The Changing Role of the WORLD BANK in Global Health

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The World Bank began operations on June 25, 1946. Although it was established to finance European reconstruction after World War II, the bank today is a considerable force in the health, nutrition, and population (HNP) sector in developing countries. Indeed, it has evolved from having virtually no presence in global health to being the world's largest financial contributor to health-related projects, now committing more than $1 billion annually for new HNP projects. It is also one of the world's largest supporters in the fight against HIV/AIDS, with commitments of more than $1.6 billion over the past several years.

I have mapped this transformation in the World Bank's role in global health, illustrating shifts in the bank's mission and financial orientation, as well as the broader changes in development theory and practice. Through a deepened understanding of the complexities of development, the World Bank now regards investments in HNP programs as fundamental to its role in the global economy.

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JUNE 25, 2004, MARKED THE 58th anniversary of the World Bank, which opened its doors in Washington, DC, in 1946. The International Bank for Reconstruction and Development, as it was initially called, was created at the Bretton Woods Conference in July 1944, along with its sister institution, the International Monetary Fund. At the outset, the bank's dual roles were reconstruction and development, as implied by its original name. Its primary function was to reconstruct Europe after World War II. However, unlike other specialized United Nations (UN) agencies the bank raised funds through private financial markets and received donations on a regular basis from the world's wealthiest countries.[1] With these funds, it provided interest-bearing and interest-free loans, credits, grants, and technical assistance to war-damaged and economically developing countries that could not afford to borrow money in international markets. These activities are ongoing, making the bank the "world's premier economic multilateral"[2] institution.

Over the course of more than 50 years, the bank's priorities and development philosophy—along with its role in the world—have changed from reconstructing Europe to alleviating poverty in developing countries. Perspectives on development also have changed dramatically during that time. New theories and evidence have deepened and transformed the international development debate and have influenced the bank's development practices and policy decisions. In particular, the bank now has a more sophisticated view of well-being, living standards, and poverty. In addition, evidence on the primary means of poverty reduction and development has accumulated throughout the bank's history, and the bank now has an improved, though still evolving, understanding of how to achieve development objectives. In the 1950s and 1960s, for example, when the prevailing wisdom was that economic growth was the key to development, the bank focused primarily on large investments in physical capital and infrastructure, because such investments were viewed as the most likely to increase national income.

However, in the 1960s through 1980s development theory shifted to encompass more than economic growth; it aimed at meeting individuals' "basic needs," because the objective was to provide all human beings with the opportunity for a "full life." This approach appealed to bank staff and especially to Robert McNamara, then president of the bank. Consequentially, the World Bank's focus began to slowly shift to investments in family planning, nutrition, health, and education. In the 1990s, the "Washington Consensus," which emphasized macroeconomic stability, privatization, trade liberalization, and public sector contraction, dominated development thinking, and the bank focused on open markets and economic management. However, lessons learned from this period of market-oriented reforms demonstrated that good governance, strong institutions, and human capital are critical

for eradicating global poverty. Today, the bank views development as a holistic and multidimensional process that focuses on people in the societies in which it operates. This "comprehensive development framework" now gives health, nutrition, and population (HNP) programs a central place in the bank's work and mission.

The World Bank has gone from having virtually no presence in global health to being one of the leading global health institutions. Over time, its loans, credits, and grants to fund HNP programs have become substantial. The largest shift occurred over the past 20 years: World Bank support for social services such as health, nutrition, education, and social security grew from 5% of its portfolio in 1980 to 22% in 2003.[3]

The World Bank is now the world's largest external funder of health,[4] committing more than $1 billion annually in new lending to improve health, nutrition, and population in developing countries. Moreover, it is one of the worlds' largest external funders of the fight against HIV/AIDS, with current commitments of more than $1.3 billion, 50% of that to sub-Saharan Africa.[5] Because it allows long repayment periods (up to 35–40 years and a 10-year grace period), it provides the time and resources to address special problems, such as widespread disease epidemics.

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THE EARLY YEARS: BRETTON WOODS

In July 1944, delegates from 45 national governments convened in Bretton Woods, NH, to adopt the Articles of Agreement for the World Bank and the International Monetary Fund, establishing the 2 entities in international law.[6] The nascent bank was the first "multilateral development bank," a uniquely public sector institution created in a post–World War II era of intergovernmental cooperation. The International Monetary Fund, by contrast, was created to stabilize the international monetary system and monitor world currencies. A year later, the UN General Assembly convened in San Francisco, Calif, to draft the UN charter. A new era of multilateralism and intergovernmental cooperation had emerged.

