D I . 5 The World Bank

The World Bank is emerging from a period of intense controversy in the wake of the presidency of Paul Wolfowitz, who stepped down as a consequence of a favouritism scandal in June 2007. Under the new leadership of Robert Zoellick, the institution is once more being backed by donors, and it has launched a high-profile new health strategy.

This chapter looks at the way the Bank's funding, structure and internal incentives shape its behaviour. It describes the history of the Bank's involvement in the field of health and raises serious questions about the central planks of its new strategy for the sector.

Overview of the Bank

History and structure

The World Bank Group comprises five parts, all set up at different times and with different roles:

- The *International Bank for Reconstruction and Development* (IBRD) is the oldest arm, established at the founding of the Bank in 1944. It was set up to finance the reconstruction and development of the war-ravaged European economies, but it gradually moved into financing large infrastructure projects in newly independent developing countries from the 1950s onwards. The IBRD lends money to governments at market interest rates. Its financial resources come from its initial endowment from its shareholders, from money raised on the financial markets and from interest payments made on its loans.
- The second major arm is the *International Development Association* (IDA), which was established in 1960 to provide grants and soft loans (i.e. with

low interest rates and long repayment periods) to developing countries. The IDA's budget is replenished by donor countries every three years.

These two core components of the World Bank Group are supplemented by three affiliates:

- The *International Finance Corporation* (IFC), which was established in 1956 to allow lending directly to the private sector. The IFC has its own staff, budget and building and is somewhat smaller than the rest of the Bank. Its aim is to facilitate private-sector investment and development in low- and middle-income countries.
- The *International Centre for Settlement of Investment Disputes* (ICSID), which was set up in 1966 to arbitrate on international investment disputes.
- The *Multilateral Investment Guarantee Agency* (MIGA), which was established in 1985 to provide financial guarantees to foreign investors wishing to invest in developing countries.

Governance

On its website, the Bank describes itself as a co-operative. There is some truth in this statement, in so far that it has 185 country members who are shareholders in the Bank. However, this comforting formulation of the Bank's identity belies the reality of an institution that mirrors global inequality. For a start, the Bank's shareholders do not have equal power. Votes are weighted according to a country's financial contributions.

The Bank's five most powerful shareholders – the United States, Japan, Germany, United Kingdom and France – control 37.24 per cent of votes in the IBRD, and 39.78 per cent of votes in the IDA (Weaver 2007). The Bank's primary clients, low- and middle-income countries (LMICs), have little say. Even larger developing countries such as Brazil, Russia, India and China struggle to influence Bank decisions. The recent call made by African finance ministers meeting in Maputo for improvements in Africa's decision-making position at both the World Bank and the International Monetary Fund (IMF) shows that this is a key issue, but their demands appear to have been left unanswered (Agencia de Informacao de Mocambique 2007).

The most powerful donor state is the US, which controls 16.4 per cent of the votes on the IBRD's board (Weaver 2007) and 14.7 per cent on the IDA board. With an 85 per cent 'super-majority' required to change the Bank's constitution, the dominance of the US is considerable. Furthermore, the Bank president is, by tradition, an American chosen by the US president in consultation with the US Treasury. Many of its staff are American or have been educated in American institutions and its working language is

English (Weaver 2007). All these factors give weight to the accusation that the Bank operates in the interest of its major shareholder.

Because the IDA is dependent on aid financing from donor countries, the three-yearly rounds of IDA replenishments are often accompanied by government lobbying, in particular by the US. For example, in 2002 the US used the IDA replenishment meetings to lobby for an 'increased role for the private sector in health care, education and water' (Weaver 2007).

However, it is important to note that the Bank has a degree of independence. Much of the Bank's resources are raised independently of governments on the capital markets. The president, senior managers and its staff are also important in setting the Bank's agenda.

When the US appointed Paul Wolfowitz, a key neoconservative in the Bush administration and an architect of the war on Iraq, as president of the Bank in 2005, there was widespread protest both in diplomatic circles and by World Bank staff themselves. His appointment was felt to exemplify US government contempt for multilateral institutions. Once in post, he brought in a team of lieutenants who 'set about administering the Bank in a brutal and highly ideological way'. They showed 'undisguised contempt for senior managers' (Wade 2007), causing widespread dissatisfaction among staff. When he was finally caught up in a favouritism scandal, the lack of support from staff contributed to him eventually losing his job.

Since then, Robert Zoellick, a former US deputy secretary of state and lead trade representative, has become the Bank's latest president. NGO reactions were unfavourable. Zoellick has close ties to the private sector, coming immediately from a stint at US investment bank Goldman Sachs and previously serving on the advisory board of US energy giant Enron.

