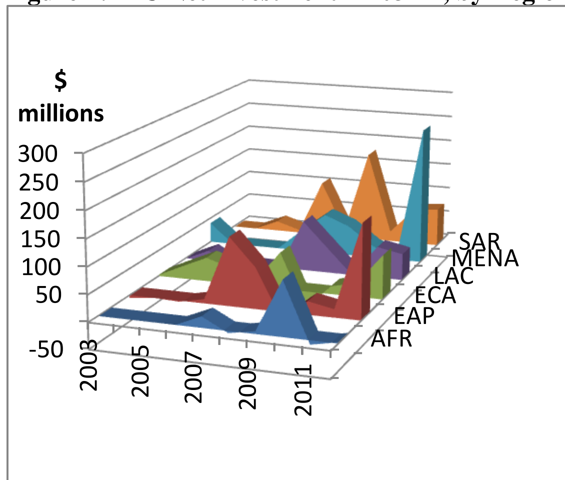
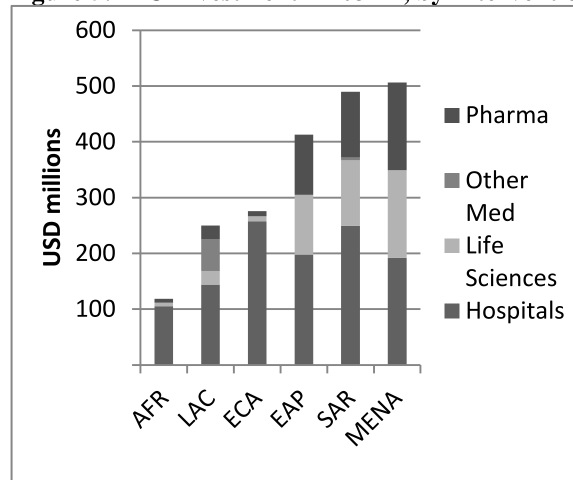


Figure 5: IFC Investment FY03-12, by Intervention



Source: IFC MIS data. Note: IFC data may be incomplete.

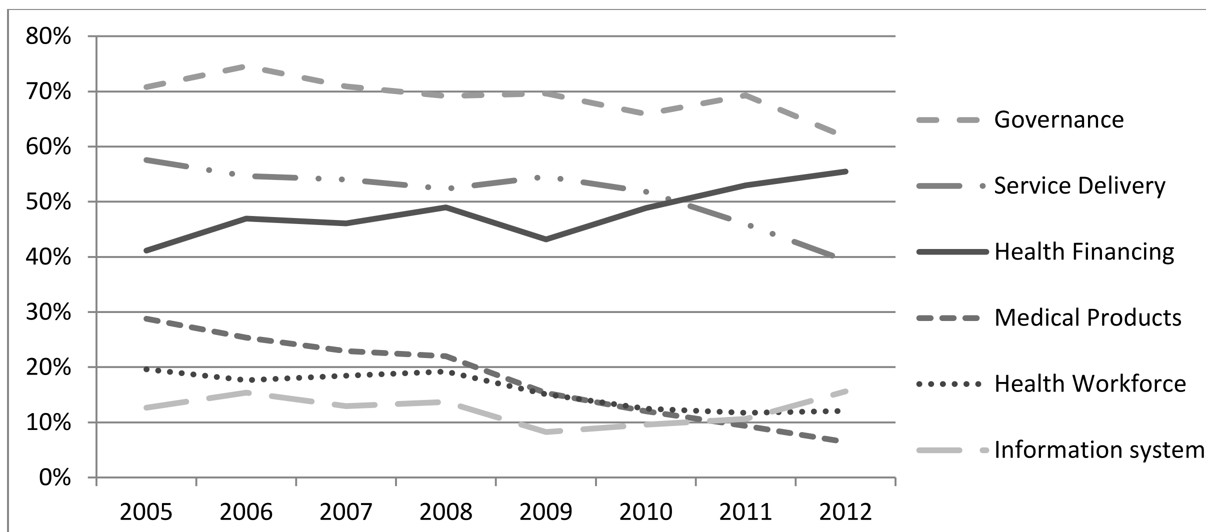
10. Output- and results-based financing is becoming more prominent in Bank operations. Between 2003 and 2012, 17 health projects were funded via the Global Partnership on Output-Based Aid (GPOBA) and the Bank, totaling $565 million and accounting for 14 percent of total OBA program outlays. Eleven of the 17 health projects were implemented in Africa. Twelve of these projects were IDA loans and five were funded through GPOBA.[3] Eight of the 12 IDA-funded OBA projects employed Results-Based Financing (RBF) mechanisms with performance-based contracts, among them 3 Poverty Reduction Support Credits (PRSCs) in Rwanda, 2 projects in Afghanistan, and one in Sudan.

