

THE WORLD BANK AND GLOBAL HEALTH

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The World Bank has played a central role in the health of individuals since the late 1960s; as such it is now the largest financier of health in low-middle income countries and provides leadership and direction to global health policy. The Bank has helped to both reduce and expand government health spending through its own model of good debt governance, provided leadership within global health governance, and developed models of privatised healthcare throughout developing countries, specifically within sub-Saharan Africa. Despite trends towards becoming the environmental Bank, the Bank's role in healthcare is here to stay, and in true Bank style, evolve to maintain its pertinence and relevance to the practice of global public health. This chapter builds upon what we know about the World Bank's role in global health, how it has led to shifts in public health policy in developing countries, and how its activities can be situated within the wider framework of liberal policy coalescence. Moreover, the purpose of the chapter is to earmark emerging trends towards new models of community-driven development and social protection as a means of exporting and embedding its own brand of market logic. As such, the chapter seeks to bring the political economy back in to our understanding of the role of the Bank within public health by drawing out main issues in regard to two specific health areas – one of 'the big three' health topics, HIV/AIDS, and a 'neglected disease' onchocerciasis (river blindness) – and how it is using this role to produce wider shifts within the state, market and civil society.

The chapter pursues its aims in the following manner. First, it puts the World Bank's role in global health into context by exploring what we know from existing research within public health and international politics. Second, the chapter unravels emerging trends within the Bank's approach to global health and new forms of financing. This section considers the role of the state, community-driven development and sector-wide interventions in global health in general and how these approaches have been put into practice in the cases HIV/AIDS and onchocerciasis. Third, the chapter outlines the consequences the Bank's role in global health has upon the state, community, and global agenda-setting; and how these

consequences and the Bank's influence can be understood in relation to the Bank's good governance and soft politics agenda. Fourth, the chapter offers some conclusions as to what this means for understanding the role of the World Bank within global health governance, and the political economy of health.

The World Bank and Health in Context

The World Bank's role within global health came onto the international agenda during the 1980s. The Bank had begun involving itself with healthcare policies through family planning programmes in developing countries in the late 1960s under the Presidency of Robert McNamara (1968 - 1981). The Bank's role in health policy has subsequently grown exponentially since the inception of the Population Project Department in 1969 (Buse, 1994, 96). However, it was not until the 1980s that the Bank became directly linked with healthcare through its co-financing of health sector programmes, and indirectly through the socio-economic impact of structural adjustment, and neoliberal reform in partnership with the International Monetary Fund (IMF). The relationship between decline in health provision, structural adjustment and debt has occupied the majority of understanding of the Bank in global health. Structural adjustment policies are a form of conditional-based lending, in which states receiving funds from the Bank for a particular project or a loan from the IMF have to adhere to specific policy recommendations towards privatisation of state services. Key to which is the reduction of state intervention, the rule of the market economismⁱ, and conditionality (Buse, 1994, 98). These policies led to the reduction of healthcare provision through a decline in hospital expenditure and staffing, the introduction of service user fees to be paid by the individual, and responsibility shifting away from the state to the individual (Ugalde and Jackson, 1995, 537). These policies shifted policy-makers away from the concerns of the community and placed the onus upon households to address health problems (Loewenson, 1995, 55-56). The impact of these policies was most acutely felt within developing countries.

Privatisation of healthcare services and the subsequent onus placed on the individual facilitated a rise in community and non-state provision of healthcare services (Lee and Goodman, 2002, 97-98; Owoh, 1996, 216) that was encouraged and in parts, financed, by the Bank. Community provision of healthcare services can be traced back to the emphasis

placed upon community involvement in primary healthcare within the 1978 Alma Ata Declaration (Rifkin, 1986, 240). The logic being that community involvement increases the amount of funds to reach the poor through greater geographical coverage, wider uptake, at less expense to users (Gilson and Mills, 1995, 219). This has led to a shift in focus towards community empowerment rather than changes in the prevalence of particular diseases (Laverack and Labonte, 2000, 256). Community empowerment within health policies exists in relation to specific groups i.e. health promoters, home-based carers etc with emphasis upon strong community attachments and local knowledge (Labonte and Laverack, 2001, 115). These empowerment policies, however, become problematic when communities are seen as static entities rather than ever-changing social structures (Labonte and Laverack, 2001, 137). Institutions such as the Bank see communities as once cohesive whole in which blueprint projects of community-driven development can be applied to.