What is the Bank?

The structure of the World Bank, with its five arms, reflects its complex nature and multiple personalities. For its first few decades, the Bank mainly invested in large infrastructure projects which could generate high rates of return. It was believed that this kind of investment would drive economic growth and development. Finance for 'human capital' was seen as wasteful, or at least money which would not generate much visible return. It was only towards the end of the 1960s that investment in people's skills began to be understood as necessary for economic growth. Subsequently, the Bank's education programmes began to grow.

The idea of development also soon came to be seen as being more than about just generating wealth – fighting poverty mattered too. It was Bank president Robert McNamara who, in the 1970s, took the Bank into the

fields of poverty eradication, agriculture, social projects, as well as urban development and public administration (Vetterlein 2007). Over time, the Bank extended its activities to the health sector.

With the establishment and growth of the IDA, the Bank began to transform into a donor agency, offering grants or soft loans. In doing so, it transformed further, by developing in-house research and policy analysis capacity as an adjunct to its lending and grant-making activities. This aspect of the Bank's work was given explicit attention during the presidency of James Wolfensohn when he sought to identify the Bank as a 'knowledge bank' for the world.

The Bank is therefore an institution with many forms of power. It has the power to raise capital for development projects. It has the power to act as a donor. It has the power to generate knowledge and frame policy development. It is therefore important that this influence is used benevolently.

But many people believe that it has not been used benevolently or wisely. For some, the Bank has been a key player in driving forward the set of neoliberal policies known as the 'Washington Consensus' which has facilitated a form of capitalism that has increased disparities, deepened poverty and enriched multinationals.

Others are critical of an internal intellectual climate rooted in and dominated by an economic rationality that leads to unnecessarily narrow policy advice (Rao and Woodcock 2007). Weaver also notes how this climate pushes staff to adopt a blueprint approach rather than a country-by-country approach. While the Bank's rhetoric consists of 'putting countries in the driver's seat', reality may be closer to what some have styled the taxi-cab approach in which 'the country is in the driver's seat, but no-one is going anywhere until the Bank climbs in, gives the destination and pays the fare' (Pincus and Winters 2002, cited in Weaver and Park 2007).

A recent high-profile peer review of the World Bank's research output also noted the use of research 'to proselytize on behalf of Bank policy, often without taking a balanced view of the evidence, and without expressing appropriate scepticism. Internal research that was favourable to Bank positions was given great prominence, and unfavourable research ignored' (Banerjee et al. 2006). This dominance of particular, 'accepted' points of view is reinforced by a low tolerance of public dissent or criticism by staff. As Wade puts it: 'the Bank's legitimacy depends upon the authority of its views; like the Vatican, and for similar reasons, it cannot afford to admit fallibility' (Wade 1996, cited in Weaver 2007).

The Bank has come under tremendous criticism from many directions for a string of failures, especially related to its structural adjustment programmes (SAPs). The scandal and damage caused by Wolfowitz, coupled with the

fact that lending to middle-income countries from the IBRD is small and declining as a percentage of total flows to these nations, suggested at one point that the Bank's influence was diminishing. However, from another perspective the Bank is in good health: the IDA was recently pledged a record $41.6 billion for the period 2008 to 2011, 30 per cent more than in the prior three years. IFC investments have also been rising and totalled $8 billion in 2007.

The World Bank in health

History

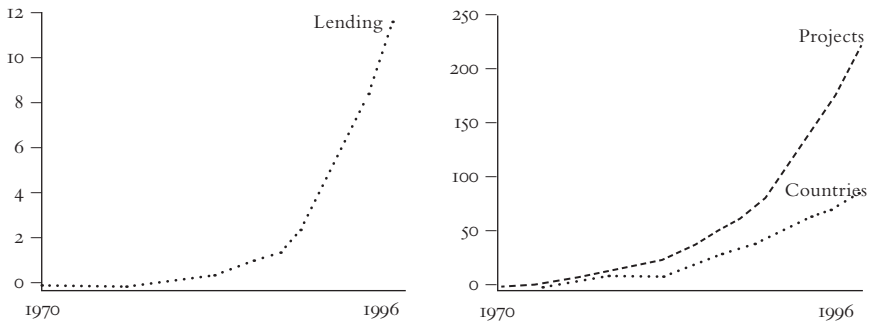
The Bank's first significant venture into the health sector was the Onchocerciasis Control Programme (regarded as one of its most successful initiatives). This was followed in 1975 by the formulation of a health policy paper which focused on basic care, the urban bias in health services and community workers. A key message that signalled a different perspective from the prevailing health policy discourse at the time was the Bank's interest in discouraging unnecessary health care and 'charging for services at their real cost' (Brunet-Jailly 1999).