11. The Bank health portfolio has evolved over time. The majority of health operations managed by HNP, SP and PREM support governance interventions in health, and more than half of the projects have components assisting governments with health financing reforms

[3] The five GPOBA funded projects supported the delivery and improved quality of medical care in Lesotho, Yemen and the Philippines; health insurance in Nigeria; and vouchers for treatment of Sexually Transmitted Disease (STD) in Uganda. IFC funded four of the GPOBA projects, including in Nigeria and Yemen.

(figure 6). Over time, health financing has become more prominent while a decreasing share of projects includes components devoted to service delivery, medical products, and human resources.

Figure 6: Components and Prior Actions supported by Bank HNP, SP and PREM health projects, in % of Projects, by FY 2003-12 Approval, 3-year moving average



Source: IEG staff. Based on World Bank Project Documents. Note: Prior actions in DPOs and Component titles in ILOs.

12. Within project components the Bank is supporting different interventions (table 4). The most frequently supported governance interventions include the design and adoption of legislation, health strategies and planning, capacity building at the Ministry of Health, and Health Management Information Systems (hMHIS). About 17 percent of Bank operations assisted governments in strengthening the collaboration with the private sector. The most frequently supported health financing interventions include budget increases for health (33%) and the expansion of health insurance (21%). About 14 percent of Bank projects support results based financing linked to the fiscal transfer. Half of Bank projects assist reforms in service delivery such as improved referral systems and family medicine. Community participation including through grants to communities was supported by one-third of Bank projects and is more common in disease-specific projects (e.g. HIV/AIDS).

Table 4: Number of WB operations supporting specific interventions, by FY of approval 2003-2012

Functions	Interventions	Share of 386 projects
Governance	Develop/implement law, regulation, strategy, planning	60.1%
	Capacity building for policy making / donor coordination etc	43.3%
	Capacity building for vertical programs	19.7%
	Information (HMIS and M&E)	43.0%
	Health facility management	23.3%
	Decentralize health sector	6.0%
	Private sector collaboration	16.8%
Health financing	Change Public spending on health	33.2%
	Reduce out-of-pocket spending on health	10.4%
	CCT to individuals to see care	3.6%
	Expand insurance coverage to informal sector	20.7%
	Results/output/performance based payment to providers	13.7%
	Provider payment reform in insurance	8.0%
Medical Inputs	Drugs and vaccines (incl procurement)	30.3%
	Medical products and equipment	29.8%
	Infrastructure	23.6%
HR	Training of medical staff	33.9%
Service Delivery	Improve delivery (family medicine, prevention, emergency, referrals etc)	49.5%
	Rationalize health care (close hospitals, increase outpatient)	7.0%
	Community involvement (education, knowledge, empower)	33.7%

Source: IEG based on World Bank project documents.

Economic Sector Work and nonlending Technical Assistance

13. Economic and sector work (ESW) and Technical Assistance (TA) managed by the HNP Sector Board were identified in Business Information Warehouse on the 7th of September 2012. The path to identify this work was: BW Web Reports/Operations/ AAA Analysis by Sector, Theme, Knowledge[4]. The following criteria were used:

- Time Period: July 2003-June 2012;
- Sector codes: BK-compulsory Health finance, BQ-Public Administration-health, FB-Non-Compulsory Health finance, JA-Health
- Theme codes: 67-Health System performance.

14. Since 2003, the Bank's HNP teams delivered 352 analytical and advisory products (AAA) (table 5). Among these are 193 ESWs and 159 nonlending technical assistance products. Geographically, the largest recipient of AAA was the Africa region (26 percent) followed by the Europe and Central Asia region (18 percent). Over time, HNP produced fewer pieces of ESW while the number of technical assistance products more than doubled. The World Bank is also conducting impact evaluations to assess project effectiveness. This list is being established.

