About the World Bank

As of 2012, the World Bank is the second largest multilateral channel for global health funding (after the Global Fund to Fight AIDS, Tuberculosis and Malaria), with health sector commitments amounting to US$12 billion between 2009 and 2012.

The World Bank lending arms providing global health funding to governments are the International Bank for Reconstruction and Development (IBRD), and the International Development Association (IDA). They are usually referred to collectively as the World Bank (the Bank). In addition, the World Bank’s International Finance Corporation (IFC) provides financing to stimulate private sector investment in developing countries (IFC activities are not covered in this profile). IBRD and IDA share the same staff, governance structure, management, and headquarters (Box 1).

The World Bank’s main objective in the health sector is to improve the health conditions of poor and vulnerable people as part of its overall goal of poverty alleviation. The Bank has been a prominent financier of global health since the late 1980s. However, the Bank’s share of global development assistance for health dropped from about 19% in 1997 to an estimated 8% in 2012, as new multilateral and bilateral initiatives started investing substantial amounts in global health, mostly targeting communicable diseases (see Financing Portfolio for further information).

In response to the changed global health architecture and to developing countries relying less on World Bank financing for global health investments, the Bank refocused its strategic approach to global health in 2007. The World Bank Strategy for the health, nutrition, and population (HNP) sectors sets out a focus on health systems strengthening (HSS), health financing, and economics. This focus enables recipient countries to make effective use of funding provided by other donors who focus on ‘vertical’ interventions and technical aspects of disease control.

In addition to providing funding in the form of loans and grants, the Bank also provides macroeconomic and financial analysis and advice on health spending, health systems constraints, and access to quality health service delivery.

The World Bank’s key department for providing health-related technical advice and strategic input is the HNP department. The department does not direct HNP funding and Bank funding is not earmarked a priori for health or intervention areas within health (unless provided through trust funds). While the HNP strategy sets out focus areas of global health engagement and defines implementation steps, baselines, targets, and timelines, financing flows to specific sectors ultimately depend upon demand from client countries for such funding.

While this demand-driven approach ensures that Bank-financed programs are part of the partner country’s priorities, it has also presented challenges. The share of financial flows targeted at HNP has not increased since the 2007 release of the HNP strategy but has continued at an average 6% of all spending. Funding targeted at HSS, however, did increase from 29% to 58% of total HNP spending following the release of the HNP strategy, which explicitly called for increased Bank contributions to this sub-sector.

BOX 1. Two World Bank lending arms provide global health funding to partner country governments

**International Bank for Reconstruction and Development (IBRD)**
- Provides low-interest loans and guarantees to middle-income and creditworthy poorer countries
- Aims to promote sustainable development
- Financing does not meet the criteria for official development assistance (ODA)
- Often referred to as the World Bank’s “hard” lending window as its loans are non-concessional (i.e., they are based on market rates)

**International Development Association (IDA)**
- Provides concessional financing in the form of interest-free or low-interest loans (“credits”) as well as grants to the world’s poorest countries
- Aims to promote economic growth, reduce inequalities, and improve people’s living conditions
- IDA financing is eligible to be reported as ODA as it meets the criterion of being concessional in character (i.e., below market interest rates)
Resource Mobilization

The IBRD and the IDA raise their financial resources through separate mechanisms.

IBRD funds stem from bonds issued on international financial markets backed by the member countries’ subscribed capital. IBRD borrows on the financial market according to the funding amounts required for its lending activities. To increase its lending capacity, World Bank shareholders approved a general capital increase in 2010 – for the first time in 22 years – raising IBRD’s capital by US$86 billion.

IDA’s financing resources are replenished every three years. At the replenishment meetings, donor governments and representatives from borrowing countries decide on the volume of resources and discuss IDA’s policies and priorities. The most recent replenishment (IDA16) covers the period from July 2011 to June 2014. Of the total US$49.3 billion raised, 64% (US$31.7 billion) is made up of donor contributions, including US$5.3 billion in contributions for debt forgiveness (Figure 1). The remainder comes from transfers of surplus funds from IBRD and the IFC (6% or US$3 billion) and from borrowers’ repayments of loans received (30% or US$14.6 billion).

While donor contributions to IDA also stem from developing countries, the vast share of IDA financing is contributed by high-income countries, with the G7 countries as the largest group of contributors. The G7 group is responsible for 68% of donor contributions to the IDA16 replenishment (Figure 2) compared to 70% at IDA 15 and 72% at IDA 14.

