

Neoliberalism and the World Bank's Changing Approach to Health

Greater involvement by the Bank in the health sector is justified for several reasons. First, the Bank's expertise in country programming and in sector analysis is needed to help ensure the success of emerging national policies to expand the coverage of health care... Second, significant involvement in the health sector is an important element of the Bank's concern for alleviating poverty in the developing countries. An expanded policy for health operations is essential to deal effectively with the problems of poverty and low productivity among the poor.

—World Bank Health Sector Policy Paper 1980: 63–64, which formally committed the World Bank to lending in the health sector

As far back as 1980, the World Bank viewed itself as an expert in global health. The Bank viewed its work with developing countries in health falling squarely under its missions of poverty reduction and economic development, as demonstrated in this chapter's opening quote. Understanding the World Bank's evolving approach to health is central to unpacking the changing shape of neoliberalism in health sector reform. In this chapter, I examine the World Bank's changing approach to health since the 1980s. I argue that the World Bank is concerned with the overarching goals of both efficiency—doing the same or more work with fewer or the same resources—and equity—increased equality in access and outcomes in health. These goals are often discussed in tandem, though common understandings suggest that while not mutually exclusive, the pursuit of one may diminish the other. The policy

instruments promoted by the World Bank, and detailed in Chap. 1, are decentralization, separation of functions, performance-based management, privatization and private sector investment, a primary health care approach, and targeting. Each of these instruments may serve the goals of equity, efficiency, or both, but have traditionally, with the exception of a primary health care approach, been viewed as neoliberal and working in the service of efficiency more than equity. While the case-study Chaps. 4–6 demonstrate that the World Bank’s approach is variable across countries, it remains useful to examine the World Bank’s overall and changing approach to health. In this chapter, I provide a comprehensive discussion of World Bank operations and discourse surrounding health since 1980.

To accomplish this goal, I trace the World Bank’s evolving approach to health, drawing from archival policy documents and interviews. Since the 1980s the World Bank has been discussing universal coverage in health however, its projects often focused on market approaches (i.e. private sector involvement in insurance markets) and a diminished, provisory, and advisory role of the state in health (i.e., targeted programs for the poor). Over time, however, its emphasis has shifted in two ways: first, in providing systemic, organizational support and recommendations both via its research and lending instruments rather than focusing only on standalone (as compared to system-wide) projects, and second, to emphasizing sometimes neoliberal means but increasingly embracing in practice its declared but neglected mission of increased access to health especially for the poor, even if it emphasizes neoliberal tools to achieve this task. The World Bank’s 1980 health policy paper, quoted at the beginning of this chapter, which commits it to lending in health notes that “countries should be willing to devise a strategy for providing access to basic health services to all citizens over a reasonable period of time. Development of health planning capacity and of a long-term plan for the health sector will be encouraged” (65). From its earliest commitment to direct lending to the health sector in developing countries, the World Bank has been concerned with not only increased access but also expanded coverage. However, it has strayed from this mission over the years, often working in a piecemeal way on disparate projects without concerted attention towards increased access. More recently, however, it has circled back to its commitment to universal health care with research, publications, and official policy statements.

BANKING IN HEALTH: THE 1975 HEALTH SECTOR POLICY PAPER

In 1975, the World Bank published its first policy statement linking health conditions and economic development with its *Health Sector Policy Paper* (Bank 1975; Coburn et al. 2015). This paper pointed to inequalities both between and within countries and discussed two options for the World Bank's involvement in health: begin lending separately for basic health services or incorporate health into its existing forms of lending. The World Bank chose to incorporate health into its existing projects, namely population projects, partly because of concerns with foreign governments' cooperation and ability to institute health reforms and infrastructure. The World Bank points to borrowing countries' weak health systems and cites the channeling of limited resources to hospitals and highly trained personnel, concentrated in urban areas, as an impediment to large-scale health reform and as obstacles to governments' implementing health reforms. Specifically, it notes that "effective political commitment to health care for the bulk of the population poses considerable problems for many governments" (60) and suggests that states are sometimes unwilling to consider significant reforms and that their health priorities "are inconsistent with equitable health programming approaches" (60). Interestingly, the report also raises questions about whether and how the World Bank should and could be involved in health sectors in developing countries.

