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A Thematic Review of the Potential Future Role of the World Bank in Financing Health Systems

CORDELIA KENNEY · AINHOA PETRI-HIDALGO · ROSIE ELDRIDGE · PETE BAKER

Abstract

Sharp aid cuts in 2025 and the immediate financing crisis they precipitated have brought to the fore calls to address longstanding challenges in the global health aid architecture. While a greater role for multilateral development banks (MDBs) moving forward has been suggested, the feasibility and suitability of such a shift have yet to be explored in depth. This paper pairs a descriptive analysis of the World Bank's health portfolio with a thematic analysis of how the Bank engages in the health sector. The aim is to describe the World Bank's current role in health financing, identify its strengths and weaknesses, and inform discussions on its potential future role—as well as the broader role of MDBs—in health financing.

We find that the World Bank is a major financier of health, with an estimated $7.0 billion in 2025 health commitments: $3.5 billion from the International Development Association (IDA), $2.8 billion from the International Bank for Reconstruction and Development (IBRD), and $713 million from trust funds. World Bank financing is equivalent to 16 percent of government health expenditure in IDA countries and just 0.4 percent in IBRD countries. However, health comprises a relatively small share of the World Bank's overall active portfolio, at 7 percent. The World Bank has substantial advantages that could be built on: a country-led approach, coverage of nearly all low-income countries, on-budget financing, the ability to use both loans and grants, and a multisectoral approach to health. The World Bank also has significant downsides. It has many competing priorities and limited tools to earmark resources for health; given its demand-driven nature, governments choose which sectors to prioritize with Bank financing, and health is often not at the top of the list. The World Bank also faces external pressures, internal incentive structures, and operational challenges that risk undermining the effectiveness of an expanded health portfolio. If these challenges can be mitigated, the World Bank has a prominent role to play in the future of health financing.

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Executive summary

Sharp aid cuts in 2025 and the immediate health financing crisis they precipitated have brought to the fore calls to address longstanding challenges in the global health aid architecture: fragmentation across funding sources, verticalization of funds for specific diseases and interventions, proliferation of extra-budgetary parallel delivery platforms, donor influence on priority-setting with variable alignment with country priorities, crowding out of domestic health investment, and dependency on external support all point to an urgent need for reform. Given the high likelihood of continued volatility and reduced aid over the medium term, health financing demands greater coherence to ensure effectiveness and impact.

A greater role for MDBs, including regional development banks, in health financing could be part of the solution to these challenges. MDBs pool a wide range of donor financing, have a broad multisectoral remit, deliver financing counted toward national budgets and work directly with country governments, and offer a range of financing tools that can be tailored to individual contexts and financing needs. MDBs can use a blend of grants and loans to customize support as countries grow, thereby supporting sustainable transitions and aid defragmentation. Three promising policy options exist for an expanded role for MDBs in health financing: taking on a greater role in country-level donor coordination; global health institutions (GHIs), such as the Global Fund to Fight AIDS, Tuberculosis, and Malaria (the Global Fund) and Gavi, the Vaccine Alliance (Gavi), co-financing Bank operations focused on health systems; and creating a World Bank IDA health window open to MDB co-financing. The practicality and suitability of MDBs absorbing a greater share of health financing, however, have not been investigated adequately to date.

To address this gap, the Center for Global Development (CGD) undertook a multi-pronged analysis intended to surface key structural constraints, operational challenges, and practical barriers that would need to be addressed before the share of health financing through MDBs could increase. More specifically, this analysis sought to describe the current role of the World Bank in health financing as the largest and most influential MDB, and to identify the Bank's strengths and weaknesses to inform discussions on its potential future role. The paper is structured into three sections: a general overview of how the World Bank works, a descriptive analysis of the World Bank's current health portfolio, and a thematic analysis of how the Bank engages in the health sector, with countries, and with other partners. The thematic analysis largely focuses on current and recent experiences, while the descriptive analysis encompasses the Bank's current health portfolio.

