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Independent Evaluation Group

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World Bank Group Support to Health Financing

AN INDEPENDENT EVALUATION

World Bank Group Support to Health Financing

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Abbreviations

AfGH	Action for Global Health
CBHI	community-based health insurance
DAH	development assistance to health
DRG	diagnosis-related group
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
GPOBA	Global Program on Output-Based Aid
HCFP	Health Care Fund for the Poor
HEF	health equity fund
HMO	health maintenance organization
HNP	Health, Nutrition, and Population
IEG	Independent Evaluation Group
IFC	International Finance Corporation
MDG	Millennium Development Goal
M&E	monitoring and evaluation
MIP	Medical Insurance Program
NCMS	New Cooperative Medical Scheme
NGO	nongovernmental organization
NHA	National Health Account
NHIS	National Health Insurance System
OECD	Organisation for Economic Co-operation and Development
OOP	out of pocket
PER	Public Expenditure Review
PREM	Poverty Reduction and Economic Management
RBF	results-based financing
SHI	social health insurance
SP	Social Protection
SWAp	sectorwide approach
USAID	U.S. Agency for International Development
WDR	World Development Report

All dollar amounts are in U.S. dollars unless otherwise indicated.

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Overview

Highlights

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.

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 show 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, DRG[1], 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 cases[2] 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

[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.

METHODOLOGY

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 (SWAps) 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[3] 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.

[3] IEG's 2009 Report *Improving Effectiveness and Outcomes for the Poor in Health, Nutrition, and Population: An Evaluation of the World Bank Group Support Since 1997*.

Management Action Record

IEG Findings	IEG Recommendations	Acceptance by Management	Management Response
Whether Bank support to health financing reforms is sustained depends on government commitments and local technical capacity. Technical capacity has facilitated understanding for health financing reforms and can be built in collaboration with local Institutions.	**1.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.	WB: Agree	The Health, Nutrition, and Population Global Practice (HNP GP) will continue and expand support to build capacity to monitor public and private sector spending, and to prioritize the use of public subsidies based on evidence. Training in the HOW and the WHAT of health financing will be expanded through various learning and knowledge management vehicles.

IEG Findings	IEG Recommendations	Acceptance by Management	Management Response
The Bank has produced an array of analytical work on health financing, including health financing analysis in PERs, poverty assessments, fiscal space analyses, and a growing body of impact evaluations. Bank reports do not necessarily examine the poverty and equity effect of health financing.	**2. 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.	WB: Agree	A Universal Health Care monitoring framework has been co-produced with the World Health Organization to monitor access to essential services, the level of financial protection granted to the population and equity in health care. Moving forward, attention to financial sustainability will become an even greater focus of attention.
Health financing requires a different skill set from that of the general health specialist. To fully use its capabilities, the Bank Group should use multi-sector teams that draw on expertise from Health and other sector experts and work across the new Global Practices and the IFC. The Bank's capabilities in health financing affect partnerships with other bodies.	**3. 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, Social Protection) to ensure that staff capacity is adequate to respond to country demand; and . • Having a clearly identified WBG focal point for health financing.	WB: Agree	The HNP GP will build staff capacity in health financing. It will work with colleagues from IFC Global Industry Groups, other global practices and with the International Monetary Fund to systematically discuss and operationalize financial sustainability of health programs, including with the use of MTEF instruments. The HNP GP will have a focal point for health financing to provide quality assurance for the World Bank Group's work in health financing.

IEG Findings	IEG Recommendations	Acceptance by Management	Management Response
The Bank can add value by stressing its comparative advantage via linking health financing with public finance and working across teams, as suggested in the 2007 HNP strategy. 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 health financing collaboration between the IFC and the Bank has been limited so far.	**4. 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.	WB: Agree WB, IFC: Agree	The second phase of the RBF will include an explicit emphasis on fiscal limits and sustainability. The HNP GP will be working on developing a joint strategic approach with IFC toward health insurance.

IEG Findings	IEG Recommendations	Acceptance by Management	Management Response
Evidence is scant on the effect of Bank and IFC operations and programs on final outcomes. The quality of project M&E is weak in Bank and IFC health projects. However, there is an increase in the number of impact evaluations. The HNP strategy stipulates that the Bank monitor how health financing affects equity in service use, risk pooling, and financial protection, but this information is rarely collected in health financing operations.	**5. Strengthen M&E in Bank and IFC health financing projects by:** • Improving appropriate M&E frameworks in Bank and IFC projects to put in place mechanisms to collect and monitor relevant indicators; and	WB, IFC: Agree	A Universal Health Care monitoring framework has been co-produced with WHO to monitor access to essential services, the level of financial protection granted to the population and equity in health care. Given IFC's limited exposure in the health financing space, IFC Management generally agrees with the IEG's recommendation to strengthen M&E frameworks and will track indicators that measure effectiveness when investing in this type of projects or conducting impact evaluations in the future.
	• Monitoring distributional indicators, including on access and outcomes, consistent with benchmarking and tracking progress towards Universal Health Care coverage.	WB: Agree	The GP will continue to improve the monitoring of health financing projects.

Chairperson's Summary: Committee on Development Effectiveness

The Committee on Development Effectiveness (the Committee) met to consider the Independent Evaluation Group (IEG's) report entitled *World Bank Group Support to Health Financing for Improving Health System Performance FY03-FY12* and *Draft Management Response*.

The Committee welcomed the timeliness of the evaluation and was encouraged that management broadly concurred with the report's recommendations. Members recognized that health is inextricably correlated with the World Bank Group corporate strategies and the mandate of poverty reduction. Members appreciated the timeliness of the evaluation, coinciding with the implementation of Global Practices, Cross Cutting Solution Areas and the "One-WBG" model. Members agreed this was an opportunity for the institution to assess comparative advantages to further enhance its development effectiveness including in the health sector.

Members noted that the evaluation covered the period from 2003 to 2012 and that the Bank's approach to the financing of the health sector has evolved significantly. They expressed strong interest in seeing the Global Practices lead to a consistent and cohesive strategy to financing across the Regions, while still appreciating the country context. Members agreed with the importance of a more holistic approach to health financing and service delivery, augmented cross-sector coordination, and increased public-private interface and partnerships, including in particular with the International Finance Corporation (IFC). In this respect, members were encouraged that the Bank and IFC are joining forces to develop a road map for collaboration on health financing as well as on broader assistance in health systems and reforms. They underscored the need for synergies in collaboration with external partners to further improve future World Bank Group support to health financing. Members emphasized the importance of monitoring and evaluation and encouraged management to focus on cost-effective means of evaluation of the relevant policies and operations.

Some members commented that the emphasis of health financing should be equally placed on financial sustainability and equity, in order to improve poverty alleviation effects and strengthen equity of health systems. Members noted the difficulty in evaluating the Bank's knowledge role, including technical assistance, in health financing and welcomed the clarification that there have been various knowledge initiatives underway to improve knowledge development and sharing, including designing a prospective impact evaluation at the inception of Bank projects. Members recognized that the divergent views with respect to results-based

financing (RBF) reflect primarily the fact that in 2012 the RBF portfolio was relatively new. They supported management's plan to continue integrating RBF with other health financing functions in order to create a more comprehensive approach.

Juan Jose Bravo
Chairperson

1. Bank Group Support to Health Financing

Highlights

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

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

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

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

Box 1.1. What Constitutes a Health System?

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

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

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

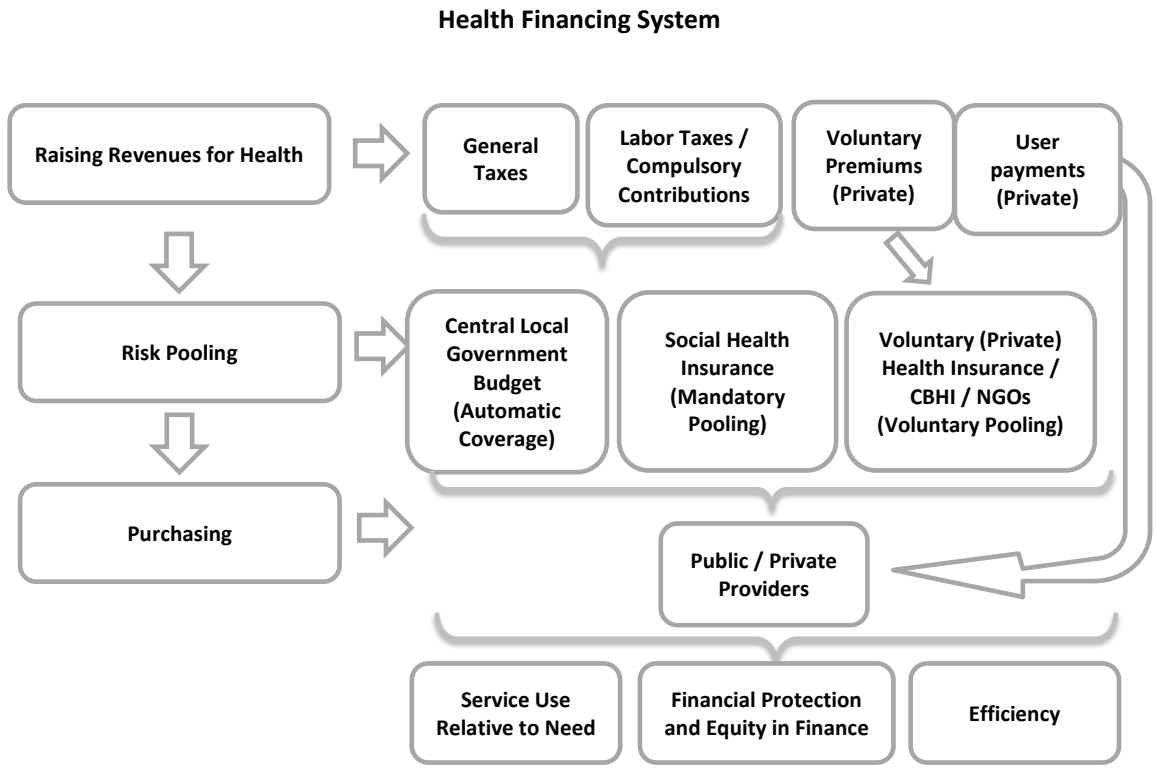
Countries are responding to these challenges by ensuring that the way they finance health care is efficient and equitable. The World Bank Group has supported these efforts through a combination of financial assistance, policy advice, and technical assistance. This is the first evaluation by the Independent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

Health Financing Influences Health System Performance

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

advice and support to health financing functions through tailored interventions, depending on country context.

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



Source: Drawn from Hsiao (2007), Kutzin (2013), and OECD et al. (2011).
Note: CBHI = community-based health insurance; NGOs = nongovernmental organizations.

Revenues to finance health systems are raised from public, private, and external sources. Governments collect revenues through direct and indirect taxes to finance public spending, including that for health care. Some of these taxes can be earmarked for health. These domestic revenues for health are then transferred to the health sector in the form of internal transfers, subsidies, and grants to the budget of the Ministry of Health and to lower levels of government (e.g., regions, states, and municipalities), and as subsidies to public or social health insurance (SHI) to finance contribution payments for groups such as informal sector workers. Compulsory contributions to SHI are paid by employees, employers, and the self-employed. Private revenues for health include voluntary premiums paid by households to private insurance and to other prepayment mechanisms, and user payments made by patients (or out-of-pocket payments) directly to public and private providers. Some private providers and pharmacies only receive revenues from user payments. Additional revenues for health are transfers from external sources including bi- and multilateral donors and nongovernmental institutions (OECD et al. 2011).

Pooled financing is money raised through taxes or insurance contributions and premiums that individuals must pay whether or not they need care (Savedoff et al. 2012). Risk pooling is about how to pool financing to share the health risk among pool members. With the exception of user payments, all revenues for health are pooled and then transferred to providers. Depending on the country context, pools can take different forms including the central and local government budget, public and private health insurance, and community-based health insurance, among others. Participation in a pool is compulsory or voluntary. Compulsory pooling of public funds includes (i) automatic coverage of the population (e.g., national health services) and (ii) mandatory participation by law for all or a defined population group in social health insurance, which can be public or private health insurance. Voluntary pooling refers to coverage of individuals at their own discretion through private health insurance and community-based health insurance (Gottret and Schieber 2006; OECD et al. 2011).

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

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

Table 1.1. Health Financing Indicators to Measure Progress toward Outcomes

Outcome	Selected indicators
Service use relative to need (equity)	Utilization of care relative to need across socioeconomic groups
Financial protection and equity in financing	Percentage of total health revenues from public funds Out-of-pocket spending as percentage of total health revenues[a] Percentage of lowest quintile household participating in risk pool[a] Percentage of households with catastrophic health expenditures Percentage of households falling into poverty because of illness
Efficiency	Percentage of health revenues spent on cost-effective services Percentage of donor funds earmarked Number of risk pools and pool size Quality and productivity in health facilities

Source: World Bank (2007).
a. Indicator for the World Bank's 2007 Health, Nutrition, and Population strategy.

What Has the World Bank Group Been Doing in Health Financing?

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

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

also commits to support countries in their monitoring and evaluation (M&E), to assess whether arrangements improve financial protection for everyone including for the poor and near-poor (World Bank 2007).

Box 1.2. Health Financing in World Development Reports

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

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

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

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

The Bank and IFC do not have a joint strategic approach to health financing. There is no joint strategic direction about the mix of public and private insurance, which population groups they should insure, and how to prevent and address risk-

selection in multiple-insurance contexts. Nor have the two institutions decided on whether and how to separate the financing and the provision of care.

HOW HAS THE WORLD BANK GROUP OPERATIONALIZED THESE STRATEGIES?

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

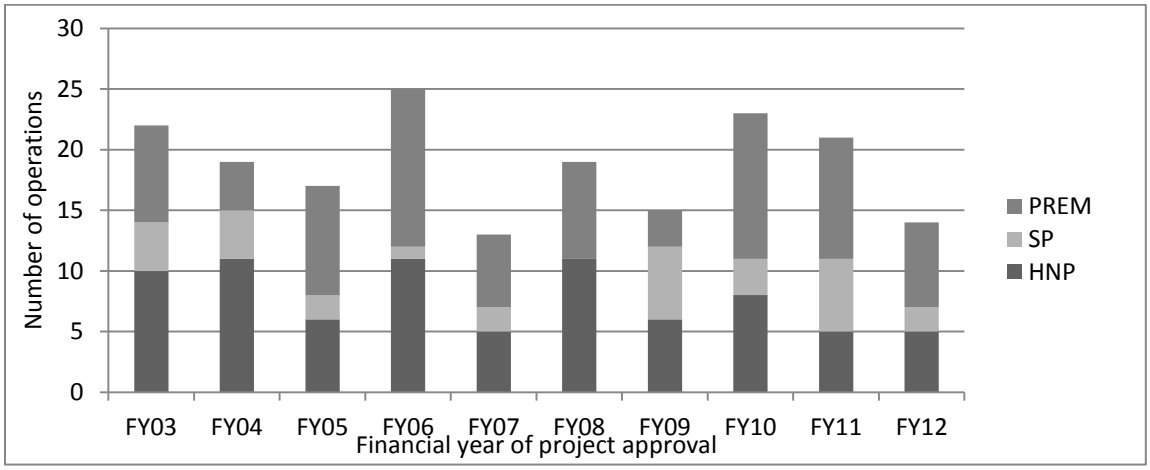
Bank support to health financing is managed by the Health, Nutrition, and Population, Social Protection (SP), and Poverty Reduction and Economic Management (PREM) Sector Boards. In addition, the Regions and the HNP anchor produce a large number of knowledge products. Health financing is a relatively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

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

increasing health care access through direct investments in health care networks, centers of excellence, and wholesaling (see appendix D).

In the same period, the Bank provided 188 loans that included health financing interventions (appendixes A and C). These loans were implemented in 68 countries through development policy operations (56 percent) and investment loans[1] (44 percent) (appendix B). The number of operations with health financing peaked in 2006 and then in 2010 when a large number of multisector development policy operations provided fast-disbursing financial support to ensure funding for social sectors during the economic crisis (Figure 1.2). About 40 percent of the Bank's portfolio includes health financing. The share of health financing operations managed by HNP and the number of newly approved projects, have decreased as more health financing operations are implemented through development policy operations managed by PREM. Most health operations with health financing activities fund a variety of interventions, including infrastructure costs, but the actual lending amount for health financing activities is unknown.

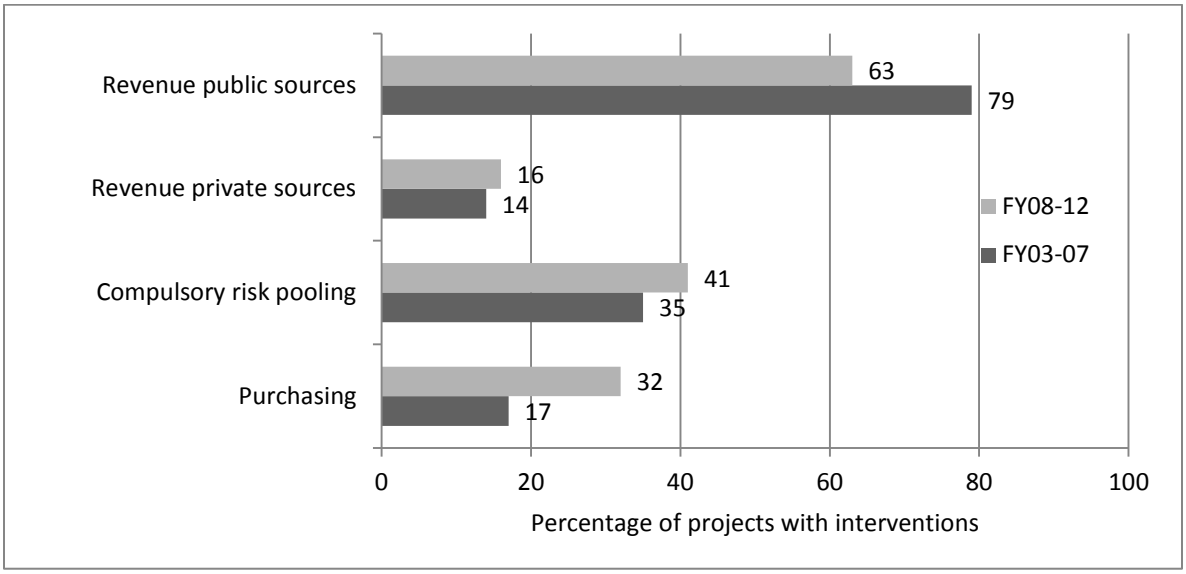
Figure 1.2. Number of Bank Operations with Health Financing Activities by Sector Board



Note: HNP = Health, Nutrition, and Population; PREM = Poverty Reduction and Economic Management; SP = Social Protection.

Most health financing projects support revenue collection from public sources (Figure 1.3). However, there has been a marked decline in this type of Bank support, whereas support to purchasing has increased substantially. Almost half of the projects support compulsory risk pooling, but few Bank operations focus on revenues from private sources, including user payments. The distribution of project interventions and objectives by Region and sector are presented in appendix B.

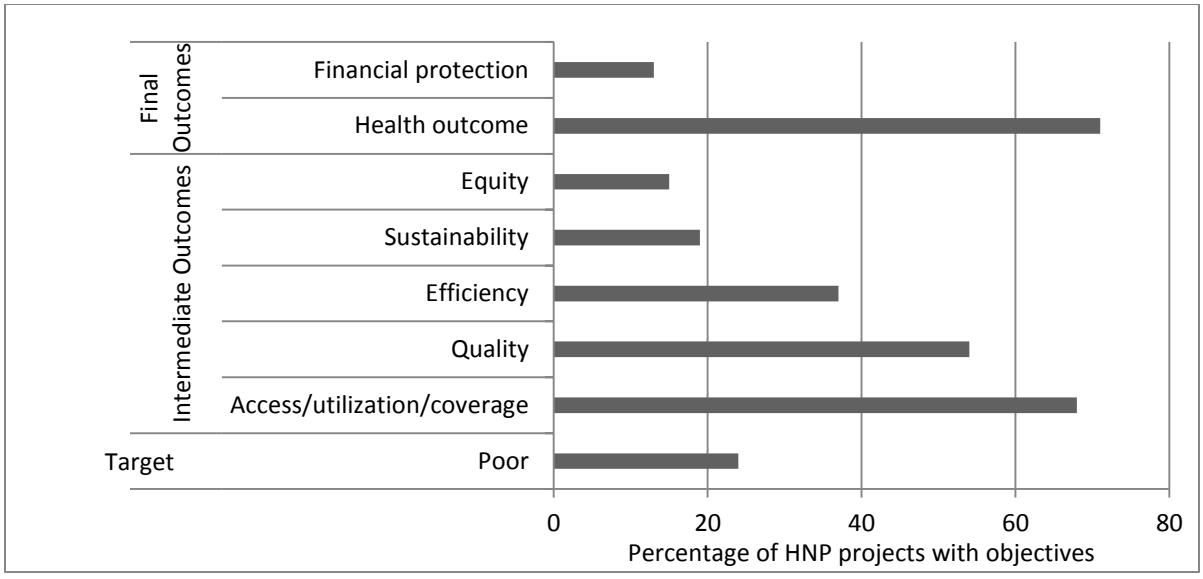
Figure 1.3. Health Financing Interventions in Bank Projects, FY03–12



Note: The total for FY03–07 is 96 projects; for FY08–12, 92 projects.

Most Bank projects in this evaluation aim to contribute to one of the four strategic objectives of the HNP strategy, namely, improving the health status of a population (Figure 1.4). Only a few health financing projects have a financial protection objective. Less than 20 percent of projects aim to improve equity in access, with access often defined as increased utilization or coverage of care. About one-fourth explicitly target the poor in their objectives (appendix B).[2]

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



Note: The IEG project portfolio review is based on 78 HNP operations with health financing interventions.

Bank lending operations are accompanied by a large body of analytical and advisory work, knowledge products, technical assistance, and training programs including the flagship course which is organized by the World Bank Institute (WBI). From 1997 to 2008 the WBI and its collaborating partners delivered 314 short-term training events on health sector reform and sustainable financing to 19,400 participants from 51 countries (Shaw and Samaha 2009). In FY03–12, the World Bank undertook analysis and promoted knowledge sharing on health financing reforms through 98 public expenditure reviews, at least 10 public expenditure tracking surveys,[3] 20 poverty assessments, about 70 economic and sector work activities, 8 fiscal space studies, and a small but growing number of impact evaluations (appendixes A and B). A large number of health financing workshops have been organized in the Regions,[4] some of them in collaboration with the WBI and with initiatives such as the South–South Network and the Joint Learning Network. In addition, the HNP anchor supports health financing, including through the Results-Based Financing (RBF) initiative[5] and the Universal Health Coverage initiative, which has conducted 25 country case studies.[6] The Bank's Development Research Group launched the ADePT health module software in 2011 which allows users to produce standard tables for health equity analysis.[7]

Objective of the Evaluation

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

This is the first time that IEG has evaluated the effectiveness of Bank and IFC support to health financing. IEG's 2009 HNP evaluation analyzed IFC and Bank portfolio performance in achieving health outcomes for the poor, conducted analysis of communicable diseases, and examined health in transport and water and sanitation operations. This evaluation will not examine lending to finance health care delivery including human resources, equipment, pharmaceuticals, and construction of facilities, nor the procurement of these products. Some of these aspects of health systems improvements were evaluated previously (IEG 2009). Also, as procurement in the health sector is not part of health financing, it will not be addressed (IEG 2014). Social safety nets through conditional cash transfers were evaluated previously (IEG 2011b).

The evaluation recognizes that reforms in health financing only are not enough to improve quality of care, ensure utilization according to need, or remove barriers in the use of care, and that additional investments are needed to assure health care. However, financing reforms are necessary to influence the provision of health care. Other factors also influence the performance of health systems and outcomes, including economic growth, demographic and epidemiological changes, new medical technologies, and the environment. However, examining these factors is beyond the scope of this health-financing-focused evaluation.

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

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

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

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

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

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

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

[3] The Bank's business warehouse database does not have a special code to identify public expenditure tracking surveys.

[4] For example: South Asia Regional High Level Forum on Health Financing in June 2010, http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTHEALTHNUTRITIONANDPOPULATION/0,,contentMDK:22669883~menuPK:282516~pagePK:148956~piPK:216618~theSitePK:282511,00.html.

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

[6] For more information, visit http://www.worldbank.org/en/topic/health/publication/universal-health-coverage-study-series.

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

2. Revenue Collection for Health

Highlights

- The challenges governments face in revenue collection include how to raise revenues efficiently and equitably to finance health care. In low-income countries, direct payments made by patients to providers are the main source of revenue, raising concerns about access to care for the poor.
- The Bank did not take an ideological stance in its work in revenue collection for health; rather it worked within the different country contexts. Bank advice focused on increasing the health budget in low-income countries. In middle-income countries, the Bank recommended managing the level of public spending and subsidizing insurance enrollment. Some timely advice on a greater role for alcohol and tobacco taxes has been given but this is very limited. The Bank gave limited attention to user payments through lending operations. In few countries did it help institutionalize monitoring and evaluation to examine the effect of health financing.
- There have been some notable successes. Bank support has helped raise domestic revenues for health and subsidize contributions to risk pools for low-income groups. Support to reduce user payments lacked the necessary fiscal and equity analysis, and evidence is missing that it has improved service use and financial protection.
- Bank support was more successful with strong government commitment at both the economy-wide and sector levels and when Bank staff drew on a variety of skills across sectors to engage government.

Revenues for health are collected from public and private sources and allocated to health care providers. Governments face challenges in raising revenues efficiently and equitably. Chapter 2 introduces these challenges, describes how the Bank supported countries in addressing them, and evaluates the effect of this support.

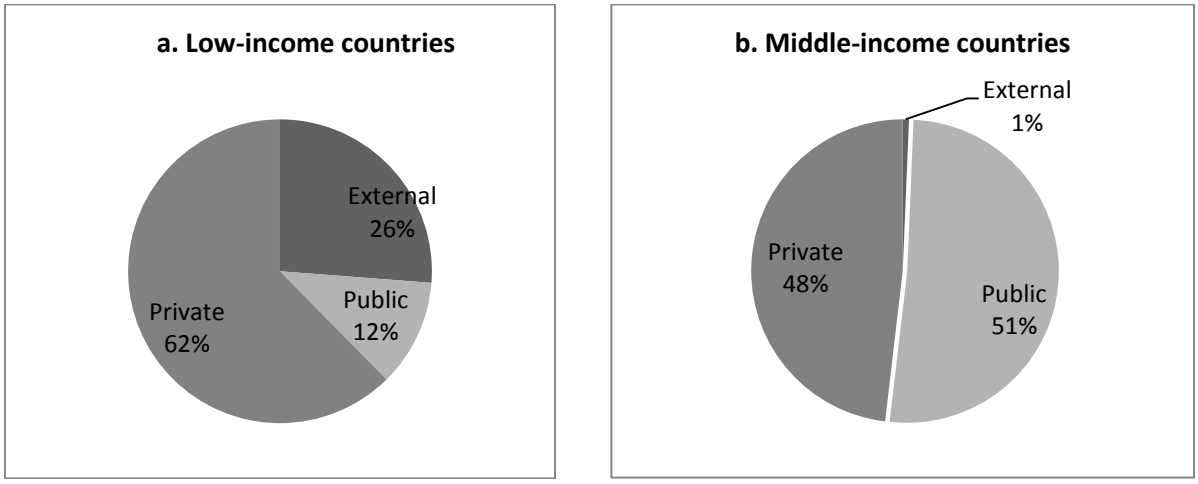
Challenges

While some countries set targets for public revenues for health, such as the Abuja target of allocating at least 15 percent of the annual government budget to health,[1] there is no consensus on how much revenue governments should allocate to health. The reasons for this diversity reflect different economic circumstances and the range of social contracts that governments have with their citizens for ideological or historical reasons. The economic rationale for devoting public revenues to health are (i) to correct for market failures (e.g., private markets do not work well when consumers and providers have different levels of information regarding the appropriate type and amount of care to purchase); (ii) to ensure that public goods are correctly funded (e.g., immunization may be undervalued if the benefits flow to

society at large); and (iii) to ensure that the poor and other disadvantaged groups are not excluded (to meet equity objectives). The concern in many developing countries is that the very low amount that many governments now devote to health is too low to fund these necessary functions.

A government's revenue-raising capacity is affected by factors such as the country's economic development, institutional constraints, level of formalization of the labor market, and tax administration capacity. Where these are weak, countries rely more on revenues from private and external sources for health. Private revenue—mainly user payments on fees charged by providers—amounts to 62 percent of total health funds in low-income countries (Figure 2.1). User fees have raised concerns about the financial consequences for poor households and the negative effect on health service use (Table 2.1). As countries grow economically, public revenue for health comes to predominate.

Figure 2.1. Share of Total Health Revenues in Low- and Middle-Income Countries in 2011



Source: World Development Indicators.
Note: Private = user payments. Voluntary insurance is negligible and is not shown.

Recent syntheses of impact evaluations find that increasing public spending and lowering payments for patients positively affects health outcomes. Using a large panel dataset at the country level, with annual data for 14 years (1995–2008), Moreno-Serra and Smith (2011) applied a two-step instrumental variables approach that directly estimates the reverse causal effects of mortality on coverage indicators. They found that higher public spending on health leads to better population outcomes, measured either by under-five or adult mortality rates.[2] A synthesis report of 16 impact evaluations found that introducing user fees decreases utilization of care, whereas removing them sharply increases utilization of curative services (Lagarde and Palmer 2011). A systematic review of 20 impact evaluations of user fees for maternal health services found that the removal of such fees contributes

to increased facility delivery but has no clear impact on health outcomes (Dzakpasu et al. 2013).

Table 2.1. Incentives and Challenges in Revenue Collection

Revenues Types	Incentives	Challenges
General taxes	Individuals underreport income to pay lower taxes; governments allocate funds to other sectors for political reasons	Low tax ratios; inadequate levels of public revenues allocated to health in low-income countries
Labor taxes and contributions to health insurance	Individuals reduce work in formal sectors; employers underreport number of employees and their salaries to tax authorities	Increased informality; increased revenue collection costs in tax authority
Voluntary premium paid by individual[a]	Individuals hide true health status to pay lower premiums	Few people can pay high premium; financial sustainability
User payments by patients	Poor seek care with lowest-price provider (e.g., pharmacies)	Poor report lower utilization of care and worse health
External sources from donors	Governments allocate funds for political reasons and to priority diseases	Rigidity because of fragmented and earmarked funding

a. Private insurers charge premiums that reflect the risk of illness for an individual or a group of individuals.

However, many developing countries struggle to mobilize adequate and stable resources because they report low tax ratios, with tax revenues often below 15 percent of gross domestic product (GDP) (IMF 2011). Thus these governments have little room to increase spending on health through domestic revenues. Still, the financing of increasing demand for costlier treatment for noncommunicable diseases (such as diabetes) and the treatment of infectious diseases put a heavy strain on their budgets. In response, governments try to manage public spending on health by setting caps on sector spending, prioritizing spending within the sector, and using central oversight (IMF 2011).

Governments have introduced taxes on wages and alcohol and tobacco to raise additional revenues for health, which can have efficiency and welfare implications.[3] If governments impose taxes on wages to finance insurance enrollment, this may affect efficiency if it leads to a reduction in the quantity of hours worked and increases informality (Table 2.1). Indirect taxes levied on goods with externalities, such as alcohol and tobacco, can increase efficiency because they aim to influence individual behavior, reduce negative externalities on others, and subsequently curb the incidence of costly diseases caused by alcohol and tobacco consumption (Begg et al. 2000). Although excise taxes on alcohol and tobacco are regressive, they have a welfare effect if the poor benefit disproportionately more than the rich in health. Nor do excise taxes have adverse effects on labor and capital (IMF 2011).

Only a small share of total health revenue comes from voluntary premiums paid to private insurance. Outside the United States, revenues from voluntary health insurance contribute less than 15 percent of total health revenues in Organisation for Economic Co-operation and Development (OECD) countries (OECD 2013). In developing countries, voluntary private health insurance raises a negligible share of total health revenues (Gottret and Schieber 2006). Few countries have community-based health insurance (CBHI), which is financed by individual contributions and in some countries subsidized by government and donor funds.

Despite the low share of government spending in low-income countries, governments still have much influence as most external resources are routed through them to finance the public health sector. External funds can, however, contribute to fragmentation in financing and service delivery, especially if they are earmarked for specific diseases, and draw away health workers and other resources from general care (Table 2.1). External funding can also be driven by external priorities, introducing both rigidity and instability into a country's health sector funding.

Bank Group Support to Revenue Collection for Health

The World Bank Group has tried to help countries address the above challenges. Two-thirds of the Bank's health financing portfolio includes interventions related to public revenue collection for health; however, this type of Bank support has been decreasing over time. Development policy operations are almost twice as likely as investment lending projects to advise governments on public revenues (appendix Table B.4).

The Bank's approach has been to help countries raise revenues to address market failure, public goods, and equity objectives. The Bank assisted countries in raising adequate levels of revenues to finance the government health budget and health insurance. It advised governments on revenues raised in the form of labor taxes and other contributions to social health insurance paid by employees, employers, and the self-employed, and on user payments made by patients to providers.

ANALYTICAL WORK

Multisector Bank teams produced analytical work, including Public Expenditure Reviews (PERs), tracking surveys, and fiscal space analysis, that informed governments and other donors about the level of public revenues for health and the allocation of funds within the sector (appendix Table A.9). Bank teams conducted 98 and at least 10 Public Expenditure Tracking Surveys since 2006 (appendix Table

A.10). However, the number of PERs with a health chapter has fluctuated and decreased over time to less than 10 reviews per year. Medium-term expenditure frameworks were supported by the World Bank in Madagascar, Nepal, and Rwanda, and helped inform governments and donors about health expenditure planning. In 2010 the Bank developed a conceptual framework for assessing fiscal space for health (Tandon and Cashin 2010). Since 2009 the Bank has conducted about eight fiscal space analyses to advice governments on how to feasibly increase revenues for health in a way consistent with the country's macroeconomic fundamentals. More recently in 2013, the Bank produced a series of macro-fiscal context and health financing fact sheets for all Regions (Pande et al. 2013).

DOMESTIC REVENUES FOR HEALTH FROM GENERAL TAXES

The Bank tailors its advice to the country context. In low-income settings the Bank advised governments to increase their budgets for health, often with the support of Poverty Reduction Support Credits. In some countries tobacco taxation is earmarked for health and other social spending. Bank analytical work advised on using tobacco taxes to create fiscal space for health**,** mainly in middle-income countries, including China (2003), Estonia (2004), Morocco (2004), Indonesia (2005), Brazil (2007), The Gambia (2012), and the Philippines (2012) as well as the Southeast Asia Region (2004).