But the Bank did not really invest in the health sector until a second health policy paper in 1980 set out guidelines for health-sector lending. Money would be funnelled towards 'basic health infrastructures, the training of community health workers and para-professional staff, the strengthening of logistics and the supply of essential drugs, maternal and child health care, improved family planning and disease control' (Brunet-Jailly 1999).

When the health systems of low-income countries were hit by the worldwide recession and debt crises of the late 1970s and 1980s, and at a time when its own SAPs were forcing cuts in public expenditure on health, Bank lending in the health sector grew enormously (Figure D1.5.1). This was partly the Bank following the general rise in international attention towards human development. In addition, it was reacting to the negative effects of structural adjustment. Health lending was a way of shoring up public budgets in the midst of economic crisis and adjustment (Brunet-Jailly 1999).

The World Bank soon became the world's leading external financier of health in low-income countries. With the World Health Organization (WHO) in decline, it also became prominent in developing international health policy and strategy. The 1993 *World Development Report*, *Investing in Health*, called for more funding for health, but linked this to a cost-effectiveness agenda and a call on governments to prioritise a 'basic package' of services. It argued that by focusing on a basic package of services,

FIGURE D1.5.1 **Cumulative growth in HNP lending and projects**
(1996 US$ billion)



Source: World Bank 1997.

governments could ensure that more public resources were spent on the poor and priority population health measures such as immunisation programmes. Other services could be purchased by patients through insurance and out-of-pocket payments. The report argued that public-sector provision could be deeply inefficient and rarely reached the poor. Governments were encouraged to boost the role of the private sector.

These ideas fitted the broader neoliberal orientation of the Bank. In contrast to the integrated, participatory and comprehensive vision of the primary health care (PHC) approach, the Bank's reforms limited the role of the public sector and encouraged the privatisation and segmentation of the health system. The multi-sectoral and public health emphasis of the PHC approach was replaced with an emphasis on technologies that were amenable to the cost-effectiveness analyses of the Bank's economists.

The expanding Bank portfolio and the criticism it was attracting led the Bank to publish a formal Health, Nutrition and Population (HNP) Strategy in 1997. Now the Bank argued against private financing of health care and promoted the need for risk-pooling, but continued to encourage the growth of the private sector's role in health-care provision.

At the turn of the century, calls began to be made on the Bank to step up its funding to combat the HIV crisis and other priority diseases. The Bank responded with the high-profile Multi-Country AIDS Programme. However, the programme has conflicted with its systems approach to health-sector policy, and been plagued by monitoring, evaluation and ownership weaknesses common in other parts of its work (See Box D.1.5.1).

BOX D1.5.1 **The Multi-Country AIDS Programme**

While adult HIV prevalence rates soared in the 1980s and 1990s, it took the World Bank's management until 1997 to acknowledge the severity of the crisis and 2000 before it began a robust funding effort to tackle it. In 1999, the Bank declared that the HIV crisis was Africa's main development challenge and committed itself to what it termed 'business unusual' by launching its Multi-Country AIDS Programme (MAP). It described MAP as 'unprecedented in design and flexibility' with emphasis on 'speed, scaling-up existing programmes, building capacity, "learning by doing", and continuous project rework'. It committed nearly US$1 billion to twenty-four countries to what was generally acknowledged as a bold and innovative approach to the pandemic (World Bank 2000).

Evaluations undertaken by the Bank's Operations Evaluation Department (OED) have shown that the Bank made substantial progress in persuading governments to increase political commitment to tackle HIV, improve the efficiency of national AIDS programmes, create and strengthen national AIDS institutions and build NGO capacity (World Bank 2005). However, these same evaluations also showed that a cluster of institutional weaknesses that severely reduced the relevance and effectiveness of the Bank's first generation of HIV interventions (1986–97) and efforts to tackle other priority diseases (World Bank 1999) continued into the new millennium and persist today.

These weakness seemed to have their roots in the fact that the Bank was an institution whose 'core business processes and incentives remained focused on lending money rather than achieving impact' (World Bank 1999). The interim review of MAP (World Bank 2001) found that although it was anticipated that the Bank would allocate 5–10 per cent of programme funds for monitoring and evaluation (M&E), it 'contributed almost no financial resources to provide M&E technical and implementation support to task teams and clients' (World Bank 2001).