Portfolio analysis key takeaways

- With an estimated $7.0 billion in 2025 health commitments across IDA, IBRD, and trust funds, the World Bank accounts for approximately 18 percent of the $39.1 billion in total development assistance for health (DAH) disbursements in 2025.*
- The World Bank committed an estimated $7.0 billion to health in 2025 across 382 active health operations, accounting for 7 percent of the Bank's IDA, IBRD, and trust fund portfolio. Health is a meaningful but relatively small part of what the Bank does. IDA contributes 50 percent ($3.5 billion) of health commitments, IBRD 40 percent ($2.8 billion), and trust funds 10 percent ($713 million).
- The Bank primarily funds health through dedicated health projects (87 percent) rather than across multisectoral operations (13 percent).
- Investment Project Financing (IPF) is the instrument used most widely across the health portfolio, accounting for 67 percent of 2025 health commitments. Program-for-Results (PforR) represents 27 percent, and Development Policy Lending (DPL) accounts for just 6 percent. IDA (78 percent) and trust funds (85 percent) are especially reliant on IPF.
- The Bank's health portfolio is highly concentrated in the largest operations. The top 25 percent of projects by size account for 75 percent of all health financing, while the bottom half account for just 7 percent of total commitments.
- The Bank has broad country coverage: 90 percent of IDA-eligible countries have active health projects, versus 57 percent of IBRD countries.
- The typical IDA-eligible country has three health projects alongside roughly 17 non-health projects. Health represents just 11 percent (mean) of IDA countries' active portfolios (7 percent median), and even less in IBRD countries (6 percent mean, 1 percent median).
- Different financing sources target different regions. IDA has a heavily Africa-focused portfolio, IBRD has a more balanced portfolio spread across the Middle East and North Africa, East Asia, Europe and Central Asia, and Latin America and the Caribbean, and trust fund financing is concentrated in the Middle East and North Africa and Europe and Central Asia, reflecting substantial flows to health projects in fragile and conflict-affected settings.
- Reflecting their different mandates, IDA health financing is more concentrated in poorer countries: low-income countries (LICs) receive 49 percent ($1.6 billion) and lower-middle-income countries (LMICs) 47 percent ($1.5 billion), with just 4 percent flowing to

* Health commitments reflect multi-year project envelopes annualized across project duration, while total DAH reflects annual disbursements as estimated by IHME. This ratio therefore overstates the Bank's share of annual DAH flows. See Institute for Health Metrics and Evaluation. Financing Global Health 2025: Cuts in Aid and Future Outlook. Seattle, WA: IHME, University of Washington; 2025. https://www.healthdata.org/research-analysis/health-financing.

upper-middle-income countries (UMICs). For IBRD, the pattern is reversed: UMICs receive the largest share at 52 percent ($1.5 billion), followed by LMICs at 41 percent ($1.2 billion).

- A significant share (44 percent) of IDA health commitments flow to countries with a gross national income (GNI) per capita above the $1,325 IDA eligibility cutoff. However, this pattern is not unique to health—across all sectors, approximately 58 percent of IDA country allocations flow to countries above the income threshold. IDA health is therefore more concentrated in the poorest countries than the overall IDA portfolio. This reflects IDA's performance-based allocation formula, ongoing disbursements from pre-graduation projects, and deliberate transition policies.
- World Bank health financing is a critical contributor for IDA-eligible countries, representing a median of 16 percent of government health spending, with several fragile states exceeding 50 percent or even 100 percent. For IBRD countries, the median is negligible at just 0.4 percent. This gap largely reflects rising domestic spending capacity and country borrowing choices—the median IBRD country spends $314 per capita on health compared to $25 for the median IDA country—rather than a withdrawal of Bank support.
- Health lending continuity after IDA graduation is highly uneven. Of 19 graduate countries with usable data, the majority sustained or increased health lending through new IBRD commitments, but six saw sharp declines. Legacy IDA disbursements can mask the distinction between countries actively securing new IBRD health financing and those simply running down existing IDA commitments.

Thematic analysis key takeaways

- Because the Bank's voting structure is based on contributions, its macro-governance is donor-controlled and US-influenced, with no civil society participation. This donor control, however, is balanced by its high degree of country autonomy over use and prioritization of funds, as well as on-budget financing (i.e., financing that flows through the national treasury and counts toward the national budget).
- At the project level, the Bank's multisectoral nature offers country autonomy over sector allocation and the potential to tackle the social determinants of health, but this orientation also means health funding is always competing with other sectors.
- The Bank's country-led approach is an asset for alignment with national priorities. At the same time, the Bank's demand-driven nature means prioritization of health cannot be guaranteed; indeed, there is considerable variability in how much of countries' World Bank portfolios goes to health, and the Bank (intentionally) lacks effective mechanisms to increase it, with the exception of small leveraging effects through the Global Financing Facility (GFF) and other trust funds.
- A larger role in health clearly fits the Bank's mandate, and the President has championed health. However, this championing may be temporary, and pressures are building to focus on other

priorities such as employment and jobs. Country-level engagement of civil society organizations (CSOs), moreover, will be an important component of scaling up Bank engagement in health.