By December 31, 1945, 29 governments had ratified the bank's Articles of Agreement. In March 1946, the board of governors of the World Bank and the International Monetary Fund were inaugurated in Savannah, Ga, where they adopted the institutions' bylaws and elected the bank's executive directors.[7] The board first met on May 7, 1946. The bank's first president, Eugene Meyer, took office on June 18, and the bank opened its world headquarters at 1818 H Street, NW, Washington, DC, on June 25 (Figure 1).[8]

FIGURE 1—1818 H Street, NW, Washington, DC. The World Bank opened for business on the 10th floor of this building on June 25, 1946 (World Bank Group Archives).

The job of being the first bank president was challenging. In the 10th anniversary issue of *International Bank Notes*, Mr. Meyer noted that, "Finding the proper path for this new experiment in international cooperation was not easy. We had only the Articles of Agreement to guide us, and they provided only the sketchiest of outlines."[9]

Meyer resigned after 6 months and was succeeded by John McCloy, who held the position for 2 years, a period that initiated a rapid change in the World Bank's work and geographic orientation.

FROM RECONSTRUCTION TO DEVELOPMENT

McCloy helped shift the bank's focus from postwar reconstruction to economic development. On May 9, 1947, the bank authorized its first loan: $250 million to France for postwar reconstruction. By August 1947, it had authorized reconstruction loans to The Netherlands ($195 million), Denmark ($40 million), and Luxembourg ($12 million).[10] These first loans were for "reconstruction" (compared with project-specific loans), and they launched the nascent bank into international capital markets. However, the international community soon realized that, instead of piecemeal loans, European and Japanese reconstruction would require a full-fledged effort by international leaders. Hence, the Marshall Plan was established in June 1947.[11] Relieved of the reconstruction burden, the bank's directors turned their full attention to development.

In the postwar era, the prevailing wisdom in development theory was that economic growth (increasing gross national product or growth rates) was the key to development. Therefore, during this era the bank focused primarily on large investments in physical capital and heavy infrastructure. From 1948 to 1961, for example, 87% of its loans to less developed countries were for power and transportation. The remaining commitments provided for other forms of economic overhead, such as industry and telecommunications, and a small fraction (4%) was invested in agriculture and irrigation.[12] Moreover, from January 1949 through April 1961, the bank provided $5.1 billion to 56 countries for 280 different loans, primarily for economic development.[13] The first development loan ($13.5 million), effective on April 7, 1949, was to Chile's Corporacion de Fomento de la Produccion for 4 electric power projects and incidental irrigation.[14] The second development loan ($2.5 million), effective the same day, focused on machinery for Chilean agriculture. Education, health, and other social sectors were not provided for in the loans.[15]

This development theory and investment philosophy remained constant for most of the bank's first 2 decades, espousing the idea that public utility and transportation projects, financial stability, and a strong private sector were the primary means to development.[16] These types of projects were also easier to finance and were considered more appropriate for bank financing.[17] During this time, the World Bank shunned public investments in sanitation, education, and health.[18] One reason for this neglect, as previously mentioned, was the prevailing development paradigm that public utility investments and other economic infrastructure were the key to economic growth. Another reason related to the bank's culture as a "financial institution," because "by the early 1950s the bank's operations and development thinking had been set into a banker's mold."[19] This financial "mold" valued investments that showed a measurable and direct monetary return. As Edward Mason and Robert Asher explain in their book, *The World Bank Since Bretton Woods*,

> The contribution of social overhead projects to increased production . . . is less measurable and direct than that of power plants. . . . Financing them, moreover, might open the door to vastly increased demands for loans and raise hackles anew in Wall Street about the "soundness" of the bank's management. It therefore seemed prudent to the management . . . to consider as unsuitable in normal circumstances World Bank financing of projects for eliminating malaria, reducing illiteracy, building vocational schools, or establishing clinics. . . .[20]

Some bank staff and advisors disagreed with this view. E. Harrison Clark, chief of the 1952 Survey Mission to Nicaragua, returned from that country with strong recommendations. The mission reported that

> expenditures to improve sanitation, education and public health should, without question, be given first priority in any program to increase the long-range growth and development of the Nicaraguan economy . . . high disease rates, low standards of nutrition, and low education and training standards are the major factors inhibiting growth of productivity. . . .[21]