The World Bank was hesitant to become involved in health because of its limited experience in this field, as well as the possible adverse effects on economic growth and poverty alleviation. The report states: "Paradoxically, health improvements may pose a threat to well-being if the net effect is to increase the rate of population growth significantly" (28). By reducing mortality and increasing fecundity, better health interventions may result in increasing populations and undermine economic growth, presumably due to a larger dependent population and strain on existing infrastructure. The World Bank further demurs from implementing large-scale health projects, partly because "the Bank would have to finance a very large share of the growth in total national government expenditure on health" (61). In the end, it was hesitant to invest in health because of the large amount of capital that would be necessary to support such a project portfolio across low- and middle-income nations. One of the primary reasons the Bank was hesitant to get involved in

health was because it viewed investment in health as squarely in the public domain, and the purview of governments. In retrospect, this approach seems somewhat ironic given its emphasis on privatization in health reforms among borrower countries in subsequent years.

In this early period, the Bank sought to support than supplant public health investments. The World Bank would re-orient member government spending in health and emphasize the need for it to target the poor. Interestingly, in the first public policy statement on health, the World Bank rejects private market involvement in the sector, stating: “[t]he private market cannot be expected to allocate to health either the amount of the composition of resources that is best from a social perspective” (29).

The preference for government-led investments in health was justified in two ways: first, because “consumers of health services” are unable to choose rationally (i.e. the World Bank points to the consumer’s lack of experience as a patient and the complexity of medical problems preventing the patient from necessarily choosing the best medication, medical course of action, etc.) and second, due to positive externalities generated by health interventions (i.e., preventing the spread of infectious diseases have benefits for communities and the broader population and should therefore not be left only to patients acting in their own individual interest). Therefore, because of these issues of information asymmetry and the related principal-agent problem (whereby doctors make decisions that impact the patient), and owing to externalities the World Bank supports public interventions in health. Importantly, though the Bank’s stance is for government involvement it still follows an economic logic: governments should subsidize care for the poor and principles of cost-effectiveness should guide decisions about which interventions to pursue (e.g., the decision on how to treat cholera should consider cost of immunizations as compared with sanitation measures at reducing the rates of cholera, 31).

During this time period the World Bank’s increasing involvement in health is a proposed collaboration with the WHO. The report notes that while the WHO has technical expertise, it has limited strength in conducting economic analyses and does not finance large capital expenditures. As such, the World Bank viewed the WHO as a complementary agency and collaboration as mutually beneficial. Despite these arguments for the World Bank’s increased involvement in health, the 1975 report ultimately favors the option of including health components and considering health effects in existing projects rather than pursuing direct

lending in health but leaves open the option of direct lending in health for the future.

WORLD BANK DIRECT LENDING IN HEALTH: 1980 HEALTH POLICY PAPER

The World Bank changed its official policy with the publication of its 1980 *Health Policy Paper*, moving away from considering health in existing projects to supporting stand-alone health investments. In this report, health is treated as a basic need as well as a means to economic development, citing a shift “in the emphasis of development from economic growth to meeting basic needs” (30). The economic costs of ill health include lost labor productivity, wasting resources (namely nutrients consumed by diseases), possible limits on exports and tourism because of fear of disease, inability to utilize resource-rich land (due to the presence of diseases that cannot be eradicated in these areas), and possible effects of human diseases on animals. This paper echoes the sentiments of the 1975 report (and indeed incorporates revised portions of that paper), noting that the private market cannot effectively provide health. Notably, this report criticizes low government expenditures in health in developing countries, noting that private health expenditure outpaces public spending. However, the report notes that not only are government commitments to health low, even these scarce resources are utilized inefficiently, focusing on hospitals and failing to provide coverage to large swathes of the population.

This report also reinforces and sets the stage for establishing more partnerships with other multilateral organizations (i.e., WHO, UNICEF, UNDP) working in health including bilateral agencies. The report notes that while the WHO in particular has expertise in health management it has “little experience, compared with the Bank, in identification, appraisal, or supervision of health care programs” and points to the WHO’s “modest financial resources” (Bank 1980). In all, the World Bank seeks to “complement the activities of the WHO” (66) and reasserts a focus on family planning (as part of a primary health care strategy) because of the relationship between health and population. In this report, the World Bank sets itself up as an important, if not the most important, player in global health, willing to work cooperatively but bringing unique resources, both financial and institutional, to this arena.

The focus as outlined in this report is squarely on primary health care and assisting countries in their planning capacity.