COMPULSORY CONTRIBUTIONS AND VOLUNTARY PREMIUMS TO INSURANCE

In a few European countries the Bank advised on labor taxes and on domestic revenue financing for social health insurance mainly through development policy operations. Where labor tax rates were already high, the Bank warned about adverse effects for the labor market and for informal workers.

The World Bank and the International Finance Corporation (IFC) did not advise on the level of premiums paid to voluntary private health insurance.

USER PAYMENTS

Only 14 percent of Bank health financing projects advised governments, (mainly in the Africa and Europe and Central Asia Regions), on the level of user payments (appendix Table B.5). The Bank through development policy operations recommended introducing copayments with exemptions for lower-income groups in Romania and for preventive services in Burkina Faso. Analytical work by the Bank on under-the-table payments made by patients to providers (Chereches et al. 2013) has not been followed up in projects, even though the measurement of progress toward the objective of improved governance, accountability, and transparency is an indicator in the Health, Nutrition, and Population (HNP) strategy.

Effectiveness of World Bank Group Support to Revenue Collection

This section focuses on how Bank advice has affected institution building and the level of revenues for government health budgets and social insurance. It presents evidence on Bank support to nonpooled funding in the form of user payments and how they have affected service use. Increased domestic revenues and subsidized contribution payments to social insurance mean that more pooled public funds are available for health. The effects associated with pooled financing are presented in chapter 3.

STRENGTHEN REVENUE RAISING INSTITUTIONS

In its analytical work, the Bank emphasized that strong institutions are crucial in ensuring that higher public spending positively affects the provision of care. Several Bank studies find a correlation between public health spending and utilization of care when institutions are strong, and Bank teams found that public sector spending improves health indicators in low-income and transition countries, mainly those with good governance systems (Gupta et al. 2002; Baldacci et al. 2008). In 2009, during the financial crisis, the Bank's Europe and Central Asia Region reiterated the importance of good governance in revenue management in its Knowledge Briefs for client countries and staff.

The Independent Evaluation Group (IEG) found that the Bank through lending and policy dialogue helped governments build institutional and technical capacity, and in some countries, Bank teams worked well with government staff. Institution building took place in Argentina where the Bank helped re-establish the ministerial and provincial health committee to coordinate health financing decision in the country (IEG 2011). The Bank supported technical capacity building through the introduction of National Health Accounts in governments to track the flow of funds, mainly in middle-income countries in the Europe and Central Asia Region (including Albania, Armenia, Kosovo, Moldova, Serbia, Tajikistan, and Uzbekistan) as well as in Mauritania and Vietnam. Information produced by government National Health Accounts was used by Bank public expenditure review teams, other donors and the government in health expenditure planning. While health accounts proved to be useful and informative, this support did not always succeed in institutionalizing the health account function within Ministries of Health (IEG 2014).

Because many institutions are involved, coordination is important. IEG found that in Tanzania, the Ministry of Health and the Bank produced their own individual PER in 2011, drawing from different datasets and thus producing different results. The Bank's PER was distributed but never published officially. As the discrepancies between the two PERs were not reconciled, the Ministry of Health uses its own

report. Collaboration between the Bank and government teams could have helped ensure that health financing analysis is coordinated and institutionalized in Ministries of Health.

INCREASED AND PROTECTED HEALTH BUDGETS

With the support of the Bank's development policy operations and policy dialogue, health budgets increased during the loan period in several lower-income countries (for example, Afghanistan, Albania, Bolivia, Burkina Faso, Cape Verde, El Salvador, Lao People's Democratic Republic, Mali, and Niger). However, these budget increases were not always sustained. IEG found in Tanzania, the Bank worked closely with other donors to ensure the government would maintain the share of public funding for health. Donors and the Bank decided to disburse earmarked funds to local government health budgets (in a sectorwide approach) and not move to general budget support when concerns were raised that this change would lead to a decrease in overall public spending for health. Despite these efforts, government spending on health decreased from 16 percent in 2007 to 11 percent of total government expenditures in 2011. The reasons for this decrease included a shift in government priorities from social sectors to infrastructure as outlined in the 2010 National Strategy for Growth and Reduction of Poverty, commonly known as MKUKUTA. Similarly, in the Kyrgyz Republic, Bank policy lending in 2002 supported the government in increasing its budgetary share for health to finance health insurance coverage for pensioners and unemployed persons and implement a categorical grant formula for health financed from the central government with the goal of decreasing the share of user payments among the poor. Until 2006, government spending on health increased steadily but then declined again to similar levels as in early 2000 because of increased government priorities for other sectors, including education (IEG 2008). The decline in budget financing for health was addressed under a Bank-supported follow-up operation (sectorwide approach), and the government implemented a set of rules governing the allocation and execution of public funds to the health sector. Subsequently, spending on health increased from 10.3 percent of total government spending in 2005 to 13 percent by 2012. Thus, competing government priorities play a role in raising revenue for health.

Bank advice through lending and technical assistance helped raise additional taxes. One Bank policy operation (Romania) advised an increase in tobacco taxes in 2009; however, as Romania follows European Union rules,[4] this increase would have happened without the Bank's input. In the Philippines, the Bank responded quickly with a multisector team to government requests to help it get the "sin tax on tobacco" through a reluctant Congress. The government of the Philippines reports substantial revenue increases from the tax, which will translate into higher funding for health

programs (AER 2014). While some countries have increased tobacco taxation, recent studies from Brazil (Euromonitor International 2013) and Indonesia (Nasrudin et al. 2013) suggest that the tax rate is not high enough. There is scope for the Bank to address tobacco taxation in low-income countries. At the same time, impoverishing effects caused by regressive taxation need to be addressed.

Bank advice on managing or protecting public revenues for health was informed by analytical work and implemented in close collaboration between the Health and Public Sector teams. IEG's review of project completion reports found that in Bosnia and Herzegovina, Colombia, and Serbia the Bank's Public Sector and Health teams (mainly through development policy operations) supported improvements in the tax collection from employers and employees which increased revenue transfers from the tax authority to social health insurance. In Eastern Europe, including in Croatia and Turkey, the Bank recommended budgetary caps on spending to manage spending growth. Bank policy lending protected the level of budgetary spending from cuts in Latvia and Tajikistan during the financial crisis, and thereby helped the government implement recommendations from recent PERs. During the economic crisis in 2010, Bank policy lending advised the Latvian government to subsidize health payments for low-income households and raise the number of nurses in health facilities to accommodate increased patient demand. In light of fiscal austerity in Argentina, Bank lending and policy advice ensured that basic and cost-effective health programs were protected and financed by the government, including the availability of reproductive health care services for low-income groups in public facilities (IEG 2011). In these countries, the Bank's Health and Public Sector teams leveraged support through a program of policy and investment lending that was informed by analytical work such as PERs and fiscal analysis.

SUBSIDIZED CONTRIBUTION PAYMENTS

The Bank also helped increase revenues for health by subsidizing contributions to various insurance institutions for low-income groups. This type of Bank support was implemented through lending and policy dialogue in countries such as Benin, Bolivia, Cambodia, the Dominican Republic, Ghana, Mexico, Rwanda, Turkey, and Vietnam. The Bank supported the explicit targeting of subsidies to finance contributions for low-income groups through means testing in Georgia, Rwanda, and Turkey and through geographic location in Cambodia and Egypt.

In other countries, similar support served to subsidize access to health insurance for low-income groups. Vietnam's public insurance fund is financed from payroll taxes and general tax revenues. For households not active in the formal sector, the government makes contributions, defined as a proportion of the minimum wage, from the state budget. In Vietnam's Mekong Region the Bank health project

cofinanced enrollment for near-poor households in the Health Care Fund for the Poor. In Georgia, Bank lending supported the publicly funded Medical Insurance Program for the poor, which provides an extensive benefit package with zero copayments. Low-income beneficiaries receive a publicly funded voucher to enroll with a private insurance company (Bauhoff et al. 2011). IEG found that in Rwanda the Bank provided technical assistance on the law for CBHI.[5] Under this law, the government and donors subsidize CBHI enrollment for the three lower-income quintiles through means-tested targeting while the remaining households pay full contributions. By 2010 about 44 percent of CBHI revenue was from the government budget, 31 percent from households, and 22 percent from donors. As a result of this Bank support, insurance enrollment has increased in these countries. Whether these subsidized contribution payments have also improved service use among pool members is discussed in chapter 3.

SERVICE USE AND FINANCIAL PROTECTION

As shown in Figure 2.1, user payments are the most important revenue source for the health sector in lower-income countries. Bank advice on reducing user fees and copayments has fiscal and equity implications. However, this type of support often lacked the necessary analytical underpinnings, and—contrary to findings from other researchers (Lagarde and Palmer 2011; Dzakpasu et al. 2013)—evidence is missing that reducing copayment levels improved service use and financial protection. While the Bank had recommended introducing copayments with exemptions for lower-income groups in Romania, a recent study found that, compared with those in neighboring countries, households in Romania are far more likely to forgo care because they cannot afford the fees, and young people are more likely to borrow or sell assets to pay for care (Tambor et al. 2013). In El Salvador the Bank supported the elimination of copayments in hospitals but did not prepare providers enough for the resulting demand increase. A 2011 evaluation finds a 40 percent increase in service use after user fees were abolished, and raises concerns about transparency and corruption in finances at unaudited hospitals. It recommends increasing staffing in hospitals to reduce waiting lists caused by the higher number of patients (AfGH 2011). A case study prepared by IEG for this evaluation found similar concerns in Kenya where the new government had just eliminated user fees for primary care in 2013 and was to allocate higher public funding for primary care to compensate for forgone revenues from user fees. The Bank estimated that an additional $8.1 million is needed to compensate providers. It also identified challenges on the flow of health funds to health facilities in a decentralized system. The Bank could analyze the fiscal and equity implications of changes in user fees, as emphasized in the HNP strategy, and inform governments on the amount of public funds needed to compensate providers for reduced or eliminated fees.

In sum, most Bank support in health financing went to public revenue collection for health. As a result of the Bank's help, government health budgets were increased; health spending was protected against budget cuts during an economic crisis; advice on fiscal space for health was considered; and governments were assisted in subsidizing compulsory contributions to various health insurance for low-income groups. Some timely advice on a greater role for alcohol and tobacco taxes has been given, but this is very limited. Public Sector and Health teams emphasized strong institutions and monitoring and evaluation to ensure revenues positively affect the provision of care. While this type of support has been decreasing over time, there have been some notable successes. Evidence indicates that these have occurred with strong government commitment at both the economy-wide and sector levels that the Bank has supported and when Bank staff drew on a variety of skills across the Bank to engage government. Bank advice and operations have also supported governments which have tried to lower user payments as a source of revenue. However, this type of support often lacked the necessary fiscal and equity analysis, and evidence is missing that Bank support to reduce copayments has improved equity in service use and financial protection.

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[1] In April 2001, heads of state of African Union countries met and pledged to set a target of allocating at least 15 percent of their annual budget to their health sector. http://www.who.int/healthsystems/publications/Abuja10.pdf

[2] An increase of $100 in government spending per capita results in a reduction of 13.2 per 1,000 in under-five mortality as well as a decrease of 2.6 and 2.2 per 1,000 in adult female and male mortality rates, respectively.

[3] Governments raise direct taxes from earnings, indirect taxes on consumption, and wealth taxes. A tax system is considered fair if it generates higher taxes on the rich to finance public goods and services, such as health services, predominantly used by the poor. Indirect taxes on consumption (e.g., value-added taxes) are regressive if the poor spend a higher proportion of their income on goods subject to these taxes than the rich. While such indirect taxes reduce the redistribution effect from the rich to the poor, they may still have a pro-poor effect if they finance public services predominantly used by the poor (Begg et al. 2000; IMF 2011).

[4] According to a directive from the European Commission's Taxation and Customs Union, member states must apply to cigarettes a specific excise duty per unit of the product and a proportional excise duty calculated on the basis of the weighted average retail selling price. For more information visit http://ec.europa.eu/taxation_customs/taxation/excise_duties/tobacco_products/legislation/index_en.htm.

[5] On December 30, 2007, Parliament passed Law No. 62/2007 on establishing and determining the organization, functioning, and management of the community-based health insurance. For more information visit http://lip.alfa-xp.com/lip/AmategekoDB.aspx?Mode=r&pid=7586&iid=2031.

3. Pooling Health Funds and Risks

Highlights

- Risk pooling is important to address equity and financial sustainability in health. Countries have multiple pooling arrangements, leading to unequal risk distributions across pools and to different pools for the various socioeconomic groups.
- World Bank support contributed to increased risk pooling in middle-income countries. Similarly, the International Finance Corporation supported risk pooling through public and private insurance.
- The World Bank Group built institutional, management, and technical capacity in government and insurance administration to manage funds and risks, and Bank analytical work informed policy decisions. However, Bank assistance to health insurance has been diminishing over time. Projects were less effective in countries with decentralized health systems.
- Equity in pooling has improved where the Bank helped subsidize coverage of the poor. But coverage did not always lead to pro-poor spending, improved service use, or greater financial protection. Fragmented pooling remains an issue and can affect efficiency. Success factors included strength in institutions, management, technical capacity, and information.

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. Pooled financing reallocates funds from healthy to sick individuals—that is, from individuals with a low risk of illness to those with a high risk who are more likely to occur higher health care costs. As countries grow economically, pooled health financing in national health systems and health insurance comes to dominate revenues from user payments.

The objective of pooling is to reduce the out-of-pocket price the patient pays when using services and to ensure financial protection against catastrophic health payments and equity in service use. But managing health revenues in a way that ensures equitable and efficient pooling is a major challenge (Gottret and Schieber 2006). Also, increased pooling contributes to higher health spending by increasing the demand for health care.

Increased pooling, in national health systems or through insurance, benefits consumers and providers. Individuals who are insured or covered in the public system will copay less when seeking care. They are thus expected to report greater service use and lower copayments than those who pay user fees. Increased pooling is also good for providers because user payments from patients are erratic revenues in low-income environments. Instead, contracted providers will receive a stable amount of revenues from the government and insurers to treat patients (Box 3.1).

Box 3.1. Risk Pooling Arrangements

Countries introduce different risk-pooling arrangements to protect individuals against the financial risk of illness. In health systems with automatic coverage, public revenues are pooled in the government's health budget, and the public sector plays an insurance role, even if it is not formally constituted as an insurance plan (Kutzin 2007; Savedoff et al. 2012). The government transfers revenues from the central and local government budgets to providers to pay for health care services provided to the population. In countries with decentralized health systems (such as Argentina, Kazakhstan, and the Philippines), health revenues from the central and local governments are pooled at the local level (state or region) and transferred to providers to finance health care delivery to patients.

In addition, public and private health insurers pool health funds, including from individual contributions, premium payments, and government subsidized contributions, to pay for the financial risk of illness among their members.

Chapter 3 summarizes the challenges related to automatic coverage and to mandatory and voluntary pooling. It then describes support from the International Finance Corporation (IFC) and World Bank to countries in meeting them. It offers evidence on how this support to pooling affects equity in health financing and service use, financial protection, and efficiency.

Challenges

In most countries, multiple pooling arrangements coexist, leading to a risk of fragmentation. Generally, formal sector workers are covered under mandatory social insurance; higher-income groups can afford paying higher premium to enroll with private voluntary insurance (to access specialist care and private providers); and the government provides automatic coverage in public health facilities for those who are excluded from these insurance arrangements, mainly the lower-income and informal sector groups. As a result, different socioeconomic groups pool their health risk among themselves in different institutions with different revenue raising capacity and access to different health benefits. The resulting fragmentation raises concerns about equity in service use across different groups. It also raises concerns about the financial sustainability of small risk pools (Box 3.2).

One of the main challenges in government health systems (automatic coverage) in low- and middle-income countries is that government allocations are often not pro-poor. Instead, a higher share of funds is allocated to hospitals in urban areas, which are mainly used by the wealthier (Table 3.1). To improve pro-poor spending, some countries have earmarked transfers to providers mainly used by low-income groups. In Mexico, for instance, the Seguro Popular is an intergovernmental revenue transfer within the national health system from the center to the states. The transfer is

defined based on the number of low-income individuals affiliated with Seguro Popular and is cofinanced by the states.

Table 3.1. Incentives and Challenges in Different Risk Pooling Arrangements

Risk Pooling	Pooling Institutions	Incentives	Challenge
Automatic coverage	Government budget (central and local)	Governments allocate funds for political reasons (e.g., urban hospital)	Pro-rich spending; underfunded services in low-income areas
Mandatory pooling	Public health insurance Private health insurance[a]	Moral hazard among insured individuals	Exclusion of informal groups; inefficient service use; cost increase
Voluntary pooling	Private health insurance Community-based health insurance	Moral hazard; risk selection	Financial sustainability

a. In some countries including Georgia, India, and Slovakia, private insurers offer mandatory insurance coverage.

Mandatory participation by law in public or private health insurance limits insurance coverage to all or a defined population group (e.g., formal sector employees). The excluded are mainly lower-income groups who work in the informal sector—the majority of the population in developing countries (Table 3.1). They receive automatic coverage through the public system; however, this is often less comprehensive. The small membership size of social insurance in countries with nascent formal sectors can endanger an insurer's financial viability. A fiscal and equity problem can arise if the government has to finance the deficit caused by the medical service use of wealthier insurance members (Box 3.2).

Box 3.2. Financial Incentives May Endanger the Sustainability of Risk Pools

Risk pooling involves trade-offs between equity gains caused by reduced uncertainty about the financial consequences of ill health and efficiency losses created by financial incentives (Arrow 1963; Cutler and Zeckhauser 2000; Zeckhauser 1970). These incentives, which include adverse selection, moral hazard, and supply side–induced demand, can lead to higher costs for the risk pool and endanger its financial sustainability.

Adverse selection arises when those enrolling in voluntary risk pools are mainly high-risk individuals, resulting in high-cost pools that may not be financially viable. Moral hazard occurs when pool members overuse medical services because they copay at a reduced price for care, which can increase costs. Finally, providers who are reimbursed by the pool based on fee-for-service payments have a financial incentive to oversupply care, which also leads to higher costs.

Some governments introduced separate institutions to pool public funds and health risk for informal sector groups. Thailand, for example, has established the government-funded Universal Coverage Scheme, which uses tax revenues to

provide coverage for individuals not covered by formal sector social insurance. Benin and Cambodia created health equity funds to strengthen financial risk protection among the poor and informal sector groups. While they differ in design, these funds were set up to manage health care subsidies for eligible population groups.

The volume of voluntary pooling in private health insurance is inconsequential. Few people can afford voluntary private insurance, and there are generally not that many private providers to contract with in developing countries (appendix D). Private health insurance pays mainly for services not covered by social insurance or by the government (e.g., specialist care in the private sector) and is used to avoid waiting lists for elective treatment. To ensure their financial viability, private insurers have an incentive to enroll people at low risk of being ill.

Community-based health insurance (CBHI) is more prominent in Africa for informal sector groups. While members of such schemes often report better access than those who pay user fees, they tend to have access to a smaller benefit package than those with social health insurance (SHI). In addition, voluntary pooling in private insurance and CBHI may lead to adverse selection resulting in small, high-risk pools with predominantly sicker individuals, and may undermine pool finances (Box 3.2).

Bank Group Support to Risk Pooling

The World Bank Group has tried to help countries address challenges in pooling arrangements. About 40 percent of the Bank's health financing operations support automatic coverage through national health systems or enrollment into mandatory health insurance in 36 countries.

The Bank Group does not take an ideological stance on risk pooling arrangements. It did not advocate for SHI or automatic coverage through national health systems, or promote private health insurance. Rather, it works within different country and risk pooling contexts. The Bank assisted Ministries of Health and local governments managing and implementing their health budgets. Management and information capacity was also built with Bank and IFC support in public and private health insurance.

ANALYTICAL WORK

The Bank produced several analytical reports, mainly in middle-income countries, to inform governments about the challenges of different risk pooling arrangements in different contexts. Of the 70 economic and sector work activities, a relevant word search suggests that 15 have tackled pooling. In addition, the Bank conducted eight

impact evaluations on risk pooling in China and Vietnam (appendix Table A.8). It also carried out limited analysis on the welfare effect of increased pooling of domestic revenues and whether the poor benefit. Only 10 Bank poverty assessments examined the distributional aspects of public spending and conducted benefit incidence analysis (see chapter 5).

AUTOMATIC COVERAGE THROUGH NATIONAL HEALTH SYSTEMS

The Bank provided technical assistance to improve resource management in national health systems. Decentralization of funding to lower levels of government was supported in several countries including Cambodia, Indonesia, Kosovo, Pakistan, Rwanda, and Serbia. It helped build technical capacity to manage fund pooling and health resources in Afghanistan, Cambodia, and Vietnam. The Bank has helped countries target the poor through automatic coverage in national health systems. In Argentina it supported the introduction of the Plan Nacer program, which targets supply-side subsidies to health facilities used by the poor (IEG 2011).

Depending on the country context, Bank support to automatic health coverage was accompanied by public sector measures to strengthen the public management of health funds. In Afghanistan the Bank supported expenditure management through program-based budgeting which links health sector spending to the national strategy and to prioritize allocation. In Kenya and Tanzania it helped with public expenditure tracking to identify inefficiencies in spending. In Kenya the Poverty Reduction and Economic Management and Health, Nutrition, and Population (HNP) teams worked with the government to improve budget transparency by adding more detailed line items to track health expenditure.

PUBLIC AND PRIVATE HEALTH INSURANCE

The Bank has advised several low- and middle-income countries on the level of contributions paid to social insurers and on subsidized enrollment. The Bank also supported the strengthening of health insurance governance and management.

The IFC has made only two direct investments in private health insurance (both originating from the Financial Markets Group) and two investments in a health maintenance organization (HMO) provider network (appendix Table D.3). The IFC has supported the expansion of Nigeria's largest integrated HMO provider network with two investments and one advisory services project (2007 and 2009), and provided funding through its Performance-Based Grants initiative to support a project under the Global Program on Output-Based Aid to support the HMO's community-based health plan targeting the informal sector. And it has supported the expansion of private insurance providers in the Europe and Central Asia and the Middle East and North Africa Regions with two equity investments in 2011 and

2012, respectively. IFC has recently approved a micro health insurance advisory project in India (appendix D).

Two equity funds have been established as part of the Health in Africa Initiative (HiA)—the Africa Health Fund and the Investment Fund for Health in Africa. Both funds include insurance as target investments. They have invested in insurance companies and HMOs in Kenya, Nigeria, and Tanzania. The initiative has also supported governments in Kenya and Nigeria in strengthening their public health insurer through IFC's advisory services. IFC support to the government of Uganda in reforming legal and regulatory frameworks aims to increase private sector participation in publicly funded health programs (appendix D).

Effectiveness of World Bank Group Support to Pooling

In practice, risk pooling may not work as expected for several reasons. This section examines how effectively Bank Group support to risk pooling has helped countries develop management and technical capacity, and improve equity in pooling, service use, financial protection, efficiency and financial sustainability of risk pools.

MANAGEMENT AND TECHNICAL CAPACITY

Management and technical capacity is important to ensure that health budgets in central and local governments are effectively implemented. Although the Bank has supported governments in increasing their health budget, budget implementation is limited in some countries. Low budget-execution rates were reported in Afghanistan and the Democratic Republic of Congo because of constrained technical capacity, lack of financial authority, and complicated financial and procurement procedures. In Afghanistan, Bank analytical work also found no clear targeting of public funds to areas with worse health outcomes, and the funds spent by the government and donors on health were not coordinated across provinces (Belay 2010). More recently, the IEG case study found, the Bank played an effective coordinating role among donors and emphasized the use of M&E which supported the government in evidence-based fund management. In Brazil, Bank support to building the institutional foundations at municipality level—including budget management, accounting, monitoring, financial management, and managerial capacity—contributed to the timely execution of the health budget in a decentralized health system (IEG 2011).

Through its multisector analytic work, the Bank provides important information about public sector reforms (such as decentralization) that affect health financing. The Independent Evaluation Group (IEG) found that in Kenya, the Bank's Health and Public

Sector teams have spearheaded several analytical products and policy discussions in health financing. The Public Sector team was supporting a fiscal space analysis to ascertain the efficiency of the health sector and determine the value for money aspect. Bank work through the 2012 Public Expenditure Review and a Public Expenditure Tracking Survey with sub-national analysis and frontier analysis helped identify inefficiencies and informed the government about challenges that need to be addressed in health sector devolution (appendix E). This type of Bank analysis helped inform policy makers in their management and technical decisions.

Health financing projects in decentralized health systems with automatic coverage performed worse than the average health financing projects in ratings of the IEG.[1] Examples include projects in Brazil, the Dominican Republic, Ghana, and Mauritania, where the Bank overestimated the political commitment and technical knowledge in the government to decentralize, and failed to calibrate project design to local capacity.

In Indonesia, three Bank health projects assisted the government in shifting responsibilities for planning and management of resources to district authorities. While district health budgets tripled, the additional resources were insufficient and ineffectually allocated. Allocation formulas were not adequately poverty calibrated, and the limited own-revenue raising capacity of poorer districts negatively affected horizontal equity across districts. Few districts reached the target of allocating at least 15 percent of local government spending to health, and health service use among the poor and near-poor increased very modestly in some districts and decreased in others. IEG found several factors that limited the success of Bank-supported health sector decentralization in Indonesia, including insufficient attention to define roles and responsibilities at different government levels, inadequate information systems, and considerable overlap and duplication of tasks across government (including in management of human resources) that generated inefficiencies in the organization and delivery of services. The Bank did help introduce better planning and budgeting methods that over time have helped improve information systems for regional monitoring. IEG concluded that Bank support to health decentralization needs to be grounded in a realistic understanding of how institutions work, and how they can be expected to change in the political context in which projects operate (IEG 2013).

Bank technical assistance and lending helped governments develop new laws and administration to strengthen social insurance management, mainly in middle-income countries. Following Bank advice governments in Albania, the Dominican Republic, Serbia, and Vietnam introduced changes to health insurance laws and regulations. In Turkey it gave advice on the Social Security Administration law and hospital budgets.

Governments in European countries introduced measures to stem the deficit in health insurance as recommended in PERs and analytical work supported under policy lending. Bank loans financed beneficiary identification and medical claims management systems in Georgia, Montenegro, and Serbia, and improved efficiency in insurance management. In these countries, Bank Public Sector and Health teams worked closely on these reforms, which contributed to successful implementation.

Although the HNP strategy highlights the Bank's comparative advantage in health insurance analytical capacity, Bank teams did not always maintain support to health insurance and address shortcomings in management and institutional capacity. In Tanzania in the 1990s and early 2000s, the Bank was instrumental in setting up the National Health Insurance Fund, the National Social Security Fund and the Community Health Fund. However, by the mid-2000s, the Bank reduced its engagement in these funds, partly because of changes in Bank resources as well as reduced demand for Bank assistance by the government as other donors increased their health financing technical assistance. By 2013, only about 8.6 percent of the population is insured in Tanzania, enrollment is highly unequal, and the National Health Insurance Fund has high financial reserves because investments are tied up, and because of a lack of understanding among health facility managers about how to submit a medical claim to the fund to get paid for care provided to insured patients. Little additional reforms were introduced to address these shortcomings. IEG finds that given the strong Bank involvement in the past, the Bank team could have provided further analysis and technical assistance to the funds to strengthen institutions and management capacity, especially since the government is now considering scaling-up insurance and raising labor taxes to finance enrollment. In Bolivia, IEG found that the Bank was instrumental in helping the government establish health insurance for mothers, children, and the elderly; however, this support was not maintained over time. Similar concerns were identified in Ghana and Rwanda, where Bank support to health insurance management has been reduced over time partly due to a shift in government priorities and Bank resources (appendix E).

In the Kyrgyz Republic the Mandatory Health Insurance Fund is nearly all funded from general government revenues and manages a state-guaranteed benefit package for the whole population. The fund is also the sole purchasing agency for health services within the health system (Kutzin 2013). The Bank has supported these reforms in collaboration with other donors, through analytical work and capacity building and as a convener of donor efforts. Health reforms have benefited from strong political commitment and technical capacity, which are important success factors. They include the 10-year (1996–2005) government health reform strategy, several champions in the government in support of the reforms, and effective use of

monitoring and evaluation (M&E) so that early successes could be publicized and used to generate support for subsequent reforms. In addition, Bank interventions and policy dialogue at key moments of political opposition sustained momentum for insurance reforms (IEG 2008).

Under the HiA, IFC has conducted a strategic review of Kenya's National Hospital Insurance Fund (IFC 2011a) and a market assessment of prepaid plans (IFC 2011b). Its recommendations were accepted by the government and are now being implemented. Through a follow-on advisory project, IFC is assisting the government on integrating private hospitals into the national health system (e.g., regulatory framework for accreditation and contracting with private providers). The evaluation's case study found the Bank is also working on recommendations made by IFC through a project on health insurance subsidies for low-income groups (appendixes D and E).

EQUITY IN POOLING

Ensuring that pooling arrangements are equitable requires an effective way to cross-subsidize across pool members and to inject the pools with a sufficient amount of public funds that are sustainable. In health systems with automatic coverage, the Bank conducted a few incidence analyses to alert governments to issues in pro-poor allocation of funds. In Indonesia the Bank found that overall allocation of public spending on health is low and spending needs to be increased strategically to reach the poor effectively and to include demand-side measures. In Ghana the Bank identified increased pro-poor spending over time. However, in Nicaragua it found that public spending on social services is not pro-poor—it benefits all socioeconomic groups about equally.

The share of poor included in risk pools increased where the Bank helped governments subsidize their enrollment (Box 3.3). In Turkey insurance coverage for the poorest increased more than fourfold between 2003 and 2011, generating a coverage rate of 85 percent for the poorest (Atun et al. 2013). The public health insurance has recently incorporated the Green Card Program, which subsidizes health care for the poorest income group and is funded by general government revenues (Atun et al. 2013). Similarly, in Colombia the Bank's development policy operation helped increase the enrollment of low-income groups in government-subsidized insurance from 10.7 million in 2002 to 18.2 million in 2007. By March 2014, about 43 million individuals or 90 percent of the population was insured in Colombia (www.sispro.gov.co). In Rwanda, IEG found that Bank support to the CBHI law makes insurance enrollment mandatory and increased CBHI enrollment to about 85 percent of the population by 2012. A Bank project in the Philippines

reached the poor in the National Health Insurance Indigent Program, but the percentage enrolled is unknown.

Box 3.3. Bank Analysis Informed Risk Pooling in China and Vietnam

Researchers have found that individuals enrolled with the voluntary Vietnamese Health Insurance (VHI) program were more likely to use outpatient care, and the poorest insured are 10 times more likely to seek care than the uninsured. But there were concerns that adverse selection and the use of unnecessary care would threaten the financial sustainability of VHI (Jowett et al. 2004). The Bank, using data from the late 1990s, confirmed improved health outcomes among VHI members (Wagstaff and Pradhan 2005). Informed by these studies, the Bank and other donors through the Second Poverty Reduction Support Credit in 2003 helped the government establish the Health Care Fund for the Poor (HCFP), which provides the same benefits as the VHI. In a follow-up study the Bank found that 60 percent of eligible households were covered by 2006, and the HCFP was well targeted to the poor; however, there was adverse selection (Wagstaff 2010). To address selection problems, Bank lending helped increase HCFP enrollment to 96 percent among the poor and 42 percent among the near-poor by 2011.

In China, based on data from the late 1990s up to 2004, the Bank found that the Rural Cooperative Medical Scheme diminished the risk of high user payments for households (Wagstaff and Lindelow 2005), and ill health can have a large impact on household income, labor supply, and medical expenditures, even for the insured, raising concerns about the effectiveness of the Scheme (Lindelow and Wagstaff 2005). This was followed up by an impact evaluation of the government-subsidized New Cooperative Medical Scheme (NCMS) established in 2003, which found lower enrollment among the poor and higher enrollment among the chronically sick, pointing to adverse selection. Service use increased, but the NCMS did not reduce user spending for the poor (Wagstaff et al. 2007). Informed by these studies, the Bank has supported the NCMS since 2009. Enrollment increased to 99 percent in 2012.

In some countries, Bank support was less successful in targeting the poor for inclusion in risk pools. In Tunisia only 9 percent of the eligible poor are covered under the government-funded Free Medical Assistance Program. The poor are not reached because of institutional constraints including nontransparent eligibility criteria that are subject to manipulation,[2] and the Bank could in fact have addressed weak targeting of the poor in the policy dialogue (IEG 2014). In Georgia, despite means testing supported by the Bank, a significant proportion of eligible households were excluded from the Medical Insurance Program, mainly because of insufficient information (Bauhoff et al. 2011).

In Ghana the National Health Insurance System covers 40 percent of the population, which are predominantly the nonpoor. The Bank was instrumental in convincing the government to extend coverage to children and youths under the age of 18 and pregnant women to achieve the relevant Millennium Development Goals. It also

discussed a more generous definition of the poor, which according to the National Health Insurance System is only 1.7 percent of the population and far below the national poverty rate of 30 percent (appendix E). But reaching the poor requires commitment by government. IEG found that insufficient political and financial commitment by the government and limited implementation capacity were constraining factors to reforms as was weak M&E systems to track equity in access for insured and uninsured individuals (IEG 2007).

The IFC supported private and public health insurers that provide both mandatory and voluntary coverage mainly for formal sector employees. In IFC's managed-care investments in Nigeria, HMO enrollees are primarily federal employees and employees of large corporations and members of the National Health Insurance Scheme. There is no evidence from the IFC's Development Outcome Tracking System to suggest the 1.2 million HMO enrollees in Nigeria and 613,000 patients served as of FY13 were poor. In Kenya, IFC advisory support to the public insurer contributed to expanding coverage to civil servants. IFC support also resulted in the government's decision to expand health insurance subsidies to the indigent population (poorest 9 million Kenyans). IFC assisted the government of Meghalaya (India) with the contracting of a private insurer to offer health insurance to low-income individuals. In Tanzania, the Investment Fund for Health in Africa invested in the largest private insurance company; its clientele is primarily corporate employees who are mainly higher- and middle-income individuals (appendix D). Dalberg (2012) finds that the equity investment through the Africa Health Fund in Kenya is reaching the poor but not the very poor.

SERVICE USE RELATIVE TO NEED AND FINANCIAL PROTECTION

Few Bank projects report how increased pooling of domestic revenues affects service use, particularly in automatic coverage systems. In Uzbekistan primary health spending to facilities mainly used by low-income groups rose from 41 percent in 2004 to 45.2 percent of public health expenditure in 2011, and the number of visits per person per year has increased from 3.8 in 2005 to 4.4 in 2010. In Tajikistan the reforms in public revenues had no effect on care seeking; as patients did not seek care, households also spent less on health. In Argentina service use of protected programs remained at a high level and increased for the treatment of tuberculosis and HIV vertical-transmission prevention (IEG 2011).