- The World Bank is well placed to use the right blend of grants and loans to meet country needs. Specific financing instruments are available to meet donor needs for accountability, control, and performance incentives.
- Trust funds can attract additional funding, and they can incentivize specific objectives, but their proliferation can increase donor influence, administrative burden, and fragmentation.
- The GFF shows both the strengths and limitations of the Bank's trust funds. As a trust fund, it can raise money from donors (including philanthropies), earmark it to health, and integrate it with Bank operations. But the trust fund model also means its governance structure is dominated by a small number of donors, it can only use grants and not loans, which limits its scale, and the administrative burden is higher than IDA since it requires a separate Investment Case and approval process.
- Despite its historic focus on investment lending, a significant share of IDA (24 percent) is in the form of grants, and these frequently cover recurrent costs.
- Expanding the World Bank's role in health financing will need to be aligned with appropriate incentives for key staff such as task team leaders (TTLs, the lead points of contact for borrowing countries), along with better tracking of results. Better tracking and communication of results is key to maintain donor support. The Bank will need to overcome operational barriers to effectiveness, such as lead times in project development. Its impact will be greatest if the Bank leads on financing and works with partners to strengthen the technical assistance (TA) and procurement ecosystem that the Bank and LMICs can draw upon, rather than leading on these functions.
- Processes perceived as slow—by clients, partners, and in the literature—along with the Bank's government-to-government approach, make it well suited to stable, low-income settings but less so to fast-moving humanitarian contexts or contexts with very low government capacity. The Bank does have a Fragility, Conflict, and Violence (FCV) strategy with a different model in these settings: 10 percent of IDA and IBRD FCV commitments went through third-party implementers in 2020–2025. An external and independent evaluation of this approach (use of third-party implementers in FCV settings), covering all major global health funders, would be valuable in guiding a future expansion of the Bank's role in health.
- There is a real risk of concentrating power and influence in a single multilateral institution in the event of a greater share of health financing being channeled and administered through the World Bank. This risk will need to be mitigated through stronger accountability, transparency, and external reviews.
- The Bank could play a greater role in supporting governments to coordinate donors at the country level and increase its co-financing with Gavi and the Global Fund. This will require

greater transparency and flexibility, investing time and leadership in communication, collaboration, and alignment of staff incentives, and will need to be accompanied by similar changes in how partners operate.

The World Bank has an important role to play in the future of health financing and in supporting countries to achieve their health goals. The Bank has several major strengths that could support an expanded role, including its offering of both grants and loans, its established presence in nearly all LICs, and its on-budget financing and partnership with ministries of finance. A larger role in health clearly fits the Bank's mandate, and the President has championed health. To enhance its suitability as a major financier of health, the Bank should consider new approaches to increase the prioritization of health spending—such as an IDA health window—learning from the GFF experience. The Bank will also need to strengthen transparency and accountability to clients, enhance tracking and reporting of results, improve alignment of internal incentives, place a stronger emphasis on LICs, continue to improve its model in FCV settings, and support countries in the design phase to ensure it is able to deliver high-impact health financing that is attractive to donors, builds health systems, and respects national health sovereignty.

Introduction

The status quo in global health is no longer tenable. The global health system writ large is losing credibility, both with the donor countries (and their voters) on which it relies for financing and with recipient countries (and their citizens) that health aid is intended to serve.[1,2] Major contributors like the US, the UK, and France are sharply cutting aid, leaving key institutions like the World Health Organization (WHO) and Gavi in financial crisis.[3,4] The result is that LMIC governments must absorb aid cuts while managing debt burdens and competing demands for scarce resources.[5]

The sharp aid cuts in 2025 and the immediate health financing crisis they precipitated have brought to the fore calls to address longstanding challenges in the global health aid architecture. First, health aid is highly fragmented across many different funding sources, which incurs high administrative costs for countries to fulfill duplicative (though not identical) application, reporting, and compliance requirements. This "fragmentation of aid" results in multiple funding streams, each with its own priorities and reporting requirements, risking overburdening countries and creating parallel structures.[6] Second, health aid is highly verticalized, with most aid earmarked for specific diseases or interventions rather than for health systems more broadly. Third, most (though not all) health aid is routed through extra-budgetary channels, creating inefficient, unsustainable parallel delivery platforms outside national budgets and government-run systems. Fourth, donor preferences still largely drive how health aid is allocated, thereby insufficiently aligning with country priorities and ownership. Fifth, health aid can create perverse incentives that crowd out domestic health investment and create dependency on external financing, even for the most essential health services.[7] Finally, aid looks set to decline relative to the previous decade and remain

volatile for many years to come, and there is an urgent need to focus what remains to ensure greater sustainability and coherence.[8]