DEBT CRISIS AND STRUCTURAL ADJUSTMENT: WORLD BANK INTERVENTIONS

The debt crisis of the 1980s and beyond, resulting in what some have called the “lost decade” in Latin America, rendered many developing countries unable to pay their foreign debts in the face of rising oil and other commodity prices and plagued by hyperinflation. The World Bank, along with the IMF, responded by rescheduling loan payments and providing borrowing nations with a new lending instrument: structural adjustment loans. These structural adjustment loans were intended to assist countries in their resolving balance-of-payment issues by requiring a borrowing nation to implement macro-economic policy reforms. The reforms included export promotion, reduction in state expenditures and sizes, and privatization (Coburn et al. 2015; Bryant and Bailey 1997). Importantly, these were originally seen as a short-term solution: “Adjustment lending was originally expected to be a short-lived diversion from the Bank’s central mission, the promotion of economic and social development through well-designed investment activities” (Chhibber et al. 1991). However, they became a staple of World Bank lending and operations in the 1980s and 1990s, and among the most heavily criticized aspect of the Bank’s work.

Structural adjustment loans and programs were somewhat successful in stimulating economic growth which allowed, among other things, the generation of funds for debt repayment. Debt repayment and economic growth and stability have, since their founding, been central concerns of both the Bank and in particular the IMF. In the quest for economic growth, however, social development and outcomes were sometimes compromised. Empirically, structural adjustment programs have been shown to adversely affect health outcomes, at least in Africa (McMichael 2016; Coburn et al. 2015). As my analysis in Chap. 3 demonstrates, World Bank conditions on loans do not appear to be significantly related to health expenditures in Latin America, calling into question the effect of structural adjustment policies on health expenditures, if not all public expenditures. Nonetheless, the World Bank received fierce criticism for its structural adjustment lending due to mounting evidence that

structural adjustment programs have a negative impact on health outcomes. This research has largely been limited to maternal and infant health outcomes in Sub-Saharan Africa (Shandra et al. 2004, 2010, 2011, 2012; Coburn et al. 2015) which may account for a lack of effect on health expenditures that I find in Chap. 3, nor does my analysis focus exclusively on structural adjustment loans. Importantly, while this research on Sub-Saharan African suggests a negative effect of structural adjustment loans on health outcomes, this same research also suggests that health loans more generally (as compared with structural adjustment loans) have a positive effect on health outcomes including child and maternal mortality rates. However, the negative outcomes of adjustment programs observed during the 1980s led to fierce criticism of the Bank, and in particular its work in health.

STRUCTURAL ADJUSTMENT “WITH A HUMAN FACE”? THE SOCIAL DIMENSIONS OF ADJUSTMENT

The World Bank itself admits that structural adjustments require tough decisions, and may have an adverse effect on safety nets in the short-term. However, it argues they are required for growth and development in the long-term. Others have been more critical. A 1987 report by the United Nations Children’s Fund (UNICEF) criticized the World Bank’s adjustment policies, noting that they had hampered the expansion and maintenance of not only health, but also education, sanitation, and housing, rendering children especially vulnerable (Cornia et al. 1987). The report led to increased scrutiny and pressure on the World Bank. The World Bank’s response to this report was initially dismissive of such concerns noting that such short-term “growing pains” were necessary to ensure economic growth in the long-term (Coburn et al. 2015). However, the Bank redoubled its efforts in health investment shortly thereafter. In particular, its investments sought to build hospitals and clinics, immunize the population, and train medical personnel (Peet 2003; Fair 2008). However, the focus on systemic reforms in the sector remained and, perhaps, intensified. Fair (2008: 9) notes: “Whereas in the early 1980s less than one-fifth of health projects included explicit reforms or systematic objectives, this number quickly multiplied to approximately one-third of all health projects in the late 1980s and continued to grow to nearly one half of all health projects by the late 1990s.” In direct