Perhaps the clearest outline of the Bank's approach to global health during this time was its 1993 World Development Report *Investing in Health* (WDR 1993). WDR 1993 was interpreted as a means of embedding the Bank's market-driven approach to welfare (Owoh, 1996, 216). It articulated the need for privatised healthcare, widespread use of user fees, minimal state interference and the role of the market (World Bank, 1993). Using health as the focus of the Bank's flagship publication makes a clear statement of both the Bank's role at the centre of global health, and its commitment to privatised forms of healthcare in developing countries.

The decline of health provision through state welfare, the introduction of new forms of co-financing and user fees by the Bank allowed it to make claims to knowledge and expertise in health reform (Buse and Gwin, 1998, 666), and consolidate its role as a central actor within global health (Lee and Goodman, 2002). Combined with the decline of the WHO as a result of internal wrangling and confusion as to its mandate, the Bank was able to enlarge the space for decision-making and influence within global health policy-making through its 'unrivalled financial resources' and the 'top-down nature' of health policy reform at the time (Lee and Goodman, 2002, 109-110). The Bank used its apparent 'non-political' specialised status and lending expertise within the wider body of the United Nations (UN) to assume this position

as opposed to its main rival body, United Nations Development Programme (UNDP) (Buse, 1994, 98; Ugalde and Jackson, 1995, 530).

External criticisms of structural adjustment, and internal Bank reviews as to the effectiveness of its health policies has led to a slight adjustment to the economic liberal values underpinning its health interventions during the late 1980s and early 1990s. Simply put, health services had not improved, and in some countries were on the decline. The Bank's explanation for this was that it had not taken account of the systemic conditions or infrastructure needed for improvement. This recognition combined with wider reform packages occurring within the Bank during the late 1990sⁱⁱ led to a re-focus of the institution's global health policies towards systemic reform as to the role of the state and privatised provision, targeted interventions, and most notably a 'sector-wide' approach (Buse and Gwin, 1998, 666). This sector-wide approach refers to the need to involve all aspects of the public and private sectors and the individual in the provision of healthcare. Central to this change in the direction of the Bank was the Director of Health, Nutrition and Population, Richard Feachem (1995 - 1999), who according to series of articles by Kamran Abbasi in the *British Medical Journal*, directed attention away from user fees and structural adjustment and towards issues of sustainability and working relations with other international actors such as the World Health Organisation (WHO) (Abbasi, 1999a; Abbasi, 1999b).

Existing knowledge of the Bank's role in global health suggests several issues that remain pertinent to our understanding of the institution's role within global health. The first is the introduction of market oriented practice in promoting efficiency within healthcare systems. The second is the shifting role of the state to make way for privatised provision, and the introduction of non-state actors as the main service providers within healthcare. Third, the emphasis the Bank places on 'sector wide' approaches, and the apportion of failure onto the state not the Bank or its policies, i.e. the culture of 'its not me, its you' as a reason for relationship failure between states and the Bank. However, these issues are often understood in isolation of the Bank's wider project and the activities of other Bretton Woods institutions in global health or how the Bank has developed these policies over the last ten years. Approaches to the Bank and health have thus far been developed by public health

specialists, with those studying structures of global political economy and global governance remaining curiously silent on the issue.ⁱⁱⁱ To understand the World Bank and global health, is to use the basis of what we know about the Bank and health as a basis for understanding current trends in Bank health policy from a political-economy governance perspective that focuses upon its relationship with health interventions, the state and non-state actors, and how this relationship fits in with the wider embodiment of the Bretton Woods institutions in general. The following section will do so by mapping recent developments in the Bank's health policy by drawing upon main themes of multi-sectoralism and social protection and how these have been operationalised through the Bank's programmes on HIV/AIDS and onchocerciasis.

Social Protection and New Forms of Health Financing

Since 1997 and the introduction of the Comprehensive Development Framework/Poverty Reduction Strategy Paper approach to lending the World Bank has attempted to distance itself from the negative connotations of structural adjustment for health. It has done so by promoting a 'good governance' agenda that facilitates partnership and dialogue between the Bank and its partner state and non-state actors. The aim is to promote participation, accountability, transparency within borrower states as key mechanisms of good governance. As such, the Bank presents the image of moving away from the 'top-down' 'hard' politics that have come to characterise the work of the WTO and IMF by promoting a holistic 'bottom up' approach to development. This approach has acutely been felt within healthcare where the Bank has developed its commitment to forms of community engagement, health system reform and sector-wide planning. The Bank's approach to health as a global public good situated within its holistic approach to development is only one explanation as to why it engages with health policy. An alternative explanation would be the role of health in maintaining the Bank's position as a leader in development knowledge and expertise. In positioning itself at the heart of global health policy, the Bank presents alternative approaches to public health that break from the norm of public health interventions. These alternatives fulfil the international community's desire for new, innovative solutions to global health, whilst consolidating the Bank's position at the centre of development knowledge and expertise, and thus its wider relevance to global politics. At the centre of these approaches is the Bank's commitment to liberal economism. The economism approach to global health