Despite these recommendations, none of the 11 loans Nicaragua received from the World Bank between 1951 and 1960 covered water, sanitation, health, or education.[22]

By virtually ignoring the social sectors, the World Bank charted a different course from the US government and other development institutions. From 1951 to 1954, more than 30% of US foreign aid to South Asia was for health, agriculture, and education.[23] In particular, US bilateral aid to Thailand for public health was a significant priority.[24] Although the primary motivation for US bilateral human resource lending in South Asia appeared to stem from the fear that poverty and ill health bred communist ideology,[25] such investments

were consistent with the US post-war emphasis on individualism and human capacity and its confidence in science and medicine.[26] Other development institutions, such as the US Agency for International Development; Food and Agriculture Organization, UN Educational, Science, and Cultural Organization; United Nations Children's Fund (UNICEF); and especially the World Health Organization (WHO), also focused on improving public health.

The rationale for the bank's independent course was both academic and financial. Academic development dialogue at the time emphasized that economic growth was the principal tool for reducing poverty in developing countries and that social services investments would be counterproductive. Davesh Kapur et al. wrote, "Such measures would be temporary palliatives, at the expense of savings and productive investment; direct and immediate attacks on mass poverty would only squander limited national resources."[27]

This "trickle down" economic approach was reinforced by the idea that industrialization and urbanization were necessary for economic growth,[28] a view dominating bank thinking during most of the 1950s and 1960s.[29] Sociologists and economists agreed that urbanization was an inevitable component of development,[30] that income inequality was inevitably linked to economic growth,[31] and that growth, not distribution, should be the focus of development.[32]

The World Bank's financial interests were equally at odds with lending policies that favored social and human resources. Robert Cavanaugh, the bank's chief fundraiser and a bridge between the New York stock market—the bank's primary funding source—and the bank's lending instruments during this period, stated in 1961,

> If we got into the social field . . . then the bond market would definitely feel that we were not acting prudently from a financial standpoint. . . . If you start financing schools and hospitals and water works, and so forth, these things don't normally and directly increase the ability of a country to repay a borrowing.[33]

Cavanaugh's statement reflected how the World Bank was influenced by potential financial market reactions, especially when it was trying to build a strong reputation within financial markets and development circles. Even if some bank officials thought health and education were important to development, academic and financial influences swayed the bank to put aside welfare matters for the first 25 years of its existence.

INVESTMENTS IN HEALTH, NUTRITION, AND POPULATION PROGRAMS

On April 1, 1968, Robert S. McNamara became president of the World Bank. During his long tenure (ending June 1981), he transformed the bank by moving poverty reduction to center stage. He sought to redefine the bank as a bona fide "development agency" and not just a financial institution[34] and was a forceful agent of change.

McNamara's arrival coincided with a shift in academic thinking and research about development. This shift began in the 1950s, when orthodox views of development[35]—focusing on economic growth—were questioned, and studies found that physical capital played a smaller-than-expected role in economic growth. Moreover, it appeared that a "residual factor" existed in macroeconomic statistical models.[36] This residual factor was believed to be investment in education, innovation, entrepreneurship, and, later, health.[37] The concepts of "human capital" and "human development"—investments in people—also gained acceptance.[38] The basic needs approach to development influenced the way academics and policymakers viewed development,[39] later forming the cornerstone of the US Agency for International Development program.[40]

These development ideas made sense to McNamara. They both appealed to him personally and were consistent with his own personal history, prior loyalties, and experience with the US government and the private sector. Moreover, internal bank studies and country mission reports revealed that hundreds of millions of people in developing countries were living in extreme poverty and lacking health clinics, primary and secondary schools, and safe drinking water.[41] Such conditions of "underdevelopment" were key barriers to productivity, economic growth, and poverty reduction, and poverty was a direct result of insufficient investments in health and education. Dragoslav Avramovic, acting head of the bank's economics department just before McNamara's arrival, was a strong critic of prevailing orthodox views. His critique of trickle-down economics later provided key aspects of McNamara's attack on poverty.[42] Although shifts in academic thinking about development influenced some bank staff in the 1960s, they did not take root in the bank's policies and institutional ethos until after McNamara arrived in 1968.