Table 5. ESW and Technical Assistance Managed by HNP, by Region FY03-12

Regions *Product*	*Africa*	*East Asia Pacific*	*Europe Central Asia*	*Latin America Caribbean*	*Middle East North Africa*	*South Asia*	*Regional studies*	*Total*
ESW	**54**	**31**	**36**	**24**	**9**	**21**	**18**	**193**
FY03-07	36	12	22	15	7	8	10	110
FY08-12	18	19	14	9	2	13	8	83
Technical Assistance	**37**	**28**	**27**	**9**	**45**	**2**	**11**	**159**
FY03-07	9	6	17	0	16	0	1	49
FY08-12	28	22	10	9	29	2	10	110
Total	**91**	**59**	**63**	**33**	**54**	**23**	**29**	**352**
FY03-07	45	18	39	15	23	8	11	159
FY08-12	46	41	24	18	31	15	18	193
Regional Distribution	**26%**	**17%**	**18%**	**9%**	**15%**	**7%**	**8%**	**100%**

Source: Business Warehouse.
Notes: includes AAA with Theme codes: Health System performance or/and Sector codes: BK - compulsory health finance; BQ-public administration-health; FB-non-compulsory health finance; JA-health

[4] Under this tab both ESW and TA by Sector and Theme are displayed. These use a filter on type of report (ESW or TA). By removing the filter in either of these databases, it was possible to get both type of reports

Country Case Studies

15. The goal of a case study is to understand the case and to use it to generate lessons. While it can be compared against a benchmark, it is not designed to make direct comparisons.

16. The universe consists of all 119 countries with more than 1 million populations that were eligible borrowers at some time during the past decade. Of the 119 countries, 79 have received WBG support to at least one health financing intervention. The 79 countries are classified into 6 mutually exclusive groups according to the Bank's regions so that region specific issues can be explored. For example, low-income country contexts in Africa are different from the contexts in middle income countries in MNA and ECA. The sample is not representative of the Bank Group regions; rather countries were chosen to form evaluation judgment on the performance of the health financing interventions in different contexts (table 6).

17. In total 16 countries are selected purposively based on the following criteria. First, all countries are selected that are members of a health system donor coordination platform. Among them are countries that report high or low levels of out-of-pocket which provide indications on issues in financial protection. Countries where out-of-pocket spending on health is more than 40 percent of total health expenditures - which is the median - were classified as high out-of-pocket[5]. In addition, two countries are selected (Vietnam and Mexico) with decentralized health sectors to examine specific health financing and performance issues in a decentralized setting. A few fragile states were selected. Field visits are proposed tentatively for Mexico, Vietnam, Turkey, Kenya, Ghana and Rwanda. The other countries will be desk-based reviews.

18. The IEG conducted Project Performance Assessment Reports (PPAR) in Argentina and Brazil on results-based financing, in Macedonia and Indonesia on health financing and insurance reforms and in Bangladesh on public-private collaboration and results-based-financing. Findings from these PPARs will be presented in the evaluation.

[5] Total health expenditure is the sum of public and private health expenditures. Out-of-pocket spending is part of private health expenditures, which also includes household payments for private health insurance.

Table 6: Proposed List of Countries for Case Studies, by Regions and Selection Criteria

Region	Country Case Studies	Out-of-Pocket		Interventions Supported By WBG			Health Systems Platform Country	Country Context
		High	Low	Level & Allocation of Funding	Risk Pool /Insurance	Provider Payment / RBF		
AFR	Benin	✓		✓	✓	✓	HSF Platform	
	Kenya	✓		✓		✓		
	Rwanda		✓	✓	✓	✓	HSF Platform, JANS	SWAP
	Ghana		✓	✓	✓	✓	ICC/HSCC/ HSF Platform, JANS	SWAP
	Tanzania		✓	✓			ICC/HSCC, HSF Platform	SWAP, Decentralization
EAP	Cambodia	✓		✓	✓	✓	ICC/HSCC, HSF Platform	
	Vietnam	✓		✓	✓	✓	HSF Platform, JANS	SWAP, Decentralization
ECA	Uzbekistan	✓		✓		✓		
	Turkey		✓	✓	✓	✓		
MENA	Egypt	✓			✓	✓		
	Yemen	✓				✓	GAVI	Fragile
LAC	Mexico		✓		✓			Decentralization
	Nicaragua	✓		✓	✓	✓	GAVI, ICC/HSCC	
	Bolivia		✓	✓	✓		GAVI	
SAR	Afghanistan	✓		✓		✓		Fragile
	Nepal	✓		✓	✓		ICC/HSCC, HSF, JANS	

Note: JANS = Joint Assessment of National Strategy; HSF = Health System Funding; ICC/HSCC = Interagency Coordinating Committee/Health Systems Coordination Committee; SWAp = Sector Wide Approach. RBF = Results Based Financing. Out-of-Pocket: high includes countries with > 40% of total health expenditures being paid out-of-pocket, whereas low includes countries where less than 40% of total health expenditures are paid out-of-pocket.