response to the effects of structural adjustment loans, during this time period, the World Bank also concerned itself with the “social dimensions of adjustment,” supporting small-scale projects to offset the negative social effects of adjustment projects (Jayarajah et al. 1996). In doing so, the World Bank argued that “[s]ocial safety net provisions, intended to enable beneficiaries to meet their immediate basic needs, are income transfers received by individuals in addition to what might be expected from economic growth channels or general (untargeted) expenditures for human resource development” (104). Safety nets were appropriate, according to the Bank, for two groups of people: those rendered “vulnerable” by structural adjustment and those already living in poverty prior to adjustment. The World Bank has supported some “government-sponsored safety net programs” since 1987 (133). Later, however, the Bank moved away from this approach with the rise of antiwelfarism (a broader political current evident with the Thatcher and Raegan administrations, and subsequent state approaches inspired by them) towards empowering the poor via market integration, rather than focusing on social and public provision of assistance (Hutchful 1994). This approach, while it has been tempered, is evident to this day in the World Bank’s discourse: an emphasis on incorporating the poor into decision-making and program processes as active agents, rather than as recipients of benefits. On the one hand, such efforts at enhancing agency among the poor are commendable, in practice, however, this often means burdening them with additional responsibility and limiting their access to basic needs in a timely manner—a goal more easily achieved via the safety net approach.

Addressing the social dimensions of adjustment, according to the World Bank, involved strengthening national data and information systems (also described in Chaps. 4–6 in projects in Argentina, Peru, and Costa Rica as facilitating targeting in identifying poor and needy populations) and via training and institutional capacity building, to allow social dimensions to be integrated into government policy plans. In 1987, the World Bank underwent internal reorganization, where two new objectives were introduced: improving health financing in terms of efficiency and equity and engaging in the systemic reform of health systems. These reforms sought to address the social and institutional barriers to health care, and engage the poor. The Bank’s reformed approach was centrally concerned with equity, in a way that it had not been previously, however, it continued to rely on policy prescriptions considered neoliberal

including targeting (typically means-tested), decentralization, and following an economic, quantitative logic. In particular, World Bank personnel developed a wealth index, which measured household wealth using assets rather than income or consumption. While this time period saw increased and increasingly careful attention to health by the World Bank, these projects were overall rated less positively than projects in other (non-health) sectors (Fair 2008) and were often smaller-scale and limited in scope. Altogether, many of these projects appeared to be providing band-aid solutions to systemic issues brought on by structural adjustment. By the early 1990s, therefore, the World Bank had undergone several shifts in its approach to health, grappling with incorporating health into larger, multi-sectoral projects and addressing it in standalone efforts, against the backdrop of structural adjustment loans.

THE 1993 WORLD DEVELOPMENT REPORT: INDIVIDUALISM, HUMAN CAPITAL, AND DALYS

It is hard to overstate the importance of the 1993 World Development Report (WDR) for cementing the World Bank's global leadership in health. It crystallized what may now be considered the neoliberal "turn" in health—economic analyses, a baseline service package, a focus on individualism in health, and circumscribing government's role in the sector—in a single, widely disseminated report. In particular, the World Bank identifies strategies by which governments could improve health systems and health outcomes. It takes as its primary unit of analysis households and individuals and suggests competition in the health services market to improve equity and efficiency in the distribution of resources, particularly public expenditures. Therefore, while there is still room for public action in health (owing to externalities), there is a clear focus on health systems and competition from private providers.

The report argues that health matters not only for well-being as an end in itself, but can be justified on "purely economic grounds" (Bank 1993) as it prevents worker illness, allows better use of natural resources and land, increases the enrolment of children in school, and frees alternative resources that would otherwise be spent on treating illnesses. This reasoning echoes the cost of ill-health identified in the 1980 World Bank Policy Paper, but instead of enumerating the cost of disease, reframes them (slightly altered) as benefits for investments in health.

The report continues by noting that the gains are relatively larger for the poor. The role of government as described in the WDR is twofold: provider but only of essential clinical services, and promoter and regulator of greater diversity and competition in the financing and delivery of health services (iii).

Of particular note, however, the World Bank calls for private sector involvement as a cornerstone for improving health: "Government regulation can strengthen private insurance markets by improving incentives for wide coverage and for cost control. Even for publicly financed clinical services, governments can encourage competition and private sector involvement in service supply and can help improve the efficiency of the private sector by generating and disseminating key information" (iii). This entails a preference for insurance schemes rather than single-payer public provision and often involved the utilization of user-fees and the incorporation of NGOs as service providers. The report reads: "Public finance of essential clinical care is thus justified to alleviate poverty. Such public funding can take several forms: subsidies to private providers and NGOs that serve the poor; vouchers that the poor can take to a provider of their choice; and free or below-cost delivery of public services to the poor." (5). Importantly, however, the report does not ignore the problems associated with unregulated private markets: escalating costs for clients because of the "moral hazard" of insurance (i.e., insurance reduces the incentives for individuals to avoid risk and expense) and the issue of asymmetrical information (i.e., health providers income depends on advice given, perhaps leading to excessive treatment given patients' lesser information) and the presence of externalities meaning that private markets provide less than optimal levels of public goods. However, the report also notes that private providers are sometimes more technically efficient and offer higher quality service. The role of government appears to be primarily of regulation of a more efficient, but flawed, private, competitive market in health, and only secondarily of public financing (including subsidies and subcontracting) of health.