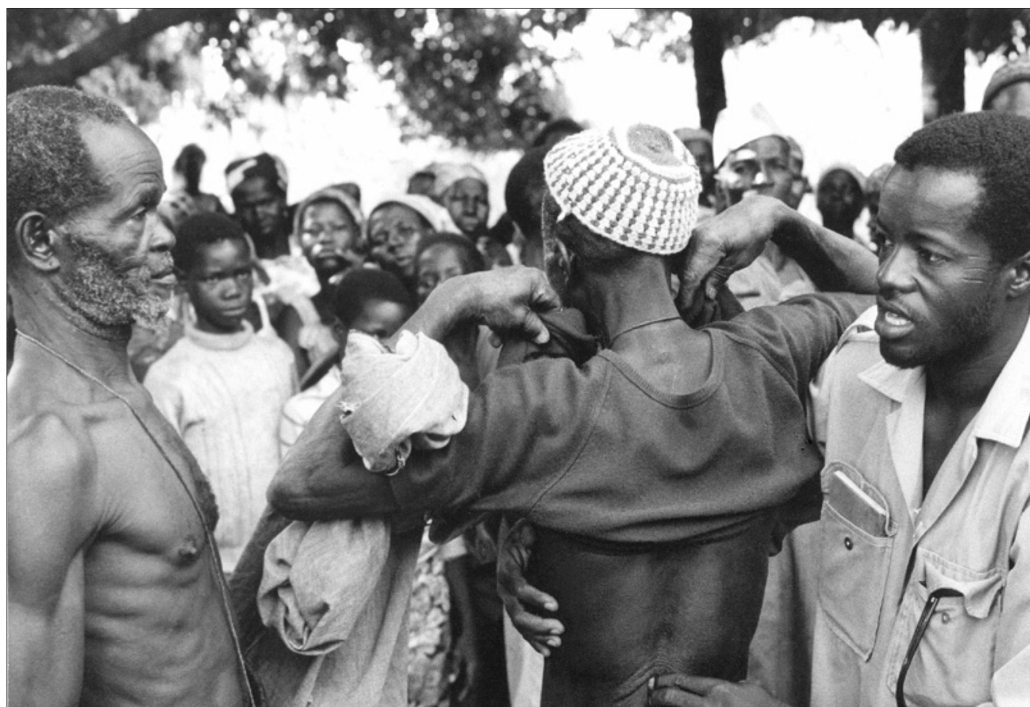

FIGURE 2—Villagers being examined by a member of the Onchocerciasis Control Program (World Bank Group Archives).

The bank's gradual shift toward more social sector lending began with an emphasis on population control, which McNamara regarded as the first step to alleviating poverty. In a landmark speech at the University of Notre Dame in 1969, he urged the international community to address population growth, the "most delicate and difficult issue of our era, perhaps of any era in history."[43] Population control was a major focus for other development agencies at the time, particularly the Ford Foundation and US Agency for International Development. By 1970, McNamara had established the Population Projects Department in the World Bank and continued to advocate population control in speeches and dialogue with governments. In June 1970, the bank approved its first family planning loan ($2 million)—to Jamaica.[44] By the end of fiscal year (FY) 1973, the bank's lending in family planning totaled $22 million, less than 10% of that given for electric power ($322 million) and telecommunications ($248 million). It was an even lower fraction of that given for agriculture ($938 million) and transportation ($682 million).[45] On August 26, 1974, the report *Population Policies and Economic Development*, which analyzed the effect of rising populations on poverty, was published.[46] However, population control failed to develop into a strong lending program, perhaps because it could not meet the bank's interest in projects that were both acceptable to borrowers and attractive to bank shareholders.[47]

McNamara's attention then turned to nutrition, motivated in part by the International Conference on Nutrition, National Development, and Planning at Massachusetts Institute of Technology in 1971 and the International Nutrition Planning Program established in 1972 at the university and funded by the Rockefeller Foundation and US Agency for International Development.[48] In November 1970, biochemist James Lee became the bank's scientific advisor and was responsible for nutrition policy along with other areas of science.[49] In his speech at the bank's 1971 annual meeting, McNamara emphasized that "malnutrition is widespread and it limits the physical, and often the mental growth of hundreds of millions and it is a major barrier to human development."[50] By January 1972, the World Bank report *Possible Bank Actions on Malnutrition Problems* led to the establishment of a bank nutrition unit. In 1973, Alan Berg's book *The Nutrition Factor* and a 1973 nutrition policy paper, which called for a more active role in nutrition, reinforced McNamara's support for eventual bank lending in that area.[51] However, the bank did not approve its first loan for nutrition (to Brazil for $19 million) until 1976.[52]