In places like sub-Saharan Africa where there is 'a dearth of information at the country level and local levels on the epidemic' (World Bank 2005), the Bank resorted to blueprint models of programming, not tailored to local needs. OED found that the Bank needs to 'improve the local evidence base for decision-making and should create incentives to ensure that the design and management of country-level aids assistance is guided by relevant and timely locally produced evidence and rigorous analytical work' (World Bank 2005). A formulaic approach obviously undermines ownership, relevance and effectiveness.

Since 2000, the Bank's dominance in health has arguably shrunk. Its lending to the health sector has fallen by nearly one-third. Middle-income countries are borrowing less from the Bank to fund their health-sector investments. The number of staff working in the HNP sector has also fallen by 15 per cent from 243 to 206. And the arrival of new actors such as the Global Fund, GAVI and the Gates Foundation have crowded out some of the Bank's policy and programmatic space.

The shrinking health portfolio has not been matched by any increase in effectiveness. In fact, the implementation quality of HNP projects is now the lowest out of all nineteen sectors in the Bank (World Bank 2007). Monitoring and evaluation data on impact are 'scarcely available', despite the recognition of this problem in the 1997 strategy (World Bank 2007).

The Bank has become more sensitive to the charge that its policies have been harmful to the poor. The pro-poor rhetoric has strengthened and it has rowed back on its advocacy of user charges. But policy contradictions remain, particularly on the central issue of commercialisation. Influence from the US, as well as internal ideological predispositions, have meant that the financing and providing role of the private sector remains high on the agenda.

The new World Bank health strategy

The Bank's latest health-sector strategy was developed in 2007, and sets out to steer the Bank into five key areas (World Bank 2007).

1 *Renew Bank focus on results*

The lack of a 'results focus' was noted in the 1997 Health Sector Strategy and criticised in the 1999 OED evaluation of the Bank's activities. Donors have been putting pressure on the Bank to focus on results within IDA. Little appears to have improved.

As the new Strategy notes, monitoring and attributing blame or praise for outcomes are difficult in the health sector. All donors face dilemmas in how to report their impact. More demands for measurement of results, if pushed too far, can have adverse affects such as focusing only on what is visible, popular and measurable, while neglecting interventions that may be unfashionable or hard to measure such as strengthening public administration, improving management systems or enhancing health worker performance. Creating the social, economic and political changes needed for health reform is also a slow process not amenable to donor demands for swift change.

A results strategy can also damage the goal of putting countries in the driving seat. Too often, results are set by the donors, measured by the donors, and their success evaluated by the donors (Eyben 2006). Not only does this weaken government capacity and undermine autonomy and sovereignty in policymaking; it also does nothing to enhance the fragile links of accountability between governments and their people.

Whilst there is a clear need for a massive improvement in monitoring and evaluation, this should not be linked to blueprint approaches to aid disbursement and more conditions on client countries. Instead, the Bank should focus resources (as the Strategy suggests) on building up country-led health surveillance systems, to enable informed debate about health priorities and policies at the country level, which Bank funding should then respond to.

2 *Strengthen well-organised and sustainable health systems*

A strong feature of the Bank's Strategy is its claim to have a comparative advantage in health system strengthening (even though the Strategy noted that the Bank itself requires 'significant strengthening' in this area). The intention of the Bank is to establish itself as the lead global technical agency for health systems policy. This intention is exemplified by its earlier role in influencing the decision to close down the Global Fund's health system strengthening 'window', and in a comment in the 2007 Strategy which suggested that the WHO's comparative advantage was not in health systems but in technical aspects of disease control and health facility management.

When it comes to health systems policy in the 2007 Strategy, the attitude taken towards commercialisation and the public sector remains largely unchanged from previous positions. A notable bias remains, with the public sector frequently described as being inefficient and anti-poor, while the potential of the private sector to deliver health care to the poor is highlighted.

The Strategy notes that private providers 'deliver most ambulatory health services in most low-income countries' (World Bank 2007). This is true. However, the Strategy fails to say anything about the importance of the public sector in the provision of in-patient services. Hospital care is nothing like as commercialised as primary level care, with most in-patient services in low-income countries taking place in the public sector. In many countries, public-sector hospitals arguably place a floor under the lack of quality and high costs that patients, especially the poorest ones, face in market-driven systems (Mackintosh and Koivusalo 2005). The health-sector strategy could have addressed this reality and proposed more support to public hospitals in poor countries.