Attachment D: Previous and Ongoing IEG Evaluations

19. Since 1999, IEG has conducted several health evaluations. In 1999, the IEG evaluation *Investing in Health* found the Bank had been more effective in achieving physical objectives than improving service quality, efficiency, and policy and institutional change. Recommendations suggested more selectivity, improving the quality of the portfolio through monitoring and evaluation (M&E), strengthening intersectoral interventions, and building alliances with development partners. A 2004 evaluation of the Bank's approach to global programs recommended a more selective engagement in global health programs focusing on where the Bank has a comparative advantage, and strengthening the links to country operations. IEG's 2005 evaluation on Bank support for HIV/AIDS projects and programs found the Bank contributed to improved access and recommended investing in M&E, strengthening local capacity, and a selective and strategic approach.

20. In 2009, two years after the launch of the 2007 HNP strategy, IEG evaluated the efficacy of Bank and IFC support to health, nutrition and population. The 2009 evaluation included IFC and all Bank projects in HNP, transport, and water and sanitation approved over FY1997-FY2006. The evaluation had a strong focus on IFC and Bank portfolio performance in achieving health outcomes for the poor, and conducted an in-depth analysis of communicable diseases, health in transport and water and sanitation operations. The evaluation identified significant underperformance in the Africa portfolio, especially in HIV/AIDS projects. Findings also show that excessive earmarking to communicable disease control can distort health systems; and that sector-wide approaches (SWAps) increase government leadership and donor coordination, but IEG found no impact on efficiency or health results. Recommendations were directed toward improving project design, including intensifying efforts to improve portfolio performance, improve HNP outcomes among the poor, improve efficiency by better defining efficiencies in project objectives and supporting health management information systems, enhancing health support through other sectors, and improving project M&E.

21. IEG's 2009 health evaluation included a comprehensive analysis of the IFC advisory and investment portfolio. Most IFC activities were found to be investments in private hospitals, public private partnerships (PPP) for hospital and specialty care, and support to generic pharmaceutical projects. However, IFC did not support health financing and insurance ventures. IEG recommended continuing support to PPPs through advisory services to innovative approaches and to private health insurance.

22. In 2011, IEG conducted a review of the GFATM, and it has just started a review of GAVI and a systematic review of impact evaluations on maternal and child health. IEG's GFATM review found the Bank should have a more complete engagement strategy with the Global Fund, including on a country level, and build a community of practice among staff to learn cross-cutting lessons (IEG 2011). IEG's ongoing GAVI review examines the partnership between the World Bank and GAVI to help improve the partnership's relevance and effectiveness and to learn lessons about innovative financing mechanisms and for the Bank's engagement.

23. The 2009 IEG evaluation did not examine Bank support to all aspects of health system. It did not include the increasing number of PREM- and SP-managed operations with health components, and the evaluation did not examine Bank support from a health system perspective, as described in the 2007 HNP strategy. The evaluation did not include an analysis of the effectiveness of Bank support to special initiatives such as the health MDGs in Africa, Bank support to health financing, risk-pooling and provider payment, financial risk protection, and Bank support for results-based financing. The evaluation did not extensively analyze the 40 percent of HNP's analytical work that was on health systems (IEG 2009). While the IEG's 2009 health evaluation included a comprehensive analysis of the IFC portfolio, the level of collaboration across the two institutions was not analyzed, mainly also because some initiatives to foster collaboration, such as the HiA were only initiated after the launch of the evaluation. Thus, so far IEG has not evaluated Bank support to the three system-level interventions, namely private-public collaboration, health financing and insurance, and results based financing.

Attachment E: Defining Health Systems

24. There are diverse views as to what should constitute a "health systems approach". 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 and others 2012). There are some common elements across the different definitions. These include the need to address fragmentation across programs and support health system performance measured by improved equity in access, quality and efficiency of care, independent of patients' diseases. However, this missing clarity poses evaluation challenges including difficulties in defining system-level interventions and causality (Mills and others 2008).

25. The 2000 World Health Report defines health systems as "comprising all the organizations, institutions and resources that are devoted to producing health actions. A health action is any effort, whether in personal health care, public health services or through intersectoral initiatives, whose primary purpose is to improve health." Health systems have three broad goals: good health, responsiveness to the expectations of the population, and fairness of financial contribution. A set of criteria measures the performance of health systems in achieving these goals. These include equity, efficiency, and sustainability. Governments are responsible for the overall performance of a country's health system and should involve all sectors of society in its stewardship (WHO 2000).