Risk pooling does not necessarily translate into improved service use and financial protection. In China no recent information is available on the impact of the use of care and how effectively the New Cooperative Medical Scheme protects households against the financial consequences of ill health. The Turkey insurance reform supported by the Bank contributed to improved equity in health financing across

income groups and substantially reduced catastrophic expenditures for the poor while increasing their service use (Atun et al. 2013). The Colombia health insurance for the poor lowers mean inpatient spending for patients and is associated with the use of preventive series and health gains for children. However, insurance does not affect spending for outpatient care nor does it increase utilization of curative care (Miller et al. 2013). In Georgia, insurance did not affect utilization of care (Bauhoff et al. 2011). Among the reasons why were low quality of care and the exclusion of pharmaceutical products from coverage (World Bank 2012). Bank analytical work should identify and address the reasons why pooling does not lead to the expected outcomes, as done in Georgia and Vietnam (Somanathan et al 2014), for example.

Insufficient information about benefits is a limiting factor. In Vietnam a Bank impact evaluation finds that while the Health Care Fund for the Poor (HCFP) has reduced user payments for members, it did not affect their service use (Wagstaff 2010). Among the reasons were that HCFP members were not well-enough informed about benefits. Thus the Bank helped improve knowledge about HCFP benefits for 98 percent of members, and by 2011, 46 percent of the poor HCFP members used hospital and outpatient care. Similarly, service use among members of the Medical Insurance Program in Georgia was low because the program provided too little information on the benefit package; beneficiaries failed to receive vouchers for enrollment; and providers continued requesting under-the-table payments from patients (Bauhoff et al. 2011).

Some countries report substantial improvements for the poor insured, but this information is limited. Other researchers report improved utilization and reduced out-of-pocket spending for the insured in some Bank-supported risk pools. Based on 2006 household survey data, CBHI in Rwanda is associated with significantly increased utilization of health services when they are needed and with lower user payments. The incidence of catastrophic health expenditure was almost four times as high for noninsured households as for the insured (Saksena et al. 2011). In Ghana the insured poor have greater access to health care, lower copayments, and better health outcomes than the noninsured poor. Insurance has also reduced catastrophic spending on health and protected households against impoverishment (Nguyen et al. 2011). In Cambodia the health equity funds led to sharp gains in utilization of key services and reduced spending by the poor, and they significantly lowered copayments, catastrophic expenditures, and debt by the poor (Flores et al. 2013).

Little evidence of the impact of IFC's support to health financing on improved service use or financial protection is due to the newness of the projects or scarcity of data (appendix D). As IFC investments in private health insurers do not monitor utilization of care and copayments by the insured, no information is on hand about

their effectiveness. Partly this is due to the transaction-like nature of some IFC's advisory services; however, recent projects have recommended post-completion reporting on access to improved services.

EFFICIENCY AND FINANCIAL SUSTAINABILITY

Efficiency concerns arise where pooling is fragmented. In East Asian countries the Bank warned about high administrative costs, duplications of benefits, and loss of negotiating power with providers (Langenbrunner and Somanathan 2011). In European countries the Bank highlighted risk-equalization issues to address fragmentation (World Bank 2009a). Bank advice to the government of Turkey in 2003 cautioned about fragmented pooling (World Bank 2003). Since then, the government has consolidated the five insurance schemes into a unified general health insurance program with harmonized benefits (Atun et al. 2013). The government has also improved revenue allocation to primary care which reduced referral rates to more costly specialist care. In Hungary and Poland the Bank successfully advised against breaking up the social health insurer into multiple pools, which would have increased fragmentation. The Bank also warned about adverse selection in countries with multiple insurance funds, including China, the Slovak Republic (World Bank 2009a), and Vietnam. Achieving development results in IFC's private insurance investments have been difficult. For example, an investment aimed at reaching underserved populations in a multiple pooling environment proved difficult.

Addressing fragmentation needs political commitment. In Bosnia and Herzegovina, Bank advice to consolidate various health insurers faced political resistance, and the government did not follow it. In Mexico a Bank study found that government-subsidized risk pooling among the poor through Seguro Popular incentivizes informality. While Seguro Popular improves access to care, it was associated with a 3.1 percentage point fall in the flow of workers into formality. The Bank also found that Seguro Popular has income effects. Members can avoid having to contribute to the formal SHI program by moving to the informal sector and receiving services under Seguro Popular (Aterido et al. 2011). Yet the government has chosen not to consolidate Seguro Popular with the formal SHI program to reduce fragmentation.

The findings of this evaluation show that almost half of the Bank's health financing portfolio supported the strengthening of pooling through automatic coverage or mandatory public health insurance. The Bank helped strengthen regulatory frameworks, resource management, and institutional foundations for budget execution, and invested in M&E. Bank and IFC analytical work and technical assistance helped inform governments about fund management and the expansion of coverage to the uninsured. However, in some countries the Bank could have

provided further analysis and technical advice to help governments strengthen insurance institutions and address weaknesses, including in targeting the poor. Equity in pooling improved where the Bank helped subsidize enrollment of the poor. But coverage did not always lead to pro-poor spending, improved service use, or financial protection. The IFC supported private and public health insurers that provide both mandatory and voluntary coverage mainly for formal sector employees, but evidence that this has improved service use is missing. Fragmented pooling remains an issue in several countries and can reduce efficiency.

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[1] Of the 188 projects included in this evaluation, 42 supported decentralization. Their rating in the Independent Evaluation Group (IEG) review of the project implementation completion report is lower for monitoring and evaluation and for efficacy.

[2] Eligibility in 2005 was determined based on visits by local social workers and included criteria such as family size, disability, age, capacity to work, and income.

4. Purchasing

Highlights

- Purchasing is important for incentivizing quality and efficiency. Countries are introducing complex payment reforms that require improved data collection and analysis and management to address adverse effects, including those on nonhealth sectors.
- A growing share of Bank operations are supporting countries in purchasing reforms and most of this support is to performance- and results-based payments in low-income settings. In addition, the Bank helped in building institutional and administrative capacity and investment in information to assess provider performance.
- Service use has increased when countries move from line-item budgets to paying providers for activities or performance. A change in provider payment method primarily benefits individuals seeking care. Demand-side barriers, such as user fees, and high administrative costs remain concerns for efficiency and financial sustainability of Bank support.
- Purchasing reforms are likely not sustained unless they are embedded in overall health financing, and the broader public finance context and future financing are assured.

The objective of purchasing is for providers to deliver quality care efficiently to individuals who need it. Purchasing is challenged by the financial incentives of various provider payment methods that transfer funds from the purchaser (e.g., government units and insurers) to providers and by the paucity of information on providers' reactions to these methods. Whether these incentives lead to the desired outcome heavily depends on the institutional context for providers and how they react to them.

How did the World Bank Group support countries in purchasing, and what evidence is there for improved equity in financing and service use, financial protection, and efficiency? This chapter addresses these questions. It also includes findings from the country case studies presented in appendix E.

Challenges

Financial incentives set by the payment method may encourage providers to change the number of services, manage costs, and improve quality of care, all of which can affect efficiency (Ellis and McGuire 1996) (Table 4.1). Line-item budgets and hospital per diem are still common in middle- and low-income countries. But these two payment methods do not set incentives for providers to become more efficient or offer better care. To increase the number of health services, governments and

insurers increasingly pay providers based on their activities including through fee-for-service and Diagnosis-Related Groups (DRGs) which reimburse hospitals a fixed amount per patient depending on the diagnosis. In the U.S. Medicare system the average length of hospital stay fell by 15 percent in the first three years after the shift to DRGs (Cashin et al. 2005). But activity-based payment has cost implications for the payer. In the Czech Republic, the move from line-item budgets to fee for service led to an increase in activities and 46 percent growth in hospital expenditures from 1992 to 1995 (Langenbrunner et al. 2005).

Table 4.1. Provider Payment Methods and Related Incentives and Challenges

Payment Methods		Financial Incentives to Providers	Challenges
Line-item budget		Increase number of input factors (e.g., bed, staff) and use full budget	Low productivity
Activity-based	Fee for service	Increase number of incentivized activities (e.g., services per patient, hospital days, admissions, cases treated)	Inefficient service use; cost increase
	Per diem for hospital day		
	Case based (e.g., DRG)		
Pay for performance		Increase number of services leading to improved quality or efficiency "Code creep" (distortion of treatment toward those with higher payment)	Transparency of information on performance Inefficient service use; cost increase
Capitation Global budget		Treat patients within budget Exclude high-risk patients	Substandard quality

Source: Langenbrunner et al. (2009).

Prospective payment—including capitation based on the number of individuals registered with the provider and global budgets to hospitals to provide a set of services—shifts the financial risk to the providers, setting an incentive to increase efficiency. In Ireland the move to capitation led to a decline of 20 percent in the number of outpatient visits (Langenbrunner et al. 2005). In the worst case, providers reduce their costs by skimping care or discourage individuals with costlier health problems from registering. Mixed payment methods are frequently used, such as capitation adjusted by some activity indicator (e.g., number or coverage of preventive services or quality).

To improve quality and efficiency, some countries including the United Kingdom and the United States have introduced performance payment to compensate providers for meeting preset quality and efficiency measures.[1] The evidence base linking performance-based payments to better quality of care is thin in Organisation for Economic Co-operation and Development (OECD) countries (Box 4.1). Similarly, no systematic review shows the impact of performance-based payments in low- and

middle-income countries. A review of nine impact evaluations finds that their effect on quality of care, antenatal care, institutional deliveries, preventive care for children, and outpatient visits is unclear. While performance-based payments increase facility revenues, their impact on efficiency is yet to be ascertained. The review also found little evidence that such payments have triggered for managerial autonomy in health facilities (Witter et al. 2012).

Box 4.1. What Is the Effect of Performance-Based Payments in OECD Countries?

The evidence base linking performance-based payments to better quality of care is thin. Most studies from the United States and United Kingdom show inconsistent efficacy or have revealed unintended effects, such as improved documentation without much change in quality of care (Epstein 2007). Maynard (2012) also finds that most studies were conducted without control groups and had methodological flaws. He finds that studies with control groups show modestly improved quality scores in participating health facilities, with the lowest improvements in the already highest performing hospitals, and that larger financial incentives produced greater effects than smaller incentives. Still, the financial incentive seems to diminish over time. U.S. hospitals reported gains for the first three years, but afterwards showed no difference in the performance of the two study groups. While the design and implementation costs of performance-based payment are considerable, none of the studies has conducted a relative cost-effectiveness analysis of these programs. Maynard (2012) concludes that the scale up of performance-based payments in OECD countries was made based on poorly designed, executed, and evaluated pay-for-performance programs, which may even raise costs and worsen efficiency.

Although performance-based payment is often introduced alongside public reporting of performance results, few studies have identified whether improved performance stems from the performance-based payment itself or from the information on provider performance, which affects the reputation of the health care provider. One study suggests that the incremental effect of performance-based payment over public reporting of performance is small, around 3 percent performance improvement over two years, and varies according to baseline performance with the largest improvements observed among the poorest performing hospitals (Lindenauer et al. 2007). This finding has important cost implications given the high implementation costs of performance payment.

In addition to these constraints in provider payments, governments are challenged by insufficient information, unclearly defined benefit packages, and institutional limitations when designing the purchasing function. Asymmetric information is a major constraint for activity- and performance-based payments, particularly in low-income settings. The difficulty is choosing appropriate measures and benchmarks, and collecting reliable and valid information on provider performance on the basis of which payments are made. But the purchaser—especially in countries with weak data systems—often has little information on how health care was delivered. Another problem is that in many countries the health care benefit package is nominally comprehensive, but in practice it is narrowly defined owing to provider and financial constraints. This means that patients continue to pay user fees for

goods and services that are meant to be in the package and financed by the government or insurance.

Institutional reforms support the effect of provider payments in public health facilities. While private providers can adjust their resources, managers in public facilities seldom have the autonomy to respond to the financial incentives set by the payment method and improve efficiency by adjusting the input mix, such as staff and medical supplies. Thus changing provider incentives needs to be accompanied by public sector reforms. Concerns arise if incentives cause adverse behavior among providers, as it may lead to cost shifting across different payers or to spillover effects in other sectors (e.g., payments may lead to wage increases in the health sector and put pressure on the government to increase wages in other sectors).

Given the complexity of purchasing, purchasing needs to be fully integrated into the overall health financing and public finance context (Box 4.2). Unintended consequences such as spillover effects on other sectors need to be examined and addressed.

Box 4.2. Integrated Approach to Purchasing

An integrated approach consists of *strategic* purchasing, defining which interventions should be purchased in response to population needs, how they should be purchased, for whom, and from which providers (Figueras et al. 2005). IEG also finds that an integrated approach to purchasing considers the broader public sector context, including relevant institutional reforms needed to implement purchasing reforms, while attempting to foresee and forestall any potentially adverse effects.

Bank Group Support to Purchasing

An increasing share of Bank health financing projects supports governments and insurers in purchasing. Bank projects generally support health care providers and the purchaser who pays providers.

In line with the Bank's 2007 Health, Nutrition, and Population (HNP) strategy, the Bank has introduced a focus on results and better performance in health facilities. The Bank assisted governments and insurers with changing their provider payment methods. It also helped build institutions through information, monitoring and evaluation (M&E), and regulations to define benefits. In some countries, these operations also support the abolition or reduction of user fees paid by patients, including in Argentina, Benin, Burundi, Djibouti, Nigeria, Senegal, and Zimbabwe.

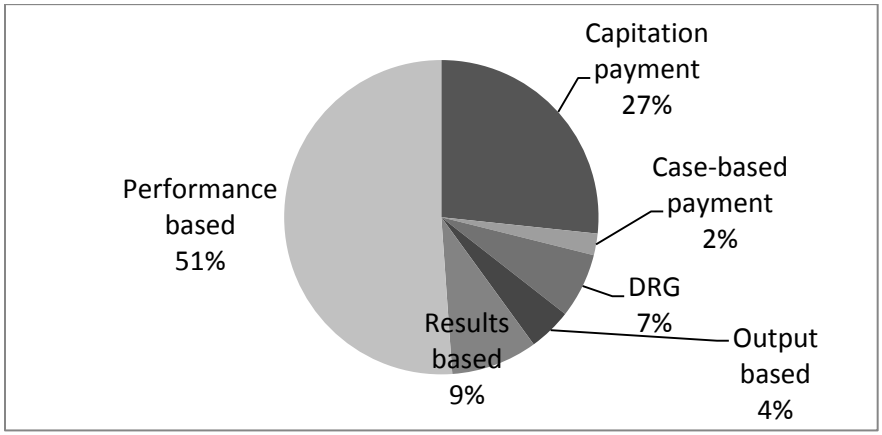
ANALYTICAL WORK

The Bank's health teams have prepared limited analytical work on purchasing (Moreno-Serra and Wagstaff 2010); however, this body of work is growing as shown by an increasing number of impact evaluations on provider payment reforms supported by results-based financing projects (appendix Figure B.4). So far, the Bank's impact evaluations have not analyzed the distributional effect of payment reforms and whether the poor benefit. M&E frameworks in Bank projects are presented in chapter 5.

PROVIDER PAYMENT METHODS

Some 60 percent of provider payment methods supported by Bank projects include a performance- or results-based component; project documents use these terms interchangeably (Figure 4.1). Most are introduced in health systems with automatic coverage in low-income settings and not by using the health insurer as the purchaser. A few Bank operations, mainly in Europe, supported DRG payment from health insurers to hospitals or some other case-based payment. Similarly, capitation payment adjusted by some activity and case-mix indicators are introduced mainly in Europe and Central Asia, Ghana, Latin American countries, and Vietnam. In Armenia, RBF is managed by the country's single payer state health agency and is implemented nationally. In some countries such as Rwanda the Bank helped scale up performance-based payment developed by other donors.[2]

Figure 4.1. Provider Payment Methods Supported by Bank Projects, FY03–12



Note: The total number of HNP projects with purchasing is 45.

A more-detailed review of the Bank's project documents categorizes Bank support in performance- or results-based payment along geographic lines. In reality, most of these payment methods are mixed payments that combine some aspects of activity-based payments (e.g., fee-for-service and case-based payment) with some quality

indicators. More recently, this type of Bank support is implemented with the support of results-based financing (RBF) operations.

- *Afghanistan.* The Bank supported the Ministry of Public Health to establish performance-based payment for contracted nongovernmental providers. Nongovernmental organizations (NGOs) are paid a capitation amount adjusted by scorecard indicators such as patient satisfaction and staff availability. The payment is a 1 percent bonus if the quality score improves. Bank support has recently transitioned to helping government paying providers a fee-for-service amount to increase the number of maternal and child health services.
- *Africa, including Benin, Burundi, Central African Republic, and Nigeria.* In these countries the Bank supports governments in the introduction of mixed payment methods to providers consisting of fee-for-service and case-based payment for specific treatments or diagnoses, such as number of hypertension cases. This payment sets an incentive to increase the number of services for which a fee is paid and to diagnose more patients with diagnoses that have higher reimbursement. It can also have adverse effects if providers "up-code" patients and diagnose them with higher-priced diseases, leading to higher costs. The payment includes a quality component as measured in scorecards or during health supervision. These projects often include a demand-side component that abolishes or reduces user fees or provides vouchers for care to poor patients.[3]
- *Argentina and Brazil.* Bank loans supported provider payment reforms and co-financed central government transfer payments to the health budgets of local governments (in addition to line-item health budgets) based on institutional performance in Brazil, and capitation adjusted by the achievement of 10 preventive care indicators in Argentina (Box 4.3). Payments encourage local governments in Brazil to invest in local administration, institutions, and fiduciary management in the health sector and in Argentina to ensure that providers have the resources to achieve the targets for preventive care indicators. Providers in both countries continue to receive line-item funding. In Argentina local governments also pay providers fee for service for preventive care to incentivize increased service provision (IEG 2011).

An increasing number of Bank projects support a shift to performance- or results-based payments in national health systems. The majority of them are run with the support of the Bank's results-based financing (RBF) program implemented through the Bank's policy and investment lending programs. In some countries (e.g., Benin and Burundi), RBF funds are pooled with funds from the government and other

donors and then transferred to providers. RBF is 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 measurable actions being undertaken (Musgrove 2011). RBF operations thus directly influence the provider payment method. The Health Results Innovation Trust Fund[4] cofinances Bank operations that finance health interventions in countries in the International Development Association. It also funds technical dialogue and learning related to RBF operations and program evaluations. The Trust Fund has a dedicated work program to monitor countries' progress using performance data and to support country teams in their data work.[5]

Box 4.3. Financing Based on Performance or Results in Argentina and Brazil

In Argentina the Bank loan disbursed an earmarked capitation amount to the government's Plan Nacer based on the number of individuals registered in the provinces. Plan Nacer is a supply-side subsidy program that provides reproductive, maternal, and child health care in contracted public and private health facilities to uninsured children and women. The National Ministry of Health signed a performance contract with the provincial governments to transfer funds from the Bank loan and the central government budget to the provincial Plan Nacer based on the number of individuals registered (capitation) and on the results achieved on 10 health indicators. The capitation part of the transfer sets an incentive to provinces to increase the number of plan members; the second part an incentive to achieve treatment targets.

The Brazilian central government, supported by the Bank, paid a bonus payment and a performance prize to municipalities for achieving explicit governance and fiduciary targets to improve management in primary care. The bonus payment was distributed as a lump sum to the 35 (of 188) municipalities that met the three criteria, and the performance prize was shared by 12 municipalities.

Source: IEG (2011).

INSTITUTIONS, BENEFIT PACKAGE, AND INFORMATION

The Bank helps countries in purchasing their essential benefit package mainly from public sector providers and NGOs. In Afghanistan the Bank supported contracting of the basic package of cost-effective services from NGOs. In middle-income countries, Bank technical assistance advised insurers to purchase care strategically. In the former Yugoslav Republic of Macedonia primary care providers were privatized in 2007. There, the national health insurance fund, with Bank support, contracted the essential package from private providers and paid capitation adjusted by age, gender, region, and preventive care indicators (IEG 2013). Bank loans financed information systems in insurance and governments to manage beneficiary information. In low-income countries where the Bank supports performance- or results-based payments, substantial investments in information were made. Data

allow for real-time monitoring and evaluation of provider performance and corrective actions.[6]

Effectiveness of Bank Group Support to Purchasing

To understand the effectiveness of Bank and International Finance Corporation (IFC) support to purchasing, one must first ask whether that support was appropriate to country conditions. In particular, was the support accompanied by an assessment of financing needs, and where appropriate, financial assistance? Also, given the demanding managerial requirements of purchasing systems, did the Bank Group tailor its support to local capacity?

INTEGRATING PURCHASING WITH HEALTH FINANCING AND PUBLIC FINANCE

In several countries the Bank has taken a more single-track approach to purchasing without integrating payment reforms with other health financing functions. This approach is contrary to the multisector approach described in the HNP strategy as the Bank's comparative advantage. IEG's case studies found that in the Republic of Yemen the results-based payment approach supported by the IFC and the Bank for a narrowly defined disease area is not linked to any broader health financing efforts in revenue collection or risk pooling. In Kenya, although the Bank and the IFC are providing health financing support to strengthen the National Insurance Fund, a parallel RBF program is being piloted in one county that does not appear to be connected to the health insurance reform. In Rwanda discussions about RBF support did not involve any analysis on the use of the existing health insurers as the fund holder for RBF, on the effect of RBF in health facilities that are paid capitation or fee for service by health insurance, or on what the overall impact would be on health insurance finances and future cost trends. In Benin there is no coordination with public sector budget reform. RBF is almost exclusively linked to using revenues from household payments and drug sales, and is not integrated with fiscal transfers to facilities. In Tanzania an RBF pilot has been introduced separate from overall ongoing public sector and health financing reforms which raises concerns about its sustainability. In Ghana the design of the Bank's RBF operation is not coordinated with the payment reforms introduced by the health insurer and fails to clearly demonstrate how it will address performance problems, given already sizable increases in health worker salaries.

Where purchasing is embedded in broader public sector reforms it is more effective in establishing the relevant institutions that are needed to make it sustainable. In Rwanda the government changed the public finance law to allow for incentive payments for public sector workers; greater autonomy to facilities in regard to

recruitment, deployment, and dismissal; and direct accountability for the performance of mayors. IEG found that the Bank provided substantial support through policy dialogue and general budget support, including legal changes and management reforms in health facilities. In other countries, however, purchasing support has had less profound effects on strengthening regulatory and management functions. The above examples suggest that the Bank could give more attention to integrate purchasing with broader health financing functions and public finance to build the necessary institutions that make payment reforms sustainable, as emphasized in the Bank's 2007 HNP strategy.

MANAGEMENT AND INFORMATION SYSTEMS

Bank support has strengthened management and information systems. In Poland the case-based payment (supported by Bank policy lending) contributes to transparency and improved data availability in the social health insurance fund (Czach et al. 2011). Similarly, in Afghanistan, Argentina, and Egypt, among others, supervision of health facilities improved as did information and reporting systems and the validity of routine data. In Serbia the Bank conducted a baseline analysis when the government considered shifting from line-item budgets to capitation. The Bank recommended additional measures to prevent possible adverse effects under capitation, including consolidated pooling of funds from the insurer and other public sources to prevent fragmented incentives; a comprehensive capitation rate to cover salaries along with public sector reforms for public employees and provider autonomy; and M&E (World Bank 2009). But in Brazil a recent Bank project failed to introduce performance-based payment because it omitted to collect the relevant information to link disbursement to results or to provide for independent technical audits of data to compute disbursement indicators.

Institutional strengthening contributed to transparency. Bank loans financed information-technology management systems in governments to monitor provider performance and in insurance companies to help process medical claims submitted by providers and monitor and assess their performance. In Argentina the Bank helped provinces invest in detailed data collection and analysis of performance indicators. Results were audited by an independent firm hired under the Bank loan, and provinces and providers were fined for incorrect data reporting (IEG 2011). In Benin, the Bank supported health strategic planning and information systems, and in Bolivia, performance agreements between the central government and the regional departments with clearly defined objectives and results. However, the contracting of international firms to carry out the verification of performance to pay providers has proved very costly in these countries.

In some cases, the Bank did support public reporting of provider performance results with the aim of informing consumers and financers about better providers (as is done in some OECD countries; see Box 4.1). RBF programs have introduced online real time performance and financial reporting at the facility level including in Benin, Cameroon, Chad, Zambia, and elsewhere.[7] The Bank did also help a few communities that were getting involved in monitoring and verification of the use of public health resources in Afghanistan, Benin, and Rwanda. IEG case studies in Nicaragua found that the Bank supported the government in bringing the community into the health sector by strengthening the use of locally collected data, including technical and social audits. The Bank in Kenya channels resources directly to health facilities and has contributed to improved reporting and accounting of revenues collected by facilities. Findings from Bank-supported research in Uganda suggest that community participation in monitoring providers can improve quality and quantity of health services as evidenced by large increases in utilization, significant weight gains for infants, and markedly lower death rates among children (Bjoerkman and Swensson 2007).

AVAILABILITY OF CARE AND SERVICE USE

Availability of care and service use has increased where countries moved from line-item budgets to activity- or performance-based payments, including where this was supported by the Bank. In Afghanistan the bonus payment has been associated with an increase in availability of skilled health workers and administrative personnel. In Egypt performance-based payment positively affected provider behaviors toward patients, reduced staff turnover, and helped lift medical encounters from three to 16 per day. In Argentina a 1 percentage point provincial health budget increase, combined with a results focus for local authorities, contributed to higher utilization rates among low-income groups who seek care in public health facilities (IEG 2011).

Few studies use control groups to compare the effect of performance payment against other payment changes such as higher salaries independent of performance, or against intrinsic factors. In an impact evaluation in Rwanda, the Bank compared higher budget funding for health facilities in control districts with performance-based payments for selected services in pilot districts. It found that the payments mainly increased utilization of services that had higher unit payments and that providers could more easily control for. There was no impact on other rewarded services such as childhood immunization, malaria prophylaxis, or curative care visits for children (Basinga et al. 2011). Distributional effects across the insured and uninsured and between socioeconomic groups were not identified. Bank research also highlighted the importance of altruistic concerns that drive the behavior of health care providers. In Uganda a Bank team found that more funding to religious

health facilities in 1999 was passed on to patients in the form of more diagnostic services and lower user fees, which reduced financial barriers; however, public facilities performed less well (Reinikka and Svensson 2003).

While the Bank did not analyze the payment effect over the insurance effect on service use, other researchers find that insured individuals in Rwanda report large and significant improvements in several rewarded and unrewarded services and a decrease in child anemia prevalence (Sherry et al. 2012). Similarly, Skiles et al. (2012) report increased service use across all wealth quintiles and insurance as a positive predictor for service use. These findings suggest that it is mainly the care-seeking insured who benefit from payment reforms. It also shows that much still needs to be learned about how to combine payment reforms with risk pooling to address barriers in access to care for patients, such as user payments.

FINANCIAL PROTECTION

As a change in provider payment method primarily benefits individuals seeking care (e.g., the insured and wealthier), provider payment reforms without measures to reduce user payments and improve risk pooling are unlikely to improve equity in service use and financial protection. So far, the Bank's impact evaluations have not analyzed the distributional effect of payment reforms and whether the poor benefit or the uninsured.

HEALTH OUTCOMES

The evidence linking payment reforms to better health outcomes is thin and mixed. Sherry et al. (2012) used 2005 and 2007 demographic and health survey data in Rwanda and found mixed results and no significant impact of performance-based payment (which was supported by Bank policy lending) on maternal and child health outcome indicators. However, one Bank study found (based on household survey data comparing households in 10 districts with the payment reform and 9 districts with traditional input-based financing) that performance payment led to large and significant improvements in child health between 2006 when the payment was introduced and 2008, and the payment is more effective among higher-skilled providers (Gertler and Vermeersch 2012). Distributional effects in health outcomes across the insured and uninsured and between socioeconomic groups were not identified.

EFFICIENCY

Insurers and government entities can purchase care strategically to ensure the efficient use of health funds. There is some indication that Bank support contributed to improved efficiency where pooling of public funding increased to purchase a

benefit package with cost-effective interventions. In Afghanistan, efficiency is considered to have been improved by the performance-based NGO contracting model because access to the contracted services increased, and those services in the package are the most cost-effective interventions available for improving overall health outcomes. In Armenia spending shifted from hospitals, which had to reduce bed overcapacity, to more cost-effective primary health care. In Serbia the Bank helped streamline benefit packages where social health insurers had committed to cover overly generous benefits. The number of staff was rationalized in the health sector in Croatia and Serbia, and the Bank recommended increasing wages for primary care workers in Tajikistan. Strong government support was essential in introducing these efficiency enhancing measures in these countries and supporting the effectiveness of purchasing.

However, adverse effects of activity- and performance-based payment reforms on sector efficiency were insufficiently examined in Bank analysis. Only in a few countries (e.g., Serbia) did the Bank conduct cost and productivity analysis to identify the payment amount. Nor did Bank analysis sufficiently examine adverse reactions by providers to the payment. A case study prepared by IEG for this evaluation found that in Bolivia, fee-for-service payment for mothers and children created an incentive for beneficiaries to seek costlier tertiary care, contributing to inefficiency. In Ghana fee-for-service payment leads providers to refer patients to hospitals or clinics for more expensive treatment. It has also resulted in lengthy processing times and prolonged the reimbursement time to providers to five months. In Vietnam moving from fee-for-service to capitation payments for hospitals contributed to efficiency gains by reducing recurrent expenditures and did not have a negative effect on health outcomes. However, a recent Bank-supported study warns of adverse spillover effects because hospitals are shifting costs across different payers from insurance paying capitation to the uninsured who pay user fees, which may have implications for access and financial protection (Nguyen et al. 2013). A ruse in Rwanda was used by hospital pharmacies to prevent drugs from running out of stock—a performance indicator—by refusing to dispense the last box of pharmaceuticals (Kalk et al. 2010). The Bank could analyze adverse effects of payment reforms systematically and help countries addressing them.

FINANCIAL SUSTAINABILITY

Purchasing reforms are not sustainable unless they are embedded in overall health financing and the broader public finance context and future financing is assured. Mainly in middle-income countries, the Bank supported purchasing reforms in social health insurance and cautioned governments about the financial consequences. A small body of Bank analytical work looked at the financial

sustainability of insurance and advised governments on streamlining generously defined benefits (Chawla 2007; La Forgia and Nagpal 2012; Langenbrunner and Somanathan 2011; Preker et al. 2013; Smith and Nguyen 2013). In the Europe and Central Asia Region, the Bank warned that social health insurers are simple disbursement agents who create a high financial risk for the government budget and recommended strategic purchasing (Chawla 2007). The Bank also recommended selective contracting with providers and shifting to capitation and case-based payment with broader health sector reforms (Langenbrunner et al. 2009; World Bank 2010).

Where performance and activity payment was introduced through the government budget, the Bank did not give sufficient attention to the financial sustainability of this support. Many RBF projects are pilots that aim to build evidence on the impact and cost effectiveness of the intervention. Still, administrative costs and the financial implications for the payer are major concerns when introducing activity- and performance-based payments, which the Bank did not address sufficiently. In Kenya verification costs for performance payment are estimated at 20 percent of the performance budget. Governments have not assumed financing responsibility in the recurrent budget for the cost of performance- or results-based payment programs, and so even programs considered effective have not been taken over by governments. In Egypt the government scaled up the Family Health Model but not the performance-payment component after donor funding ended, even though it was perceived as successful. In Ghana plans are going ahead with a new RBF program supported by the Bank in parallel to the provider payment reforms of the National Health Insurance System, but because of financial sustainability concerns, the program will need to be financed by the Bank or donors. In Argentina cofinancing of the Plan Nacer by provincial governments encountered long delays (IEG 2011). In low-income countries, RBF is a separate budget line and mainly financed by donors from sector budget support. In Rwanda challenges of sustainability came to the fore as donor funding was scaled back (Ministry of Finance and Planning 2011).

The Bank did not examine how a change to the provider payment in the public sector affects the governments wage bill, yet this may have substantial financial implications for the government. A case study prepared by IEG for this evaluation found that the Rwandan government allocated about 10 percent of the domestic health budget to performance payments in 2010, which were used by health facilities as they saw fit, including topping up salaries and improving the facilities (Ministry of Finance and Planning 2011). In the first two years, performance-based pay increased facility budgets by 22 percent on average, most of which (77 percent) was paid as a salary top-up, resulting in an average 38 percent salary increase for staff

(Basinga et al. 2011). In absolute terms, results-based financing helped lift health workers' salaries by $75–750 a month depending on their function and facility performance (Kalk et al. 2010). This is considerably higher take-home pay for health workers than for other public employees, such as teachers, and can pressure governments to increase other public sector wages. However, in none of the countries did Bank teams analyze the public sector wage impact of results-based financing.

As in OECD countries, decisions to scale up payment reforms were not always based on lessons from pilots, which may affect sustainability. Most of the Bank's performance- or results-payment reforms supported by RBF programs were piloted. However, decisions were made to scale up regardless of weak, inconclusive, or incomplete pilot results. In Benin several failed RBF pilots introduced in 2007 were redesigned and reintroduced with a grant from the Bank's Health Results Innovation Trust Fund. The evaluation of the pilot supported by this fund is not yet complete. Nonetheless, plans have been made to scale up RBF to all 34 health zones. Similarly, in Tanzania, despite multiple failed RBF programs and before the evaluation of the most recent pilot becomes available, the Bank and other donors have voiced interest in supporting a scale up to a national RBF scheme. This is a concern as early findings from an evaluation by the Ifakara Health Institute suggests that the RBF programs are burdensome, incompletely understood, unevenly implemented, not particularly effective, and unlikely to be sustainable (Chimhutu et al. 2014). In Argentina the Bank's impact evaluation (Gertler et al. 2011) was not ready to inform the scale up of Plan Nacer nationwide. Instead, the government decided to scale up based on routine administrative data and qualitative analysis (IEG 2011).

The IEG found that in some countries, the Bank supported additional payments and transfers with questionable sustainability. In Rwanda, the Ministry of Finance raised concerns over the sustainability of the Bank-supported payment program to community health workers who are volunteer members of a cooperative (Ministry of Finance and Planning 2011). Under a former Bank project, pregnant women also received a baby kit if they delivered in health facilities or an umbrella if they have four antenatal care visits—but these in-kind transfers were stopped due to high procurement costs. Again, these examples emphasize the importance of integrating purchasing with broader health financing and institutional reforms to support sustainability.

In sum, countries are introducing complex payment reforms to incentivize providers to improve quality and efficiency. A growing share of Bank operations are supporting countries in these purchasing reforms, and most of this support is

through RBF in low-income settings. In addition, the Bank helped in building institutional and administrative capacity and investment in information to assess provider performance. IEG's country case studies found that where Bank purchasing support was integrated with other health financing functions (risk pooling and revenue collection) and linked to public sector reforms rather than limited to narrowly defined provider payment methods, it has been relatively more effective because it addressed broader institutional reforms which in turn support sustainability. The availability of care and service use improved in countries where the Bank helped introduce activity- and performance payment often with RBF support. However, limited evidence from impact evaluations with control group points to broadly similar effects for performance-based payment and budget increases for health. Moreover, performance-based payment systems have high overhead costs for performance verification. As a change in provider payment method primarily benefits individuals seeking care (e.g., the insured and wealthier), Bank-supported provider payment reforms without measures to reduce out-of-pocket user payments and improve risk pooling are unlikely to improve equity in service use and financial protection. Payment reforms are likely not sustained unless they are embedded in overall health financing and the broader public finance context.