not only offers alternatives to more traditional forms of public-health - in this instance public systems of provision of welfare - but offers a further explanation as to why the Bank involves itself within health policy. The purpose of health policy within the Bank's liberal economism is threefold: i) the global economy requires healthy reproducers, producers and consumers to function and expand effectively; ii) emerging markets are located in countries where poor healthcare may discourage financial investment, lack of investment in key parts of the world will stunt the expansion, completion, and thus logic of the world market; and iii) state-led interventions within global health have failed, and market oriented approaches not only present more effective, affordable healthcare in the long-term through competition but implemented sector-wider have the ability to embed this logic at every level of health governance. Developments in these areas reveal much not only about the Bank's role within global health, but the current nature and status of global health policy making.

The Bank has developed and expanded its role in global health through: i) increased and new forms of financing, and (ii) flagship projects. According to data from the Bank's Health Nutrition and Population sector; total health financing peaked at US\$2.4billion in 1996, maintained a median average of US\$1.4billion between 1997-2007 (World Bank, 2007). Such data suggests a plateau within the Bank's lending to health over the last decade. What is clear is the steep linear curve within the Bank's health lending from 1970 onwards, as demonstrated below.

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Pertinent to understanding the role of the Bank within global health is not the quantity of finance, but the type of financing and how it develops models of best practice. Over the last ten years the Bank has developed these models through its 'soft' approach to conditional lending as part of its wider good governance strategy prioritises government 'ownership', community 'participation', a 'sector-wide' approach to health, and new forms of lending. In health terms, this has translated into the following types of programmes and directives.

The first shift in approach has been the Bank's relationship with borrower states and a focus away from purely health aspects of government. The Bank's holistic, sector-wide approach

to global health has seen a prioritisation of multiple aspects of government systems within developing countries, grouped together under an umbrella co-ordinating agency located at the centre of government, nominally the Office of the President/Prime Minister. The logic being that many health issues are influenced and influence themselves by a number of development concerns such as education, agriculture, gender; and thus cannot be addressed purely as linear health topics. What we thus see is a trend towards taking health out of the health sector. The Bank's focus has been to continue to help strengthen health systems and maintain emphasis upon privatisation as a form of efficiency and cost-effectiveness, but in terms of planning and vertical health interventions the process is to establish new government institutions that invoke the participation of all sectors of the state. The most acute form of this can be seen in the Bank's HIV/AIDS programmes in sub-Saharan Africa, wherein the Multi-Country AIDS Programme has seen the establishment of National AIDS Councils (NACs) in over thirty of the countries that receive MAP funds. These agencies were established within the project, by the Bank, to co-ordinate the national response to HIV/AIDS across the government at the national and district level, as well as financing and monitoring the activity of local and international non-state actors. Key to which was the emphasis placed on the National AIDS Councils owning their own mandate, strategic AIDS plans, and MAP programmes, despite the Bank articulating and designing these functions as a condition of lending for this sector. The National AIDS Councils provide the most explicit example of a shift away from Ministries of Health as the most natural partner for global health interventions by the Bank; however the Bank's involvement with onchocerciasis suggests a more latent expression of this trend. The Onchocerciasis Control Programme (OCP), and its successor, the African Programme for Onchocerciasis Control (APOC) both emphasised the need for regional co-operation between states, and the development of sector-wide interventions to expand its mandate from the health sector to include agriculture (World Bank 2008b). Whilst this did not show a major shift in the Bank's approach to state partnership it highlights how the Bank began to develop non-health ministry specific interventions with states. What this does reflect is the role of the Bank in breaking with wider strategies in global public health. Sector-wide approaches and regional co-operation have been a central part of global health governance; however activities within the state have been firmly located within the health sector. Organisations such as the WHO have traditionally prioritised health sector strengthening and relations with the Ministry of Health

as the central focus of state strategies in global health. The difference in approaches between the two is evident from the institutional rivalries between these new non-health health agencies and Ministries of Health, specifically within HIV/AIDS governance. The Bank's approach further reflects the shift away from traditional discourses of 'public' health, to new forms of state intervention that include multiple non-state actors, as evident from the rise in community and private sector inclusion.