26. The framework presented at the World Bank Institute health flagship course is the control knob framework (Hsiao and Sparkes 2012). "Control knobs" are the interventions available to policy makers – including health financing and payment, health sector organization, regulation and persuasion of consumers - to strengthen system performance. In this framework, policy makers change one or more of these control knob interventions to affect access, efficiency, equity and quality in health service delivery and ultimate health system outcomes including improved health, public satisfaction and financial risk protection. The control knob framework is currently being combined with the WHO framework to present an integrated framework (Hsiao and Sparkes 2012).

27. The World Bank defines health systems in its Health Nutrition and Population (HNP) Strategy 2007 "Healthy Development." It states that a "health system encompasses 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" (p.49). The following key functions describe what health systems do to achieve their goals (World Bank 2007, p. 50):

- Health financing, including public and private funding, fiscal space, risk pooling arrangements, and health service purchasing and provider payment
- System governance and stewardship, including policy, law and regulations
- Health service delivery interventions
- Resource (input) generation, such as human resource training, technology for disease control, pharmaceuticals, medical infrastructure, and equipment.

28. According to the HNP strategy the Bank does not have a comparative advantage in all health system functions. Rather, the Bank's strengths lie in its multisectoral nature, its core mandate on demand-side interventions including governance and health financing, and its fiscal, general economic, insurance, and analytical capacity. The strategy also emphasizes a focus on results; strengthening health systems and ensuring synergy between health system strengthening and priority disease interventions; strengthening Bank intersectoral advisory capacity; selectivity, strategic engagement, and agreement with global partners on collaborative division of labor for the benefit of client countries (World Bank 2007).

29. Health systems interventions are expected to improve system performance as expressed by intermediate outcomes: access to health care, equity, efficiency, and quality of health care; as well as health system goals including health outcomes, responsiveness of the system and financial protection (WHO 2000; World Bank 2007; Hoffman and others 2012). In low-income countries, health outcomes are characterized by high rates of communicable diseases and maternal, child, and infant mortality. Middle-income countries face different health challenges due to changing demographics and aging societies (table 7). In many countries, health systems responsiveness is characterized by public dissatisfaction with low quality care, absentee health workers, unavailability of pharmaceuticals, and informal payments.

30. Financial risk protection implies that individuals receive care when needed and are not excluded from care because they cannot afford paying fees (Gottret and others 2008). Countries introduce different risk-pooling arrangements to protect individuals against the financial risk of illness. The goal is to reduce the out-of-pocket price the patient pays when using services. However, health insurance is often limited to the formal sector workforce, and few countries have expanded insurance coverage for low-income groups active in agriculture and the informal sector. This leads to the exclusion from care of many low-income individuals who cannot afford paying fees, leading to inequity in access and health outcomes.

Table 7: Key Health Outcome Indicators by Regions

	Regions					
Health Outcome Indicators	**AFR**	**SAR**	**ECA**	**LCR**	**MNA**	**EAP**
Life Expectancy at birth (years), in 2010	54	65	71	74	72	72
Infant mortality rate (per 1,000 live births), in 2011	69	48	18	16	26	17
Maternal mortality rate (per 100,000 live births), in 2010	500	220	32	81	81	83
Under 5 mortality rate (per 1,000 live births), in 2011	109	62	21	19	32	21
Percentage of people who are undernourished (% of total population), in 2008	20	20	2	7	2	11
Cause of death, by non-communicable diseases (% of total all deaths), in 2008	28	51	84	72	69	76

Source: World Development Indicators database and HNP Stats data.
Notes: Non-communicable diseases include cancer, diabetes mellitus, cardiovascular diseases, digestive diseases, skin diseases, musculoskeletal diseases, and congenital anomalies.

Attachment F: Detailed Timeline

Item	Date
IEG One-Stop Review for Approach Paper	November 14, 2012
Submission of Approach paper to Bank Group Management	March 4, 2013
Comments on Approach paper from Bank Group Management	March 27, 2013
Submission of Approach paper to CODE	April 2, 2013
Data gathering and analysis	October 1, 2012 – Sept 2013
Country Visits	April 2013 – May 2013
First draft	October 9, 2013
IEG One-Stop Review for Report	October 13, 2013
Report submitted for Internal Bank Group review	November 16, 2013
Report finalized and distributed to CODE	December 13, 2013