World Bank Trust Funds

In addition to regular resources, the Bank finances health interventions through a range of donor trust funds for global health. The largest trust fund in the Bank’s current HNP portfolio is the Health Results Innovation Trust Fund (HRITF). The HRITF is a multi-donor fund established for the timeframe 2007–2022 to support results-based financing approaches in the health sector, with a particular focus on MDG 4 (reducing child mortality) and MDG 5 (improving maternal health). The trust fund is financed by Norway and the UK at a total of US$575 million.
Another example is the Health, Population and Nutrition Sector Development Programme, a multi donor trust fund established to co-finance the Bangladeshi government’s HNP programs. Four donors (Australia, the UK, Sweden and the US) are contributing a total of US$280 million over a five year period. Germany, the Netherlands, and Canada have also announced that they will contribute to the program.

Financing Portfolio

The World Bank classifies countries into three groups according to their per capita gross national income (GNI). These income categories (low, middle, high) are widely used by other international institutions and governments.

Eligibility for IBRD and IDA financing depends on a country’s income group and its credit worthiness. Only creditworthy countries can access IBRD funding. IDA only supports countries with a GNI per capita below a certain income threshold (currently US$1,195 per capita). “Blend countries,” such as India and Pakistan, are creditworthy countries that can borrow from the IBRD and that are also eligible for IDA funding based on their GNI.

IDA provides part of its financing as grants. Grant eligibility is limited to countries with accumulated debt and the subsequent risk of debt distress. Critics argue that such eligibility criteria create perverse incentives as countries that accumulate more debt will be eligible to receive grants.

Between fiscal year (FY) 2006 and FY2012, grants made up an average of 19% of total IDA funding. Except for FY2008, when the share of grants peaked at 30%, the share ranged between 15% and 19% of total IDA funding. In FY2012 the share of grants fell to 15%, which is the lowest observed in the seven-year timeframe (Figure 3).

In FY2012, 6% of total World Bank commitments (US$2.0 billion) went to HNP. HNP funding more than doubled in absolute terms between FY2006–FY2008 and FY2009–2011, from an annual average of US$1.3 billion to an annual average of US$3.3 billion. In FY2012, there was a sharp fall in IDA and IBRD commitments, in the number of projects targeting HNP, and in the relative share of IDA funding to health (see Figures 4 and 5).
Figure 6
HNP commitments by theme, FY2002–FY2012
(US$ millions – current prices, and as percentage of total HNP commitments)

Source: New HNP thematic lending by theme and region; data as of September 2012

Funding commitments to HNP reached an all-time high of US$4.2 billion in FY2010, which is largely explained by a substantial increase in IBRD funding. The global financial crisis made it difficult for many countries, especially middle-income countries, to access capital markets, which in turn made these countries rely more heavily on IBRD borrowing. Both IDA and IBRD funding levels for HNP appear to be returning to pre-crisis levels. The high funding levels for HNP between FY2009 and 2011 were thus most likely caused by the financial crisis rather than by the launch of the 2007 HNP strategy.

While the trends in overall funding levels do not necessarily reflect an increased World Bank focus on HNP (Figure 4), HNP commitments over the last decade show an increased emphasis on health systems strengthening (HSS), which is in accordance with the 2007 HNP strategy. The first HNP strategy, in 1997, did emphasize HSS, although less strongly than the 2007 HNP strategy. Since FY2008, HSS commitments have been responsible for an
average of 58% of total HNP commitments by the IDA and IBRD, reaching an all-time high of 73% in FY2010. In comparison, HSS commitments averaged just 29% of total HNP commitments between FY2002 and FY2007.

The share of funding for population and reproductive health, on the other hand, has decreased since the launch of the 2007 HNP strategy, from an average of 12% of total HNP commitments in FY2002–2007 to an average of 7% in FY2008–2012. In all four years between FY2008–2011, the annual average share of funding for population and reproductive health was below 12% (i.e., below the pre-2007 average), although it did rise to 17% in FY2012 (Figure 6).

Funding for disease-specific programs targeting HIV/AIDS, malaria, and tuberculosis has fallen since the 2007 strategy was launched, which is partly a response to the maturing role of the Global Fund to Fight AIDS, Tuberculosis and Malaria in financing control of these three diseases. Between FY2002 and 2007, average annual funding for such programs made up 19% of total HNP commitments, but from FY2008–2012 it made up just 9% of total HNP commitments. In FY12, programs targeting HIV/AIDS, malaria, and tuberculosis received less than 2% of all thematic HNP funding (Figure 7).

As in recent years, HNP funding committed by IDA in 2012 had a regional focus on Sub-Saharan Africa and South Asia. The single largest recipient in FY2011 was India, followed by Nigeria and Tanzania (Figure 8).