Despite the limited role of public financing of health in the 1993 WDR the issue of how to allocate such funding remained central. The 1993 WDR introduced the idea of the global burden of disease framework in order to allow governments to better allocate health spending based on estimations of the extent to which populations suffer from diseases via Disability-Adjusted Life Years (or DALYs). DALYs are to be

used as a tool to prioritize particular health interventions and accounts not only for premature mortality but also disability (Anand and Hanson 1998). DALYs are intended to provide a summary measure of population health and allow a comparison of the cost of treatment and prevention across diseases. They seek to capture the impact of both premature mortality (quantity of life) and morbidity or disability (quality of life) and measure the number of life years lost. When the burden of disease is high and cost-effectiveness of intervention is high the intervention can be considered a priority (Bank 1993). Overall, the report focused on investing in health and education, especially among poorer segments of the population to achieve the dual objectives of economic and social development, particularly in the form of economic growth and poverty reduction. In using this tool, the focus shifted to cost effectiveness via the reduction of DALYs. Though the emphasis of the report is firmly on efficiency and economic growth, it also turns its attention to poverty reduction in its own right. This may be seen as a promotion of direct intervention in the health sector in the service of equity, which is quite different than the previous approach of allowing economic growth to trickle down and in this way ameliorate poverty (Bank 1997).

The methodology and creation of the DALYs metric was subject to much debate. On the one hand, it was said to have “greatly facilitated scientific and political assessments of the comparative importance of various diseases, injuries and risk factors, particularly for priority-setting in the health sector, and has led to strategic decisions by some agencies, e.g. the WHO, to invest greater effort in program developments to address priority health concerns such as tobacco control and injury prevention” (Lopez 2005). As such, the WDR then did not only establish some priorities but introduced a methodology by which more specific priorities could be established at international and national levels.

On the other hand, the report was also referred to as a “prescription for health disaster” (Antia 1994). Criticisms can be categorized along three broad themes: first, the Western ahistorical approach implicated in the report, second, the lack of attention to solutions and instead the focus on DALYs as a diagnostic, and third, the lack of attention to equity and the assumption of equality across DALYs. Related to the first criticism, the WDR was criticized for prioritizing a Western approach to health including hospitals, technologies, and medical doctors without accounting for local cultures and customs. In addition, there is no

attention to social and political context, and DALYs take a piecemeal approach to health and illness. Further, the WDR did not consider some of the inequalities and conditions in developing countries that the report and the Bank seek to address are the result of the systemic inequality inherent in global economic relationships, some of which are enhanced by the World Bank's own practices, including structural adjustment (Antia 1994). Second, some argue that while the DALYs were systematically applied the same could not be said for the cost-effectiveness of interventions to address these issues, that is, solutions seeking to address the identified priorities were sometimes costly with little payoff (Paalman et al. 1998). Finally, a third criticism centers on issues of equity. That is, a DALY gained is treated equally net of whom it is gained for whether they be generally healthy or not, as well as the fact that at basic package of service stands in opposition to comprehensive care.

Understanding the World Bank's changing approach to health and criticisms of such is central therefore not only because of the financial power it wields and conditions it can impose on government spending and behavior, but also because of its normative power in outlining appropriate measurements, priorities, and policy instruments in health. This role has become even more important as other international organizations have entered the global health arena, reducing the World Bank's relative financial commitments to health but arguably not its ideational, technical sway. The World Bank has consistently devoted several billion dollars to health assistance from the mid-1990s and beyond as demonstrated in Fig. 2.1.

While the Bank's involvement in health has not diminished it has been far outpaced by the growth in spending by bilateral agencies, international and domestic NGOs, and new foundations, namely the Bill & Melinda Gates Foundation. However, through the 1990s the World Bank was the single largest external funder of global health (Ruger 2005) and as such, as a single institution was a leader in global health norms and policies. In addition, as consistently mentioned since its official commitment to lending in health in the 1980s, its comparative advantage in financial and economic domains has allowed it to retain its important role despite its falling share of expenditures in global health.