Since 1970, McNamara had been advocating bank support of health and nutrition programs, as in speeches at Columbia University (1970) and the bank's annual general meetings (1972). In June 1973, he requested a health policy paper from bank staff.[53] The resulting 1975 *Health Sector Policy Paper* was 1 of the bank's first efforts to generate and disseminate knowledge on health policy issues. In 1974, 1 of the bank's most successful programs, the Onchocerciasis Control Program (OCP), was created to eliminate onchocerciasis (river blindness) and enhance country and regional control of the disease (Figure 2). This health initiative involved 11 countries in West Africa and was sponsored, along with the World Bank, by United Nations Development Program (UNDP), Food and Agriculture Organization, and WHO. It also involved the private sector and

nongovernmental organizations. Onchocerciasis is caused by a parasitic worm and is spread by black flies that breed in fast-flowing water. The group determined they could stop flies from transmitting the disease by treating the water flow. The OCP also established a program of insecticide application to prevent the growth of black flies.[54]

Because the bank was not notably engaged in health issues at the time, its decision to tackle river blindness was a turning point. The program, which continued for some 30 years, protected an estimated 34 million people from river blindness and cleared nearly 25 million hectares of land for agricultural use.[55] The OCP gave the bank a boost in the health sector. In 1979, the bank established a health department and a policy to consider funding stand-alone health projects, as well as health components in other projects.[56]

These efforts in the health arena were influenced by the growing recognition in academic and policymaking development discourse that the basic needs approach was essential to poverty reduction.[57] McNamara, in particular, engaged with this dialogue. In his 1976 address to the annual general meeting of the board of governors in Manila, the Philippine Islands, he underscored the need to reexamine trickle-down economics and to focus on the unmet basic human needs of hundreds of millions of people in developing countries.[58] Over the ensuing years, he called for further research within the bank before endorsing a full-scale lending program for basic needs.

Despite its failure to become fully institutionalized in World Bank culture and policy, the basic-needs approach laid the foundation for further expansion in the bank's HNP sector. Official recognition of this shift came most publicly in the *World Development Report, 1980* which demonstrated that malnutrition and ill health were 2 of the worst symptoms of poverty and that both could be addressed by direct government action, with bank assistance. The report also suggested that improving health and nutrition would likely accelerate economic growth. After a series of research papers suggested that health and education were directly productive, these findings were incorporated in the *World Development Report, 1980* to argue for greater emphases on social sector lending.[59]

The bank translated development theory and research into action by creating the Population, Health, and Nutrition Department in October 1979 and allowing stand-alone health loans. A 1980 *Health Sector Policy Paper* was 1 of the first attempts to provide a rationale for stand-alone investments in the health sector.[60]

In 1980, the bank approved another nutrition loan—to the India Tamil Nadu Nutrition project. In 1984, it provided a $2 million grant for social emergency programs, and, in 1985, it gave a $3 million grant to the World Food Program for emergency food supplies to sub-Saharan Africa.[61] The creation of the Population, Health, and Nutrition Department became a landmark in the World Bank's involvement in health.

On February 10, 1987, the bank cosponsored—with WHO and United Nations Population Fund—a conference in Nairobi, Kenya, on safe motherhood.[62] This conference launched the bank's Safe Motherhood initiative, which was its first global commitment to health issues of this nature; the program is now in its 17th year. This initiative solidified the bank's commitment to family planning and maternal and child health. The public and financial commitments resonating from this initiative became important pillars of the bank's health sector work. Safe motherhood projects increased from 10 in 1987 to 150 in 1999, with an annual commitment of $385 million between 1992 and 1999—30% of total bank HNP lending.[63] Between 1987 and 1998, the bank supported safe delivery activities in 29 countries.[64] In 1987, it loaned $10 million for Zimbabwe's Family Health Project and $11 million to Malawi for its Second Family Health Project. In 1990, it supported a $267 million loan to Brazil's Second Northeast Basic Health Services Project.[65]

A second global health conference on safe motherhood, sponsored by the World Bank, WHO, UNICEF, and United Nations Population Fund, took place on Janu-