The second shift in the Bank's approach to global health has been community provision. As a wealth of research into global public health interventions would suggest, community participation and inclusion in delivery of health services is not a new phenomenon.^{iv} However, the Bank has developed processes of community inclusion through new forms of community financing. The first is through more money. As part of its community-driven development approach, the Bank has directed unprecedented funds to non-state actors, specifically grassroots community groups. It has done so through the formation of local state structures designed to identify, fund and monitor community activity, and through making funds available to loose-knit organisations without any stringent conditions or guidelines. The purpose of which was to support those individuals who had bear the brunt of health provision by giving them funds to support their activities and grow into more organised forms of collective action. The overall aim of the funding would be for communities to hold government activity to account, and promote forms of good governance – accountability, transparency and participation in decision-making.

Emphasis upon community-driven health responses can be seen within the Bank's HIV/AIDS programmes with community actions funds/initiatives being an integral part of MAP funding. Here money was directed through the National and District AIDS Councils direct to various types of community groups, be it a grandmother providing food for 6 of her grandchildren, or a local group of teenagers educating their peers on methods of HIV/AIDS prevention. The crucial distinction being that health money was not necessarily going to clear health activities. Part of this can be attributed towards AIDS Exceptionalism as a non-health disease. However, analysed against the ACOP programme, a similar pattern arises. A key part of ACOP was community distributed treatment (ComDT) wherein communities would establish distribution networks alongside local health centres (World

Bank, 2008d). These networks followed similar rationale of being able to monitor and assist with treatment, to make sure the drugs prescribed were reaching the right people and being administered correctly, as well as being able to reach wide rural and geographical locations. What is crucial about the Bank's involvement is the scale to which it elicited community participation. Whilst other international non-governmental organisations (INGOs) and donor agencies have been promoting this form of intervention within healthcare for some time, the scale of the Bank's programme and its relationship with borrower countries enabled it to establish this type of health intervention as best practice. Moreover, the Bank has brought community groups in line with state-run systems, got them to collaborate and engage with national and global systems through participation in strategic planning, and building both states and the Bank's claims to local expertise and knowledge.

The World Bank has come to develop this approach to community financing and forms of community-driven development under the umbrella of 'social protection.' Social protection by the Bank aims to target the needs of specific groups within healthcare. Specifically this has come to mean women, gender and families. This approach has generated a shift in discourse within health elements of the Bank towards conditional cash transfers that direct funds straight to families as a form of comprehensive intervention for orphans and vulnerable children (OVCs). As such the Bank is becoming more targeted in its community interventions, and is showing clear recognition of the individual, and in particular, women in healthcare provision. The role of women here is of particular relevance. As previously outlined, part of the role of healthcare within the Bank's wider economism agenda is the health of reproducers, producers, consumers within the global economy. Women form a specific function within this as they are not only integral to reproduction, but provide the care, support and upbringing of consumers and producers within the global economy. Social protection funds not only address the core of health provision and ensure healthy workers and consumers, but expand the market by bringing women into its logic through lending, competition and efficiency. Social protection thus reflects the workings of the Bank's liberal economism logic at the most personal level of international intervention: the family and the individual.

The third change in the Bank's global health strategy has been the emphasis placed on sector-wide approaches to health. Sector-wide approaches have been used interchangeably with multi-sectoral inter-sectoral by the Bank to mean the involvement of multiple actors within responses to global health. This approach is evident in the Bank's emphasis upon the involvement of non-health sector within the national governance of health issues and with the level of community involvement within these initiatives. The inclusion of community groups alone points to a shift away from not only state centric provision that arose out of lack of public welfare during the 1980s, but the incorporation of these community groups within decision-making. A key aspect to multi-sectoral inclusion has been the emphasis the Bank places on sector-wide approaches, or SWAs that facilitate joint procurement structures, planning exercises, health packages and performance reviews. The purpose being to enhance cross-sector collaboration and address the underpinning socio-economic drivers of particular health illnesses.