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[1] The underlying rationale for performance payment is that quality varies across health facilities because providers deliver care differently. Reducing this variation by setting financial incentives was expected to increase quality and productivity of the health system. Performance-based payment methods differ substantially, however, and reflect local conditions including information technology, data availability, and providers' willingness to participate (Maynard 2012).

[2] Hospitals are paid on their performance in 52 quality indicators assessed quarterly. Health centers receive payments based on 24 indicators on service delivery measured monthly. Hospitals and health centers also receive a provider payment, including fee-for-service and case-based payments and capitation, from the social health insurance fund and from community-based health insurance.

[3] In Burundi, results-based financing (RBF) is a national program, and the Bank's funds are pooled with other donors and government funding to finance RBF and user fee abolition. In Senegal and Zimbabwe, poor women receive vouchers to seek care. The Nigeria health project introduces exemption policies for the poor. Most of these projects are still in the design phase or early implementation.

[4] This is financed by the governments of Norway and the United Kingdom. The number of HNP projects with cofinancing from this fund increased from three in 2007 to nine in 2013 for a total committed amount of $260 million.

[5] The trust fund supporting the RBF operations has a requirement that each country program is paired with a rigorous impact evaluation and is accompanied by a well-funded impact evaluation grant. In parallel with the requirement, extensive technical support is provided to the country teams to assure the rigor of such evaluations. At present, the portfolio consists of 34 impact evaluations and eight program and process assessments.

[6] All RBF programs collect and verify performance data which allows for real-time monitoring of performance and necessary corrective actions. Most programs have an extensive database which stores administrative data and allows for a close examination of performance down to the facility level. Data collected for the most part are integrated in the countries Health Management and

Information Systems (HMIS) and beyond that also contain information on quality of care. Some countries, like Zambia and Zimbabwe, make use of HMIS data to monitor possible negative spill-over effects of RBF on nonincentivized services. The Bank team designed an RBF module for ADePT to make it easier and faster to analyze data and focus on results (http://www.worldbank.org/adept/) Discussions with the World Bank Institute's Innovation Lab explore options to show cross country RBF data on the web.

[7] RBF programs introduced online performance dashboards to show real-time performance and amount spent. This information is public. Examples of the online dashboard can be found at http://www.beninfbr.org/ (Benin), http://www.fbpsanteburundi.bi/ (Burundi), http://www.fbrcameroun.org/ (Cameroon), http://www.fbrtchad.org/ (Chad), http://cd.thenewtechs.com/ (Democratic Republic of Congo), https://nphcda.thenewtechs.com/ (Nigeria), and http://www.rbfzambia.gov.zm/ (Zambia).

5. Factors in Successful Bank Group Support

Highlights

- Government commitment to health financing reforms is influenced by political and fiscal constraints. The World Bank Group can reinforce commitment by building technical capacity but needs to be flexible and able to adjust to the local political and technical context.
- Bank analytical work has informed the international health financing dialogue and could be expanded to help institutionalize health financing reforms and build local capacity.
- To fully use its capabilities in health financing, the Bank Group should draw on the expertise from health staff jointly with public finance and fiscal experts and work across the new Global Practices.
- The Bank's health financing portfolio is changing and focusing on one subintervention—performance-payment reforms, which is increasingly supported by results-based financing operations. Purchasing needs to be integrated with other health financing functions and public finance to be sustainable as outlined in the 2007 strategy for Health, Nutrition, and Population.
- This evaluation may be missing some successful Bank engagement in health financing because of weak monitoring and evaluation (M&E) in health projects. Learning from the Bank's rich country experience is constrained by weak M&E in health projects.

The common success factors seen in the previous chapters that would make for good engagement in revenue collection, risk pooling, and purchasing include:

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

Chapter 5 discusses how these factors cut across the three pillars of health financing and influence the effectiveness of Bank Group support and the implementation of the Bank's Health, Nutrition, and Population (HNP) strategy. Chapter 2 showed that in governments that are committed to improving health outcomes and increasing support to the sector, efficient and equitable revenue instruments need to be used, taking into account the overall public finance context. Similarly, to address the many challenges in risk pooling described in chapter 3, strong institutions, management, and technical capacity are needed as well as information capacity to manage pooled funds. Bank analytical work helps inform governments in these health financing decisions. As seen in chapter 4, purchasing depends on integration with risk pooling to address financial barriers and thus revenue collection and with public finance. Purchasing depends heavily on information systems, M&E, technical capacity to analyze performance and define payments, and government commitment to

institutional reforms to allow providers to respond to financial incentives. The Bank's 2007 HNP strategy—chapter 1—sees health financing as a comparative advantage for the Bank because of its analytical capacity and multisector nature. Chapter 5 also contains lessons learned from the country case studies conducted for the evaluation (appendix E).

Government Commitment, Technical and Information Capacity, and Flexibility

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

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

Government commitment is also affected by political, not just financial and technical constraints. In Bolivia, Bank lending and analytical work guided much of the policy discussion in health financing reform. However, since the government changed in 2006, the Bank has not been considered a technical partner in health financing. Similarly, in Egypt the Bank was engaged through lending and analytical support in consolidating insurance reform and the family health model, which was widely considered coherent and innovative. But discord within the government over the reform led to implementation difficulties, and the Bank has since found it hard to reengage. In Rwanda, Bank support was conducted through policy dialogue and general budget support, which addressed a wide spectrum of health financing reforms. But in 2009, the government decided under its division of labor policy that the Bank should redirect funds to other sectors. The Bank has since been absent from the health financing policy dialogue there. Although the Bank provided extensive

technical assistance to drafting the health financing policy in Rwanda, after the Bank's health financing team left, momentum drained and the draft policy has yet to be finalized (IHP+ 2012). In Kenya, by contrast, the relationship with the government has improved markedly since 2009. The Bank is now engaged in an array of health financing activities, including analytical work on the level and allocation of fund, and the government has provided additional $50 million in FY 13–14 to compensate providers for free maternity care. The International Finance Corporation (IFC) has convened the stakeholder dialogue and supports management reforms in the public health insurer. In addition, the Bank financial collaboration with health facilities has contributed to improved reporting and accounting of revenues in Kenya.

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

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

In some cases, Bank support needs to be more flexible and adjust to the local political and technical context. In a low-capacity environment like Afghanistan, the Bank demonstrated such flexibility. Given the limited ability of the Ministry of Health to provide or purchase services, the Bank supported contracting with NGOs

and provided large-scale assistance. Similarly, in Benin, Bank support to pooling and purchasing was calibrated to the local context. In Tanzania, however, other donors viewed Bank financing as inflexible as it proved hard to finance one of the nine option papers on fiscal space to feed into a larger health financing strategy paper. Beyond flexibility, in some countries including Egypt, the Bank would have been more useful had it possessed a better understanding of the political economy.

Depth and Relevance of Analytical Work

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

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

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

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

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

Indicators used in poverty assessments	Country of poverty assessment
Benefit incidence analysis	Azerbaijan, Bangladesh, Chad, Ghana, Indonesia, Kenya, Nicaragua, Paraguay, Senegal, Zambia
OOP expenditure in health as percentage of total health expenditure	Azerbaijan; Georgia; Tajikistan; Uzbekistan; Venezuela, RB
OOP expenditure in health as percentage of total household expenditure	Azerbaijan, China, Georgia, Iraq, Nicaragua, Tajikistan, Uzbekistan
Percentage of lowest income quintile households participating in risk-pooling schemes	Argentina; China; Georgia; Ghana; Indonesia; Macedonia, FYR; Nicaragua; Paraguay; Russian Federation; Venezuela, RB
Percentage of households with catastrophic health expenditures	Azerbaijan, Georgia
Percentage of population falling below the poverty line because of illness	Azerbaijan, Georgia
Severity of poverty because of OOP expenditures	Azerbaijan, Georgia

Note: For Kenya see www.worldbank.org/SDI; OOP = out-of-pocket user payments.

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

Capabilities and Collaboration in Health Financing

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

The Bank's comparative advantage lies in HNP's ability to collaborate with the Public Sector and Macro and Fiscal Management teams and facilitate dialogue on health financing at all government levels, including the Ministry of Finance as outlined in the HNP strategy. To fully use its capabilities, the Bank Group could use a multisector team that draws on the expertise from Health and other sector experts and works across the new Global Practices and the IFC. Most IEG country cases found there was collaboration between the HNP hub and the Regions but limited cross-support from the Development Research Group[2] or the Human Development chief economist, which is also confirmed in the HNP staff survey. Collaboration with the IFC was limited to the Health in Africa and India initiatives. Within the jointly established Health in Africa Initiative, an external mid-term review found that the Bank Group did not leverage synergies within the group and "operated without complementarity" (Brad Herbert Associates 2012). In several countries, including Argentina and more recently in Kenya, this collaboration has worked well and has improved results. Collaboration is essential in a broad-based systems approach to link health financing reforms (in purchasing, pooling, taxation, and user fees) to public sector reforms and lead the health financing dialogue at all government levels. However, the evaluation's country case studies and the international health financing experts noted that the Bank does not often exert this leadership role.

The Bank's Health and Public Sector teams could enhance collaboration to fully embed health financing in broader public sector reforms. In Vietnam, health support has not been a significant part of overall public sector reform in the past, and a need to enhance coordination was emphasized in the IEG case study by the HNP and Poverty Reduction and Economic Management teams, with a view on macro-level issues of health financing reform such as fiscal space, costing of coverage, and affordability and sustainability of reforms. Similarly, in Benin reforms were intra-health focused without drawing enough on expertise on how to create fiscal space or considering longer-term implications of fiscal sustainability. In Tanzania the health team was involved in government-wide public financial management reform to track resource allocations to decentralized levels of government. Still, an attempt was made (without

success) to harmonize three independent reforms in this area. In Uzbekistan treasury reform supported by the Bank's Public Sector team reintroduced rigidities in spending that reduced intended increases in autonomy and flexibility at health institutions. This created a contradiction between public financial management and health financing reforms—one that has yet to be resolved.

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

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

Integrating All Health Financing Functions

The evaluation showed that the Bank's health financing portfolio is changing, and there is a growing focus on purchasing. Within purchasing most attention is given to one subintervention—performance- or results-based payment reform. This trend is

continuing. Since FY13, the Bank has approved 11 new RBF projects that are cofinanced by the Health Results Innovation Trust Fund. This is an impressive shift in the portfolio given that in previous years, HNP reported about six new health financing operations annually.

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

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

These findings suggest that the Bank could revisit its approach to performance- and results-based financing and integrate purchasing, including that in RBF projects,

with other health financing functions and public finance. The Bank could link provider payment methods with public reforms to help institutionalize these changes. It could also help governments disseminate information on provider performance that affects the reputation of health care providers and informs consumers (e.g., infection rates, cleanliness in health facilities). As performance- and results-based payments mainly benefit patients who seek care, payment reforms need to be linked to pooling so as to reduce demand-side barriers in accessing care. In countries with social health insurance, such as Ghana, Kenya, and Tanzania, the Bank could explore working with the insurer to implement its results-based financing activities with ongoing insurance payment reforms, instead of implementing a parallel activity. This would help streamline financial incentives, reduce fragmentation, and build institutions that support sustainability.

Monitoring and Evaluation in Health Financing Projects

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

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

spending on household incomes; even so, these are indicators identified in the 2007 HNP strategy results framework. Only seven of 19 HNP projects with poverty objectives monitor changes in utilization of care for the poor.

Table 5.2. Health Financing Indicators in HNP Strategy and Health Financing Projects

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

Source: World Bank (2007).

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IHP+ (International Health Partnership + Related Activities). 2012. *Joint Assessment of Rwanda's Third Health Sector Strategic Health Sector Strategic Plan.* Geneva and Washington, DC: IHP+.

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

[2] Most collaboration with the Bank's Development Research Group was on impact evaluations (see Table A.8).

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

6. Conclusions and Recommendations

This evaluation examined World Bank and the International Finance Corporation (IFC) support 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 and provided an active analytical program. The IFC delivered a small program with six investments and nine advisory services. The Bank's Health, Nutrition, and Population (HNP) 2007 strategy sees health financing as a comparative advantage for the Bank because of its analytical capacity and multisector nature. The Bank and IFC do not have a joint strategy or strategic approach about the mix of public and private health insurance.

The Bank Group did not take an ideological stance in its work in revenue collection and different risk pooling arrangements; rather, it worked within the 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. An increasing number of this work is implemented with the support of results-based financing (RBF) operations.

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 proved to be elusive in its implementation, including integration and monitoring and evaluation (M&E). The reasons mainly evolve around capabilities and cross-sector collaboration and are areas for further reflection for the global practices.

The factors for successful Bank support include government commitment to address the many challenges in revenue collection for health and risk pooling, ensure pro-poor spending, introduce institutional reforms, and build technical and information capacity. Purchasing needs to be integrated with risk pooling to address financial barriers for poor individuals in accessing care and with public finance to manage adverse effects. Bank analytical work and collaboration across teams helps inform governments in these health financing decisions. These health financing functions heavily depend on information systems, M&E, technical capacity to analyze performance, and government commitment to sustain reforms.

The evaluation recognized that reforms in health financing only are insufficient, and 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. They include decisions about how to mobilize and

allocate funds for health, how to pool these funds, and how to purchase care from health providers.

The evaluation found that evidence is scant on the effect of Bank and IFC operations and programs on final outcomes, and much remains to be learned about the health benefits, equity in service use and finance, and financial protection value of public spending, pooling, and purchasing supported by the Bank Group. There is also a critical need to strengthen evidence on implementation processes so as to identify the reasons that contribute to success. Sound analytical work about adverse effects and financial sustainability are particularly important for all countries.

The four main conclusions of the evaluation are the following:

- There have been some notable successes of Bank support to all three health financing functions, including revenue collection, risk pooling, and purchasing. Evidence suggests that these have occurred when the Bank Health and other sector teams drew on a variety of skills across sectors to engage government and where government commitment to reforms was strong. The collaboration between the IFC and the Bank has been limited so far, given the small health financing IFC portfolio.
- Bank support has helped increase governments' health budgets and protect health spending against budget cuts during economic crisis. 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, 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. There is a greater focus on financial incentives to increase the number of specific services and monitoring of service use. 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. This shift has happened without the necessary evidence for financial protection and sustainability and potential adverse effects on the broader public sector, including on wages.
- 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. This

approach comprises efficient and equitable revenue instruments (tax and non-tax) for health, taking into account the overall public finance situation. It also includes moving toward compulsory pooling and reduced fragmentation in pooling, and a focus on strategic purchasing that examines 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 Public Sector and Finance teams to help facilitate the dialogue on health financing at all government levels.

In a reorganized World Bank Group, health financing operations could benefit more from thinking and coordination across the Bank's HNP, Governance, Macro and Fiscal Management, Poverty, and Social Protection teams as well as the IFC. This could include, for example, streamlining the methodology in the Bank's diagnostic program to include analysis on both financial protection and adverse effects set by financial incentives, and integrating health financing analysis into the new Systematic Country Diagnostic framework which will focus on the critical challenges to achieving the twin goals of reduced poverty and shared prosperity.

This evaluation makes five recommendations to guide the Bank Group's future work on health financing:

1. **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.

2. **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.

3. **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.

4. **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.

5. **Strengthen M&E in Bank and IFC health financing 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.

Appendix A. Data Sources, Methods, and Limitations

1. This appendix describes the sources of data and the methodology used in the evaluation, *World Bank Group Support to Health Financing for Improving Health System Performance*. The evaluation focuses on FY03–12.

Data, Methods, and Limitations

2. The evaluation covers the health-relevant portfolio of closed and ongoing operations approved since FY03, relevant economic and sector work (ESW), and engagement by the World Bank and the International Finance Corporation (IFC) in the health financing dialogue at the country level. Evidence from a variety of sources has been collected and triangulated:

- A **portfolio review of World Bank loans** (investment and policy-based) was conducted of those directly supporting health programs and managed by the Health, Nutrition, and Population (HNP), Poverty Reduction and Economic Management (PREM), and Social Protection (SP) sector boards. Among a health portfolio of 390 projects, 188 health financing operations were retained for in-depth analysis (see appendix Tables A.1 and A.2 and Table C.1).
- **Implementation Completion and Results Report (ICR) Reviews** drew on evidence of closed World Bank operations. Among the 188 health financing operations, 143 were closed, of which 106 had a completed ICR Review by November 18, 2013.
- **A portfolio review of IFC investments** was undertaken. Out of 782 potentially relevant investments, six were considered relevant to health finance and retained for further analysis (see Table A.3.).
- **A portfolio review of IFC's health-related Advisory Services** was conducted. Between 2005 and 2012, nine health finance Advisory Services were undertaken (see Table A.3.).
- **Sixteen purposefully selected country case studies**, of which 10 were field-based studies and six were in-depth desk studies (see Table A.4).
- The **health section was reviewed in 20 poverty assessments** conducted by the Bank between 2007 and 2012 (see Table A.5).
- **Project Performance Assessment Reports** (PPARs) on health done by the Independent Evaluation Group (IEG) were reviewed, and findings on health financing were synthesized (see Table A.6).

- **Semi-structured key informant interviews were carried out with 25 international health financing experts** working in leading positions at the headquarters of 21 organizations (see Table A.7).
- **An electronic survey was done of 109 graduates** of the World Bank Institute (WBI) who had attended a component of the "Health Sector Reform and Sustainable Financing" Flagship course.
- The **Development Impact Evaluation** (DIME) was used to identify 14 health financing impact evaluations conducted by the World Bank (Table A.8).
- **Bank analytical work** was examined including Fiscal Health Assessments and Public Expenditures Tracking Surveys (Tables A.9 and A.10).
- **An electronic survey was done of 68 World Bank health staff** (Table A.11).

3. The evaluation uses data collected through these sources. Data were entered in Excel and analyzed in STATA or Excel. Methodological triangulation was used to study each evaluation question. Results from quantitative and qualitative sources were compared to identify similar results and establish validity.

Identification and Analysis of the World Bank Lending Portfolio

4. 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 October 28, 2013 based on the following criteria:

- approval between FY03–12;
- agreement type: International Development Association (IDA) or International Bank for Reconstruction and Development (IBRD) only;
- Sector codes: Health (JA); Compulsory Health Finance (BK); Public Administration–Health (BQ); and Noncompulsory 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); and Tuberculosis (93);
- for "project count" type analyses, additional financing was excluded.

5. Based on this selection process, 608 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 review of their objectives and components, as described in their project documents, to exclude operations with a health code that do not include any health activity or objective. This review identified 390 health projects. Their project components and prior actions in development policy

operations (DPOs), as described in legal agreements and project documents, were reviewed for the following criteria to identify health financing operations: Bank support to (1) revenues collected from public sources for health; (2) revenue from private sources; (3) risk pooling; and (4) purchasing. This led to 188 health financing operations which were retained for the health financing review (see Tables A.1 and A.2).

Table A.1. Distribution of Number Projects Reviewed at Identification Stages, FY03–12

Number of IDA and IBRD Operations	Sector Board						Total
	HNP	SP	EP	PO	PS	Other	
Operations identified from Business Warehouse	191	76	92	37	33	179	608
Operations identified for detailed document review	191	76	92	37	33	—	429
Operations included in health portfolio review	189	62	79	31	29	—	390
Operations included in health financing portfolio	78	30	49	19	12	—	188

Source: World Bank Business Warehouse, accessed on October 28, 2013, FY03–12 approvals.
Note: EP = Economic Policy; HNP = Health Nutrition and Population; PO = Poverty Reduction; PS = Public Sector; SP = Social Protection. "Other" includes the following sector boards: agricultural and rural development; education; energy and mining; environment; financial and private development; global information and communication technology; social development; transport; urban development; and water.

6. ***Excluded Projects***. Two main limitations apply to this selection process. First, administrative data for a given project are 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 Business Warehouse database could exclude projects that later did include health-related activities. Second, the number of sector codes or themes that can be entered for a given project in Business Warehouse is limited to five each. Some projects, in particular DPOs, are multisectoral 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 sixth or higher order of priority, it is unlikely to play a major role in terms of activities or results. This evaluation does not include projects that pay conditional cash transfers (CCT) to individuals to seek care. CCT programs are social assistance programs that redistribute income to provide a short-term safety net function. The recent IEG evaluation on Bank support to social safety nets also examined the effectiveness of CCT in health (IEG 2011a).

7. ***Financial Commitments.*** A limitation is the impossibility to identify the actual project amount spent on health financing activities. Projects with health financing fund a variety of activities, including infrastructure, goods, and services. The Bank's operations portal database reports funding estimates by project components, which include several activities, but it does not identify the project amount spent on specific health financing activities within a component. As a result, the actual amount spent on health financing activities is unknown. Therefore, the health financing analysis refrains from making estimates that may give an inaccurate picture.

Table A.2. Number of Projects with Health Financing Managed by Sector Board, Regions, and Year

Sector Board	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	Total
AFR	2	2	1	5	2	4	1	3	1	4	25
LCR	3	3	1	—	1	4	2	2	3	—	19
ECA	2	6	2	3	1	—	2	—	1	—	17
EAP	2	—	1	3	—	3	—	2	—	1	12
SAR	1	—	1	—	1	—	1	—	—	—	4
MNA	—	—	—	—	—	—	—	1	—	—	1
HNP total	*10*	*11*	*6*	*11*	*5*	*11*	*6*	*8*	*5*	*5*	*78*
LCR	3	3	2	—	1	—	1	2	3	1	16
ECA	1	1	—	—	—	—	3	1	2	—	8
AFR	—	—	—	1	1	—	2	—	1	1	6
SP total	*4*	*4*	*2*	*1*	*2*	*—*	*6*	*3*	*6*	*2*	*30*
AFR	3	2	4	8	3	3	2	2	3	—	30
ECA	2	1	3	3	3	2	1	7	4	4	30
EAP	1	—	1	2	—	2	—	1	1	1	9
LCR	1	—	—	—	—	1	—	2	2	2	8
SAR	1	1	1	—	—	—	—	—	—	—	3
PREM total	*8*	*4*	*9*	*13*	*6*	*8*	*3*	*12*	*10*	*7*	*80*
Grand total	***22***	***19***	***17***	***25***	***13***	***19***	***15***	***23***	***21***	***14***	***188***

Source: World Bank Business Warehouse, accessed on October 28, 2013, FY03–12 approvals.
Note: AFR = Africa; EAP = East Asia and Pacific; ECA = Europe and Central Asia; LCR = Latin America and the Caribbean; MNA = Middle East and Northern Africa; SAR = South Asia.

8. ***Coding Objectives.*** The stated Project Development Objectives in the project or program document for the 188 health financing projects were coded by IEG, following the evaluation's health financing framework. A bottom-up methodology was used for coding project objectives, which resulted in the following list of objectives:

- **Final outcomes**: Projects aimed at improved: (i) health status or outcome; and (ii) financial protection or reduction in catastrophic spending;
- **Intermediate outcomes**: Projects with objectives to support improved: (iii) access, utilization, or coverage of health services; (iv) efficiency; (v) equity; (vi) quality; and (vii) sustainability.
- **Targeting**: IEG identified whether objectives targeted the poor, vulnerable, or gender.

9. ***Coding Interventions.*** IEG reviewed the project documents for the 188 projects to determine the planned activities it would support, as reported under the components

section for Investment Lending or in the prior actions for DPOs. The activities were categorized and coded into the following intervention categories:

- **Revenues for health from public sources:** Bank support to: (i) domestic revenues including taxation, increased health budget or public financing for health, government budget reforms in health such as a global health budget with limits for allocation to specific cost centers, improved budget reporting, and medium-term expenditure frameworks to direct public funds to the MDGs or nutrition, targeting; and (ii) compulsory contributions, comprising increased budget allocation to compulsory health insurance including to subsidize enrollment of the poor, targeting, and technical advice on the level of contributions (e.g., payroll taxes).
- **Revenue from private sources**: Bank support to user payments including defining co-payment exemptions, higher co-payment levels for specific services, and eliminating user fees for specific services.
- **Risk pooling:** Bank support to (i) automatic coverage including increased fiscal transfer for health to Regions and revised resource allocation formulae to Regions adjusted by population and poverty or other indicators; (ii) mandatory pooling comprising amendments to the insurance law or regulations, strengthening health insurance management; measures to stem the deficit in health insurance, expanding insurance or universal insurance coverage through administrative support, and beneficiary identification information systems; and (iii) private insurance.
- **Purchasing:** Bank support to (i) provider payment methods including line-item budgets, fee-for-service, case-based payment, per diem payment, performance- or results-based payment, capitation, global budget, and performance payment; (ii) benefits package, including defining contracts, and performance agreements with providers and the government; (iii) data management comprising information systems and monitoring and evaluation to conduct provider performance analysis and define payment levels, and conduct audits of providers; and (iv) institution building including law, regulation, or decree or strategy on purchasing, and measures to support provider autonomy or management.

10. ***Evaluation Approach***. Of the 188 health financing operations, 143 are closed. IEG has prepared an ICR review for 106 of the closed projects. A full assessment of project outcomes against intended objectives using data from ICR reviews for health financing activities is not possible, because the project outcomes rating is a composite indicator consisting of relevance of objectives and design, efficacy, and efficiency in project implementation. Thus, IEG identified progress toward the relevant health financing sub-objectives based on the information reported in the efficacy section of the ICR

Review on progress toward relevant health financing sub-objectives. This information is supplemented by other data sources where available including from impact evaluations, PPARs, country program evaluations, and country case studies.

Identification and Analysis of the IFC Portfolio

11. The IFC investment portfolio in health was identified via the Management Information System (MIS), accessed on October 11, 2012. The database encompasses all investments recorded in the 10 years leading up to FY13 and reflects net commitment amounts (original commitments less cancellations less transfers less sales). IFC's health portfolio was constructed by identifying all new investments (approvals) made between FY03–12 using primary and secondary sector codes, identifying 620 potential health sector related investments. Table A.3 shows the search strategy.

Table A.3. Distribution of IFC Health Investments and Advisory Services by Type

IFC Investment and Advisory Services	Health Care	Insurance	Private Equity Funds	Commercial Banking	Leasing	Other	Total
Investments (FY03–12)							
Investments reviewed	82	24	32	397	46	39	620
IFC health investments	82	2	5	2	1	2	94
IFC health finance investments	2	2	2	—	—	—	6
Advisory Services (FY05–12)							
Advisory Services reviewed	31	8	1	95	17	619	771
IFC Health Advisory Services	31	—	—	—	—	6	33
IFC Health Finance Advisory Services	9	—	—	—	—	—	9

Source: IFC Management Information System.

12. An in-depth review of the project documents leaves 94 health investments and six that were in the area of health finance, namely two in private equity funds, two in insurance, and two in health care. Excluded from the health finance portfolio are investments in companies offering general composite insurance including health but are not health focused.

13. The IFC Advisory Services project database was accessed on October 15, 2012. Active, completed, and client-facing projects were considered. Of the 771 Advisory Services reviewed, 33 were health-related services, which were identified through a targeted key word search using the terms "health," "hospital," "clinic," "insurance," "biotechnology," "life science," "pharmaceutical," "medicine," "drug," and "HIVAIDS." A detailed project document review of these resulted in the identification of nine Advisory Services in the area of health finance.

Identification and Analysis of Country Case Study Programs

14. Countries face different health financing situations. The evaluation takes these differences into account with 16 country case studies to understand the nature of the World Bank Group's work on health financing in different contexts. The case studies describe the main challenges to health systems performance; health financing interventions by the government to address them; World Bank Group and other donor support to the government; and the effectiveness of World Bank Group support to health financing interventions and its contribution to equity, efficiency, and financial protection. The World Bank Group is typically one player among others in health financing reforms. The case studies generate lessons from each country that can be compared against a benchmark; however, it is not designed to make direct comparisons across countries. Appendix E contains the summaries of the 16 country cases.

15. ***Identification.*** The case country selection covers all Regions of the Bank so that Region-specific issues can be explored. The selection is not representative of the Regions. From the 68 countries that have received World Bank Group support *to at least one health financing intervention* (see Table B.3), 16 were selected based on the following criteria (Table A.4). First, countries were selected that report very high or low levels of user payments, which provide indications on issues in financial protection. In addition, three countries were selected (Mexico, Tanzania and Vietnam) with decentralized health sectors to examine specific health financing and performance issues in a decentralized setting. More countries in Sub-Saharan Africa (five countries) were selected to reflect the large World Bank involvement in health. Priority was given to countries that are developing or implementing interesting health financing reforms. Countries where IEG had already conducted a PPAR (Table A.6) were not selected.

16. ***Data collection.*** The country study protocol with 51 questions was developed to collect relevant information in different country contexts. Some questions were factual while others required an evaluation judgment based on data and evidence to support the assessment. The protocol was field-tested in Tanzania in June 2013. A team of ten IEG staff and consultants undertook the 16 country case studies, with two authors working on one country. At the start of the work, IEG organized a one-day workshop for the team to review the case study protocol, data sources, and methodology, and reach a common understanding of required information and the basis of assessment. One panel reviewer vetted all 16 draft case studies to ensure consistency and evidence base. Another one-day workshop was organized and attended by all authors to discuss for each evaluation question detailed findings across the 16 country cases.

17. **Field visits** were undertaken to Benin, Cambodia, Ghana, Kenya, Mexico, Nicaragua, Rwanda, Tanzania, Turkey, and Vietnam. The other countries were desk-

based reviews. Each desk-based case study took about ten days to complete, while field-based case studies took about 15 days. Data sources consulted for the studies included:

- Substantial in-depth reviews of World Bank Group project and program documents with health activities that became effective since 2003 (including project appraisal documents, program documents, ICRs, ICR Reviews, Implementation Status Reports, PPARs, and country strategies).
- Reviews of project documents and studies related to health financing, undertaken by other organizations.
- Reviews of research documents, advisory and analytical assistance documents, evaluation reports, and articles published in the peer-reviewed literature.
- Interviews with World Bank and IFC staff involved in health operations to the countries, and interviews with clients, key stakeholders, and development partners in countries with field visits.

18. ***Analysis.*** The 16 studies compiled illustrative material to identify contextual factors in the causal link between health financing interventions and outcomes. As with any policy intervention, country case studies do not have a counterfactual situation to attribute outcomes to Bank Group interventions as this is the case in statistical analysis. Instead, the evaluation uses analytical generalization to compare the empirical results of different health financing features across different countries (Yin 2009).

19. The health financing intervention is the unit of analysis. Issue notes were prepared related to the main evaluation questions to explain why and how certain interventions may have worked (or not), by comparing Bank Group support to the interventions against the expected outcome. Factors were identified that affect performance of health financing interventions, what gave rise to the factors, and how the factors influenced Bank performance and health financing reforms and vice-versa. The intention was to generate detailed information on the different health financing reform context the Bank Group works, how the Bank and IFC function in practice, the pathways through which Bank and IFC work affects performance of health financing interventions, and the relationship between the Bank Group and other organizations working on health financing. Analytical evidence from the 16 cases was triangulated with evidence from other evaluation inputs and incorporated into the final report.

Table A.4. List of Countries for Case Studies by Regions and Selection Criteria

Country Case Studies		Country Context			Interventions Supported by the Bank Group		
Region	**Country**	**Out-of-pocket spending**	**Platform**	**Setting**	**Revenues for health**	**Risk pooling**	**Purchasing**
AFR	Benin	High	IHP+	SWAp	✓	✓	✓
	Ghana	Low	JANS	SWAp	✓	✓	✓
	Kenya	High	IHP+, JANS	SWAp	✓	—	—
	Rwanda	Low	IHP+, JANS	—	✓	✓	✓
	Tanzania	Low	—	SWAp, Decentralization	✓	-	-
EAP	Cambodia	High	IHP+	-	✓	✓	✓
	Vietnam	High	IHP+, JANS	SWAp, Decentralization	✓	✓	✓
ECA	Uzbekistan	High	-	-	✓	—	✓
	Turkey	Low	-	-	✓	✓	✓
MNA	Egypt	High	-	-	-	✓	-
	Yemen, Rep.	High	-	Fragile	-	-	✓
LAC	Bolivia	Low	-	-	✓	✓	-
	Mexico	Low	-	Decentralization	-	✓	-
	Nicaragua	High	–	-	✓	✓	✓
SAR	Afghanistan	High	-	Fragile	✓	-	✓
	Nepal	High	IHP+, JANS	SWAp, Fragile	✓	✓	-

Note: IHP+ = International Health Partnership; JANS = Joint Assessment of National Strategy; SWAp = sectorwide approach. Under out-of-pocket spending, "high" refers to countries with equal to or greater than 40 percent of total health expenditures being paid out-of-pocket; "low" refers to countries with less than 40 percent of total health expenditures being paid out of pocket in 2011 or latest year available. AFR = Africa; EAP = East Asia and Pacific; ECA = Europe and Central Asia; LCR = Latin America and the Caribbean; MNA = Middle East and Northern Africa; SAR = South Asia.

Poverty Assessments with Health Financing

20. The evaluation includes an analysis of poverty assessments with health content. Of the 43 assessments conducted between 2007 and 2012, 20 examine the country's health financing situation. Table A.5 provides an overview.

Table A.5. Poverty Assessments with Health Financing Discussion, 2007–2012

Year	Country	Report Name
2007	Afghanistan	National Risk and Vulnerability Assessment, P125221
2007	Chad	TD-Poverty Assessment FY07); P091109
2007	China	CN-Poverty Assessment; P085127
2007	Congo, Dem. Rep.	DRC-Poverty Assessment (FY07); P091988
2007	Indonesia	Indonesia Poverty Assessment; P085485
2007	Nicaragua	NI Poverty Assessment; P101315
2007	Uzbekistan	POV ASSMT; P090577
2007	Venezuela	Venezuela Poverty Assessment; P094884
2008	Bangladesh	Bangladesh Poverty Assessment; P099963
2008	Georgia	Programmatic Poverty Assessment; P107775
2008	Kenya	KE-Poverty Assessment (FY08); P090315
2008	Senegal	SN-Poverty Assessment (FY08); P107293
2009	Azerbaijan	Programmatic Poverty Assessment; P107773
2009	Macedonia, FYR	Programmatic Poverty Assessment; P101462
2009	Russian Federation	Programmatic Poverty Work (STAGE 2); P074995
2009	Tajikistan	POVERTY ASSESSMENT; P112973
2010	Ghana	GH-Poverty Assessment; P113250
2010	Iraq	IQ - Poverty Assessment; P101824
2010	Paraguay	PY Programmatic Poverty; P101174
2012	Zambia	Zambia Poverty Assessment; P123548

Source: World Bank Business Warehouse.