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ary 30, 1989, in Niamey, Nigeria. A November 1989 bank report, *Sub-Saharan Africa: From Crisis to Sustainable Growth*, followed and called for doubling expenditures on human resource development.[66] Together, these events provided further momentum for investments in family planning and child and maternal health. In 1998, the bank loaned $300 million for India's Women and Child Development Project and $250 million for Bangladesh's Health and Population Program Project.[67] The bank's family planning work was not without controversy, however. Its *World Development Report, 1984: Population and Development* which emphasized governments' role in reducing fertility and mortality,[68] was criticized, as were its family-planning projects (drawn into abortion politics) in Latin America and elsewhere (Figure 3).[69]

Other noteworthy early HNP activities included the first loan in 1981 to Tunisia to expand basic health services, the 1987 study *Financing Health Services in Developing Countries: An Agenda for Reform*, and the bank's seminal *World Development Report, 1993: Investing in Health*.[70] The 1987 document, in particular, underscored the need for improved health sector financing and included user fees/charges, which are highly controversial, as 1 instrument for mobilizing resources. The *World Development Report, 1993* was a watershed in international health, giving the World Bank greater exposure and legitimacy in the health sector. The first *World Development Report* devoted entirely to health (signaling the bank's commitment), its overall aim was to make the case to the broader development community for investing in health. The *World Development Report, 1993* identified several major problems in international health systems, in particular, inefficient use of funds and human resources, inequitable access to basic heath care, and rising health care costs. As a result, the bank advocated several key recommendations for improving health: educating girls and empowering women, reallocating government resources from tertiary facilities to primary care, investing in public health and essential clinical services, and promoting private and social insurance and competition in health services delivery. Although generally well received, the report was criticized for introducing disability-adjusted life years (DALYs), for lacking a strong evidence base, and for promoting privatization.[71]

THE WORLD BANK'S INCREASING INVOLVEMENT IN GLOBAL HEALTH

The *World Development Report, 1993* has been supplemented over the past decade with bank operational research and analysis, including the bank's Special Program of Research, Development and Training in Human Reproduction, the WHO/United Nations Development Program/World Bank Tropical Diseases Research Program, and the Global Micronutrient Initiative.[72] Since 1993, the bank has also increased its support of country-specific research and analysis of HNP issues, primarily through bank loans and credits, which has resulted in significant external HNP research funding in developing countries.[73] The World Bank's own Policy Research Department has also grown its interest in HNP issues and now spends $1 million annually (8% of the department's total research budget) on HNP studies.[74] Such policy research builds on the bank's comparative advantage in economic and intersectoral analysis related to health issues. Other areas of bank

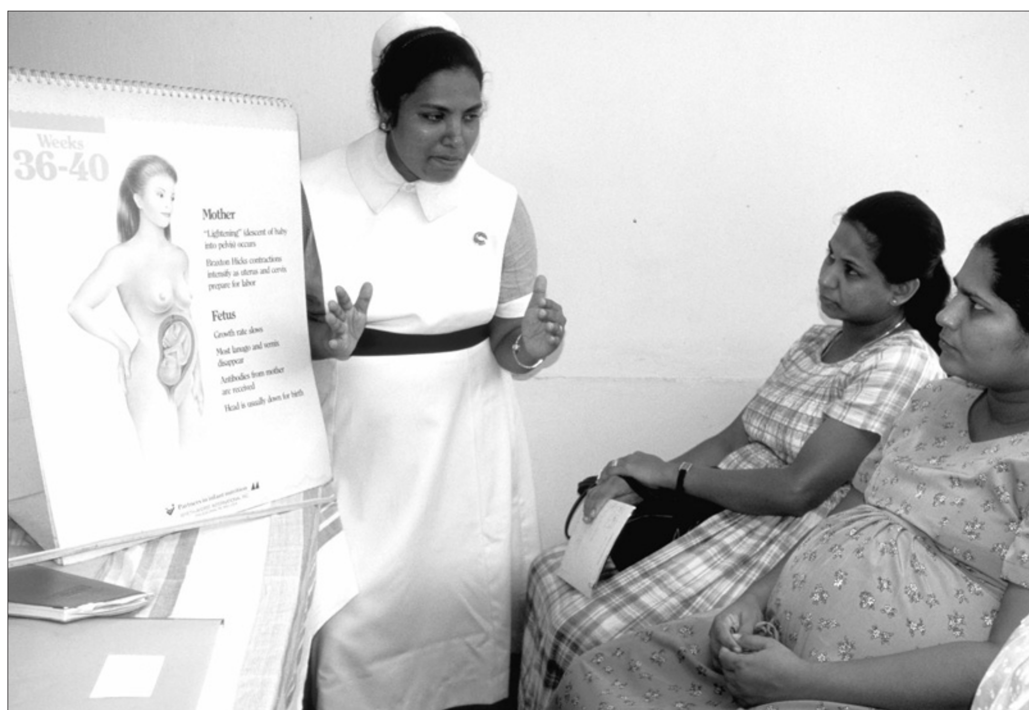

FIGURE 3—Prenatal health education class for women in Sri Lanka (Dominic Sansoni/The World Bank).