IBRD funding for HNP in 2012 went largely to Europe and Central Asia (58%), followed by Latin America and the Caribbean (28%). Romania and Colombia were the largest recipients, accounting for 58% of all IBRD funding committed to HNP sectors in 2012 (Figure 9).
Organizational Structures and Governance

The World Bank’s shareholders are its member states, represented in the Board of Governors, the World Bank’s highest decision-making body. Meetings take place annually.

The body that decides on operational policy and approves financing activities is the Board of Directors, which has 25 members representing all member countries either individually or in constituencies, based on each country’s share of subscribed capital. The share also defines a country’s voting powers. The five largest shareholders—the United States, Japan, Germany, France, and the United Kingdom—each appoint one Executive Director. China, the Russian Federation and Saudi Arabia hold “single constituency” seats. The remaining countries are organized in 17 constituencies.

The President of the World Bank, currently Dr. Jim Yong Kim, is responsible for overall management of the institution and is elected by the Board of Governors.

With over 10,000 employees based in the Washington D.C. headquarters and in 124 country offices, the Bank has a global reach.

The Bank is a matrix organization structured into six regional units and five thematic network units (Box 2).

The World Bank’s HNP department provides strategic input and expertise for activities targeting global health. The department is part of the Bank’s broader human development network, which also includes World Bank activities in fields such as education, social protection, and labor. HNP was created in 1979 when the Bank first started direct lending activities in the health sector.
The Bank’s HNP staff comprises about 220 staff members, of which 160 work in country and regional offices and 60 in the HNP sector department. These staff members work in close cooperation with the Bank’s in-country teams and with Country Management Units (CMUs) to ensure that the Bank’s activities are country-focused and that multi-sectoral effects contribute to health outcomes.

**Allocation System**

IBRD and IDA lending activities are approved by management and ultimately by the Board. While CAS include an indicative business plan for each country, funding levels and areas of intervention are not binding to either the Bank or recipient countries. Funding amounts for individual countries are limited. The limit is set through allocation systems that differ between the two agencies:

- **IBRD’s loans** to countries are capped either by the Equitable Access Limit, which refers to 10% of IBRD’s subscribed capital, or the Single Borrower Limit, which depends on a country’s overall portfolio risk. The latter is determined annually by the Board of Directors. For FY2012, the Single Borrower Limit was set at US$17.5 billion (for India) and the Equitable Access Limit, as of June 2011, was US$22 billion.

- **IDA funds** – as provided through the replenishment process – tend to be well below the amounts needed and requested by IDA-eligible countries. IDA thus allocates available resources through a Performance-Based Allocation (PBA) system while also taking into account country needs through population size and GNI per capita. Allocation criteria are reviewed regularly. In addition, a range of exceptional measures define each country’s final IDA funding allocation. These measures ensure that the allocations reflect the needs of three groups of countries: (a) fragile and conflict-affected states, (b) small states, and (c) countries that had been disengaged from IDA for a long period of time. At the same time, allocations are capped for countries with large populations and for “blend countries” (those eligible for both IDA and IBRD borrowing).
Results

IBRD and IDA measure results of their financing activities at project, country, and global level. CAS are the main vehicle to assess outcomes at country and regional level as they include results frameworks to monitor Bank and client country performance. Since July 2009, the Bank has also measured Core Sector Indicators in the form of standardized data from projects in seven sectors, including health.

More recently, in addition to the Health Results Innovation Trust Fund, the World Bank has introduced further instruments to promote Results-Based Financing for health mechanisms, including a Program-for-Results (PforR) instrument in January 2012. For the initial 12 months of the PforR, two health projects worth more than US$337 million are in the World Bank pipeline. One project targets the achievement of the Health MDGs in Ethiopia and the other aims at health sector reform in Romania.

In addition, since 2011, the Bank has produced an annual electronic Corporate Scorecard, with a 4-tier structure, which assesses:

• overall development progress in Bank client countries as a group (Tier I),
• Bank support to countries in achieving results (Tier II), and
• overall performance of the Bank’s agencies in terms of operational and organizational effectiveness (Tiers III & IV).

The health-related tier II indicators of the latest scorecard, released in September 2012, found that the bank-supported programs in FY2012 had contributed to immunizing 128 million children and to providing 19.5 million people with access to basic packages of health services.