These patterns, however, also vary across regions. Figure 2.1 obscures both cross-regional and cross-national variability in the sources of

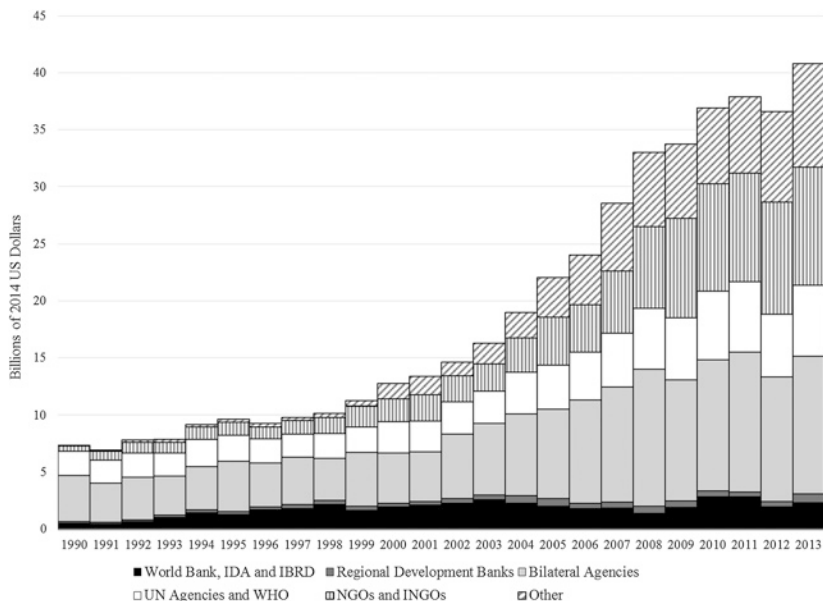


Fig. 2.1 Development assistance for health globally, 1990–2013. *Source* Institute for Health Metrics and Evaluation (IHME). *Notes* Other includes public–private partnerships (for example, the Global Fund to Fight AIDS, Tuberculosis, and Malaria), US Foundations, the Bill & Melinda Gates Foundation, the European Commission

development assistance for health. Figure 2.2 presents this same data on sources for Development Assistance in Health regionally in Latin America and the Caribbean. In this region, the World Bank's spending on health comprises a much larger share of overall development assistance in health, and indeed in some years far outpaces each of the other sources. Therefore, while Fig. 2.1 suggests that the World Bank may be losing its financial clout as a funder of health in some countries or regions, there is reason to expect that it continues to be especially if not increasingly important in some countries and regions, including Latin America and the Caribbean, as suggested by Fig. 2.2. This variation further motivates the regional focus of this book.

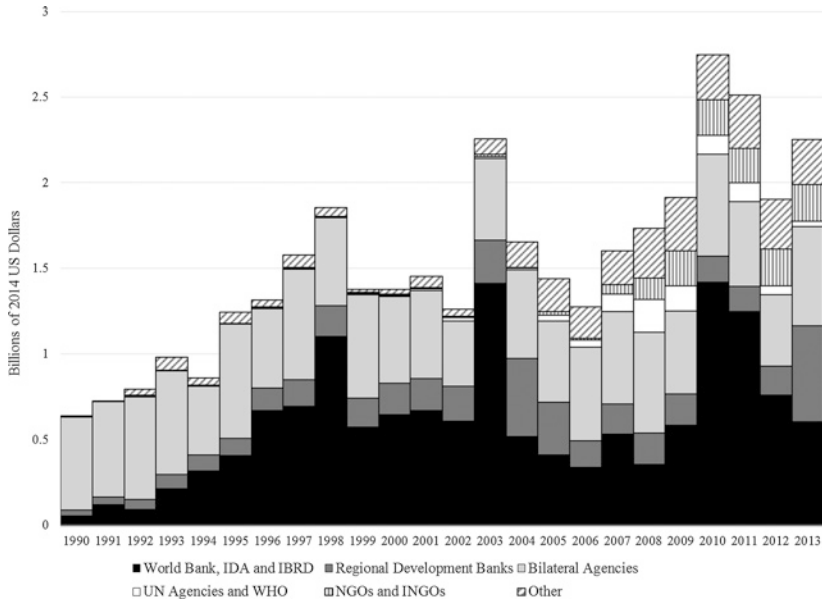


Fig. 2.2 Development assistance for health in Latin America and the Caribbean, 1990–2013. *Source* Institute for Health Metrics and Evaluation (IHME). *Notes* Other includes public–private partnerships (for example, the Global Fund to Fight AIDS, Tuberculosis, and Malaria), US Foundations, the Bill & Melinda Gates Foundation, the European Commission