The Bank also shows how better-off groups in society tend to capture more of the benefits of public spending on health than poorer ones. While true, this again shows only part of the picture. Public spending may be unequally distributed, but it is generally not as unequally distributed as market incomes. In fact public spending on health frequently narrows these inequalities. Chu et al. (2004) show that in sub-Saharan Africa 'all thirty available studies find government health spending to be progressive' in that the poor benefit more relative to their private income or expenditure than the better-off. But building on these redistributive effects – maintained in desperately poor circumstances – is not, it appears, a priority for the Bank.

User fees are downplayed much more than in the Bank's past, but there is still an emphasis on strengthening demand-side interventions through financial incentives, to be mediated by insurance schemes of various sorts. There is little in the Strategy about strengthening public-sector management and service provision, encouraging non-financial incentives for health workers, or building effective public accountability and community empowerment mechanisms. In overall terms, the Strategy suggests a continued inclination towards pro-private, market-oriented policies and segmented health systems, with a public sector charged mainly with the responsibility for financing a basic package for the poor.

3 *Ensure synergy between health system strengthening and priority disease interventions*

Buried in the appendices of the HNP Strategy are two shocking figures: whilst aid devoted to HIV/AIDS more than doubled between 2000 and 2004, the share devoted to primary care dropped by almost half; at the same time only about 20 per cent of all health aid goes to support the government programme (as general budget or sector-specific support), whilst about half of health aid is off-budget (World Bank 2007).

The Bank acknowledges the problems caused by vertical disease programmes but maintains that health system strengthening can be achieved whilst concentrating new resources on priority diseases (World Bank 2007). But, as discussed in other chapters, the claims that this will be done lack the credibility that would come from a concrete description of how it will happen.

4 *Strengthen inter-sectoral action*

The Bank is an immense creature with many different parts. The potential for the Bank to join up different sectors to promote health is highlighted in the 2007 Strategy. However, the Bank itself admits that intersectorality is difficult to realise 'due to both Bank and client constraints' (World Bank

2007). Hall (2007) explains that one reason for this is that there are few incentives for cross-departmental collaboration within the Bank. In fact, 'a department's kudos is judged by the size of its own managed portfolio rather than by its participation in cross-sector collaboration.' This leads to competition over project ownership and under-recognition of cross-sectoral activities. This tendency is reinforced by the fact that staff promotion is based on project portfolio size and financial turnover, which creates further inter-departmental competition. The Strategy is silent on how these constraints will be overcome.

5 ***Increase selectivity and improve engagement with global partners on division of labour***

The HNP Strategy sensibly proposes a better division of labour to prevent duplication of effort and reduce the number of institutions to engage with. It suggests that the Bank should work with others that share its comparative advantages in 'health system finance, intersectorality, governance and demand-side interventions' (World Bank 2007), and also collaborate to develop policy and knowledge; it will increasingly concentrate its advocacy strength on health systems rather than global partnerships.

But the strategy paper goes further to implicitly marginalise the role of agencies such as the WHO and United Nations Children's Fund (UNICEF), which are already involved in health system policy at the global level. There is no systematic comparison of strengths and weaknesses between these agencies and the Bank, so there is some uncertainty as to why the Bank feels it has a comparative advantage.

Private-sector development, the IFC and health

As mentioned earlier, the IFC has grown in size recently. The health sector is not currently a prominent part of the IFC. Of its US$8.2 billion budget for 2007/08, health and education together accounted for 2 per cent (US$164 million) (Warner 2008). The recent independent evaluation of IFC projects noted that the health and education sector on average performed the worst of all the IFC's investments (World Bank IEG 2007). There are also no clear criteria for determining when and whether it is appropriate to support private-sector growth in the health sector. Nevertheless following an upbeat study of the Bank's potential role in private-sector development undertaken by McKinsey's and financed by the Bill and Melinda Gates Foundation, the IFC announced that it would coordinate some $1 billion in equity investments and loans to finance private-sector health provision in sub-Saharan Africa.

Conclusion

The World Bank remains an institution that promises much but that still delivers poorly. It remains unduly influenced by the rich countries of the world, and by the same economic orthodoxy that has largely failed the planet over the past few decades. Civil society organisations should call for:

- An independent panel to review the Bank's role in health and the comparative advantages of the Bank and the other leading global health institutions. This should include an assessment of the depth of these different organisations' accountability to developing countries. It is unclear how far an organisation with the skewed accountability of the World Bank should be involved in setting global health priorities and policy guidelines.
- Country-level debate about the Bank's vision of greater private-sector involvement in the health sector.
- More country-level analysis of the health impact of the World Bank's projects and policies.

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