These monitoring exercises are complemented by evaluations led by the Bank’s Independent Evaluation Group (IEG). In 2009, the IEG undertook an evaluation of the World Bank Group’s support in HNP between 1997 and 2008. The evaluation found that only around two-thirds of the World Bank’s HNP lending had produced satisfactory outcomes and that this proportion had remained constant over the course of the review period. In contrast, 79% of projects in other sectors had produced satisfactory outcomes and the proportion had increased between 1997 and 2008 by 10%. Projects targeting HIV/AIDS fared particularly poorly, with only 18% generating satisfactory outcomes. In African countries, only a quarter of the HNP projects had satisfactory outcomes.

The IEG further found that the World Bank’s support for HSS was unsatisfactory: in middle-income countries, only 71% of HSS projects had satisfactory outcomes, compared with 86% of HNP projects with other objectives. While HSS requires a strong cross-sectoral focus, the IEG’s evaluation also reinforced the results of an earlier study that concluded that the Bank should more effectively link health sector strengthening to broader in-country macroeconomic and budgetary issues. As part of the evaluation, the IEG reviewed the Bank’s 137 CAS (the main vehicle for achieving multi-sectoral synergies at country level). Although the Bank itself claims to have a comparative advantage in cross-sectoral work, the IEG review found that hardly any of these CAS proposed any HNP targets or common management arrangements to ensure that interventions from other sectors help to achieve health outcomes.

The evaluation included a detailed list of recommended actions to respond to the findings. These recommendations have been largely endorsed by the Bank management. They include:

• intensifying efforts to improve the performance of HNP support through adapting project design to country context and capacity;
• renewing the Bank’s commitment to HNP outcomes among poor people;
• strengthening the Bank’s ability to assist countries in improving the efficiency of their health systems; and
• implementing a results agenda and delivering incentives for evaluation.

To address the weaknesses identified in the IEG’s evaluation, all HNP projects under preparation now receive quality enhancement inputs from Quality Enhancement Reviews, a new tool introduced to the project results framework by the 2007 HNP strategy, focusing on institutional and risk assessments, M&E, and technical quality.

Progress has been made since the 2009 evaluation. In its 2012 annual report on Results and Performance of the World Bank Group, the IEG compared investment projects closing in FY06–08 with projects closing in FY09–11. It found that HNP, together with education, was the only area in which the share of development outcomes that were rated moderately satisfactory or higher had increased. The report also found that Bank supervision for HNP projects had improved significantly and proposed closer examination for the underlying reasons.
Outlook

For the period up to 2027, IDA will likely face dramatic changes in its client base as more than 50% of all IDA eligible countries will graduate (i.e., their GNI per capita will increase to a level that makes them lose their IDA eligibility). The remaining countries will nearly all be in sub-Saharan Africa and will mostly be fragile or post-conflict states. IDA will have to adapt its business model to this changed environment and to the challenges that the smaller group of client countries will face.

Since May 2012, the World Bank’s presidency has been held by Dr. Jim Yong Kim, a medical doctor and global health expert who co-founded the non-governmental organization Partners in Health and who served as the director of the WHO’s HIV/AIDS department from 2004 to 2006. At the September 2012 Every Woman Every Child event in New York City, which coincided with the 67th United Nation General Assembly, President Kim announced the establishment of a new World Bank funding mechanism aimed at leveraging IDA funding and enabling donors to increase funding flows for maternal and child health (MDGs 4 and 5). This new mechanism aims to provide additional funding for projects targeting MDGs 4 and 5 and to incentivize the Bank’s client countries to increasingly demand funding for maternal and child health services.

The Bank has yet to define the details of this mechanism, including the funding arrangements and eligibility criteria. To finance this initiative, IDA management proposed attracting additional IDA donor contributions and reallocating US$253 million in unused funds within IDA.

This proposal was discussed in November 2012 when IDA stakeholders gathered for the IDA 16 mid-term review meeting. While no final decision was taken at the meeting, participants expressed concerns about reallocating funds to MDGs 4 and 5 as IDA’s country demand-driven model generally excludes the earmarking of funding for specific purposes. Stakeholders called on IDA’s management to further analyze its proposal and to present options for final decision at the first IDA17 replenishment meeting in 2013. At the replenishment meeting, IDA stakeholders will begin talks on priorities for the period starting in mid-2014 and will review IDA’s graduation policy.

Funding and Authorship

This profile was funded through a general operating support grant from the Bill & Melinda Gates Foundation to the Global Health Group at UCSF, with a subcontract to SEEK Development. The Foundation played no role in writing the profile. The profile was written by authors at SEEK Development (Emil Richter, Marco Schäferhoff, and Christina Schrade), and E2Pi at the UCSF Global Health Group (Gavin Yamey). For information on authors’ competing interests, see www.e2pi.org (click on Smarter Aid section).