THE LATE 1990s, EARLY 2000s: HEALTH OUTCOMES AND SYSTEMS

In the 1990s the World Bank largely followed the lead it had established in the 1980s and 1990s, focusing on governments establishing a basic package of services (including in Argentina and Peru, as described in Chaps. 4 and 5) and increasing government regulation in health and primary care and essential services, with some targeted programs aimed at poverty alleviation. Fair (2008) calls this the “health outcomes and systems” phase where the objectives were to improve outcomes for the poor and better the performance of health systems. While ostensibly concerned with systems, the World Bank is less concerned with what a health care system is than what it does—especially compared to other

international organizations such as the World Health Organization (Kaasch 2015). In its 1997 *Health, Nutrition, and Population Sector Strategy Paper* the World Bank focuses on outcomes, again discussing health in the context of growth and poverty reduction: “Investing in people is at the center of the World Bank’s development strategy as it moves into the twenty first century, reflecting the fact that no country can secure sustainable economic growth or poverty reduction without a healthy, well nourished, and educated population” (Bank 1997).

This renewed focus on the poor and their health outcomes corresponded to an organizational shift in the World Bank: In 1996, Richard Feachem directed the newly created Health, Nutrition, and Population Sector, which subsequently became more sympathetic to public health, as compared with health economics, approaches (Deacon 2007; Abbasi 1999). Improving health outcomes was to be achieved via stimulating demand for health services and promoting client-generated and driven strategies and via intersectoral collaboration. This approach was motivated in part by an emerging understanding among World Bank personnel that the focus on user fees, emphasized in the early 1990s, needed to be revisited as it was having a devastating effect on health and economically on families (Irvine et al. 2013). The clients in this formulation are governments, though the Bank recognizes the complexity of health sectors in borrowing countries: “it is necessary to reconcile the divergent views of the various interest groups—the Bank’s clients (typically the ministries of health and finance), stakeholders (local communities, health care providers, and insurance companies), beneficiaries (patients, the poor, women, children, and other vulnerable groups), and other development partners” (10). The report also highlights the importance of the Bank’s collaborative work with other organizations and self-describes the Bank as a “global knowledge broker” (12) in health. Given that its share of financial commitments to health is falling (Fig. 2.1), this emphasis on partnerships is strategically advantageous to the Bank. Partnerships then take on a new meaning for the World Bank: It continues to provide loans in health and becomes a knowledge broker, related not only to its partnerships with governments, beneficiaries, and other organizations, but also to its ability to collect, compile, and disseminate data. This statistical contribution began with the DALYs, cost-effectiveness calculations, and burden of disease data but it has continued with the provision of the World Development Indicators among other data. This self-concept as a knowledge broker has also seemingly created an

opening for the Bank to be more self-critical than before. For example, the report notes that the Bank has not paid “sufficient attention to the political economy of reform and its economic, regulatory, and institutional underpinnings” (13).

The World Bank’s commitment to health outcomes and data collection were combined and crystallized with the Millennium Development Goals (MDGs). The MDGs were established at the Millennium Summit in September 2000, a series of targets to be reached by 2015 to address extreme poverty. Of the eight goals, five (Goals 1, 4, 5, 6, and 7) dealt with health, in particular: eradicating extreme poverty and hunger, reducing child mortality, improving maternal health, combating HIV/AIDS, malaria and other diseases, and ensuring environmental sustainability including halving the proportion of people without access to safe drinking water. While the MDGs reinforced the Bank’s commitment to health outcomes, they did not focus on distribution. As such, there was concern that health outcomes would improve overall but not focus specifically on the poor (Fair 2008). While the World Bank’s approach to health varied across countries (as detailed in the case-study Chaps. 4–6 and further examined in Chap. 7) the next WDR to address health in a major way did not come until over 10 years after the 1993 WDR, with the 2004 WDR: *Making Services Work for Poor People*.