Project Performance Assessment Reports

21. The evaluation synthesizes findings from 14 Bank health projects that have been assessed by IEG in a Project Performance Assessment Report (Table A.6).

22. PPARs assess the programs and activities of the World Bank for two purposes: first, to ensure the integrity of the Bank's self-evaluation process and to verify that the Bank's work is producing the expected results, and second, to help develop improved directions, policies, and procedures through the dissemination of lessons drawn from experience. As part of this work, IEG annually assesses 20-25 percent of the Bank's

lending operations through field work. In selecting operations, preference is given to those that are innovative, large, or complex; those that are relevant to upcoming evaluations; and those that are likely to generate important lessons.

23. To prepare a PPAR, IEG examines project files and other documents, visits the borrowing country to discuss the operation with the government and other in-country stakeholders, and interviews Bank staff and other donor agency staff both at headquarters and in local offices as appropriate. Each PPAR is subject to internal IEG peer review, panel review, and management approval. Once cleared internally, the PPAR is commented on by the responsible Bank department. The PPAR is also sent to the borrower for review. IEG incorporates both Bank and borrower comments as appropriate, and the borrowers' comments are attached to the document that is sent to the Bank's Board of Executive Directors. PPARs are disclosed to the public.

Table A.6. Project Performance Assessment Reports with Health Financing Discussion, 2007–2012

Year	Country	Report Name
2006	Bangladesh	Health and Population Program Project
2007	Ghana	Second Health Sector Program Support Project
2008	Kyrgyz Republic	Kyrgyz Republic Health Sector Reform Project and Second Health Sector Reform Project
2009	Peru	Health Reform Program (PARSALUD)
2011	Argentina	Provincial Maternal and Child Health Sector Adjustment Loan and Investment APL1
2011	Brazil	Family Health Extension Adaptable Lending Program
2013a	Indonesia	Provincial Health Project I, II, and Health Workforce and Services III
2013b	Macedonia, FYR	Health Sector Management Project
2014	Albania	Health System Modernization Project and Social Sector Reform Development Policy Loan

Source: IEG (2006, 2007, 2008, 2009, 2011b, 2013a,b, 2014); World Bank (2013).

Key-Informant Interviews

24. Semi-structured key informant interviews were conducted with 25 international health financing experts (Table A.7). The names of these experts were identified based on a list of organizations proposed by the Bank. Twenty-three organizations were contacted and 21 responded and identified their experts to be interviewed. The interviews were conducted from August to September 2013 either in person or by phone by two IEG evaluators. The objective was to identify views about the value of

collaboration with the Bank and the quality and usefulness of the knowledge work produced by the Bank.

Table A.7. List of Key Stakeholders Interviewed

Name	Institution
Adelhardt, Michael	Providing for Health
Baeza, Christian	McKinsey & Company
Bitran, Ricardo	Bitran and Asociados
Borrowitz, Michael	Global Fund to Fight AIDS, Tuberculosis, and Malaria
Evans, David	World Health Organization (WHO)
de Ferranti, David	Results for Development Institute
Glassman, Amanda	Center for Global Development (CGD)
Hennig, Jennifer	Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ)
Hsiao, Bill	Harvard University
Kress, Daniel	Bill & Melinda Gates Foundation
Lagomarsino, Gina	Results for Development Institute
Lorenzoni, Luca	Organisation for Economic Co-operation and Development
Mills, Anne	London School of Hygiene and Tropical Medicine
Murray, Chris	Institute for Health Metrics and Evaluation
Nachuk, Stefan	Rockefeller Foundation
Peters, David	Johns Hopkins Bloomberg School of Public Health
Rannan-Eliya, Ravi	Institute of Policy Studies
Regalia, Ferdinando	Inter-American Development Bank
Savedoff, William	CGD
Scheil-Adlung, Xenia	International Labor Organization
Schmidt, Jean-Olivier	GIZ
Shang, Baoping	International Monetary Fund
Watson, Julia	U.K. Department for International Development
Yates, Robert	WHO
Zhao, Feng	African Development Bank

World Bank Institute Health Financing Flagship Course

25. An electronic survey was conducted of 109 individuals who had attended a component of the WBI's Health Sector Reform and Sustainable Financing flagship course. On September 12, 2013, the survey was received by 1,027 individuals who were on the WBI mailing list. The mailing list IEG received from the WBI also contained names of individuals who were interested in attending the course but have not attended. Overall, 109 valid questionnaires were retained for the analysis (thus the response rate is at least 10.6 percent). The questionnaire included 25 questions about individuals' professional and socio-demographic background, how the topics learned during the course were applied in their daily work, and which additional topics should be covered in future courses. The analysis was sent to the WBI course manager. The findings were incorporation into the evaluation.

Identification and Review of Impact Evaluations

26. An updated database from the Bank's DIME was used to identify all health and health financing impact evaluations conducted by the World Bank. The DIME database was received by IEG on August 22, 2013. It is the most comprehensive database of World Bank Impact Evaluations, comprising 605 closed and ongoing studies. DIME identifies basic information on factors such as thematic area, methodology, country, and status. Some studies evaluate interventions that have not been supported by Bank projects.

27. IEG identified 178 health-related impact evaluations in DIME. In terms of regional distribution, around 45 percent of the health impact evaluations analyze projects in Sub-Saharan Africa, followed by Latin America (26 percent), East Asia and Pacific (13 percent), and South Asia Regions (11 percent). Only 7 studies were conducted in Europe and Central Asia, and 2 in the Middle East and North Africa Region. Randomization is the most frequently used method, followed by propensity score matching and difference-in-difference. Out of 178 studies, most of which are ongoing, 54 do not have information on evaluation methods.

28. Of the 178 health-related studies, 39 are health financing impact evaluations. IEG coded the 14 health financing impact evaluations that were completed against the health financing matrix (see Table A.8). The remaining 25 studies are still ongoing. The 14 completed studies mainly evaluate the impact of health insurance interventions and programs to reduce out of pocket expenditures (10/14).

29. The large majority of the 25 ongoing impact evaluations is analyzing the effect of results-based financing (18/25), and only four studies evaluate the impact of insurance.

The remaining three ongoing impact evaluations assess the impact of case based and capitation based payments, social accountability, and user fees against a community health fund.

Table A.8. Impact Evaluations in Health Finance

Country or Region	Authors	Intervention	Year Published	Study Title	Observation Period	Evaluation Method	Outcome Measures
Argentina	Paul Gertler et al.	Results-based financing	2011	Impact of Plan Nacer on the Use of Services and Health Outcomes	2001, 2005–2009	FE regression, IV	Increased utilization of care for women and children; improved quality of services; improvements in birth weights and neonatal death rates
China	Lindelow and Wagstaff	Health insurance coverage	2005	Health Shocks in China: Are the Poor and Uninsured Less Protected	1991, 1993, 1997, and 2000	Other	Negative health shocks are associated with a significant increase in OOP health spending; increase is greater for the insured than the uninsured
China	Wagstaff and Lindelow	Health insurance coverage	2005	Can Insurance Increase Financial Risk? The Curious Case of Health Insurance in China	1991–2004	Fixed-effect logit; IV	Increased financial risk with some insurance schemes and reduced financial risk with others; increases in OOP spending.

Country or Region	Authors	Intervention	Year Published	Study Title	Observation Period	Evaluation Method	Outcome Measures
China	Wagstaff and Yu	Health insurance coverage	2007	Do Health Sector Reforms Have Their Intended Impacts? The World Bank's Health VIII Project in Gansu Province, China	1999 and 2004	DiD; PSM	Reduction of OOP and catastrophic health spending, especially among very poor; reduced impoverishment from OOP health spending; negligible impact on utilization; some improved immunization coverage
China	Wagstaff et al.	Health insurance coverage	2007	Extending Health Insurance to the Rural Population: An Impact Evaluation of China's New Cooperative Medical Scheme	2003 and 2005	DiD; PSM	Increased access, but insignificant for the poor; no evidence on OOP spending or reduction of catastrophic spending
Europe and Central Asia	Wagstaff and Moreno-Serra	Health insurance coverage	2007	Europe and Central Asia's Great Post-Communist Social Health Insurance Experiment: Impacts on	1990-2004	Systematic review; regression-based generalization of the DiD	Social health insurance increased national health spending and hospital activity rates, but did not lead to better health

Country or Region	Authors	Intervention	Year Published	Study Title	Observation Period	Evaluation Method	Outcome Measures
				Health Sector and Labor Market Outcomes			outcomes.
Indonesia	Pradhan et al.	Public spending on health, out-of-pocket expenditure	2004	Did the Healthcard Program ensure Access to Medical Care for the Poor during Indonesia's Economic Crisis?	1996, 1998, 1999	PSM, IV, OLS with FE	Increased utilization for poor (health card owners); increase in supply of public services resulting from budgetary support received through the SSN program
Rwanda	Basinga et al.	Results-based financing	2011	Effect on maternal and child health services in Rwanda of payment to primary health-care providers for performance: an impact evaluation	2006 and 2008	RCT; DiD	Increase in access, utilization, quality; no effect on immunization schedules
Rwanda	de Walque et al.	Results-based financing	2013	Using Provider Performance Incentives to Increase HIV Testing and	2006 and 2008	DiD	Increase in utilization of services especially for married couples

Country or Region	Authors	Intervention	Year Published	Study Title	Observation Period	Evaluation Method	Outcome Measures
				Counseling Services in Rwanda			
Uganda	Reinikka and Svensson	Public spending on health	2003	Working for God? Evaluating Service Delivery of Religious Not for Profit Health Care Providers in Uganda	1999	Other	Improved provision of services, quality and reduced prices in nongovernmental health facilities.
Vietnam	Jowett et al.	Health insurance coverage	2004	Health Insurance and Treatment Seeking Behaviour: Evidence from a Low Income Country	1999	Other	Increased utilization of outpatient facilities, especially public providers; effect strongest at the lower income levels
Vietnam	Wagstaff and van Doorslaer	Out-of-pocket expenditure	2001	Paying for Health Care : Quantifying Fairness, Catastrophe, and Impoverishment , with Applications to Vietnam, 1993–98	1993 and 1998	Other	Reduction of incidence and intensity of catastrophic payments less concentrated among the poor

Country or Region	Authors	Intervention	Year Published	Study Title	Observation Period	Evaluation Method	Outcome Measures
Vietnam	Wagstaff and Pradhan	Health insurance coverage	2005	Health Insurance Impacts on Health and Nonmedical Consumption in a Developing Country	1993 and 1998	PSM; DiD	Improved health status for young school children and adults; increased inpatient and outpatient utilization; reduction in annual OOP expenditures on health
Vietnam	Wagstaff	Health insurance coverage, out- of-pocket expenditure	2007	Health Insurance for the Poor: Initial Impacts of Vietnam's Health Care Fund for the Poor	2004	PSM, Single difference	Substantial increase in service use, especially inpatient care; reduced risk of catastrophic spending; no evidence of reduced average out of pocket spending, negligible impacts on use among poorest decile

Source: IEG Review of DIME database.
Note: DiD = difference in difference; FE = fixed effects; IV = instrumental variable; OLS = ordinary least square; OOP = out of pocket; PSM = propensity score match; RCT = randomized controlled trial.

Fiscal Space Assessments in Health and Public Expenditure Tracking Surveys

30. To identify the Bank's knowledge work, IEG used the same search strategy in the Business Warehouse as was done for project identification which yielded 447 studies. Bank coding of knowledge products is inconsistent and therefore sector and theme codes may not accurately reflect the actual analytical work conducted in health financing. The Business Warehouse does not include academic papers, impact evaluations, or reports that are produced as technical assistance.[1]

31. Fiscal space health assessments were included in the evaluation (see Table A.9). This list may be incomplete because fiscal space studies are not catalogued separately in Business Warehouse.

Table A.9. Fiscal Health Assessments

Year	Country	Report Name
2009	Indonesia	Giving More Weight to Health: Assessing Fiscal Space for Health in Indonesia
2009	Rwanda	Rwanda: Fiscal Space for Health and the MDGs Revisited
2010	Cambodia, India, Indonesia, Rwanda, Tonga, Uganda, Ukraine	Assessing Public Expenditure on Health from a Fiscal Space Perspective
2010	India	Government Health Financing in India: Challenges in Achieving Ambitious Goals
2010	Indonesia	Indonesia Health Sector Review. Financing Universal Coverage: Assessing Fiscal Space for Health
2010	Nepal	Assessing Fiscal Space for Health in Nepal
2010	Solomon Islands	Health Financing Options—see Fiscal Space Chapter 3
2010	Uganda	Fiscal Space for Health in Uganda
2012	Botswana, South Africa, Swaziland, Uganda	The Fiscal Dimension of HIV/AIDS in Botswana, South Africa, Swaziland, and Uganda
2012	Ghana	Health Financing in Ghana—see Fiscal Space Chapter
2013	Jamaica	Jamaica's Effort in Improving Access with Fiscal Constraints
2013	World	Macro Fiscal Context and Health Financing Fact Sheets for all Regions

Source: IEG strategic search on WB operations portal.

32. The 10 Public Expenditure Tracking Surveys conducted since 2006 are listed in Table A.10.

Table A.10. Public Expenditure Tracking Surveys in Health

Year	Country	Report Name
2006	India	Expenditure Tracking Study
2006	Indonesia	ID-Public Expenditure Tracking Surveys
2007	Lao PDR	Laos Public Expenditure Tracking (PETS)
2007	Cambodia	KH-Expenditure Tracking (PETS/HNP)
2008	Tajikistan	PPER 2
2009	Niger	NE-Public Expend Tracking Survey
2010	Egypt, Arab Rep.	Egypt GAC—Health Pets
2010	Honduras	HN PER Expenditure Tracking
2011	Sudan	SD Public Expenditure Tracking Study
2011	Indonesia	HIV/AIDS PET Study (UBW 1st Tranche)

Source: World Bank Business Warehouse.

World Bank Staff

33. An electronic survey of 68 World Bank staff was conducted. On September 23, 2013 the questionnaire was sent to 188 health staff mapped to HNP. The objective was to better understand Bank support to health financing in countries. The response rate was 36 percent. Of the 68 survey participants, 58 confirmed to have worked on health financing, and 40 responded to all questions (Table A.11).

Table A.11. Response Rate for HNP Staff Survey by Grade Level

Grade Level	Received (number)	Responded (number)	Response Rate (percentage)
GF	42	15	35.7
GG	108	38	35.2
GH	38	15	39.5
Total	*188*	*68*	*36.2*

Source: World Bank Human Resource database.

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[1] Since fiscal space studies are not catalogued systematically, all studies were identified via a keyword search of "fiscal space" and "health" in the project portal, and therefore may be incomplete.

Appendix B. World Bank Projects with Health Financing Approved in FY03–12

1. This appendix provides additional information on the trends and scope of the World Bank's health financing lending portfolio. Appendix C lists the projects included.

World Bank Support to Health

2. Between FY03 and FY12, the Bank approved 608 operations across all sectors that were coded for health. The total number of projects approved by fiscal year dropped from 75 in 2003 to 41 in 2012, reflecting a consistent downward trend in health operations (Figure B.1). The projects managed by the Health, Nutrition, and Population (HNP) Sector Board jointly accounted for $15.6 billion loaned through 189 health operations (Table A.1). Lending has peaked in 2010, which is reflected in higher commitments of the International Bank for Reconstruction and Development (IBRD). International Development Association (IDA) funding for HNP has remained largely flat (Figure B.2).

Figure B.1. Number of Projects with Health Managed by Sector Board

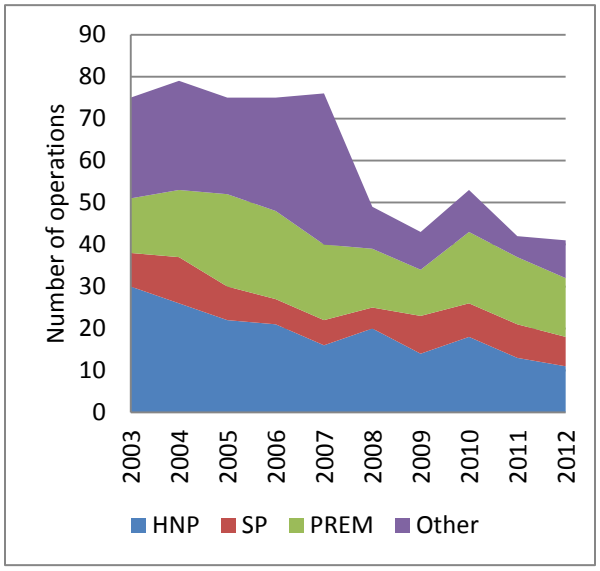
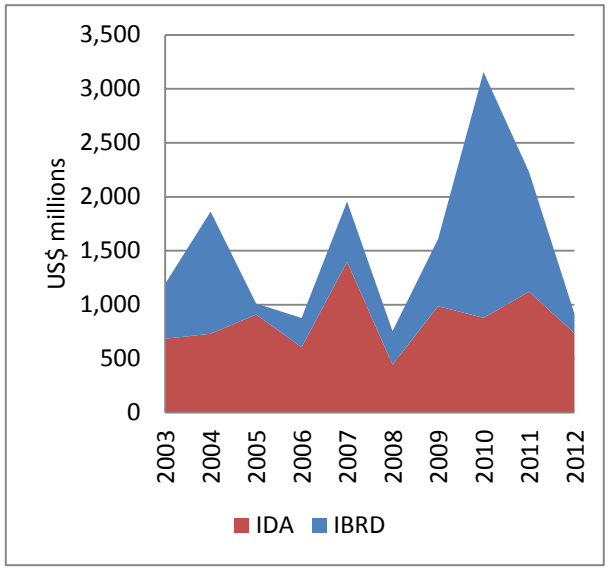


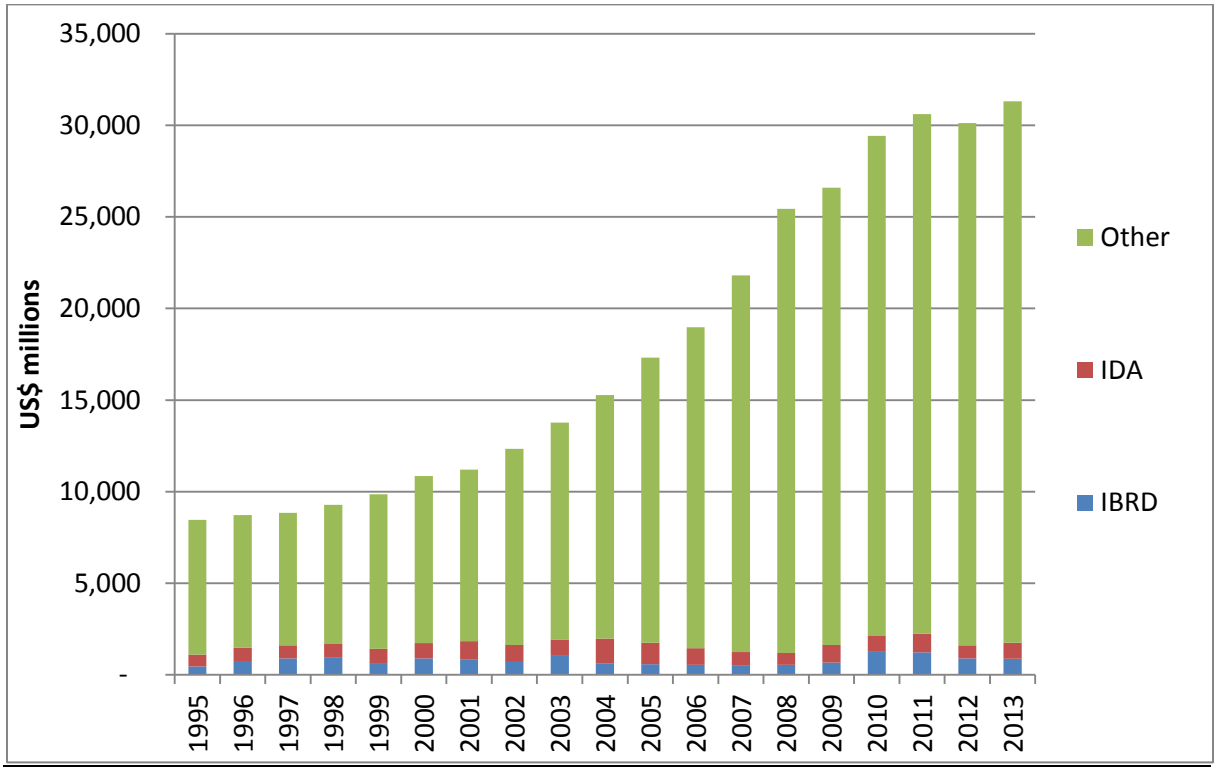
Figure B.2. IDA and IBRD by HNP



Source: Business Warehouse. FY03–12 Approval.
Notes: See appendix A 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.

3. World Bank financing to health plays a relatively small role in terms of global development assistance to health (DAH). Total DAH for health has increased to more than $30 billion in 2013. However, the Bank's share of total DAH is small and has decreased since 1998 from almost 20 percent to about 6 percent of total DAH in 2013 (Figure B.3). Most DAH comes from the U.S. government and the Global Fund for AIDS, Tuberculosis, and Malaria (IEG 2011b). Non-governmental organizations and private foundations spend three times more than the World Bank on health. Bank support to health includes spending for a wide range of activities in a health system, whereas other donors have identified priority areas such as immunization or specific diseases.

Figure B.3. Development Assistance to Health, 1995–2013



Source: IHME (2014).
Note: Development assistance to health (DAH) is 2011 U.S. dollars. The line with the World Bank share is percentage of global DAH.

World Bank Support to Health Financing

4. Health financing is a public sector issue and strongly represented in multisector operations. Of a total of 390 health projects, about half of them (188) supported health financing interventions (Table A.1). HNP and PREM managed an equal number of health financing projects (Table B.1). Africa and the Europe and Central Asia Regions implemented more than half of health finance operations

(Table B.2). While the number of new health financing operations approved by fiscal year has steadily declined for HNP from 10 in FY03 to 5 in FY12, PREM managed to maintain a similar number of about 8 operations per year (Table A.2). However, HNP is expected to see an increase in new IDA operations co-financed by the Health Results Innovation Trust Fund (HRITF) to support results-based financing (RBF) projects. In FY13, nine IDA operations were approved with HRITF co-financing, suggesting an increased focus on RBF.

Table B.1. Distribution of Health Financing Operations by Sector Board, FY03–12 Approvals

Health Financing Operations (percentage)	Sector Board			Instrument		Total
	HNP	Social Protection	PREM	DPOs	SIL	
	(n = 78)	(n = 30)	(n = 80)	(n = 106)	(n = 82)	(n = 188)
Distribution	41	16	43	56	44	100
FY03–07 (n = 96)	55	43	50	52	50	51
FY08–12 (n = 92)	45	57	50	48	50	49
Share of DPOs	5	90	94	100	0	56

Source: IEG portfolio review based on World Bank data.
Note: DPOs = development policy operations; HNP = Health, Nutrition, and Population; PREM = Poverty Reduction and Economic Management; SIL = specific investment loan.

Table B.2. Distribution of Health Financing Operations by Regions, FY03–12 Approvals

Health Financing Operations (percentage)	AFR	ECA	LCR	EAP	SAR	MNA	Total
	(n = 61)	(n = 55)	(n = 43)	(n = 21)	(n = 7)	(n = 1)	(n = 188)
Distribution	32	29	23	11	4	1	100
FY03–07 (n = 96)	56	51	42	48	86	0	51
FY08–12 (n = 92)	44	49	58	52	14	100	49
Share of DPOs	52	69	56	43	43	0	56

Source: IEG portfolio review based on World Bank data.
Note: AFR = Africa; EAP = East Asia and Pacific; ECA = Europe and Central Asia; LCR = Latin America and the Caribbean; MENA = Middle East and North Africa; SAR = South Asia.

5. Table B.3 lists all 68 IBRD and IDA countries with health financing operations and the intervention categories supported by these projects. Almost 60 percent of these health financing operations were implemented in IDA countries. The Bank in IDA countries mostly supports interventions in public revenue collection. Support to risk pooling is much more common in IBRD countries than in IDA countries. The inverse is true for support in purchasing (see Table B.3).

Table B.3. IBRD and IDA Health Financing Operations and Interventions, by Country

Country or Type	Number of Projects	Revenues Public	Revenues Private	Risk Pooling	Purchasing
IBRD	77				
Albania[a]	1	✓	—	✓	✓
Argentina	6	✓	✓	✓	✓
Armenia[a]	2	✓	✓	—	✓
Brazil	6	✓	—	—	✓
Bulgaria	2	✓	—	✓	—
China	2	✓	—	—	✓
Colombia	5	✓	—	✓	—
Croatia	4	✓	✓	✓	—
Dominican Republic	7	✓	✓	✓	✓
Ecuador	1	✓	—	—	—
Egypt, Arab Rep.	1	—	—	✓	—
El Salvador	1	✓	✓	—	—
Georgia[a]	1	✓	—	✓	—
Guatemala	1	✓	—	—	—
Indonesia	3	✓	—	✓	—
Latvia	2	✓	✓	—	—
Macedonia, FYR	6	✓	—	✓	✓
Mexico	1	—	—	✓	—
Peru	6	✓	—	✓	✓
Philippines	3	✓	—	✓	—
Poland	3	✓	—	✓	✓
Romania	2	✓	✓	—	—
Slovak Republic	2	✓	—	✓	—
Turkey	5	✓	✓	✓	✓
Uruguay	4	✓	—	✓	✓
IDA	111				
Afghanistan	2	✓	—	—	✓
Albania[a]	4	✓	—	✓	✓
Armenia[a]	3	✓	—	✓	—
Azerbaijan	1	✓	—	—	✓
Benin	4	✓	✓	✓	✓
Bolivia	3	✓	✓	✓	—

APPENDIX B
WORLD BANK PROJECTS WITH HEALTH FINANCING APPROVED IN FY03–12

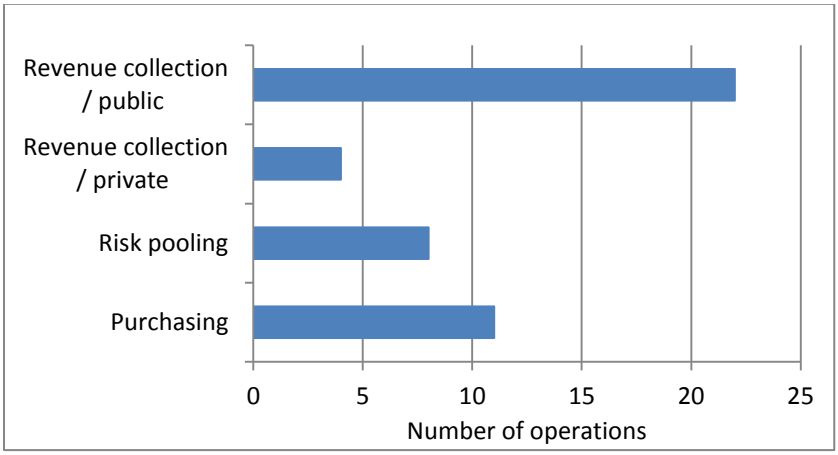
Country or Type	Number of Projects	Revenues Public	Revenues Private	Risk Pooling	Purchasing
Bosnia and Herzegovina	2	—	—	✓	✓
Burkina Faso	4	✓	✓	—	—
Burundi	2	—	✓	—	✓
Cambodia	2	✓	✓	✓	✓
Cameroon	1	—	—	—	✓
Cape Verde	1	✓	—	—	—
Central African Republic	1	—	—	—	✓
Chad	1	✓	—	—	—
Congo, Dem. Rep.	2	✓	✓	—	—
Congo, Rep.	1	—	—	✓	—
Ethiopia	1	✓	—	—	—
Georgia[a]	2	✓	—	✓	—
Ghana	6	✓	✓	✓	✓
Guinea	1	—	—	✓	—
India	1	✓	—	✓	—
Kenya	2	✓	✓	—	—
Kosovo	1	—	—	—	✓
Kyrgyz Republic	2	✓	—	—	—
Lao PDR	5	✓	—	—	—
Lesotho	1	✓	—	✓	—
Madagascar	3	✓	✓	—	—
Mali	5	✓	✓	✓	✓
Mauritania	1	✓	✓	—	—
Moldova	1	—	—	✓	✓
Montenegro	2	✓	—	✓	✓
Mozambique	1	✓	—	—	—
Nepal	1	✓	—	✓	—
Nicaragua	2	—	✓	✓	✓
Niger	5	✓	—	—	✓
Nigeria	1	—	—	—	✓
Pakistan	3	✓	—	—	—
Rwanda	7	✓	—	✓	✓
Senegal	4	✓	—	✓	✓
Serbia	2	✓	✓	✓	✓

Country or Type	Number of Projects	Revenues Public	Revenues Private	Risk Pooling	Purchasing
Sierra Leone	1	✓	—	—	—
Tajikistan	3	✓	—	—	—
Tanzania	3	✓	✓	—	—
Uganda	2	✓	—	—	✓
Uzbekistan	2	✓	—	—	✓
Vietnam	6	✓	✓	✓	✓

Source: IEG portfolio review based on World Bank data.
Note: IBRD = International Bank for Reconstruction and Development; IDA = International Development Association.
a. Albania, Armenia, and Georgia have both IBRD and IDA loans.

6. The health financing situation in fragile and post-conflict states can be described by a high reliance on donor financing and user fees, high informal payments by patients to health staff, and the lack of prepayment or health insurance. Bank support to fragile states mainly supports public revenue collection for health (Figure B.4). In some fragile states, including Afghanistan, the Bank helped strengthen purchasing including contracting with nongovernmental organizations (NGOs) to provide health services where government capacity is feeble. Many post-conflict countries experiment with performance- or results-based funding, including Afghanistan, Rwanda, and South Sudan (Witter 2012). The World Bank implemented 35 of 188 health financing operations in 20 fragile states.

Figure B.4. Health Financing Interventions in Fragile States Supported by World Bank



Source: IEG portfolio review based on World Bank data for 20 fragile states comprising 45 projects.

Health Financing Interventions Supported by the World Bank

7. Interventions reflect the priorities of the managing sector and country status. HNP managed operations are more likely to support public revenue collection and

purchasing, whereas PREM and SP are more focused on public revenue collection and risk pooling. The Africa, East-Asia Pacific, South Asia, and Latin America and Caribbean Region invest substantially in public revenue collection. Risk pooling is most frequently supported in Europe and Central Asia. Development policy operations are the predominant lending instrument for public revenue collection and risk pooling. A greater share of purchasing interventions is done through investment lending. A breakdown of Bank interventions is provided in Tables B.4 and B.5.

Table B.4. Interventions Supported by Health Financing Projects by Sector Board and Lending Instrument, FY03–12 Approvals (percentage)

Intervention Type	Sector Board			Lending Instrument		Total
	HNP	SP	PREM	IL	DPO	
	(n = 78)	(n = 30)	(n = 80)	(n = 82)	(n = 106)	(n = 188)
Revenue collection, public	51	97	81	52	86	71
Revenue collection, private	17	13	14	17	13	15
Risk pooling	37	47	35	33	42	38
Purchasing	44	20	6	43	9	24

Source: IEG portfolio review based on World Bank data.
Note: IL = investment lending; DPO = development policy operation.

Table B.5. Interventions Supported by Health Financing Projects by Region, FY03–12 Approvals (percentage)

Intervention Type	AFR	EAP	ECA	LCR	MNA	SAR	Total
	(n = 61)	(n = 21)	(n = 55)	(n = 43)	(n = 1)	(n = 7)	(n = 188)
Revenue collection, public	74	76	60	79	0	86	71
Revenue collection, private	20	10	16	12	0	0	15
Risk pooling	21	43	49	44	100	29	38
Purchasing	25	14	24	28	0	29	24

Source: IEG portfolio review based on World Bank data.

What Objectives Do Health Financing Operations Aim to Achieve?

8. Most projects included in this evaluation aim to improve the health status of a population, but only a few (7 percent) have a financial protection objective (Table B.6). All Regions have a strong focus on improving health outcomes and access to care. Operations in the East Asia and the Pacific and South Asia Regions are more likely to include a poverty objective than in other regions (Table B.7).

Table B.6. Objectives in Health Financing Operations by Sector Board and Lending Instrument, FY03–12 Approvals (percentage)

Type of Project Development Objective		Sector Board			Lending		Total
		HNP	SP	PREM	DPO	IL	
		(n = 78)	(n = 30)	(n = 80)	(n = 106)	(n = 82)	(n = 188)
Final Outcomes	Health outcome	71	33	28	29	68	46
	Financial protection or catastrophic spending	12	0	5	5	10	7
Intermediate Outcomes	Access, use, coverage	68	40	21	27	65	44
	Efficiency	37	27	28	29	34	31
	Quality	54	17	14	14	52	31
	Sustainability	19	20	6	10	18	14
	Equity	15	17	8	10	15	12
Target	Poor	24	47	31	36	24	31

Source: IEG portfolio review based on World Bank data.

Table B.7. Objectives in Health Financing Operations by Region, FY03–12 Approvals (percentage)

Objective Type in PDO		AFR	EAP	ECA	LCR	MNA	SAR	Total
		(n=61)	(n=21)	(n=55)	(n=43)	(n=1)	(n=7)	(n=188)
Final Outcomes	Health outcome	66	43	18	51	0	86	46
	Financial protection or Catastrophic Spending	3	19	13	2	0	0	7
Intermediate Outcomes	Access, use, coverage	57	57	33	35	0	29	44
	Efficiency	16	38	45	33	100	14	31
	Quality	39	38	22	30	0	14	31
	Sustainability	8	14	27	5	100	0	14
	Equity	10	19	9	36	0	14	12
Target	Poor	30	43	29	28	0	43	31

Source: IEG portfolio review based on World Bank data.

Monitoring and Evaluation in Bank Projects

9. Health financing projects have weak results frameworks and few collect any health system outcome data. Only 22 percent of HNP projects perform Substantial or High in their monitoring and evaluation (M&E) ratings as per IEG ICR Review,

which compares to a Bank wide average of 32 percent. Health finance projects perform marginally better than the HNP average.

10. Evidence on the achievements from the Bank and the IFC project portfolio has been difficult to obtain, because projects do not collect the relevant indicators. Of the 34 closed HNP projects few report the financial protection indicators stipulated in the HNP Strategy Results Framework (Table B.8). Only Vietnam looked at out-of-pocket expenditure as a share of total household expenditure. Insurance enrollment of the poor was reported in Bosnia and Herzegovina, Turkey, and Vietnam, but only Vietnam also reported this in combination with utilization and out-of-pocket expenditure. Cambodia was the only project reporting on the share of the population experiencing catastrophic health expenditures even though this was not in its results framework. None reported on the percent of population falling below the poverty line because of illness. None of the HNP projects reported out-of-pocket expenditures as a share of a country's total health expenditure.