Beyond changes within the state apparatus of health provision and community inclusion, sector wide approaches pertain to inclusion of the private sector, multiple international agencies, and regional organisation. The Bank has promoted these types of health sector directives in the following ways. The first is by developing models for business inclusion within wider privatisation packages of healthcare, and working with the private health sector, most notably pharmaceutical industries, to provide treatment at lower rates and medical equipment to developing countries. As part of World Development Report 2005 *A Better Investment Climate for Everyone* the Bank is further tying health to promoting the investment climate for developing countries, both for external international companies, and by promoting the infrastructure for local investment and the development of business initiatives. Key to which has been the apportionment of in-country forms of corporate social responsibility, such as providing incentives for free voluntary counselling and testing for HIV and other STIs at the workplace. In the case of onchocerciasis, the Bank's inter-sectoral collaboration with other health donor agencies, INGOs, and most notably Merck and Co. ensured that Ivermectin to treat onchocerciasis was provided free of charge for as long as it was needed (World Bank, 2008c). The increase in drug availability and financing for the disease co-ordinated by the Bank reached 65million people by 2007 (World Bank, 2008a).

The most notable form of sector-wide approaches relates to the co-ordination of international efforts around specific health issues. The multiplicity of actors involved in public health often leads to over-crowding of finance, multiple funding structures and systems, projects and people in specific vogue-health issues, burdens on national health systems and government agencies, an imbalance in health financing, confusion, frustration and competition over knowledge, expertise and finances between actors. This has been particularly acute within HIV/AIDS where the amount of international aid being earmarked for the epidemic in sub-Saharan Africa has grown to US\$10 billion per annum. This funding has been accompanied by a growth in international actors, objectives and policies. The ensuing problems and confusion surrounding arising from this growth has resulted in an international concerted effort to co-ordinate resources and policies at every level of the response. Co-ordination occurs through general adherence to UNAIDS' 'The Three Ones' principles (UNAIDS, 2008).

The Bank's approach to global health over the last ten years presents a change towards a more 'soft politics' form of intervention. The above examples of state ownership, community participation, and multi-sectoral collaboration present the image of a collaborative Bank that whilst maintaining a level of conditionality is much more friendly-faced than the IMF and its structural adjustment reform. The Bank's economism, conditional-lending, liberal emphasis remains; but whereas these issues were presented as problems in the past, the 'good governance' incarnation of liberalism is presented by the Bank as more adaptable to the needs of states in their ability to respond to global health concerns. However, closer interrogation of these shifts in Bank policy from a political economy perspective suggests these interventions transcend problems of business-as-usual Bank economism and global health, but are leading to shifts within the state and market that has become embedded at every level of health governance. It is these long-term underlying factors that reveal the most about the Bank's role in global health, and the future ability of global health governance to fully address these concerns.

Making sense of the Bank and Health: the consequences of reform

Trends and developments in the World Bank's global health strategies mark a process of embodiment of the Bretton Woods' liberal reform packages. The function of health policy as

integral to the functioning of the global market that underpins the Bank's intervention into public health derives from the liberal consensus at the heart of the Bretton Woods institutions. It is no longer relevant to assess whether the new forms of Bank reform in healthcare is structural adjustment by a different name, this is of little consequence for our understanding of the Bank or its policies; what is relevant is what impact developments within the Bank's health strategies are having upon the political economy of global health. This can be seen in regards to the impact they have upon the state, the market, the community, and the governance of global health. This section will address each of these areas and how it fits in with the wider work of the Bank's partner organisations - the IMF and the World Trade Organisation (WTO).

The Bank's emphasis upon state ownership of health sector reform and sector-wide approaches has several consequences for the state. The first is that the state is not necessarily in decline, its role and position within global health is just shifting. Whereas the state was under decline with the introduction of privatised forms of healthcare during the structural adjustment era of the 1980s, the emphasis of state ownership by the Bank has brought the state back in as a leader in healthcare. What has changed are those state structures which occupy this leadership position. Through vertical lending to specific projects the Bank has prioritised the role of non-health aspects of the state apparatus. Health has become bounded within wider programmes on poverty and development, and has thus been integrated throughout different agencies within government under the aegis of a sector-wide or multi-sectoral approach. This has had several consequences. First, it has shifted focus away from the medical aspect of global health towards its socio-economic underpinning. Second, it has created tension between the health sector and these new government agencies. Third, it has fudged the line of who is responsible for the welfare of a country's population. In 'owning' specific health programmes, this responsibility lies with the government; however in funding and directing specific programmes there is a high degree of responsibility on the Bank itself. This results in a hollow form of health ownership which establishes long-term antecedents of future state management of the healthcare of its people. Fourth, distinctions between the state and civil society become obsolete. The removal of global health from health and medicine has marked a shift from the public health approach taken by institutions such as

the WHO to the liberal economic approach towards privatised health as a development model by the Bank.