involvement in global health knowledge include training and seminars on HNP topics for policymakers in developing countries. Over the past several years, the bank has produced 210 country-specific HNP sector studies and staff appraisal reports and hundreds of country strategy documents on HNP topics,[75] including, for example, a study in Morocco on health financing and insurance.[76]

Although the bank's role in generating and disseminating global health knowledge is important, its main advantage compared with other international institutions is its ability to mobilize financial resources. By far the most dramatic change in its role in global health has been its increased financial support for HNP through loans, credits, and grants. Indeed, it is now the "single largest external source of HNP financing in low- and middle-income countries."[77] In contrast to approving only 1 HNP loan in 1970, it had financed 154 active and 94 completed projects in 1997 with a total of $13.5 billion.[78] From 1987 to 1992 alone, it tripled its HNP lending, and the average number of new projects per year increased from 8 in FY 1987–1989 ($317 million annually) to 21 in FY 1990–1992 ($1.2 billion annually).[79] HNP projects grew from less than 1% of total World Bank lending in 1987 to nearly 7% in 1991.[80] By the end of FY 1996, the World Bank's new annual lending was $21 billion, and 24% of that was directed to HNP (11% or $2.4 million), education (8%), and social protection (5%).[81]

The types of HNP activities pursued by the bank also have changed over the past several years. Early projects focused primarily on strengthening countries' basic HNP infrastructure and services, specific diseases (e.g., OCP), and certain populations (e.g., rural development). However, a late-1990s review by the bank's Operations Evaluation Development Department of 120 projects conducted between FY 1970–1995 found that the narrow focus on capital investment failed to achieve the significant institutional and systematic changes necessary for project effectiveness. It also found that the bank's HNP portfolio was fragmented and of uneven quality.[82] This assessment has led the bank to shift its HNP activities away from basic health services toward broader policy reforms.[83] The Operations Evaluation Development Department review also called for a strategic policy direction and for lending supported by rigorous analysis and research. The bank responded with its 1997 *HNP Sector Strategy Paper*.[84] The review also recommended enhanced selectivity, involving a focus on country needs and an analysis of the costs, benefits, and risks (including political, institutional, and economic) of all planned HNP activities (Figure 4).

FIGURE 4—Doctor giving health check to child from slum area in charity-run hospital in India (John Isaac/The World Bank).

The World Bank also tried to tune into the international dialogue on the need to improve the effectiveness of development assistance through cooperation among agencies. A key lesson learned over the past decades is that institutions acting alone cannot meet complex HNP challenges. Thus, the bank has been working to strengthen its collaboration with other international organizations. In Brazil, Uganda, and Ghana, it collaborated with other donors through its sector-wide approach programs, which aim to bring multiple donors together to fund an entire sector, develop comprehensive sector-wide policies, and pursue similar policy objectives. Sector-wide approach programs are an improvement on the previously fragmented

approach of multiple donors funding ad hoc projects without coordination, but they have not been without controversy.[85]

However, the World Bank recognizes that it must do more to strengthen its partnerships with client countries, civil society, stakeholders, and other agencies. Recently, it entered into collaborative agreements with WHO that will provide technical assistance for improving the design, supervision, and evaluation of bank-supported projects. The WHO and the World Bank are collaborating to advance international understanding of HNP issues, as was done, for example, through the recent Framework Convention for Tobacco Control, through which the bank worked with WHO to establish the evidence base on effective methods of curbing the prevalence and consumption of tobacco products.

CRITICISMS OF THE WORLD BANK

The World Bank and its policies are among the most hotly debated and highly criticized in the global development community. With regard to health sector policies, key concerns involve user fees, structural adjustment, use of DALYs, and privatization.