THE 2004 WORLD DEVELOPMENT REPORT: PURSUING ACCOUNTABILITY AND A PRO-GROWTH, PRO-POOR AGENDA

The 2004 WDR provided a sharp refocusing of the World Bank’s agenda on poor people and revisited the original goal of the “Washington Consensus,” which had not quite materialized in the 1980s and 1990s: pro-growth and pro-poor policies (Williamson 2000). Then World Bank President Wolfensohn, in the foreword to the 2004 WDR discusses health in terms very different than those of the 1993 WDR and the MDGs. In direct response to the focus on numbers, the World Bank sought with this WDR, a more “human” approach: “Development is not just about money or even about numerical targets to be achieved by 2015, as important as those are. It is about people. The WDR focuses on basic services, particularly health, education, water, and sanitation, seeking ways of making them work for poor people. Too often, services fail poor people. These failures may be less spectacular than financial crises,

but their effects are continuing and deep nonetheless” (xv). The recommendations are threefold: first, individual-oriented clinical services, population-oriented outreach, and family-oriented services. While the focus is still on individuals: as purchasers, coproducers, and monitors of health services this WDR does discuss not only individuals and families but also community programs. The long-standing emphasis on health as a basic need remains a running theme in the 2004 WDR, and while community programs are discussed, the framework is still market-oriented, characterized by individuals making choices, which was also the underpinning of earlier, market-oriented, individualist, and consumerist approaches such as user fees.

The logic remains decidedly economic and utilizes neoliberal tools: private sector involvement (especially via public–private partnerships), separation of functions, decentralization, and targeting. Government financing of services remains justified on the grounds of market failures, though there is an opening for its justification on human rights grounds in the 2004 WDR. More centrally, this WDR foregrounds accountability to poor people of social, including health, policies, and programs. However, while the 2004 WDR seeks to empower the poor by bringing them into the policy process, it also places additional responsibilities, and therefore burdens, on this already disadvantaged group to make sure that services are allocated and working appropriately.

2005 AND BEYOND: BACK TO BASICS IN HEALTH?

With the hiring of Jim Yong Kim as the World Bank’s 12th president in 2012, there was much anticipation, especially for the Bank’s work in health. Kim, a physician, and anthropologist, was a cofounder of a non-profit organization which sought to bring advanced medical care to the poorest areas of developing countries. As Fig. 2.1 demonstrates, while many other organizations have entered into the global health financing arena the World Bank has maintained its commitments to health in absolute terms, and often works in cooperation with bilateral and other agencies, allowing it to maintain its status as a normative, technical, and financial authority in health. Since 2007, the World Bank has focused on health systems strengthening, further emphasizing its focus on institutional development and the connection between systems and outcomes.

Altogether, the World Bank has circled back in its discourse: in the 1980s, it focused on government involvement in health, though this was never truly implemented in deed. It then espoused a more individualist, market-oriented approach to health, and is reaffirming its commitment to promoting universalism. Importantly, this universalism is to be achieved not only by governments but still with the participation of the private sector and in particular, public–private partnerships (Stephens 2007). The World Bank has consistently argued that this is where its expertise lies, and where it has the most to offer: in cost-effectiveness and the financial aspects of health sector reform. Together with the case-study analyses presented in the following chapters, this suggests that the World Bank is now promoting universalist ends, but via policy tools that many consider neoliberal: separation of functions, targeting, decentralization, etc.

Today, the World Bank champions universalism. A review piece published as part of its “Universal Health Coverage Studies Series” notes that “universal health coverage (UHC) interventions in low- and middle-income countries improve access to health care. It also shows, though less convincingly, that UHC often has a positive effect on financial protection, and that, in some cases, it seems to have a positive impact on health status.” (Giedion et al. 2013). Universalism is also clearly emphasized in the third of the seventeen Sustainable Development Goals (SDGs) for 2030, which replaced the MDGs which themselves expired in 2015 (UN 2015b). The SDGs consist of 17 goals with 169 global targets, spearheaded by the UN through a deliberative process involving member states, civil society, and other organizations. Among the targets of the third goal are: “Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all” (UN 2015a). Universal access to health is a cause also generally championed by Kim, as he states in a speech given in 2016: “The evidence tells us there is no better prescription for health, wealth, and security as a health care system that provides equal coverage to every single person” (Bank 2016). The World Bank then appears to be circling back to its original goals as outlined in its 1980 health policy paper, where it embraced the goal of universal access to basic health services and committed to providing help towards that goal. However, how and whether these intentions will materialize into implementation by the World Bank, as well as where and how, remains to be seen.

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