The inclusion of community participation within global health is led by the Bank. As the examples of HIV/AIDS and onchocerciasis indicate, the emphasis upon community-driven development as a condition of lending has placed emphasis on states to include non-state actors within decision-making and earmark a substantial proportion of their health budgets to fund their activities. This is irrelevant of the history or culture of relations between the state and non-state actors. As this chapter earlier suggested, non-state actors have been involved in the provision of healthcare for quite some time, and their presence became acute in response to the withdrawal of the state under structural adjustment. However, this involvement was predominantly local communities looking after their sick friends and family unpaid, or INGOs providing services and finance to community operations. The World Bank was the first to direct funds straight to the community through state structures and involve local communities within spheres of influence and decision-making in government. The types of community-driven development or engagement mechanisms used by the Bank suggest specific consequences for non-state activity within health provision and reform. The first is that communities have come to occupy the position of privileged relations between the state and international organisations that INGOs once occupied. Second, the role and presence of civil society actors within healthcare does not reflect an emancipatory advocacy movement that has arisen out of discontent or the need for change, but is underpinned by the same movement towards privatised activity that led to the emergence of these actors in the first place. Civil society activity within global health is constructed by money and financial flows to community groups. As such, the Bank has brought community members into the liberal market logic of provision and health welfare where community groups have to compete for resources, seek private partnerships, and supplant the role of the state in providing welfare for key demographics. Accountability and transparency – two of the central pillars of the Bank's good governance agenda – exist in such a way as to maintain the status quo of the Bank's programme for global health. Civil society groups and the state must be accountable, but the World Bank does not have to be as it does not own the project. However, the ability for civil society groups to hold the state or the Bank accountable are frustrated by the need for resources to keep their activities, and provision for the sick

sustained. This leads to a second consequence of the widespread absorption of the Bank's approach to community driven development: the role of civil society or the community as somewhat separate from the state. Both in the examples of onchocerciasis and HIV/AIDS the Bank and the state has been keen to note the separation between state and civil society as a key tool of accountability within health systems. However, the nature of funding practices by international organisations through the state, and the inclusion of CSOs within decision-making structures within the state suggest a Gramscian view of civil society being intrinsic to the formation of state-structures within global health pertain.

The third and perhaps neglected consequence of the Bank's approach to community engagement is the impact upon women and gender. Women play a central part in the provision of health care services and the link between economism and healthcare through social protection. Within developing countries, women form the majority of home-based carers, take care of sick relatives, and girls are more likely to drop out of primary education to care for the sick, manage family households than boys. Social protection loans account for women's function of producing and ensuring a healthy workforce. In placing emphasis upon the role of communities within health, and prioritising funding to community actors, the Bank's interventions have the following consequences for women and their position within the global political economy. The Bank provides remuneration for women's work that has often been assumed as a gender role for women: care. This in some form embeds the role of women, but as funding increases, attracts men to these sort of role as they become paid employment. What we see then is a movement, albeit a slight one, towards male involvement in female gender roles. Crucially however, this is a role of finance. Whereas the role of women and micro-finance has been well-documented; the role of women as the recipients of community-driven health funds has been neglected. These funds involve women in an intricate form of global finance, as they export the market logic inherent within specific Bank programmes. This does not necessarily remove women from traditional boundaries of the 'private sphere' of political activity, but introduces market logic within it. The movement towards conditional cash transfers direct to families from the Bank embeds women's role as facilitators of Bank liberal market logic further. Not only does it bring women in to this type of economy, it confronts specific roles within communities that have deeply embedded gender norms and practices. The Bank is thus not involving itself in the macro politics of

states and markets, but is embedding its own brand of health sector reform within communities and families, and in so doing challenging gender roles. Giving women more power through the market is not necessarily a bad thing in the short term, but becomes problematic when it is the very logic that has undermined gender equality for the last thirty years, specifically within global health.