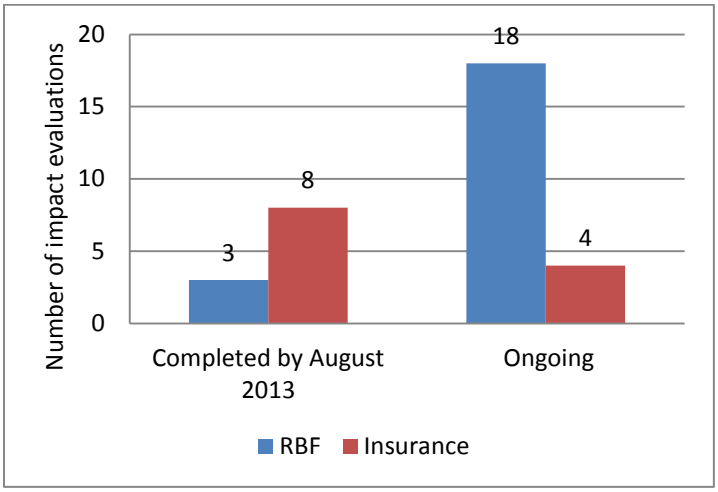
Table B.8. Projects in Countries Using Health Financing Indicators in Closed HNP Projects

Country	OOP Spending as Percentage of THE	Percentage of Poorest Households in Risk Pool	OOP HE as Percentage of Total HH Expenditure	Percentage of Households with Catastrophic HE	Percentage of Population Falling Below PL because of Illness	Utilization by Poorest Insured
Bosnia and Herzegovina	—	✓	—	—	—	—
Cambodia	—	—	—	✓	—	—
Tajikistan	—	—	✓	—	—	—
Turkey	—	✓	—	—	—	—
Uzbekistan	—	—	—	—	—	—
Vietnam	✓	✓	—	—	—	✓

Source: Project development outcome indicators from ICRs.
Note: HE = health expenditures; HH = households; OOP = out of pocket; PL = poverty line; THE = total health expenditures.

11. An increasing number of health financing projects include an impact evaluation. The DIME database reports 14 impact evaluations that examine the impact of a health financing interventions. Most ongoing work is on RBF (Figure B.5). Impact evaluations are funded by different sources including the Bank's operational budget and various trust funds, including the HRITF, the Strategic Impact Evaluation Fund, and others.

Figure B.5. Impact Evaluations of RBF and Health Insurance



12. Organisation for Economic Co-operation and Development (OECD) countries describe their health expenditure and financing situation using data on health expenditure per capita, health expenditure in relation to gross domestic product, health expenditure by function, pharmaceutical expenditure, expenditure by disease and age, financing of health care, and trade in health services (OECD 2013). These data are collected through the countries' Systems of Health Accounts. Most low- and middle-income countries do not collect this level of detailed data. Some countries compile this information regularly using the National Health Accounts (NHA) methodology[1]which is then reported by the World Health Organization. However, only in a few countries, has the Bank helped institutionalizing NHA, even so this effort has been temporarily supported by the Bill & Melinda Gates Foundation.

Economic and Sector Work

13. The Bank's analytic work includes reports with a focus on health financing (Table B.9). IEG has reviewed relevant reports in the country case studies. The number of Health Sector reviews and other health studies conducted by the Bank has declined quite sharply since 2009. Most of the 98 health finance related public expenditure reviews (PERs) were conducted in the Europe and Central Asia and Africa Regions. However, the number of PER with health chapters has also decreased since 2009.

14. The Bank conducted eight free-standing fiscal space analyses in health all of which were conducted in 2009 or later (see Table A.9). Most studies were from East Asia and Pacific, South Asia, or Africa Regions. In 2010 the Bank developed a conceptual framework for assessing fiscal space for health, including country case studies of Cambodia, India, Indonesia, Rwanda, Tonga, Uganda, and the Ukraine. In

addition in 2013 the Bank produced a series of Macro-Fiscal Context and Health Financing Fact Sheets for all Regions.

Table B.9. Health Financing Analytical Work by Type and Year

ESW	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	Total
PA	n/a	n/a	n/a	n/a	8	4	4	3	—	1	20
PER	16	18	8	7	15	4	5	10	6	9	98
PETS	—	—	—	2	2	1	1	2	2	—	10
HLT	6	3	9	5	7	5	8	6	5	1	55
HSR	3	6	9	3	2	1	4	3	2	—	33
Total	*25*	*27*	*26*	*17*	*34*	*15*	*22*	*24*	*15*	*11*	*216*

Source: World Bank Business Warehouse.
Note: ESW = economic and sector work; HLT = health study; HSR = Health Sector Review; n/a = not available; PA= poverty assessment; PER= public expenditure review; PETS = Public Expenditure Tracking Survey.

15. An in-depth analysis of all 43 poverty assessments between 2007 and 2012 show that 20 contain an analysis of health financing of some sort. Most frequently assessed is the percentage of the lowest-income quintile participating in risk pooling schemes and the benefit incidence of public health expenditure. Only two studies look at impoverishment because of catastrophic health expenditures, and only two are reporting on out-of-pocket expenditure rates in combination with access. Table B.10 provides more detail on the indicators reported by these 20 assessments.

Table B.10. Poverty Assessments with Health Financing Analysis

Year	Country	OOP Expenditures in Health as a Percentage of Total HH Expenditures	Percentage of Lowest Income HH Participating in Risk Pooling Schemes	Percentage of Individuals Falling Below Poverty Line Because of Illness	Percentage of HH With Catastrophic Health Expenditures	Benefit Incidence Analyses	OOP Expenditures in Health as Percentage of Total Health Expenditures	Poverty Gap because of OOP Expenditures	OOP Expenditures and Utilization
2007	Argentina	—	✓	—	—	—	—	—	—
2007	Chad	—	—	—	—	✓	—	—	—
2007	*China*	✓	✓	—	—	—	—	—	—
2007	Congo, Dem. Rep.	—	—	—	—	—	—	—	—
2007	Indonesia	—	✓	—	—	✓	—	—	—
2007	Nicaragua	✓	✓	—	—	✓	—	—	✓
2007	Uzbekistan	✓	—	—	—	—	✓	—	✓
2007	Venezuela	—	✓	—	—	—	✓	—	—
2008	Bangladesh	—	—	—	—	✓	—	—	—
2008	Georgia	✓	✓	✓	✓	—	✓	✓	✓
2008	Kenya	—	—	—	—	✓	—	—	—
2008	Senegal	—	—	—	—	✓	—	—	—
2009	Azerbaijan	✓	—	✓	✓	✓	✓	✓	✓
2009	Macedonia, FYR	—	✓	—	—	—	—	—	—
2009	Russian Federation	—	✓	—	—	—	—	—	—
2009	Tajikistan	✓	—	—	—	—	✓	—	✓
2010	Ghana	—	✓	—	—	✓	—	—	—
2010	Iraq	✓	—	—	—	—	—	—	—
2010	Paraguay	—	✓	—	—	✓	—	—	—
2012	Zambia	—	—	—	—	✓	—	—	—

Source: IEG review of poverty assessments.
Note: HH = households; OOP = out of pocket.

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[1]See World Health Organization, National Health Accounts: http://www.who.int/nha/en/.

Appendix C. Health Financing Projects in Portfolio Review

Table C.1. List of Health Financing Projects in Portfolio Review by Fiscal Year of Bank Approval and Sector Board

FY	Sector Board	Project Number	Project Name	Country	Revenue, Public	Revenue, Private	Risk Pooling	Purchasing
2003	HNP	P054119	Bahia Health System Reform Project	Brazil	—	—	—	✓
		P070542	Health Sector Support Project	Cambodia	✓	✓	—	✓
		P071004	Social Insurance Technical Assistance Project	Bosnia and Herzegovina	—	—	✓	—
		P071374	Multisectoral HIV/AIDS Project	Rwanda	—	—	✓	—
		P073649	Second Health Sector Program Support Project)	Ghana	✓	—	✓	—
		P073772	Health Workforce and Services (PHP 3)	Indonesia	✓	—	—	—
		P076802	DO: Health Reform Support (APL)	Dominican Republic	✓	—	✓	—
		P077675	Health Project (Serbia)	Serbia	✓	—	—	✓
		P078324	Health Sector Emergency Reconstruction and Development Project	Afghanistan	✓	—	—	✓
		P082395	Programmatic Human Development Reform Loan Project	Ecuador	✓	—	—	—
	SP	P069861	Social Sector Adjustment Loan Project	Colombia	✓	—	✓	—
		P073817	Programmatic Social Reform Loan Project (02)Reform Loan II	Peru	✓	—	—	—
		P078390	Social Sector Adjustment Credit (SOSAC) (Serbia)	Serbia	✓	✓	✓	—
		P082700	BO Social Safety Net SAC	Bolivia	✓	✓	✓	—

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FY	Sector Board	Project Number	Project Name	Country	Revenue, Public	Revenue, Private	Risk Pooling	Purchasing
	PREM	P071061	Governance Structural Adjustment Credit (GSAC)	Kyrgyz Republic	✓	—	✓	✓
		P075378	Poverty Reduction Support Credit (2)	Burkina Faso	✓	✓	—	—
		P075398	Poverty Reduction Support Credit II	Vietnam	✓	—	✓	—
		P075758	Structural Adjustment Credit 5 (SAC 5)	Armenia	✓	—	—	—
		P075810	Sindh Structural Adjustment Credit Project	Pakistan	✓	—	—	—
		P077781	Chad Fifth Structural Adjustment Credit)	Chad	✓	—	—	—
		P080345	Emergency Economic Recovery Credit	Madagascar	✓	✓	—	—
		P083074	Argentina Economic and Social Transition Structural Adjustment Loan	Argentina	✓	—	—	—
2004	HNP	P065954	Health Reform Project	Slovak Republic	✓	—	✓	—
		P071025	AR-Provincial Maternal-Child Health Investment Project (1st phase APL)	Argentina	✓	—	—	✓
		P072637	Provincial Maternal-Child Health Sector Adjustment Loan (PMCHSAL)	Argentina	✓	—	✓	✓
		P073974	Health Systems Modernization Project)	Armenia	—	—	✓	—
		P074053	Health Transition Project)	Turkey	✓	✓	✓	—
		P077513	HIV/AIDS and Health (MAP program)	Congo, Rep.	—	—	✓	—
		P082223	Healthcare System Improvement Project (Montenegro)	Montenegro	—	—	—	✓

FY	Sector Board	Project Number	Project Name	Country	Revenue, Public	Revenue, Private	Risk Pooling	Purchasing
		P082335	Second Health Sector Development Project)	Tanzania	✓	✓	—	—
		P082879	Health Sector Modernization Support Technical Assistance Project	Slovak Republic	—	—	✓	—
		P086670	Ith Sector Management Project	Macedonia, FYR	—	—	✓	✓
		P087841	BO-Social Sector Programmatic Credit	Bolivia	✓	—	—	—
	SP	P077739	Poverty Reduction Support Credit 2 (PRSC 2)	Albania	✓	—	—	—
		P078951	Programmatic Social Reform III	Peru	✓	—	—	—
		P079060	CO: Programmatic Labor Reform and Social Structural Adjustment Loan	Colombia	✓	—	✓	—
		P085433	Social Crisis Response Adjustment Loan	Dominican Republic	✓	—	✓	—
	PREM	P072003	Poverty Reduction Strategy Credit - 1st PRSC	Benin	✓	✓	—	—
		P074893	Public Sector Management Adjustment Loan 2 (PSMAL 2)	Macedonia, FYR	✓	—	—	—
		P076908	Poverty Reduction Support Operation (3)	Burkina Faso	✓	✓	—	—
		P079635	NWFP SAC II	Pakistan	✓	—	—	—
2005	HNP	P040613	Nepal Health Sector Program Project	Nepal	✓	—	✓	—
		P051370	Health 2 Project	Uzbekistan	✓	—	—	✓
		P065126	Health Sector Support Project	Guinea	—	—	✓	—
		P078991	Health Services Extension and Modernization (2nd APL)	Nicaragua	—	—	—	✓
		P079628	Second Women's Health and Safe	Philippines	✓	—	—	—

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FY	Sector Board	Project Number	Project Name	Country	Revenue, Public	Revenue, Private	Risk Pooling	Purchasing
			Motherhood					
		P088663	Health Sector Enhancement Project	Bosnia and Herzegovina	—	—	—	✓
	SP	P083968	PE-Programmatic Social Reform Loan IV	Peru	✓	—	—	—
		P095028	Uruguay Social Program Support Loan	Uruguay	✓	—	✓	—
	PREM	P074313	SECOND POVERTY REDUCTION STRATEGY CREDIT	Benin	✓	—	—	—
		P074908	Structural Adjustment Credit 2 (SAC 2) (Montenegro)	Montenegro	✓	—	✓	—
		P075287	Lao PDR First Poverty Reduction Support Credit	Lao PDR	✓	—	—	—
		P078674	Economic Policy and Public Expenditure Management Technical Assistance Project (PEMTAG)	Kosovo	—	—	—	✓
		P078806	Pakistan PRSC I	Pakistan	✓	—	—	—
		P078995	Poverty Reduction Support Credit (5)	Burkina Faso	✓	—	—	—
		P083275	Niger Public Expenditure Reform Credit	Niger	✓	—	—	—
		P083337	Poverty Reduction Support Credit 3 (PRSC 3)	Albania	✓	—	—	—
		P085192	Poverty Reduction Support Credit 1 (Health, Water, Energy, Education)	Rwanda	✓	—	—	—
2006	HNP	P074027	Health Services Improvement Project	Lao PDR	✓	—	✓	—
		P075464	National Sector Support for Health Reform	Philippines	✓	—	✓	—

FY	Sector Board	Project Number	Project Name	Country	Revenue, Public	Revenue, Private	Risk Pooling	Purchasing
		P076658	Lesotho: Health Sector Reform Project Phase 2	Lesotho	✓	—	✓	—
		P079663	Mekong Regional Health Support Project	Vietnam	—	—	✓	—
		P082814	Health System Modernization Project	Albania	—	—	—	✓
		P083350	Instit. Strengthening and Health Sector Support Program	Niger	✓	—	—	—
		P084977	Health and Social Protection Project	Kyrgyz Republic	✓	—	✓	✓
		P088751	DRC Health Sector Rehabilitation Support Project	Congo, Dem. Rep.	—	✓	—	—
		P090615	Second Multisectoral STI/HIV/AIDS Prevention project	Madagascar	✓	—	—	—
		P094220	Health Sector Reform Project	Azerbaijan	✓	—	—	✓
		P094278	Health and Nutrition Support Project	Mauritania	✓	✓	—	—
	SP	P096411	Rural and Social Sector Policy Reform Credit 1	Niger	✓	—	—	—
	PREM	P056201	Second Poverty Reduction Support Credit	Mozambique	✓	—	—	—
		P071052	Programmatic Public Sector Development Policy Loan (PPDPL)	Turkey	—	—	✓	—
		P078996	Poverty Reduction Support Credit (6)	Burkina Faso	✓	✓	—	—
		P082278	Croatia Programmatic Adjustment Loan	Croatia	✓	—	—	—
		P086361	Vietnam - Poverty Reduction Support Credit V	Vietnam	✓	—	✓	—
		P090303	PDPL 1	Macedonia, FYR	—	—	✓	—

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FY	Sector Board	Project Number	Project Name	Country	Revenue, Public	Revenue, Private	Risk Pooling	Purchasing
		P090881	Uganda Poverty Reduction Support Credit 5	Uganda	✓	—	—	—
		P091051	SN-PRSC 2	Senegal	✓	—	—	—
		P091990	Democratic Republic of Congo Transitional Support for Economic Recovery	Congo, Dem. Rep.	✓	—	—	—
		P092944	Second Poverty Reduction Strategy Credit	Rwanda	✓	—	—	—
		P095509	Tanzania PRSC-4	Tanzania	✓	—	—	—
		P095730	Fourth Poverty Reduction Support Credit	Ghana	✓	✓	✓	—
		P096635	Lao PDR Second Poverty Reduction Support Operation (PRSO2)	Lao PDR	✓	—	—	—
2007	HNP	P071160	India: Karnataka Health Systems	India	✓	—	✓	—
		P081712	Total War Against HIV and AIDS (TOWA) Project	Kenya	✓	—	—	—
		P095250	Health Services and Social Assistance	Moldova	—	—	✓	✓
		P095515	AR Provincial Maternal-Child Health Investment APL 2	Argentina	—	—	✓	✓
		P103606	Madagascar Sustainable Health System Development Project	Madagascar	✓	—	—	—
	SP	P094097	CO-3rd Prog. Labor Reform and Social Development Policy Loan	Colombia	✓	—	✓	—
		P098963	Rural and Social Policy DPL II	Niger	✓	—	—	—
	PREM	P074889	Programmatic Development Policy Grant	Tajikistan	✓	—	—	—
		P096205	Development Policy Loan (DPL)	Albania	✓	—	✓	—
		P098129	Third Poverty Reduction Strategy	Rwanda	✓	—	—	—

FY	Sector Board	Project Number	Project Name	Country	Revenue, Public	Revenue, Private	Risk Pooling	Purchasing
			Grant					
		P098548	Second Programmatic Development Policy Loan	Macedonia, FYR	—	—	✓	—
		P098964	PRSC III	Senegal	✓	—	—	—
		P099287	Fifth Poverty Reduction Support Credit	Ghana	✓	—	—	—
2008	HNP	P050716	UY Non Communicable Diseases Prevention Project	Uruguay	✓	—	—	—
		P082672	Northern Upland Health Support Project	Vietnam	—	✓	—	—
		P083997	Alto Solimoes Basic Services and Sustainable Development Project in Support of the Zona Franca Verde Program	Brazil	✓	—	—	—
		P084437	Rural Health Project	China	✓	—	✓	✓
		P095626	Second Family Health Extension Adaptable Lending	Brazil	—	—	—	✓
		P101206	Expanding Access to Reduce Health Inequities Project (APL III)--Former Health Sector Reform - Third Phase (APL III)	Bolivia	—	—	✓	—
		P101852	Health Insurance Project	Ghana	—	—	✓	✓
		P102284	Cambodia Second Health Sector Support Program	Cambodia	✓	—	✓	—
		P104525	Cameroon Health Sector Support Investment (SWAP)	Cameroon	—	—	—	✓
		P105092	Nutrition and Malaria Control for Child Survival	Ghana	—	—	—	✓
		P109964	Second Multisectoral HIV/AIDS (FY08)	Burundi	—	—	—	✓
	PREM	P096930	Programmatic Development Policy	Tajikistan	✓	—	—	—

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FY	Sector Board	Project Number	Project Name	Country	Revenue, Public	Revenue, Private	Risk Pooling	Purchasing
			Grant 2					
		P101296	PDPL 3	Macedonia, FYR	—	—	✓	—
		P101324	Minas Gerais Partnership II SWAP	Brazil	✓	—	—	—
		P103466	PRSC 2	Mali	✓	—	—	—
		P103631	Sixth Poverty Reduction Support Credit	Ghana	✓	—	—	—
		P104990	Fourth Poverty Reduction Strategy Grant	Rwanda	—	—	✓	✓
		P105287	Vietnam Poverty Reduction Support Credit 7	Vietnam	—	—	✓	—
		P107242	Lao PDR Fourth Poverty Reduction Support Operation	Lao PDR	✓	—	—	—
2009	HNP	P086669	Development of Emergency Medical Services and Investment Planning Project	Croatia	✓	—	—	—
		P088716	QUALISUS-REDE Brazil Health Network Formation and Quality Improvement Project	Brazil	✓	—	—	✓
		P101160	Health Sector Development Support	Burundi	—	✓	—	✓
		P102172	Project in Support of Restructuring of Health Sector	Turkey	—	✓	✓	✓
		P107843	Federal District Multisector Management	Brazil	✓	—	—	—
		P112446	Afghanistan — Strengthening Health Activities for the Rural Poor (SHARP)	Afghanistan	—	—	—	✓
	SP	P101177	Second Results and Accountability (REACT) Development Policy Loan-Deferred Drawdawn Option	Peru	✓	—	✓	—
		P102160	Social Sectors Institutional Reform	Bulgaria	✓	—	✓	—

FY	Sector Board	Project Number	Project Name	Country	Revenue, Public	Revenue, Private	Risk Pooling	Purchasing
			Development Policy Loan (SIR DPL II)					
		P103022	Ethiopia Protection of Basic Services Program Phase II Project	Ethiopia	✓	—	—	—
		P106834	RW-First Community Living Standards Grant)	Rwanda	✓	—	—	✓
		P115400	SIR DPL3	Bulgaria	✓	—	✓	—
		P116125	Poland Employment, Entrepreneurship and Human Capital Dev. Policy Program DPL	Poland	—	—	✓	✓
	PREM	P106502	POVERTY REDUCTION SUPPORT CREDIT IV	Cape Verde	✓	—	—	—
		P106963	Third Programmatic Development Policy (PDPG3)	Tajikistan	✓	—	—	—
		P107498	Fifth Poverty Reduction Support Grant-PRSC 5	Benin	✓	—	✓	—
2010	HNP	P074091	Health Sector Support	Kenya	✓	✓	—	—
		P080228	Health Insurance Systems Development Project	Egypt, Arab Rep.	—	—	✓	—
		P095275	Central North Region Health Support Project	Vietnam	—	—	✓	✓
		P106619	Health Sector Reform Second Phase APL (PARSS 2)	Dominican Republic	✓	—	—	✓
		P113202	Health System Performance	Benin	—	—	✓	✓
		P113341	Health Professional Education Quality Project	Indonesia	✓	—	—	—
		P115563	Uganda Health Systems Strengthening Project	Uganda	—	—	—	✓
		P116226	Support to the Social Protection System in Health	Mexico	✓	—	✓	—
	SP	P106708	CO DPL on Promoting an	Colombia	✓	—	✓	—

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FY	Sector Board	Project Number	Project Name	Country	Revenue, Public	Revenue, Private	Risk Pooling	Purchasing
			Inclusive, Equitable and Efficient Social Protection System					
		P115732	Latvia First Special Development Policy Loan: Safety Net and Social Sector Reform Program	Latvia	✓	✓	—	—
		P116972	First Performance and Accountability of Social Sectors Development Policy Loan	Dominican Republic	✓	—	—	—
	PREM	P102018	DPL	Romania	✓	—	—	—
		P110109	Fifth Poverty Reduction Support	Lao PDR	✓	—	—	—
		P112495	RESTORING EQUITABLE GROWTH AND EMPLOYMENT PROGRAMMATIC DEVELOPMENT POLICY LOAN	Turkey	✓	—	✓	—
		P112700	Georgia: First Development Policy Operation (DPO-1)	Georgia	✓	—	✓	—
		P115145	Public Finance and Social Sector Development Policy Loan	Dominican Republic	✓	—	✓	—
		P115626	Armenia First Development Policy Operation	Armenia	✓	—	—	—
		P116984	Development Policy Loan	Macedonia, FYR	—	—	✓	—
		P117270	ML—Fourth Poverty Reduction Support Credit	Mali	✓	—	✓	—
		P117273	Poverty Reduction Support Credit 4	Senegal	✓	—	✓	—
		P117665	Fiscal, Social and Financial Sector Development Policy Loan (DPL)	Croatia	—	✓	✓	—
		P117666	Third Development Policy Loan	Poland	✓	—	—	—
		P118036	Sustaining Social Gains for Economic Recovery	El Salvador	✓	✓	—	—
2011	HNP	P106735	Provincial Public Health Insurance	Argentina	✓	✓	✓	✓

FY	Sector Board	Project Number	Project Name	Country	Revenue, Public	Revenue, Private	Risk Pooling	Purchasing
			Development Project					
		P106870	Improving Community and Family Health Care Services Project	Nicaragua	—	✓	✓	—
		P110599	Essential Public Health Functions Programs II Project	Argentina	✓	—	—	—
		P113349	Health System Improvement Project	Uzbekistan	✓	—	—	—
		P116167	HIV/AIDS Support Project 2	Niger	—	—	—	✓
	SP	P116264	Third Results and Accountability (REACT) Programmatic DPL	Peru	✓	—	✓	✓
		P116937	Social Sector Reform Development Policy Loan	Albania	✓	—	✓	✓
		P117310	Results in Nutrition for JuntosSWAp	Peru	✓	—	—	✓
		P121778	Second Performance and Accountability of Social Sectors Development Policy Loan	Dominican Republic	✓	—	—	—
		P121796	Second Safety Net and Social Sector Reform Program	Latvia	✓	✓	—	—
		P122157	Rwanda Third Community Living Standards Grant	Rwanda	✓	—	—	✓
	PREM	P112821	ML- Governance and Budget Decentralization Technical Assistance Project	Mali	✓	—	—	—
		P116215	First Programmatic Public Sector, Competitiveness and Social Inclusion Development Policy Loan	Uruguay	✓	—	—	✓
		P116451	Second Development Policy Operation	Armenia	✓	—	—	✓
		P117698	Georgia: Second Development Policy Operation	Georgia	✓	—	✓	—

APPENDIX C
HEALTH FINANCING PROJECTS IN PORTFOLIO REVIEW

FY	Sector Board	Project Number	Project Name	Country	Revenue, Public	Revenue, Private	Risk Pooling	Purchasing
		P118931	Philippines Development Policy Loan to Foster More Inclusive Growth	Philippines	✓	—	✓	—
		P121178	Poverty Reduction Support Credi 5	Senegal	✓	—	—	✓
		P122221	Economic Recovery Development Policy Loan	Croatia	—	✓	✓	—
		P122370	Emergency Support for Social Services	Guatemala	✓	—	—	—
		P122483	Fifth Poverty Reduction Support Credit	Mali	✓	—	✓	—
		P123073	Second Restoring Equitable Growth and Employment Programmatic Development Policy Loan	Turkey	✓	—	—	—
2012	HNP	P119815	Health System Support Project	Central African Republic	—	—	—	✓
		P120798	Nigeria States Health Investment Project	Nigeria	—	—	—	✓
		P124054	Strengthening Reproductive Health	Mali	—	✓	—	✓
		P125740	Basic Health Services Project	Tanzania	✓	—	—	—
		P126210	Chongqing Urban Rural Integration Project II-Health	China	—	—	—	✓
	SP	P119355	Decentralized Service Delivery Program II	Sierra Leone	✓	—	—	—
		P125806	DO—3rd Performance and Accountability of Social Sectors DPL	Dominican Republic	✓	—	—	—
	PREM	P122195	Third Development Policy Operation	Armenia	—	✓	—	—
		P122202	Georgia: Third Development Policy Operation	Georgia	—	—	✓	—

FY	Sector Board	Project Number	Project Name	Country	Revenue, Public	Revenue, Private	Risk Pooling	Purchasing
		P122222	Development Policy Loan 3 (DPL 3)	Romania	—	✓	—	—
		P122982	Indonesia Development Policy Loan 8	Indonesia	✓	—	✓	—
		P123242	2nd. Programmatic Public Sector, Competitiveness and Social Inclusion Development Policy Loan with Drawdown Option	Uruguay	—	—	✓	—
		P123267	First Programmatic Fiscal Sustainability and Growth Resilience Development Policy Loan	Colombia	✓	—	✓	—
		P127433	First Development Policy Loan	Poland	—	—	✓	—
Total					**134**	**28**	**71**	**45**

Appendix D. IFC Investments and Advisory Services with Health Financing Approved in FY03–12

1. This appendix provides an overview of the strategy of the International Finance Corporation (IFC) in health and health finance, a brief description of private voluntary health insurance in developing countries as well as an overview of IFC's role in the market, and more detailed information on IFC's health financing investments and Advisory Services (AS). The Multilateral Investment Guarantee Agency (MIGA) does not have a health sector strategy and has, to date, guaranteed only one private investment in health finance—guaranteeing the equity investment for a private health insurance company in Kenya (see Box D.1).

Box D.1. MIGA Guarantees to Health Insurers in Kenya

Kenya's private health care sector is among the most developed and dynamic in Sub-Saharan Africa. In 2011, MIGA supported one project in health financing by issuing a guarantee of $2.05 million to ADC Financial and Corporate Development, a private equity fund, for its equity investment in Resolution Health East Africa Limited (RHEA) in Kenya, the fifth largest health insurance provider with a market share of 10 percent in 2011. ADC's investment would support improved performance of the insurer through introduction of new techniques, processes, management, and corporate governance. ADC's investment was also expected to help the company to expand delivery of medical insurance in Kenya, Tanzania, and other East African countries in the future.

While the project has not been evaluated, it appears that since MIGA's support, the insurance company has expanded successfully to be the second largest provider (as measured by in sales), now covering 65,000 active members and with more than 500 medical service providers in Kenya.

Source: MIGA.

Evolution of IFC's Health Strategy

2. The IFC's 2002 health strategy remains the relevant strategy by which to evaluate IFC's activities in the health sector between FY03 and FY12 (IFC 2002). The strategy's objectives were to continue investing in hospitals and to diversify IFC's health portfolio into nonhospital investments, pharmaceuticals, private insurance in countries without universal risk pooling, and health worker education and training with a wider geographic cover (IFC 2002: 37). IFC sought to increase its engagement

in the health sector through innovative financing mechanisms, such as local currency finance and health investment funds. A central tenet of IFC investments under this strategy has been that private spending on hospitals and clinics will relieve the burden on public health systems.

3. In the 2002 strategy, IFC defined health financing to include private health insurance and managed care, which is expected to promote efficiency gains through cost control (IFC 2002: 23). IFC believed its role and contribution would be high in the pre-paid market, by expanding access to health insurance to the middle and lower-middle classes in countries that did not have universal risk pooling. Passing mention was made to opportunities in the supplemental insurance sector, which was expected to grow in many IFC client countries (IFC 2002: 38). Products identified with the potential to increase risk pooling included general indemnity insurance, micro-insurance, and integrated health maintenance organizations.

4. In 2007, IFC outlined a specific strategy for engaging in the health sector in Africa consistent with the 2002 strategy (IFC 2002). The 2007 IFC strategy was based on a major report by the IFC with support from the Bill and Melinda Gates Foundation, *The Business of Health in Africa: Partnering with the Private Sector to Improve People's Lives* (World Bank 2008). IFC expected its role in health to include: (i) assisting governments to develop appropriate regulatory frameworks to support growth in the private health sector; (ii) increasing access to capital; (iii) promoting quality standards for service delivery; and (iv) supporting risk pooling (IFC 2007: 7). It expected to mobilize and invest $1 billion to improve access to health care by increasing financing for private providers targeting the poor and underserved. Continued advisory support for the health sector in Africa resulted in the establishment of a private equity vehicle for health in Africa to address issues of scaling-up successful businesses, expanding proven business models, and rationalizing fragmented industries. Another major report, *Healthy Partnerships: How Governments Can Engage the Private Sector to Improve Health in Africa* (IFC 2011), outlined opportunities for public-private engagement in Africa's health sector.

5. IFC expected to increase its engagement in prepaid plans and private voluntary insurance, requiring collaboration between departments in IFC. Products identified with the potential to increase risk pooling included general indemnity insurance, micro-insurance, and integrated health maintenance organizations. IFC's operational execution of its health strategy has tended to emphasize increasing health care access through direct investments in health care networks, centers of excellence, and wholesaling; health financing activities have primarily been advisory projects with government. This was in line with IFC's response to IEG's 2009

recommendation to increase its investments in private insurance. IFC reported no business case for direct, stand-alone investments in private health insurers. Instead IFC would support private equity funds and other financing facilities to facilitate investments in health SMEs. This was confirmed by IFC staff interviewed for this evaluation.

6. While insurance remained an objective of the 2002 health and 2007 Africa strategies, the operational execution of the strategy has tended to emphasize increasing health care access through direct investments in health care networks, centers of excellence, and wholesaling. IFC briefed the Board in March 2007 outlining its emphasis on supporting health care providers who (i) operate chains of hospitals, clinics, and other health services in multiple markets and have potential to increase access to care and move down-market to reach lower-income households; (ii) create centers of excellence in emerging markets; and (iv) provide employment opportunities for skilled professionals to remain in their country or Region (IFC 2007). Interviews with IFC staff suggest that introducing and expanding private health insurance proved difficult. IFC overestimated the demand from international private insurers wishing to expand into developing countries. Few people in low-income countries can afford paying premium to enroll with voluntary insurance, and there are not that many private providers to contract with. The resulting small risk-pool would be too risky for an IFC. Investment.

IFC's Role in Health Finance

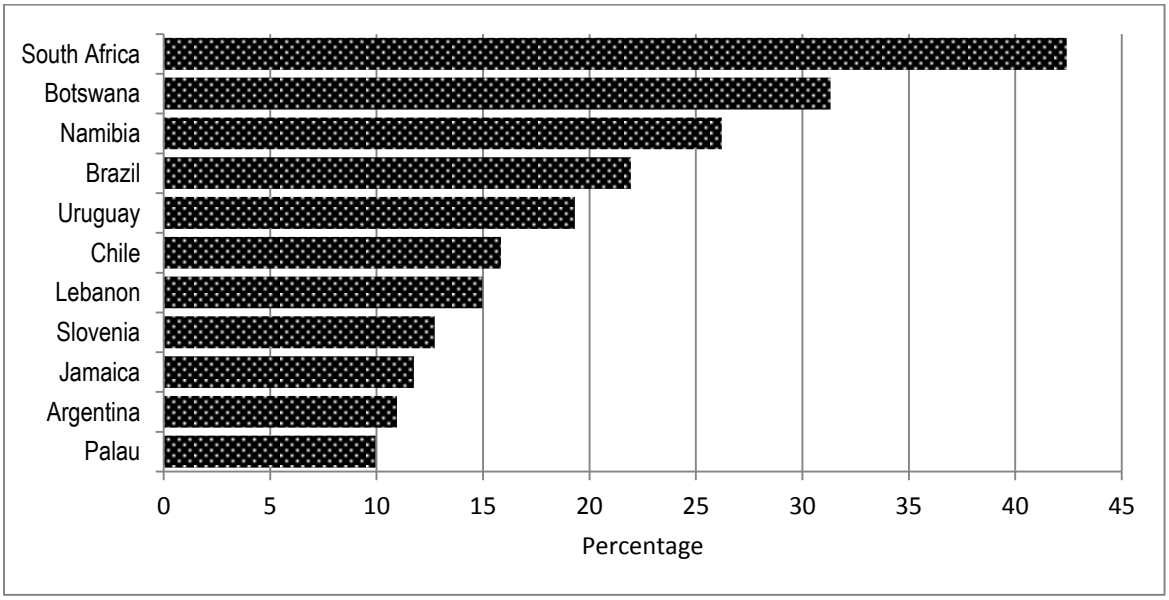
7. Voluntary private health insurance involves individuals or groups of people purchasing health insurance coverage from private insurers. Premiums are charged based on buyers' risk profiles. Few people can afford enrolling in voluntary private insurance. Private health insurance is used mainly by higher-income individuals for services not covered by social insurance or the government (e.g., specialist care in the private sector) and to avoid waiting lists for elective treatment. A few countries, (e.g., France and Slovenia), allow private insurers to cover co-payments charged by the public insurance system. In some countries, such as Slovakia and Switzerland, private insurers manage the compulsory health insurance package (World Bank 2009).