In its 1987 report on financing, the bank highlighted user fees as an instrument for mobilizing resources. However, empirical evidence demonstrates that user fees reduce the demand for both necessary and unnecessary care and that they disproportionately affect poor and sick people. Evidence also suggests that such fees have not been overwhelmingly successful in raising revenue or enhancing efficiency. In its 1997 sector strategy, the bank claimed that it does not support user fees; however, it maintained that such fees are 1 tool for mobilizing resources. By contrast, critics prefer the bank to reject user fees entirely, a policy the World Bank has yet to pursue.

In the 1980s and 1990s, the bank pressured countries to adopt "structural adjustment" programs for their economies and to follow many prescriptions of the "Washington Consensus" by emphasizing economic management, macroeconomic stability, privatization, trade liberalization, and public sector contraction. This involved opening markets (trade liberalization), reducing government expenditures (in some cases for health), and privatizing state-owned enterprises. Critics argue that such programs reduce health care spending and have deleterious health effects.[86] UNICEF estimated that structural adjustment programs may have been associated with 500 000 deaths of young children in a 12-month period,[87] even though a 1998 study of the effect of structural adjustment operations on health expenditures and outcomes and the World Bank's own research[88] found no negative impact.[89] Still, much concern remains both within and outside the bank on the efficacy and negative effect of such programs, and the bank has moved away from endorsing them.

The bank also was criticized for introducing DALYs to global health assessments. It described DALYs in the *World Development Report, 1993* as a way to conceptualize and measure the global disease burden and to associate this burden with health and other social policies. Critics argue that DALYs lack a sound theoretical framework and are inequitable because they value years saved for the able-bodied more than for the disabled, the middle-aged more than the young or old, and the currently ill more than those who will be ill tomorrow.[90] By introducing DALYs, the bank contends it improved analysis of international health systems. Critics remain concerned with its use in global health, and the debate continues.

Critics also have been concerned about the negative effects of the World Bank's support for privatization in general and the health sector specifically.[91] Research focused on private markets in the health sector has demonstrated that a strong government is necessary to address market failures that occur in financing, consuming, and providing both personal and public health services. Insurance market failures, credit shortages, information asymmetries, and insufficiencies, in particular, can inhibit people from realizing economic benefits that accrue from collective risk reduction through risk pooling.[92] However, although the bank now admits that open markets and economic management are insufficient and that good governance and strong institutions are critical for eradicating poverty, in the health sector, more specifically, critics argue the bank needs to present a clearer position on the trade-offs between public and private financing and delivery of health services.[93]

CONCLUSION

The World Bank today is very different from the organization conceived at Bretton Woods in 1944. Its mission has changed from post–World War II reconstruction and development to worldwide poverty alleviation.

Although the bank invested almost exclusively in physical infrastructure in its early days, its focus has broadened to include significantly more social sector lending. A major expansion of the bank's work in HNP took place between the late 1980s and late 1990s, and the bank is now the world's largest external funder of health and one of the largest supporters in the fight against HIV/AIDS.

The World Bank's role in global health has evolved through a better understanding of development, which the bank now sees as a holistic, integrated, and multidimensional task that should balance the strengths of the market and other institutions and focus on people in client countries.[94] This approach reflects, in part, a new paradigm of academic thought that development is the process of expanding the real freedoms people enjoy,[95] a concept set forth by Amartya Sen. Lessons learned from 50 years of development experience and theory suggest that economic growth, investments in infrastructure and physical capital, macroeconomic stability, liberalization, and privatization still matter, but that development is multifaceted and our understanding of it must be broad and inclusive. A number of key elements, including economic growth and stability, a thriving private sector, investment in people and physical assets, a sustainable environment, and sound institutions and policies are necessary to promote prosperity, reduce poverty, and improve the human condition.

In the late 1990s, the bank's *Voices of the Poor* study, which provided detailed interviews of impoverished people in developing countries,[96] showed that the experience and determinants of poverty are multidimensional. Poor people require not only higher incomes but also security and empowerment, opportunities for education, jobs, health and nutrition, a clean and sustainable environment, a well-functioning judicial and legal system, civil and political liberties, and a rich cultural life. Reflecting these views, the Bank's *World Development Report, 2000–2001* on Poverty[97] identified good health and nutrition and effective reproductive policies and health services as critical for allowing countries to break the vicious circle of poverty, high fertility, poor health, and low economic growth.

All of these changes in the bank's mission, leadership, research, and philosophy have made health, nutrition, and population programs priorities for its work and for the wider development community. The World Bank's evolution, like development research and thinking, has been slow and steady, suggesting that health's importance to development[98] is a concept with long-lasting implications. ■

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