This view has been adopted and promoted by but is not limited to the Bank. The Bank's government ownership, community participation, good governance approach to global health has been adopted not only by states and community groups bound to the conditions of health programmes, but international organisations that have come to promote a similar agenda. As the chapter previously indicated the Bank has supplanted much of the role of the WHO as the lead agency in health provision, and came to the fore at the expense of UNDP during the 1990s. The Bank has consolidated this position by more strategic vertical forms of health financing, its close working relationship with governments – specifically within sub-Saharan Africa, and its claims to knowledge and expertise. In presenting itself as both a lender to specific health projects, as well as an organisation that can provide expertise and direction arising from its experience direct from the field, the Bank is able to mark itself out from other rival UN agencies. This has specifically been the case within the HIV/AIDS response, where UNAIDS and its 'The Three Ones' organising structures have adopted and followed the principles of the Bank's approach to the epidemic as enshrined within the MAP (Harman, 2007). However, this trend is not only limited to HIV/AIDS. The Bank has used models developed within HIV/AIDS and onchocerciasis programmes to export its specific form of community-health responses to health concerns such as avian flu. What is specific to the Bank's approach, however, is the latent expression of this influence upon the international health system. Health specialists acknowledge the Bank plays a central role in global health yet, in maintaining the role of state ownership and multi-sectoral partnership, the Bank presents the image of taking a backseat role within this, and thus to a certain extent, remains unaccountable to those it affects. Moreover, where new health institutions and funding such as the Global Fund to fight AIDS, Tuberculosis and Malaria have appeared to threaten or challenge the Bank's authority within global health, in most instances these institutions have been designed and implemented within the same liberal framework

for global health articulated by the Bank. The role the Bank has in global health is thus that of leadership through soft power.

To make sense of the World Bank's role in global health, one must make sense of how it exerts its power and the origins of its approach. Where the Bank once deployed a clear form of economic conditionality in partnership with the IMF as a form of exerting its influence, the Bank has maintained such conditionalities but exerts them through a form of soft power that gives the appearance of promoting state and community led-health strategies. This form of soft power is expressed through the Bank taking on the role as benevolent lender. The Bank partners states and helps them strengthen and develop specific health strategies and implements its plan through government agents and community groups. States have not retreated or become eroded within this model of global health, but have internalised and promoted the Bank's interests in such a way that the state health concerns are intrinsically aligned with the Bank's health concerns. Health concerns reach individuals on a global scale, thus to imbue reactions to global health with a logic of liberal economism, the Bank is able to extend its global influence to every aspect of the world, and embed its practices at the state to community level whilst remaining unaccountable to those people its policies affect. Disaggregate structures of monitoring, feedback and design distort the position of the Bank and allow it to promote its own form of good governance with little reciprocity. Where health strategies are failing, responsibility is apportioned to all actors but the Bank, with the solution being: more Bank.

The Bank is further able to extend this influence through the filtering of key actors within global health through the Bank system into other international actors working on global health. For example Richard Feachem, the first Executive Director of the Global Fund (2002 – 2007) was Director for Health, Nutrition and Population (1995 – 1999) at a strategic time in the Bank's arrival on the global health stage. Bank-staff are briefed in the art of 'paradigm maintenance' (Wade, 1996) wherein they are employed, promoted and recognised for taking an approach to global health that fits in with the Bank's over-arching commitment to economic liberalism (Broad, 2006). As is often the case within the development field, there is much cross-over between professionals in global health organisations. However, this cross-over does not signal a cross-germination of public health

and a liberal economism approach to global health. The policy space is one-way, with liberal economism supplanting 'public' health approaches within these organisations. What is specific about the World Bank's role in health is how it has exerted its influence and embedded its own paradigm for global health through a combination of individuals, state and community partnership.

The Bank's 'soft politics' role within global health exists in partnership with the more 'hard politics' strategies of the WTO and the IMF. Combined, these hard and soft policy options result in a shrinking of policy space for states, international organisations and non-state actors within global health. Regardless of whether it has shifted in expression, the liberal orthodoxy promoted by the Bretton Woods institutions have been at the root of global health since the late 1970s and has become embedded within every aspect of global health strategy. Actors must align their programmes, projects, and strategic plans with this orthodoxy to ensure global recognition, finance, and legitimacy. Global health governance is thus not a contested terrain of political activity but an embodiment of liberal market values. While the WTO and IMF have promoted this brand of global health directly to states, it is the role of the World Bank as the soft arm of power that has embedded this logic at every level of global health governance. The Bank is thus the central institution for understanding the governance and political economy of global health.