8. In developing countries, "voluntary" private health insurance raises a negligible share of total health revenues (Gottret and Schieber 2006). The voluntary nature of these schemes can lead to adverse selection resulting in small high-risk pools with predominantly higher-risk individuals enrolled which could compromise

the pool's financial sustainability (Begg 2000). To ensure their financial viability, private insurers have an incentive to enroll people with a low risk of becoming ill.

9. With the exception of the United States, voluntary health insurance contributes less than 15 percent of total health revenues in Organisation for Economic Co-operation and Development (OECD) countries (OECD 2013). In developing countries, "voluntary" private health insurance raises a negligible share of total health revenues (Gottret and Schieber 2006). As of 2011, 11 middle-income countries had voluntary private health insurance spending greater than 10 percent of total expenditure on health (Figure D.1).

Figure D.1. Private Expenditure on Pre-Paid Plans as a Percentage of Total Health Expenditure, 2011

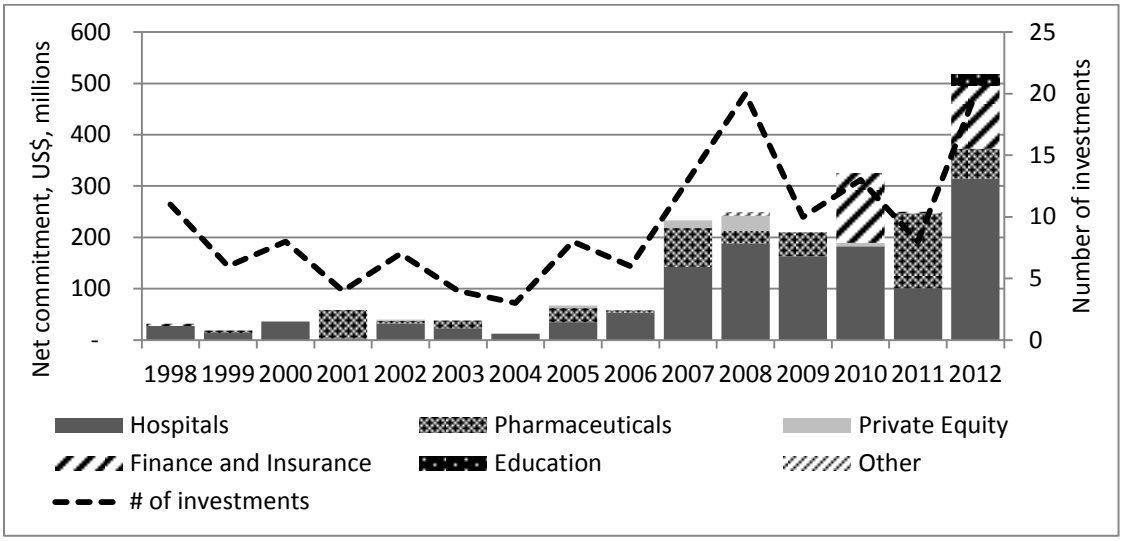


Source: WHO.

IFC Support to Health

10. IFC investments in private insurance and HMOs are limited. Private insurance is constrained by income, an understanding of insurance, a small number of private sector providers to name a few. The volume and number of IFC health investments have increased over the years (Figure D.2 and Table D.1).

Figure D.2. IFC Net Commitments and Number of Investments in Health, FY03–12



Source: IFC.

11. IFC has been more successful in expanding its investments in hospitals and pharmaceuticals than in health insurance. IFC approved 106 health investments (99 health projects) between FY03 and FY12 with net commitments of $2 billion. Of these, 74 investments were direct investments in hospitals and clinics ($1.2 billion) and 18 were direct investments in the pharmaceutical industry ($399 million).

Table D.1. Number of IFC Investments in Health by Type and Net Commitment, FY03–12

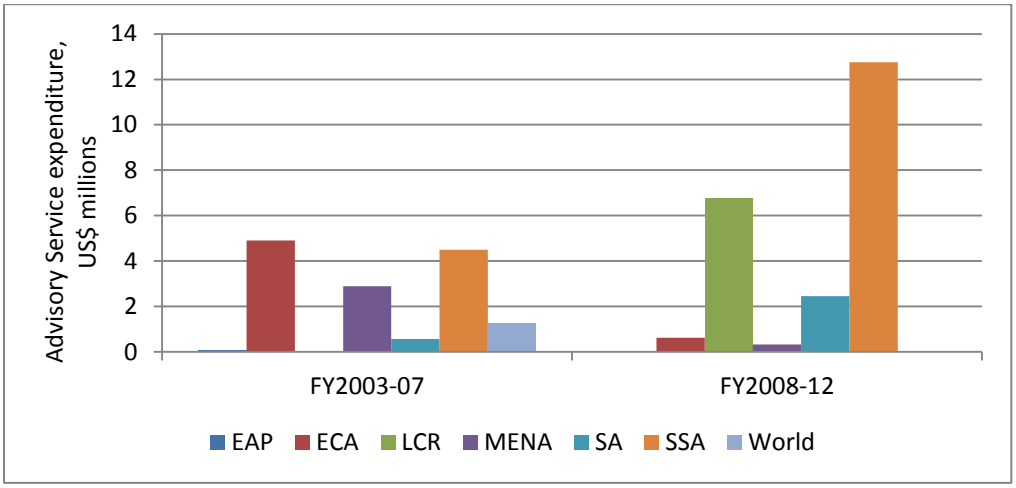
HOSPITALS AND CLINICS		PHARMACEUTICALS	FINANCE AND INSURANCE	PRIVATE EQUITY	EDUCATION	OTHER	TOTAL INVESTMENT	TOTAL NET COMMITMENT (US$, MILLIONS)
Projects by fiscal year of approval								
FY03–07	19	10	0	2	1	2	34	408
FY08–12	51	8	6	3	1	3	72	1,564
Total	*74*	*18*	*6*	*5*	*2*	*5*	*106*	
Health Finance	2		2	2			6	
(Percent)	3%	—	33%	40%	—	—	6%	
Net commitments								
Total	*1,173*	*399*	*263*	*56*	*20*	*6*		*1,972*
Health Finance	7		127	27				161
(Percent)	0.5	—	48%	48%	—	—		8%

Source: IFC.

12. Expenditures on health-related AS between FY05 and FY12 amounted to $32 million (39 projects) and accounted for 3 percent of all AS projects approved during

that time period, both in commitment volume and number of projects approved. IFC's AS increased in Sub-Saharan Africa and Latin America and the Caribbean Regions (Figure D.3). Over FY03–12, 70 percent of all advisory expenditure was dedicated to PPP projects with another 26 percent accounted for by Investment Climate projects, which is where the Health in Africa projects are housed.

Figure D.3. IFC Advisory Services in Health by Region and Volume, FY03–12



Source: IEG portfolio review based on IFC data.

IFC Support to Health Finance

13. Although the 2002 IFC health strategy included private health insurance as a strategic objective, IFC has made only two direct investments in private voluntary health insurance for a total of $127 million (Table D.1). IFC investments and advisory projects in health finance include investments in insurance companies or HMOs, public-private partnerships between governments and insurance companies, or other assistance to governments related to public health finance. Both direct investments in private health insurance originated from the Global Financial Markets Department; the two investments in the health maintenance organization originated in the Health Department.

14. IFC's investments and AS in health financing are recent (Table D.5). This annex therefore mainly describes the design and implementation of projects from project documentation, supervision reports, credit risk ratings, and data collected from staff interviews. IFC's health financing investments accounted for 7 percent of net commitments in health and 6 percent of investment approved between FY03 and FY12. Expenditures on health financing related advisory projects accounted for $13.4 million (42 percent) in nine projects (23 percent) (See Table D.2.). Six out of nine

advisory projects were in the Africa Region. In total, IFC supported health financing interventions in 11 countries and two Regions (Table D.3).

15. IFC has a long-standing investment in Nigeria's largest integrated HMO-provider network with two investments. Two investments and an associated Advisory project supported the company's expansion in order to accommodate the federal government's decision to transfer sector health care service delivery for its employees to the private sector. IFC also provided funding through its Performance-Based Grants Initiative to support the HMO's community health insurance plan targeting the informal sector.

Table D.2. IFC Expenditure and Number of Advisory Service Projects in Health by Type of Intervention, FY05–12

	Assistance to Investment Clients	Health Finance	PPP	Retail	Studies	HIV/AIDS	Total
Number of health advisory projects	2	5	21	2	3	6	39
• Of which in health financing	1	5	—	—	3	—	9
Total advisory expenditures in health in US, millions	0.1	4.8	17.1	0.4	8.6	1.0	32
• Of which in Health finance	—	4.8	—	—	8.6	—	13.4

Source: IEG calculations based on IFC data.

Table D.3. IFC Health Financing Interventions by Country or Region

Instrument	Private Voluntary Insurance	HMO	Public Mandatory Insurance	Purchasing (OBA)
Investment, equity	Africa, ECA, and MENA Regions[a]	Africa[a]		
Advisory Services	Tanzania	Nigeria	India, Kenya	Uganda
GPOBA				Nigeria; Yemen, Rep.

Note: ECA = Europe and Central Asia; GPOBA =Global Program on Output-Based Aid; MENA = Middle East and North Africa; OBA = output-based aid.
a. Either the Africa Health Fund or Investment Fund for Health in Africa invested in private voluntary insurance or in a health maintenance organization.

16. In 2011, IFC invested in its first insurance project—an equity investment supporting the expansion of a private insurer with a model of doing business that combined health insurance with health clinics. The provider had successfully bid with the government to insure pensioners, children below the age of six, and

individuals below the poverty line. The investment failed due in part to the fragmentation in the insurance market and the high-risk pool being insured, sponsor integrity issues, and the financial crisis.

17. In 2012, IFC invested in an established insurance provider in the Middle East and North Africa Region interested in expanding into countries in the Region with low insurance penetration. Both insurance investments were expected to increase the number of insured individuals and gross written premiums (Table D.4).

18. The Health in Africa Initiative (HiA) encourages governments to develop the best combination of risk pooling mechanisms and encourage donors to channel some aid through risk pooling organizations to expand coverage of the poorest by, for example, subsidizing their health insurance premiums (IFC 2007). The HiA targeted an investment of up to $1 billion to increase access to health care by improving financing and provision of private health services for underserved population groups. IFC succeeded in establishing two private equity funds. The Funds have invested in insurance companies and health maintenance organizations in Kenya, Nigeria, Tanzania, and Uganda. The Africa Health Fund invests primarily in small- and medium-sized health enterprises and was designed to incentivize investments in companies that serve individuals living in poverty with limited access to health facilities. Unlike the Africa Health Fund, the Investment Fund for Health in Africa does not include financial incentives to target the poor.

19. Through AS, IFC has supported the governments of Kenya, Nigeria, and Uganda on the path to social health insurance. Under the auspices of the HiA, IFC is providing advice to the government of Nigeria on scaling-up the Nigerian Health Insurance Scheme and is working to increase the private sector's role in Uganda's public health programs through contracting. The Initiative has conducted a strategic review of Kenya's National Hospital Insurance Fund and a market assessment of prepaid plans in Kenya. IFC's recommendations were accepted by the government of Kenya and are now being implemented. Through a follow-on advisory project, IFC is assisting the government on integrating private hospitals into the national health system (e.g., regulatory framework). The Bank is also working on recommendations made by IFC through a project on health insurance subsidies. Private sector health assessments[1] were conducted in Burkina Faso, Ghana, Kenya, Mali, and the Republic of Congo (Barnes et al. 2010; Lamiaux et al. 2011; Makinen et al. 2011; Makinen et al. 2012). They found that implementation of insurance and inclusion of the private sector will require a better understanding of insurance and increased capacity in underwriting, MIS and ICT and regulatory reform.

20. A mid-term review of the HiA found that it had facilitated substantive dialogue on the role of the private health sector but had "not sufficiently addressed how its efforts will benefit the underserved" (Brad Herbert Associates 2012: 4). Overall the initiative was found to suffer from a large and unfocused scope with limited staff resources. Since the review, IFC has produced both a revised strategy and an evaluative framework for HiA.

21. In 2012, through the Health in India Initiative, IFC and the Bank jointly assisted the government of Meghalaya in designing a universal health care scheme. This scheme aims to insure individuals not covered by the Rashtriya Swasthya Bima Yojana social insurance. IFC conducted a survey to register individuals targeted for universal coverage and provided assistance to the government of Meghalaya on structuring a public-private partnership with a private insurance provider. Another insurance advisory project in India targets micro-insurance which may include but is not focused solely on health. IFC is recommending impacts on the ground (e.g., enrollment) be assessed post project implementation.

22. The objectives and indicators for IFC's health financing interventions are given in Table D.4. IFC investments in private health insurers do not monitor utilization of care and out-of-pocket spending by the insured, thus no information is available about their effectiveness. IFC's AS are generally short in duration and provide support for a narrowly defined output objective. However, recent AS have recommended post-completion reporting on access to improved services. For example, the project in Meghalaya targets the poor and IFC incorporated components to ensure high enrolment and utilization and project monitoring.

23. Because of the newness of the projects or a lack of targeting, evidence is thin on the effect of IFC's support to health financing on improved service delivery or financial protection. However, some lessons emerge. Investments in pre-paid schemes that target the formal employment sector do not reach the poorest. In IFC's managed-care investments in Nigeria, HMO enrollees are primarily federal employees and employees of large corporations, and members of the National Health Insurance Scheme. There is no evidence to suggest the 1.2 million HMO enrollees in Nigeria and 613,000 patients served as of FY13 were poor (IFC's Development Outcome Tracking System). In Tanzania, IFHA invested in the largest private insurance company; its clientele is primarily corporate employees, who are mainly higher- and middle-income individuals.

24. For the one health financing investment through the Africa Health Fund, an independent evaluation by Dalberg Global Development Advisors found that in

2010, 74,000 poor patients were served as part of pre-paid plans in Nairobi. But the company was not reaching the poorest of the poor.

Table D.4. IFC Investments and Advisory Services in Health Finance, FY03–12

Project Name	Approval FY	Objective	Indicators
Archimedes	2012	Expand access to health insurance to under-served population Crowd-in investments in health insurance Provide financial protection to individuals requiring health care	Gross written premiums Number of individuals insured
MedGulf	2012	Support the growth of private sector health insurance Enhance access to health care for the bottom of the pyramid enhance household social stability	Number of individuals insured Number of outstanding premiums Gross written premiums
Hygeia	2007 2009	Increase the supply of, and access to, quality health care Expand the number of lives covered by the health maintenance plans	HMO enrollments
HMO Industry Expansion Program	2007	Improve the quality of health services offered, including accreditation Increase access by strengthening risk management	Number of improved procedures Number of entities reporting improved performance
Hygeia GPOBA	2007	Promote pre-paid plans among lower income individuals Increase utilization private capacity Demonstrate a business case for Community-Based Health Insurance	Enrollment, payments, co-payments, quality of care
Yemen Safe Motherhood	2008	Demonstrate the case for private involvement in Yemen's maternal and child health strategy Subsidized maternal health care	Percent of births assisted by skilled attendants Percent of women with potential or acute obstetric complication referred to the hospital. Patient Volume and Utilization Percent of women that complete basic antenatal care visits (4 visits) Percent of women that complete basic postnatal care visits (1 visit)

APPENDIX D
IFC INVESTMENTS AND ADVISORY SERVICES WITH HEALTH FINANCING APPROVED IN FY03–12

Project Name	Approval FY	Objective	Indicators
Private Health in Sub-Saharan Africa	2007	Improve the financing and provision of health services delivered by the private sector in Sub-Saharan Africa	No indicators
Health in Sub-Saharan Africa Strategy	2008	Increase, improve and extend the reach of financing and therefore provision of health services in Africa.	No indicators
Kenya NHIF	2010	Conduct Strategic Review of the NHIF with a view to improving the efficiency and reach Assess Kenya's pre-paid health schemes including private health insurance/HMOs to determine their scope and probable role in on-going health financing reforms	No indicators
Nigerian National Health Insurance Scheme	2011	Support expansion of risk pooling Reduce barriers to private participation in health Unlock sustainable investments in the private health	Number of individuals receiving access to improved services Value of investments generated
Kenya Health in Africa Program	2012	Create enabling environment for improving the quality of health services delivered by the private sector Unlock sustainable investment in the private health sector	Number of people enrolled and active in risk pooling mechanisms Number of people receiving access to improved services Value of investments generated
Uganda Health in Africa Initiative	2012	Increased outsourcing and contracting with the private sector benefitting additional 200,000 people	Value of public private contracts closed through expanded OBA Number of health PPP transactions
Micro Insurance Vimo SEWA	2012	Improved access to micro-insurance services for low-income families	Insurance reach Value of premiums collected
Universal Health Insurance, Meghalaya	2012	Increase the number of people receiving access to improved health services Ensure universal coverage and financial protection.	Number of individuals insured

Note: GOPBA = Global Program on Output Base Aid.

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[1] The complete list of private health sector assessments as well as other Health in Africa publications can be found at https://www.wbginvestmentclimate.org/advisory-services/health/health-in-africa/health-in-africa-publications.cfm.

Appendix E. Summaries of Country Case Studies

1. This appendix summarizes the main findings from the 16 country case studies that were conducted for this evaluation (see Appendix Table A.4). For each country, the main health system and reform issues are described, government and Bank interventions are summarized, and changes in system performance are identified.

Afghanistan

2. Afghanistan is a country emerging from decades of conflict during which health systems and other government functions essentially collapsed. Health outcomes are among the poorest in the world, particularly in the areas of maternal and infant health. Lack of access to and poor quality of basic health care is particularly acute among remote, rural populations, compounded by the continued insecurity in various pockets of the country. Total health expenditures also remain at very low levels, because of the levels of poverty especially in rural areas and the government's inability to adequately finance public health services. Out-of-pocket payments constitute the majority of private health expenditures, and social protection systems are virtually nonexistent. External resources remain a significant source of funding for the health sector.

3. After the fall of the Taliban regime in 2001, the new government took major steps to rebuild the health system, aided by significant financial and technical investments from the international community. Given the deterioration of public health facilities, nongovernmental organizations (NGOs) were contracted by the government, supplemented by donor funds, to provide basic health care. The Ministry of Public Health deliberately took on a stewardship and policy-making role, rather than service-delivery role. The Ministry defined a standardized "Basic Package of Health Services" and established it as the focal point of the national framework for primary health care, funded almost entirely by external donors.

4. The Bank played an active role in the initial policy discussions to delineate the health sector framework and provided substantial levels of funding for the expansion of basic health care services, particularly in rural areas. The Bank also took the lead in coordinating donor support in the health sector and produced analytic work with direct bearing on policy and lending activities. A series of Bank

lending operations in the health sector has instituted a results-based financing (RBF) approach to NGO-provided primary health care, with monitoring and evaluation processes. Other public sector reform interventions, though limited in scope, have been closely linked to the Bank's work in the health sector.

5. Bank support has contributed to increased equity in health service utilization for rural populations and females, and improved quality of care in some areas. However, while coverage and quality of care have improved significantly, coverage of important preventive and curative services remains low by global standards, including use of modern contraceptives, antenatal care, assisted delivery, and diphtheria, pertussis, and tetanus immunization. The impact on levels of private spending on health or on poverty is unknown. There has been no impact on financial protection. Limited evidence shows increased efficiency in the use of health funds, although efficiency gains have likely been achieved through harmonized donor activity as well as the use of widely recognized cost-effective interventions in the Basic Package.

6. Bank support has contributed to these outcomes through increasing the level of funding specifically for primary health care, providing strategically-focused and high-quality policy advice to define a clear health policy framework, and funding technical capacity in the Public Health Ministry to implement Bank operations, namely RBF. Other interventions include supporting civil service reforms to increase the availability of skilled personnel and ensuring monitoring and evaluation to assess project impact. Bank support during this time period is marked by strong, pragmatic leadership—both in technical support and donor coordination—and willingness to take risks in championing innovative approaches, while drawing on the multiple prongs of support available through the Bank. However, this support has entailed substantial financial and institutional capacity demands. While institutional capacity has been built in the Ministry to continue to implement RBF of NGO service provision, the longer-term financial sustainability is of great concern as donor assistance is reduced.

Benin

7. Health outcomes in Benin are unsatisfactory, and the country is lagging in reaching Millennium Development Goal (MDG) targets for both maternal and child mortality. Public health facilities are insufficiently funded. Government transfers cover only some 22 percent of annual nonsalary recurrent spending. As a result, out-of-pocket spending is high, in part due to high drug prices that are an important source of revenues for health facilities. Drugs account for some 76 percent of out-of-

pocket spending. The availability and quality of health services are limited. The distribution of services is heavily skewed toward urban areas and better-off population groups. Quality is low, both in terms of competence and patient responsiveness, reflecting weak accountability for results.

8. To help address these health problems, Benin is in the process of introducing major health financing reforms. They include universal coverage and RBF and the exploration of the potential for leveraging service provision through public-private partnership arrangements. Universal coverage and public-private partnerships are still in the stage of good intentions rather than substantive action. RBF is being piloted with the help of donors, including the Bank. With Bank support, the government is also working toward a sectorwide approach (SWAp) to health care provision, drawing together all donors around a common strategy. It includes (i) undertaking a diagnostic of community financing, provider payments, the role of the private sector, and the role of social security; (ii) proposing technical responses to the issues that might arise from the diagnostic; and (iii) developing a health financing strategy.

9. The country faces several constraints that are likely to make it difficult to move forward on any of these initiatives. The government has little in-house capacity to design or implement major reforms. Public spending on health is low and falling as a share of the government budget, and actual spending falls short of budgeted amounts. With limited public funding of health facilities, formal and informal out-of-pocket payments have become an important source of financing for the system. The system has only one risk-pooling mechanism, a health equity fund that provides a defined set of benefits for locally selected poor households. Some interventions are also free to the public including Cesarean-sections, kidney dialysis, selected diseases, and medical evacuations. The system is inequitable, with the quality of care in poorer areas being particularly weak. These areas lack the financial base for out-of-pocket payments to complement insufficient public funding of services.

10. The Bank has played a leading role in laying the basis for the reforms that the government is contemplating. Key products underlying the reform effort were a Bank 2009 analytical report on health and poverty that is widely recognized as the catalyst for the reform thinking; and a Health Systems Performance Project that was initiated in 2010. Both pieces took a comprehensive approach to tackling constraints in the country's health system, moving away from a more piecemeal approach that had previously characterized the relationship. The project, in particular, is providing technical advice on the main reform initiatives—RBF, universal health insurance, and improvements to the health equity fund—and is helping the government move

forward on its SWAp initiative. Involvement by the International Finance Corporation (IFC) includes the ongoing development of a private "benchmarking" hospital (i.e., a private hospital that essentially sets standards for care). The Bank and IFC have collaborated closely in developing this initiative. The business development prospects were examined by the Bank team, and a feasibility study for the hospital was conducted jointly by a Bank and IFC team.

11. While it is too early to expect results from the recent health financing strategy design effort, incremental progress is being made in the design process. In the Benin context, the Bank has been indispensable for health systems development to move forward. Neither government nor other donors seem to have the necessary capacity to do so, and they look to the Bank to take the lead in the reforms. The Bank has done so, but the effort is still seen as insufficient. Reforms are still in the crucial early stages of taking shape, and both government and donors express the need for Bank leadership, considering the scope of the reform program that the government is attempting to initiate. In the absence of technical staff to offer timely advice, progress on reform has stalled, with the exception of the effort in RBF, where a Bank initiative is leading the way.

12. The technical and leadership contributions of the Bank in health financing have been critical in Benin; however, it is clear that broad and in-depth reform may require Bank expertise on the ground. Supporting and managing from afar seems to have slowed down the effort, even with a willing government and engaged donors. That said, technical support albeit at a distance has been quite well calibrated to local capacity, taking care not to introduce overly sophisticated models of RBF and universal health insurance which would be challenging to manage, administer, and implement when local capacity is limited.

Plurinational State of Bolivia

13. Bolivia has one of the highest infant and child mortality rates in the Latin America and the Caribbean Region, with noteworthy rural to urban disparities that largely reflect inequality in access to services. Similarly, while maternal mortality rates are improving slowly, two-thirds of the poorest still deliver at home. The health system is regressive and marred by inefficiencies. The distribution of health staff is unequal, with poorly qualified staff working in rural areas and an oversupply of doctors in urban areas. The salary system does not provide incentives to work in underserved areas. There is little commitment to maintenance, and investments in infrastructure deteriorate quickly. Furthermore, data and analysis are insufficient on the flow of funds in the health sector, equity in access and quality of

care, and the financial and fiscal impact of health financing reforms. The public health sector is underfunded as the share of public finances for health has decreased, which raises concerns about the financial sustainability of various programs. Coverage of social insurance is limited, the role of the private sector undefined, and access to health services is unequal.

14. Bolivia has embarked on a number of major health financing reforms over the past decade. The government instituted a universal right to access in health. The government introduced free maternal and child health services for all, a universal benefits package for the elderly, an outreach program for rural and remote population groups (EXTENSA), and a conditional cash transfer (CCT) program (Bono Juana) that provides financial rewards for facility visits for maternal and child care, supported by a push on the supply side through investments in health infrastructure. It was envisioned that these various programs would be consolidated and transition to a Single Health System to attain universal coverage. This consolidation, however, has not yet progressed.

15. The health sector has seen a substantial increase in government financing in absolute terms because of higher revenues from carbon taxes and an increased allocation to social security funds. However, the share of general government expenditures on health has declined between 2005 and 2010, from 10.9 percent to 7.9 percent. Out-of-pocket expenditure still makes up about a third of total health expenditure. Access is particularly a problem for the poorest, and an unequal distribution of infrastructure investments and human resources has resulted in the poor being unlikely to benefit from recent reforms. The government received strong donor support in the early 2000s, but has become increasingly reluctant to work with donor organizations since the Morales administration took over in 2006. The current government strategy, to create a Single Health System, was not costed out adequately.

16. From the late 1990s until the mid-2000s, the Bank supported the government in its early stages of decentralization and with a series of adaptable program loans supporting all of the above-mentioned programs. Bank technical assistance included sector analyses and expenditure reviews. The set of programs developed and supported in the 1990s was strong and sustainable, as they outlived many changes in government and are still the main health programs of the government today.

17. However, after a new government critical of the Bank came into power in 2006, the Bank found it much more difficult to engage. Since then support became less comprehensive and focused on investments rather than policy dialogue. The Bank attempted to continue its assistance to health financing. However, the relevant

activities to strengthen the Single Health System were dropped at the request of the government in 2012. Bank support to health is now concentrated in areas where the country is more receptive, particularly in infrastructure and access to essential medicines and services, but not in health financing. Two projects related to financing were approved since 2003. They have been disbursing slowly due to insufficient government commitment. There are few or no data on the impact of the current Bank-supported programs. Available indicators suggest moderate progress.

18. In sum, when political support was available, the Bank provided a comprehensive package of funding with associated technical assistance that had a lasting impact on the health financing environment. Without government commitment in recent years, the Bank has been unable to capitalize on its comparative advantage, has found it difficult to engage in policy dialogue, and has not been able to contribute to addressing shortcomings in the system that are widely acknowledged.

Cambodia

19. The overall policy context in Cambodia is challenging. The country has gone through a period of significant internal conflict which has had long-term repercussions on the country's capacity to develop and implement policies. Although Cambodia is among countries that have achieved the fastest rates of poverty reduction, about 20 percent of the population is still poor. The general health situation of Cambodia has improved over the past decade. The life expectancy of both men and women has increased, and key mortality rates have decreased. However, Cambodia continues to experience relatively high levels of disease burden from both communicable and noncommunicable diseases, as well as from injuries and accidents. The effects of the country's past are evident with respect to health financing, as the sector is lacking a clear vision for its development and a coherent strategy for the implementation of interventions. The first attempt to articulate a plan was made in 2003. The large number of development partners, also for health financing, is also a complicating factor.

20. The main challenges that can be addressed by health financing reform are high levels of out-of-pocket spending by households, low and inequitable access to services, poor planning and management capacities on the side of the government, and significant inefficiencies in health spending. The key health financing intervention introduced in the early 2000s and supported by many donors, including the World Bank, was the creation of Health Equity Funds (HEF), which

operates as third-party administrators, reimbursing providers for care for those eligible for a fee waiver.

21. The World Bank Group's main support to the Cambodian health sector over the past decade has been the Health Sector Support Project I and II (2002–2014). The main components of this project have focused on strengthening health systems, including health financing. In particular the Bank, along with a handful of other development partners, has supported the development and implementation of province-based HEF. These contracted NGOs act as third-party administrators to manage the reimbursement to providers for the fees to cover the care given to eligible poor households in some 40 districts. In addition, a series of health systems and financing related analytical and technical reviews have been produced addressing issues of key importance, including health expenditure efficiency, human resources for health and compensation, and mapping of health markets.

22. The Bank's support through two health projects (along with that of other partners) to the development and funding of the HEFs have contributed to providing coverage to some two-thirds of the poor, with the government committed to scaling up to 100 percent coverage of the poor by 2015. The HEFs have helped to reduce out-of-pocket payments for care by those eligible for assistance. Furthermore, HEFs have been found to reduce the health-related debt of eligible households by about 15 percent on average. Evaluations have not, however, found an impact on nonhealth consumption or on health care utilization. The analytical and technical work has provided Cambodian policy makers with much needed evidence on key issues, including the relatively low efficiency of health spending, in particular for pharmaceuticals.

23. By providing both project support and technical assistance, the Bank has been able to affect health financing outcomes in Cambodia, including financial protection of the poor. The Bank has participated actively in donor coordination initiatives, including the Health Partner Group led by the World Health Organization and the Joint Partnership Group with a rotating chairmanship, and various technical sub-working groups including for health financing. Furthermore, the Bank has engaged closely with other key Cambodian policy makers outside of the Ministry of Health to advance health financing issues. The Bank also has engaged several departments, including Poverty Reduction and Economic Management (PREM) and Development Economics, to inform its health financing work.

24. The relatively strong health financing capacity that has been present in the local Bank office and the ability to work effectively across sectors explain the ability of the Bank to leverage some of its comparative advantages and to bring added

value to the health financing policy development of Cambodia over the past half-decade or so. A strong health team led by an experienced task team leader has established good relationships with key counterparts and development partners, which has enabled the World Bank Group to "lead from behind" in many important areas, including a public expenditure review (PER) and health expenditure analysis. The relationship between PREM and the Human Development Network has been effective and health has reportedly been at the forefront in much of the overall policy work of the World Bank Group in Cambodia over the past years.

Arab Republic of Egypt

25. Health outcomes in the Arab Republic of Egypt are steadily improving. The country is on track to meet its MDG targets for both child and maternal mortality. But the Egyptian health care system is profoundly inequitable when it comes to access and out-of-pocket spending. Only 60 percent of pregnant women in rural Egypt access antenatal care, compared to 90 percent in urban areas. Health spending increased 40 percent faster than growth in gross domestic product, and out-of-pocket expenditures constituted 72 percent of total health expenditures in 2008–2009, up from 62 percent in 2001–2002. The government allocation to health is insufficient and inefficient favoring secondary and tertiary care to primary care, and allocations are not necessarily based on burden of disease and need.

26. Health financing constraints to the system performance include a sharp increase in out-of-pocket expenditures; inequities in health spending and outcomes; fragmented insurance system with low coverage; poor budget allocation to health accompanied by heavy donor dependence for reform implementation; little protection against catastrophic health expenditures; and technical and allocative inefficiencies in the system. The government of Egypt, with some key donor partners, drafted a comprehensive health sector reform program in 1997–1998 to address both service delivery and health financing constraints by creating a Family Health Model (service delivery) and a Family Health Fund (health financing). These models were piloted in five governorates and supported by several donors, with the expectation of scaling nationally.

27. In addition, reform of the Health Insurance Organization was also designed to address the shortcomings of the insurer, in particular to separate its payer and provider functions and make it more efficient. From 1998–2009, the Bank support (Health Sector Reform Project) included providing universal access to a basic package of primary care through the Family Health Model and the Family Health Fund in two governorates, and reforming the insurer. The financing component

envisaged re-channeling of funds from direct financing to contract financing through Family Health Funds at the governorate level. Facilities that contracted with the Funds to participate in the financing component were called "contracted" facilities. A one-time co-payment was required for opening a file at the facility and a co-payment for each visit. Poor people would be exempt from the co-payments. It was expected that this pilot would serve as a catalyst to effect a transition from a system driven by budget inputs to a "money follows the patient" demand-based system. In 2006 Bank support was revised to include financing for avian influenza and introduce a new subcomponent to link disbursement to actual enrollment and utilization by the poor and uninsured in the Family Health Fund. In 2008–-2009, the Bank worked directly with the Ministry of Finance and the Social Insurance Organization to draft a health insurance law.

28. Project evaluations have revealed that the Bank's health project service delivery component succeeded in increasing provider satisfaction and productivity through the use of results-based incentive systems in the *reformed* facilities. It also succeeded in increasing patient satisfaction and demand for primary care services by utilizing a family health approach to patient care. The financing component of the pilot project had limited success. Financing of services remained fragmented and the bulk of the costs of family health providers were covered by the donor organizations. The role of the Fund's was limited to disbursement of provider incentives. The reform also failed to create new sustainable funding sources.

29. The health financing situation has worsened rather than improved. Up to now, Egypt does not have a comprehensive health strategy that clearly outlines its long-term objectives and planned interventions. The health insurance law has not yet been promulgated, and the health insurance reform also has yet to accomplish its key objective. While in 1994 household expenditures accounted for 51 percent of total health expenditures, by 2008 it increased to 72 percent. Public contribution to health as a percentage of total government expenditures declined from 5 percent in 2001–2002 to 4.3 percent in 2008–2009, far from the target of 15 percent for low-income countries. The RBF initiative in the reformed facilities virtually stopped after the donor funding dried up. Overall, the reform process faltered and did not produce the expected outcome.

30. Lack of leadership and governance has been persistent. The reform did not address some of the systemic constraints and missed several opportunities. There is an over-supply of medical specialists, and all graduating physicians are employed by the government irrespective of whether any open position is to be filled. In addition there was discord between the Minister of Health and Minister of Finance and turnover in the leadership at the Ministry of Health. By 2008, donors reduced

their support to Egyptian health reform. With very limited donor funding, the reform efforts slowed down further, followed by the Arab spring uprising (with three new Ministers of Health in the last two years since the political upheaval), effectively halting the reform efforts. The Bank and other partners lacked a clear understanding of the complexity of the political economy. The Bank's current project does not address several of the systemic constraints, which initially caused the reform to falter.

Ghana

31. Any discussion of health financing in Ghana is dominated by the decision taken in 2003, and implemented starting in 2005, to establish a National Health Insurance System (NHIS). The primary objectives were to provide access to health services for those who could not afford to pay fees for service and to protect those who might be impoverished by the medical costs of a serious illness. The NHIS is extremely popular with the public at large and is one of the few programs supported by both the government and its opposition. It provides free access to medical care for children under 18, pregnant women, and the elderly. However, only 35-40 percent of the population is actively enrolled in the NHIS, and the targeting to the poor is only partial at this stage. Nonetheless, the financial protection effect and the impact on utilization tend to be greater among the poor. Critics claim the system is subject to a great deal of fraud and inefficiency, and the failure of the NHIS to expand coverage is inhibiting the achievement of the MDGs. Although the evidence is mixed on the success of the NHIS on providing coverage, from the viewpoint of financial sustainability the system is at a cross-roads, and revenues and expenditures will have to be brought into balance to maintain sustainability and expand coverage.

32. Bank support for the NHIS began early in its development. The initial reaction of the Bank and other donors to the introduction of national health insurance in Ghana was that it was premature and ran the risk of re-directing resources to those who could pay the insurance premiums or were already part of a community- or employment-based insurance scheme. The Bank was soon convinced that since the government was determined to go ahead with the NHIS, the Bank and other donors should provide support to the system rather than staying on the sidelines. With some exceptions, other donors remained focused on the MDGs and supporting the key vertical programs in areas such as malaria control, tuberculosis, HIV/AIDS, and vaccination. While the Bank also continued support for vertical programs at this stage, it took the decision to provide a small amount of funding ($12 million) directly to the newly established NHI Authority. The funding was to

focus on setting up the management information system and electronic claims management.

33. The Bank's support to the insurance authority has been important and generally relevant, although not always timely. In terms of effectiveness, the Bank's impact has been more muted than it ought to have been given the targeted lending operation with associated technical advice and support, and the substantial program of analytic work. Currently, two important pilot projects on capitation payments and RBF are being supported by the Bank. The support for the first is drawing to a close, and the second is due to begin in the near future. It is unclear at present to what extent they will be mainstreamed in the future and what support the Bank will provide for this mainstreaming.

34. During the initial years of the project, the Bank provided considerable technical support and advice to the insurance authority which arguably would not have been possible without the project being in place. The project funds did not disburse, however, partly due to the new agency's unfamiliarity with Bank procurement procedures, and by 2009 the project was receiving an unsatisfactory rating. Under new Bank leadership, the project was restructured in 2009, and work was initiated on a pilot on capitation payments from the NHIS to providers financed through a trust fund grant. In addition, a major program of analytic work produced two books on the Ghana health sector, one of which related specifically to health financing. This study is still a fundamental source of background analysis and information on the topic. More recently, changes in Bank staffing have resulted in reduced support for health financing. Partly as a consequence, the Bank's support for health financing in the past two years has not had the same intense focus as in the initial phase.

35. The policy dialogue and the supporting operational agenda of the Bank seem to have depended largely on the efforts of individual staff. The direction the Bank has taken has reflected the interests of the individual staff and their commitment, rather than a considered World Bank approach reflecting positioning of the health financing issue within the country strategy. Also, the Bank did not take note of the potential of the Ghana case as a pilot in health insurance in a low-income (now lower-middle-income) country and its potential broader applicability in the African context. Overall, the lack of effectiveness of the Bank's involvement reflects inadequate management oversight and input.

Kenya

36. Insufficient progress has been made in reducing child and maternal mortality in Kenya, making it unlikely that the country will meet its MDG targets. Infant and child mortality has declined between 2003 and 2009; however, the maternal mortality rate in 2008 remained high at 488 per 100,000.[1] Huge regional disparities in health outcomes continue to persist. More recent preliminary household survey data show a continued trend of improved access to outpatient and inpatient health care. Government expenditure on health as a share of total government expenditure was halved between 2001 and 2009 dropping from 8 percent to 4.6 percent, moving further away from Abuja commitments.

37. Health financing constraints include inequity in health outcomes; insufficient and inefficient health spending; low insurance coverage; minimal risk pooling; poor access to quality care; catastrophic health expenditures; and poor quality care particularly in rural areas. Some of these constraints are to be affected by Kenya's ambitious plan to become a middle-income country, as articulated in its *Vision 2030*.

38. A new constitution promulgated in 2010 has fundamentally changed the governance structure, devolving power to two levels of government: national and county. Several aspects of the planned devolution directly impact the health sector, including direct transfer of funds from the center to facilities through the Health Sector Services Fund (HSSF). User fees for outpatient services and some in-patient are abolished, and block grants from HSSF are to compensate the facilities for lost revenue. This mechanism is designed to improve equity-based resource allocation and efficiency, and ensure equity of services by entrusting the local authorities and communities. Other health financing reforms include moving toward universal coverage through an improved National Hospital Insurance Fund, subsidized health insurance enrollment for about 25,000 poor individuals, and a RBF pilot in Samburu County for maternal and child health services.

39. With support from partners including the World Bank and IFC, the government is in the process of drafting a health financing strategy. Prior to 2009 the Bank was not engaged in health financing issues in Kenya. The relationship between the government and the Bank was particularly tenuous following the withdrawal of a previous health project by the Bank because of management issues. The relationship has improved in the past three years, and the Bank is now actively engaged in health financing issues. The Bank, through its ongoing health project, is providing technical and financial support to the health reform—particularly hospital insurance reform; RBF pilot; and implementation of Kenya's Essential Package for Health through HSSF grants—in addition to capacity building. The health and

PREM team supported the Public Expenditure Tracking Survey (PETS). The Bank is only one of two donors (the other donor being the Danish International Development Agency) providing pooled financing to the sector.

40. The IFC's engagement included two equity vehicles that enable small- and medium-sized enterprises to provide access to health insurance. Advisory Services support the policy dialogue and reforms aimed at strengthening the National Hospital Insurance Fund and expanding risk pooling. The IFC and Bank teams support the government's efforts to achieve Universal Health Coverage, including reforms of the National Hospital Insurance Fund, and public-private partnerships. IFC support includes convening and facilitating stakeholder dialogue on the role of the Hospital Insurance Fund.

41. Preliminary household survey findings suggest that utilization of primary health care and hospital admission rates are increasing, and more sick people are seeking care when they need it. The early assessments of the Samburu County RBF pilot have also shown improvement in quality of care and increase in access. However, the hospital insurance reform has faltered for political reasons and has yet to show real impact.

42. The Bank assistance in health financing has been recent and limited. In the past, health financing reforms lacked the support of consistent leadership from the government. Government leadership was disrupted by the political upheaval Kenya has faced since the 2008 elections, including the splitting of the Ministry of Health into two ministries and then merging again, a new constitution, and devolution. More recently, the Bank has supported the development of a high level policy dialogue on health financing and devolution, and convened other partners to support the implementation of the health financing strategy.

43. Today Bank and IFC health financing support in Kenya includes an active program and responds to the expectation from various stakeholders for the Bank to play a more active leadership role in health financing. The Bank has started a programmatic analytical work program for the health sector including a fiscal space analysis to inform sustainability of innovative financing options and assessment of efficiency of public and private health facilities. In addition, PREM and HNP teams are preparing a public expenditure review with a focus on the sub-national level. Public sector and government teams are working with the health team to support the government in developing policies and guidelines for "conditional grants" to counties. The next Kenya Economic Update will have health as its focus theme.

Mexico

44. Mexico, a middle-income country, has relatively good health statistics. Mexico has largely passed the "epidemiological transition" and faces growing health challenges from a variety of noncommunicable diseases. Access to health care and health outcomes are quite inequitable, with important discrepancies largely determined by geographic location, income, and employment status. Formal sector workers (around half of the population) have access to high quality social security services. Informal workers rely on lower quality public health providers and expensive private providers. The government introduced a new reform to improve access and quality for the poorer population, through a program commonly called Seguro Popular (People's Insurance) in 2004. The reform included a continued increase in public spending on health, transfers made to the state health systems on a per capita basis instead of historical costs, and a guaranteed benefit package for all. The federal government provides most of the funding to Seguro Popular which is co-financed by the states. Enrolled families pay a small contribution according to their estimated income. The bottom 40 percent households are exempt from paying contributions.

45. Health care reform was a government initiative. During the design of the reform, the government asked the World Bank to concentrate on improving the quality and availability of public health providers in geographic areas where Seguro Popular is likely to have a major impact on enrollment. The World Bank did not provide any direct support to the development of the initiative. After the Seguro Popular program was established and operating, the government requested more targeted support from the World Bank. This included a package of technical assistance and financial support. In 2010, the World Bank approved $1.25 billion for the Social Protection System in Health Project to support Seguro Popular. Under the project, the Bank disbursed against the number of enrollees, financing part of the total budget of Seguro Popular. The World Bank also provided operational support including with an Indigenous People's Plan that played an important role in supporting the expansion of the program in indigenous communities. In addition, the World Bank supported the reform with technical assistance activities that were financed under different sources. These supported workshops, studies, and conferences. The World Bank also provides support to Mexico's CCT program, known as Oportunidades, which provides incentives for the poor to join Seguro Popular.

46. Early results show that Seguro Popular has been successful in increasing the per capita spending on health and in reducing the gap between the population covered by social security and the informal sectors. This has led to a significant

reduction in out-of-pocket expenditures, particularly for catastrophic health events. Evidence suggests that it has also led to an increase in health care utilization by the poor. There is no evidence as of yet that this has impacted health outcomes. One area of concern was the possibility that Seguro Popular, along with other social welfare programs, would lead to an increase in informality as it would reduce the incentives to seek formal employment with all of its mandatory benefits. Studies show that while there is some "crowding out," the impact has been small.

47. Mexico has a high level of technical competence and is able to finance Seguro Popular without support from the World Bank. The Bank's major contribution was largely in the form of a "trusted adviser" or a "sounding board" that worked with the government in several areas. The World Bank's financial support served mainly as budget support, with the Bank's loan substituting existing resources providing the government with more fiscal space. The project did provide operational and fiduciary support to the Seguro Popular program. In particular, the Indigenous Peoples' Plan was widely seen as a major contribution to the program. On the technical side, the project supported around 50 studies. These ranged from operational support to long-term reform options. All of these studies were financed by the government, as part of its co-financing contribution to the project. In some cases, the World Bank worked with the project team to develop these studies. In addition, the Bank provided independent technical support that served to validate government findings and provide legitimacy.

48. Successes of the first 10 years of Seguro Popular are largely the result of concerted government efforts to implement an ambitious reform program that have continued through three administrations. The Bank did not contribute directly to the success of the Seguro Popular, but it did help to strengthen its performance. In addition, by acting as an "unbiased adviser," the Bank may have strengthened the political acceptability of the program. The Bank's project served as an important mechanism to maintain a presence in the sector and to support the government in financing its overall budget. Moving forward, the Bank is continuing its role as an adviser, focusing on selected technical assistance.

Nepal

49. In the past decade, Nepal has made substantial gains in improving the population's health status, including significant reductions in infant and maternal mortality. This makes it likely that the country will meet most or all of the health-related MDGs. Despite these gains, there are significant issues of health equity, with differences in health care outcomes largely driven by geographic location, caste,

education, and household income. Emerging from a prolonged period of civil conflict, the government has made a strong commitment to increase public spending on health, with a particular focus on eliminating the user fees for most publicly provided services. Nepal has a public health system that focuses almost entirely on providing centrally-financed services. There is no health insurance or formal demand-side health financing. Catastrophic health events have a significant impact on household welfare. The largely unregulated private sector plays a major role in providing health services. These are almost entirely financed out of pocket.

50. Since 2004, the World Bank has been an active member of a health sectorwide approach (SWAp) with other donors. While the World Bank's country strategies did not include a focus on health financing directly, the Bank assisted in convening others and providing support to donors focusing on health financing. This included providing training through the World Bank Institute Flagship Course, contributing to health financing research, and providing technical input in health financing. In addition, the Bank did focus on improving health care equity with a specific focus on the poor. Development partners collectively, through the SWAp, have been working with the government to develop a health financing strategy to reform the health sector. Although the Bank has not led this process, it has been an active contributor both through knowledge products and working with partners to develop a common understanding of health financing issues. The World Bank Group's health efforts have been focused almost entirely on the public sector.

51. Nepal has a weak statistical system in all sectors, including health. Little systematic information is collected on health financing and analyses have relied on occasional surveys and estimates. Government spending on health as a percentage of total health expenditure increased from 24 percent to 39 percent between 2000 and 2011. However, it is uncertain whether or not this has translated to lower out-of-pocket payments for households. The increase in attended deliveries suggests a greater use of public health services. There is also indirect evidence that discrepancies between health outcomes for the poor and those for higher-income groups have narrowed. The government's policy of eliminating fees probably played a role in the increase in attended deliveries as well as in the reduction of child and maternal mortality. However, it is unclear if this has reduced the impact of catastrophic health events.

52. The Bank was providing a coordination role for health financing among donors. This helped developed a consensus on how to move forward and allowed greater coordination. The World Bank did not lead in developing knowledge products, as other partners had more resources for technical activities. However the Bank did provide support in a number of areas, including targeted technical

assistance as well as designing and implementing high-level training for the development community with the World Bank Institute.

Nicaragua

53. Nicaragua has made substantial progress on reaching the health-related MDGs. In Nicaragua, most health services are provided by the public sector. The private sector provides some clinical and hospital services, mostly in cities and for formal sector workers and higher-income groups. There are major differences in access and quality, with poorer regions significantly behind other areas. The government is strongly committed to free health services for all citizens as part of its commitment to improve equity. A major challenge for the government is how to target resources so that they reach the poor within the context of free services. While government spending has increased substantially in recent years, it still remains largely allocated by historical budgets, which have favored richer areas. Another long-standing issue is the low absolute amount of resources spent on health, which seriously impacts the quality of health infrastructure. Donors contribute an important part of health financing, accounting for around 10 percent of total health expenditures. While the government does coordinate this assistance, cooperation among donors is limited. Presently, many donors are leaving or are planning to leave Nicaragua.

54. In January 2007, the government of Nicaragua initiated a demonstration project that extended the Nicaraguan Social Security Institute's health insurance program for formal sector employees to informal sector workers using microfinance institutions as agents to manage enrollment. The World Bank did not support the government in this program. Instead the Bank focused on results-based financing and improved data collection.

55. The Bank's primary mechanism of support to the health sector is through investment loans, complemented by a variety of technical work. The current health sector project, Improving Community and Family Health Care Services, focuses on improving financing and efficiency in poorer municipalities by providing RBF to local health centers. The RBF model aimed to improve the level of monitoring and planning. The health project provides a capitation payment to local governments, which is adjusted by local progress on several intermediate and final indicators. In addition, the Bank has supported several technical products. These have generally been well received by the donor community and the government, and have played a role in designing and modifying new health interventions. The Bank also supported

a South–South knowledge exchange with Argentina to support the introduction of RBF.

56. There are limited data on changes in equity in Nicaragua. For the poor, public facilities are often the only source of health care. However, Nicaraguans of all income groups rely on the private sector for drugs and other health services. The World Bank's present project is quite recent (approved in 2010), and it is too early to assess its impact. Government officials indicated the project has played an important role in increasing the monitoring and planning by local health authorities as they adjust to the introduction of capitation payment for health. The government has shown interest in expanding this model. The Bank was able to focus its technical and operational experience to strengthen its collaboration with national and local officials, providing appreciated support to data collection and results-based financing. However, this support was not integrated with the other health financing functions.

Rwanda

57. Rwanda has experienced strong economic growth and introduced major health financing reforms during the past decade, including almost universal health insurance coverage through community-based health insurance (mutuelles). The government contracts with public and faith-based health facilities and provides results-based payment in hospital and health centers. More recently, conditional cash transfers were introduced for unsalaried volunteer community health workers. In-kind incentives were given to pregnant women to seek prenatal and maternal care. Health indicators have improved substantially, and the country is on track to reach the MDGs for maternal and child health.

58. The government introduced fiscal decentralization to districts with needs-based monthly block grants (including based on poverty level) to health centers and hospitals. Civil service reform is ongoing, including decentralization of the public sector wage bill to districts and devolution of personnel management authority to the service provider level. Government spending on health in 2011 is estimated at 11.6 percent of general government expenditures and below the Abuja target of 15 percent. To increase equitable insurance enrollment, the health insurance premium for households in the lower two quintiles is fully subsidized by the government and external contributions. About half of private spending on health is out of pocket despite high insurance enrollment, suggesting an insufficient insurance benefit package. The government has received strong donor support for these reforms, and donors contribute about 60 percent of total health financing. In 2009, the government

introduced a Division of Labor policy, limiting the number of donors by sector. Bank support was redirected to other sectors because of substantive financing from the U.S. government and the Global Fund.

59. Constraints to health system performance that could be addressed through health financing reforms include high donor dependency and low levels of domestic financing for health care; concerns about the financial sustainability of RBF, the sustainability of community-based health insurance, and payments to community health workers, which are all heavily donor funded; fragmentation of funding because of a high financing share for malaria and HIV/AIDS; the division of labor policy which contributes to the health sector being dominated by vertical funds; and insufficient data and analysis on the flow of funds in the health sector, equity in access and quality of care, and the financial and fiscal impact of health financing reforms.

60. From 2005 to 2010, basic health service utilization indicators increased as did patient satisfaction. Insurance enrollment increased from about 30 percent in 2005 to 80 percent in 2011. Inequity in utilization of basic health care decreased across income groups. Household survey analysis in 2005 found the insured spent 6.8 percent of their income on health while the uninsured spent 13.4 percent. Catastrophic health spending was reported by 2.2 percent of insured compared to 8.6 percent of uninsured individuals. The insured report significantly higher utilization of care than the uninsured. However no recent analysis is available on utilization and financial protection by insurance status. Various studies on RBF found mixed effects. RBF mainly increased the use of services with higher unit payments which were easier to control by providers. But service use for other rewarded services did not change. Studies found having health insurance is a positive predictor for service use, and RBF without measures to address demand-side barriers has limited effect on equity in service use.

61. Prior to 2009, Bank support to health financing was comprehensive and addressed issues of governance in health financing and insurance through the medium term expenditure framework, health financing and insurance laws, and policy formulation. The Bank was instrumental in supporting health insurance policy, including funding insurance subsidies for the poor, and the scale-up of RBF under the HIV/AIDS project and general budget support operations. The Bank also provided analysis and advice on the level of government health spending on health; on equity in insurance enrollment and in access to care by subsidizing premiums and co-payments for the poor; and on improvements to quality of care by providing financial and policy support to the roll-out of RBF in the sector. The Bank also

produced several health reports and comprehensive analysis on the sustainability, equity, quality, and fiscal impact of reforms.

62. Bank advice helped to introduce income-dependent insurance contributions and subsidized insurance enrollment for lower-income groups; however, there is no recent analysis on the insurance effectiveness, and the Bank did not leverage its budget support to promote increased government spending on health toward the Abuja target, nor did the Bank assist in the development and implementation of an overarching, fiscally sustainable, health financing strategy. Recent Bank analytical work has been limited to impact evaluations of RBF reforms, with no examination of process issues, or of the impact of other Bank-supported health financing reforms.

63. When the government introduced the Division of Labor policy in 2009, the Bank's work led by Health, Nutrition, and Population ended. Rwanda continued to receive Bank support under the Regional Laboratory Project and a Social Protection program. This support to community health workers is linked to RBF health reforms but not to any broader health system financing strategy or policy dialogue. The Bank does not participate in donor collaboration on health financing reforms anymore. The Bank therefore has not had the opportunity to contribute to policy dialogue on health financing. It has been absent from technical discussion on provider payment reforms to introduce case-based payments in hospitals, and did not conduct an analysis of the fiscal impact of RBF. Important factors of success in health financing reform in Rwanda prior to 2009 included strong financial and technical donor support and government capacity and willingness to put in place credible reforms supported by donors. Continuation of this success will depend on continued analysis and policy dialogue regarding the impact of health financing reforms and their fiscal impact and financial sustainability.

Tanzania

64. Tanzania has experienced strong economic growth in the past decade; however, growth was not inclusive and poverty remains high at 87 percent of the population. Health outcomes have improved and the country is on track to reach the child mortality MDG but reports insufficient progress in reducing maternal mortality and high-fertility rates. Beginning in the 1990s, Tanzania embarked on a series of health financing reforms with the support of the World Bank, introducing user fees, creating a National Health Insurance Fund for civil servants and the formal labor force, and setting up two Community-Based Health Insurance Schemes for the poor rural and urban populations. More recently, the government piloted several RBF schemes which it intends to roll out nationally. To improve equity in

access, maternal and child health services and services for people over the age of 65 and the poor are waived from payment; however, there is no clear identification strategy for the poor, and informal payments are common.

65. Decentralization was pursued, whereby the Regions plan and budget for themselves, although the majority of public financing comes through the central government. The health sector is still largely underfunded at $30 per capita, and government contributions to health fluctuate around 10 percent of general government expenditures, significantly below the 15 percent Abuja target. The health sector has benefited from strong donor support that accounts for 40 percent of total health expenditure, the majority of which is channeled through a joint government and donor basket funding mechanism that makes up the majority of the recurrent budget, apart from personnel expenditure.

66. Constraints to health system performance that could be addressed through health financing reforms include high donor dependency and low levels of domestic financing for health care; fragmentation of the various insurance schemes; large amounts of financing being channeled through vertical programs such as malaria and HIV/AIDS; limited financial protection due to low insurance enrollment; high levels of out of pocket expenditures; and poor quality of services.

67. The World Bank Group was active in health financing in the 1990s and early 2000s, when it was instrumental in setting up the National Health Insurance Fund, assisted with the decentralization process, and was a vital partner in the pooled donor fund that channeled funds to the Regions. However, its engagement in health financing was reduced in the mid-2000s, partly because of changes in Bank resources as well as reduced demand for health financing assistance by the government as other donors began providing more health financing technical assistance.

68. The Bank's most recent project, the Basic Health Services Project, did not explicitly address health financing constraints related to the level and allocation of government financing to health; weaknesses in the NHIF management and the scale-up of CHF; and the provider and payer split. Thus, Bank active support decreased over time, compared to the Bank's previous leadership in this area, and was taken over by other donors (i.e., the German Agency for International Cooperation and Swiss Development Cooperation) and technical advisers working on health financing reforms placed at the Ministry of Health. The Bank did provide a strong financial contribution to the pooled donor fund, and the Bank participated in joint government and donor coordination mechanisms over the past decade. The IFC, in collaboration with the U.S. Agency for International Development (USAID), recently conducted a well-received private sector assessment.

69. World Bank and other donor coordination reduced donor project fragmentation and supported country ownership. However, it is not clear how donor support through the Basket Fund has contributed to improving health services and enhancing health status. The World Bank Group seems to have missed a number of opportunities to provide the expected level of analytical support and leadership to influence Tanzania's development of its health financing strategy. One Bank study that is praised by the Bank is not perceived as well integrated by donors and the government. There was also a missed opportunity to provide World Bank Group expertise or to fund consultants to help in developing the health financing options papers currently under development. As a result, the health financing dialogue is led by other donors.

Turkey

70. Health status in Turkey, as reflected in life expectancy at birth, has shown steady improvement since the early 1990s, rising from 65 years in 1990 to 74 years in 2011. At the same time, the country has made remarkable progress toward attaining MDG goals. The Health Transformation Program, introduced in 2003, aimed at strengthening key health systems functions of governance, financing and service delivery. The main elements of the program were in place by 2010, and the program is being refined under a subsequent and ongoing strategic plan for the health sector, covering the period 2010–2014. Major health financing reforms that were put in place under the Program included the introduction of universal health insurance, which integrated the various insurance schemes, including the Green Card program for the poor, under the umbrella of the Social Security Institution. The Social Security Institutions became a single payer and undertook reforms to provider payment mechanisms, including RBF. A private sector system, including private, voluntary insurance, continues to run in parallel with the public system. Today, 97 percent of the nonpoor population and 85 percent of the population in the poorest decile is covered by insurance. Increased public health expenditures generated by implementing the Health Transformation Program have been kept affordable because of additional financing, efficiency gains from changes to provider payments and more appropriate referral systems, price controls on drugs, and reduced cost pressures as a result of the elimination of dual practice.

71. The Bank played a key role in the whole process of conceiving, developing, and implementing the Health Transformation Program through extensive informal brainstorming sessions and timely and targeted technical advice. The Bank provided technical support within a country context favorable to reform, including strong political underpinnings, a dedicated team of professionals led by the Minister of

Health, and a strategy of "quick wins" that maintained broad support for the longer-term aims of the program. While the informal discussions are mentioned as the most effective knowledge transfer mechanism both by the Turkish authorities and Bank staff, formal products also played an important role. A key product was a health sector report produced in 2003, which developed the roadmap for reform. Other key products were a PER in 2007, discussing options for efficiency improvements in health spending; and a health sector report in 2011, focusing on the financial sustainability of universal health insurance. Important lending activities were two policy loans in 2004 and 2009, respectively, which served as vehicles for providing technical support for the Health Transformation Program. Legal and regulatory actions related to the reform were supported by two sets of development policy loans.

72. The IFC appears to have played a modest role in reform, possibly because the Health Transformation Program was a public sector-focused initiative. Early on, there was fairly close collaboration between the Bank and IFC in reforming the pharmaceutical distribution system. Subsequently, IFC's focus has been on promoting private hospitals as investment targets; raising the quality of private services; and supporting local manufacturers of medical equipment. While all of these efforts are relevant to the ongoing reform process, and especially in trying to define an appropriate role for the private sector, there does not seem to be close collaboration between Bank teams and the IFC in these efforts.

73. Outcomes of the Health Transformation Program have been positive. Total health expenditure in Turkey rose from 5.5 percent of GDP in 2005 to 6.7 percent of GDP in 2011. Public sector funding rose from 68 percent of total health expenditures in 2005 to 75 percent in 2011. Out-of-pocket payments fell from 22 percent of total health expenditures to 16 percent. Access to care reached 97 percent of the population, and utilization of primary care services had increased from less than 2 visits per client in 2004 to 2.8 visits in 2008. User satisfaction with primary care (reflecting a gradual transformation to family practice) rose from 69 percent in 2004 to 86 percent in 2008. Maternal mortality fell from 29 per 100,000 in 2005 to 20 in 2010; under-five mortality fell from 24 per 1,000 in 2005 to 15 in 2011; infant mortality fell from 19 per 1,000 in 2005 to 12 in 2011; and life expectancy rose from 72.1 years in 2005 to 73.9 years in 2011.

74. In assessing the influence of the Bank in the health reform process in Turkey, it should first be recognized that the Health Transformation Program consisted of a coherent and comprehensive package of measures to improve performance in the system. The merit of the reform may be that it was broad- based. It looked at the health sector as a system of interlinked elements that could not easily be tackled

piecemeal. This effort at coherence appears to have been at least in part Bank-driven. It is reflected in policy discussions between Turkey and the Bank during the years preceding the reform, and is reflected in the previously mentioned 2003 analytical and advisory assistance product which is recognized as forming a roadmap for launching the reform. The coherence of the reform was sustained through subsequent, often informal, dialogue and analysis between a committed group of Bank professionals and an equally committed group of clients. This sustained dialogue and support appears to have been a significant element contributing to the overall success of the Turkish reform, which is internationally trumpeted as a successful model of health systems reform.

75. In summary, factors of success included a country context receptive to a systemic approach to reform; political stability and economic growth creating the space for reform initiatives to thrive; and the ability of reformer to combine quick wins with longer-term change to sustain support for reform. The Bank was able to add value within this context by building on the technical and interpersonal skills of Bank staff who established long-term and sustained relationships of trust. These relationships fostered technical advice and dialogue which were sustained throughout the reform process.

Uzbekistan

76. Uzbekistan is not on track to achieving MDG goals in under-five mortality and maternal mortality. The Uzbek government finances health care and provides automatic coverage to the population in the public sector. The Bank's interventions have spanned three consecutive projects. Health I (1998–2004) reconstructed and equipped rural primary care facilities in three pilot oblasts and trained primary care physicians and facility managers. It introduced a system of capitation payments, with autonomy for facilities to reallocate savings as they saw fit. This pilot was perceived to be so successful that the Ministry of Finance enthusiastically endorsed its rapid national scale-up under the latter part of Health I and Health II (2004–2011). Attempts to replicate this success in urban primary care facilities under Health II and Health III (2011–2018) have encountered political resistance. Similarly, attempts at hospital rationalization, based largely on Bank efforts to introduce case-based payments, have also stalled at regional and central levels.

77. The introduction of per-capita financing for rural primary facilities has improved funding predictability and accountability in management and the use of public funds. The share of primary health care and outpatient health services in the overall public health expenditure structure rose from 41 percent in 2004 to 45.2

percent in 2011. The introduction of a modern treasury system in 2009 has increased reliability in the flows of funds, reduced delays in cash releases, and improved transparency and financial reporting. However, it has also decreased the financial and managerial autonomy of rural primary care facilities.

78. Bank support was able to reverse the poor quality of rural health care through increases in the clinical competencies and management skills of personnel and, with the capitation reforms, through increased incentives to provide higher-quality care. There were initial positive effects of oblast-level pooling of primary health care funds, in particular an immediate improvement in equity of resource allocation. Less progress in the urban primary care and inpatient sectors has stemmed from political resistance and overestimation of capacity to implement sophisticated provider payment reforms in hospitals. Subsequent treasury reform (supported in part by PREM) re-introduced rigidities in spending that reduced intended increases in autonomy and flexibility at health institutions. This created a strong contradiction between public financial management reforms and health financing reforms that has not been resolved.

79. Positive outcomes with rural primary care reform were due largely to effective synergies with government priorities, positive demonstration effects from early pilots, and crucial on-the-ground implementation support from USAID. Once political roadblocks were encountered in the crafting and implementation of urban primary health care and hospital reform, however, a coherent strategy for movement forward has not been developed. With the stalling of these reforms for political reasons, Bank priorities have shifted elsewhere, even within the social sector. Also, Bank-supported public finance management reforms (the treasury reform) have not been consonant with health finance reforms, reversing important gains in autonomy for rural primary health care centers and decreasing incentives for those centers to generate savings.

Vietnam

80. The Vietnamese health sector has made considerable advances over the past decades, and health outcomes are now comparable with much richer countries. Changes have also been made to the way health services are funded. In particular, Vietnam has introduced a series of health financing reform initiatives over the past decade to expand population coverage of health insurance, reduce out-of-pocket payments by patients, and enhance access to services, especially for the poor and vulnerable groups. One key government health financing reform has been the introduction of Health Care Funds for the Poor, province-level special funds to

finance the health services provided to those identified as poor. Another program provides free health care for children under six. Both of these programs were integrated into the national health insurance system with the consolidation of social health insurance more generally.

81. Donor spending on health makes up a very small share of total resources for health and the majority of this support goes to vertical disease specific programs resulting in fragmentation of service delivery and policy development. A donor coordination mechanism has been introduced in Vietnam in which the World Bank is an active partner. The World Bank has been moderately successful in providing support to the reform process through both operations and analytical work. Through its support to the Health Care Funds for the Poor in several regions, the Bank contributed to the effective implementation of the main policy initiative to address the challenges of the poor. Furthermore, there is strong indication that the World Bank Group has led much of the development partnership dialogue on health financing and systems reform in Vietnam.

82. The Health Care Funds for the Poor program was found to enhance access to care and reduce out-of-pocket payments of the target groups. Furthermore, it enabled the government to improve the allocative efficiency in health spending by focusing on those most in need in certain geographic areas, such as remote and mountainous regions. Along with the policy of free health care for children under six, the Health Fund for the Poor enhanced financial protection for vulnerable groups, such as the poor and ethnic minorities. Contribution payments to the national health insurance system operated by Vietnam Social Security are subsidized by the government for the poor.

83. Through the long-term engagement with the government, the Bank has been able to build a strong relationship across several sectors that is based on mutual trust and understanding. This is evident in the health sector where the Bank is seen as a dependable partner. Furthermore, the relatively stable political situation in Vietnam with few changes of key counterparts has also been favorable to the Bank's work. Finally, the ability to work on several levels in the Vietnamese health sector, from district to province to central level, has benefited the Bank's understanding of the sector.

84. A relatively strong indication suggests that the Bank has been strategic in its support to the health sector in Vietnam more generally and to the health financing reforms specifically. For instance, the Bank exhibited patience in not pursuing RBF-type of funding when the government expressed limited preparedness for this type of support. In addition, the Bank's project support and analytical support provided a

strong position from which to lead the policy dialogue. The Bank's technical support, also across other sectors, was generally seen as being of high quality, which further strengthened the Bank's collaboration with the government and other partners.

Republic of Yemen

85. The Republic of Yemen is a low-income country characterized by a significant proportion of poor, rural, and geographically dispersed population groups. These traits contribute to significant geographic and financial barriers to health services. Health outcomes are generally poor, particularly for maternal and child health. Health service utilization is marked by low coverage of the overall population and inequity in coverage between urban and rural populations and between upper- and lower-income populations. Financing of the health sector in Yemen is characterized by low total health expenditures, low levels of public expenditures, high out-of-pocket expenditures, and little to no financial protection mechanisms.

86. The government has laid out an ambitious health sector reform agenda, as reflected in its various development and health sector strategies over the past decade. Government initiatives have included decentralizing the health system, introducing user fees in public health facilities, exempting the poor from payments, and exploring social health insurance options. However, the government has thus far been unable to translate its strategic objectives into effective policy choices. The fragile security situation (most recently, civil unrest occurred in 2011) has also negatively affected the government's ability to provide financing for the health sector and to deliver basic services through the public health system.

87. Given the significant financial and capacity constraints of the public health sector, the Bank and other donors have mostly focused on vertical health programs to address immediate health needs, including maternal and child health and communicable disease control programs. The Bank through the Global Partnership of Output-Based Aid (GPOBA) provided financing to two private health care providers supported by the IFC and one nongovernmental organization. The feasibility of a more integrated approach is unclear and may be limited by weak strategic capacity at the government, and the overall lack of capacity in the health sector. The Bank has therefore taken a very gradual and slow approach to supporting the health sector and has not initiated a major health finance reform agenda in Yemen. The initial steps in this approach have been to expand service delivery to improve access and coverage of basic health services.

88. The impact of Bank support on overall health financing has been modest thus far because of the limited extent of the Bank's engagement on this issue. However, Bank support has contributed to increased access to public health services and has helped to draw attention, including donor financing, to some of the more prevalent health challenges in Yemen.

[1] See the Partnership for Maternal, Newborn & Child Health, "Maternal And Child Health: Kenya," http://www.who.int/pmnch/media/membernews/2011/20121216_kenyaparliament.pdf.

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