Conclusion

Over the last thirty years the Bretton Woods Institutions have come to occupy a central role within global health governance. The most complex, far-reaching, and central actor of these institutions is the World Bank. The Bank has been commonly associated with global health for its role within the promotion of structural adjustment policies and the introduction of the market to public health within developing countries around the world. The subsequent impact this has had upon reduced health systems and provision and the ability of countries' respond to 'the big three' diseases has been the focus of much research. However, despite the negative connotations associated with its health policies, the Bank remains the leader of global health knowledge, programming, and agenda-setting. It continues to be the preferred partner to states whose health systems suffered from its previous recommendations, and

establishes the mandate for global responses to high profile issues such as HIV/AIDS in which multiple international organisations that used to occupy this role follow.

The Bank has done this by applying its strategy of comprehensive development, good governance politics to specific global health interventions. These strategies have promoted the use of government ownership of Bank strategies, community partnerships, and sector wide approaches that the Bank has been able to develop through a mixture of finance, claims to knowledge, individual staff members and the presentation of its status as a non-political, trustworthy agency. In promoting this strategy the Bank has underpinned the current paradigm of global health policy, and thus maintained its central leadership role despite the emergence of new forms of actors earmarking unprecedented funds towards health. New actors and new forms of finance have to align themselves with the need for co-ordination and commitment to single Bank-articulated strategic health plans as states do. Any contradiction of this is seen as an affront on state sovereignty or global collaboration. The Bank no longer needs to use large loans with stringent conditionalities to influence global health as through strategic interventions it has established a global agenda with its commitment to liberal market economism at the centre. The Bank's commitment to the principles of good governance has been applied throughout its development programmes. However, what makes health specific is the global interconnectedness of policy and impact, the ability to affect and influence the personal, and its relation to the functions of production and consumption within the global economy.

The application of the Bank's strategy has had several implications for the political economy of global health governance. First, the state still has a role within global health. However, application of the Bank's agenda has removed health from the health sector, either taking a sector wide approach or situating it within more centralised forms of government and the Ministry of Finance. The role of the state has not diminished, but is at the hub of the Bank's promotion of good governance. Second, the role of non-state actors is permanent within healthcare provision. However these non-state actors are primarily community groups which have become imbued with the market logic of state interventions into healthcare. As such remuneration of healthcare at the community level is bringing women to the centre of the political economy of health. Women have played an intrinsic role within global health, but

movements towards new forms of social protection by the Bank sees a new form of macro political economy within healthcare. Third, there is a shrinking of political space for alternative approaches to global health to develop. The approach of the Bank, as reflected in the wider agenda of its Bretton Woods partners, has dominated the agenda and is embedded in such a way it will continue to do so.

Financial crises, the emergence of new actors, and institutional inertia all post a threat to the future role of the World Bank within global health. However, its antecedents are intrinsically embedded within every level of global health policy-making to affect the future of global health for the next twenty years. Global health governance is thus not in a state of flux or change, but is an intrinsic part of the World Bank's model of liberal economic global health intervention.

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ⁱ I am principally concerned with one of the first definitions of economism articulated by Matthew Sparke within this book: economism of market fundamentalism, when I discuss economism in regards to the World Bank and public health.

ⁱⁱ The World Bank underwent several reform processes under the presidency of James Wolfensohn (1995 – 2005). This reform saw the introduction of the Bank's 'good governance' agenda, and a shift away from structural adjustment towards the Comprehensive Development Framework approach that emphasised the role of governments, civil society, and sector-wide approaches to development projects. This period saw the Bank reach out to its critics and involve itself in multiple development topics. Health, and high-profile issues such as HIV/AIDS was a specific priority during this time.

ⁱⁱⁱ This claim is based on a revision of books and articles from leading international politics and development journals over the last 20 years that consider the role of the Bank. Health has mainly been addressed within international politics as an example of shifts in the Bank's institutional development under McNamara (Goldman, 2005) and post-Cold War (Weaver and Leiteritz, 2005); the detrimental impact of structural adjustment (Peet, 2005); or in reference to HIV/AIDS (Harman, 2007; Mallaby, 2004; Woods, 2006). Understandings of the Bank's conception of participation, accountability, good governance, influence and role within the global political economy can be applied to how we understand its role in healthcare, but do not directly use global health as a means of understanding the Bank. In recent years there has been an increase in publications on the political economy and governance of HIV/AIDS.

^{iv} See Lee and Goodman, Rifkin, Gilson and Mills, Labonte and Laverack, Laverack and Labonte