On paper, MDBs have the potential to address many of these challenges. First, the broad remit of MDBs, combined with their on-budget and demand-driven funding approach, enables them to support governments investing in systems rather than pursuing short-term, project-specific outcomes. Second, MDBs offer both grants and loans at varying levels of concessionality, depending on the country. This financial model allows for leveraging additional on-budget financing for health priorities and increasing resources available to health systems while reducing reliance on grant funding in an era of aid austerity. Offering both grants and loans also allows MDBs to support countries as they grow, tailoring the type of financing to different points on the path of transition. Because of this broad remit and on-budget financing model, MDBs can deliver on a single set of priorities, and therefore deliver the allocative efficiency that vertical, disease-centric initiatives cannot. Third, MDBs can pool donor financing, thereby channeling funding through a single source and facilitating defragmentation.

Three promising policy options exist for an expanded role for MDBs in health financing. The first option involves taking on a greater role in country-level donor coordination. This enhanced role could include convening other donors and external partners to ensure alignment with country priorities and championing sector-wide approaches and the pooling of funding. The World Bank's National Health Compacts could be used for this purpose; however, as the compacts are currently designed, minimal accountability is built in for donors.[9] The second option involves Gavi and the Global Fund co-financing Bank health operations. The Global Fund and Gavi collectively disburse billions for health systems strengthening (HSS), and the World Bank has already engaged in some limited co-financing operations with these entities.[10] The third option is the creation of an IDA health window, open to MDB co-financing. While ambitious, this third option would maximally secure the benefits of MDB financing.[11]

MDBs already have a long history of supporting health systems and health programs in LMICs. The World Bank began direct lending for health in 1979 with the creation of the Population, Health, and Nutrition department, extending earlier work on population control into a broader health financing agenda.[12,13] The relative role of MDBs in health more generally, however, has shifted significantly in the intervening decades: the share of all DAH originating from MDBs dropped from 17 percent to 7 percent between 2000 and 2019.[14] While MDBs previously played a larger role in financing health, the health financing landscape shifted toward specific diseases—marked by the creation of the Global Fund, Gavi, the US President's Malaria Initiative, and the US President's Emergency Plan for AIDS Relief (PEPFAR)—leaving MDBs with a diminished share. The future nature and scope of MDB engagement in health cannot simply involve repeating approaches from the past, however; MDBs must both learn from previous mistakes and identify new strategies for meeting the complex, interconnected challenges of the present, as all global health actors will need to do moving forward.

Open questions remain about the suitability and feasibility of channeling and administering a greater share of health financing through MDBs in the future. The role and position of MDBs in the global health architecture, their performance in building health systems, their comparative advantages over other GHIs, and institutional and operational barriers associated with an expanded role have all received limited scrutiny to date. No formal, independent evaluation of the World Bank's role in health financing, for example, has been conducted in the last decade.* An analysis of these issues would likely yield insights that could inform the prerequisites for a partial consolidation of health financing mechanisms.

Aims

Given the World Bank's position as the largest and most influential MDB in terms of financing volume and global reach, we undertook a multi-pronged analysis of the World Bank's current health portfolio and engagement in the health sector to explore some of the themes outlined above. The aim of this paper is to describe the World Bank's current role in health financing and to identify its strengths and weaknesses to inform discussions on the future role of MDBs in health financing more broadly.

Descriptively, we aimed to identify the nature and distribution of the World Bank's projects and operations in the health sector. Thematically, we aimed to summarize commonly identified strengths and weaknesses of the Bank as identified in the literature and through stakeholder interviews, as well as any institutional rules, norms, or capacity constraints that would pose challenges to a significantly larger role in global health financing.

Methods

The overall rapid assessment included three primary methodological components:

A rapid **literature review** encompassing both published and gray literature on the role of the World Bank and other MDBs in health. The purpose of this review was to inform our understanding of how the World Bank and other MDBs have engaged in health since 2010, including mechanisms, lending trends, trust funds, and evaluations of effectiveness. Academic papers, institutional reports, independent evaluations, and gray literature were reviewed using academic databases (Google Scholar, PubMed, Scopus, Web of Science), institutional databases (World Bank, WHO, the Organisation for Economic Co-operation and Development (OECD), the Asian Development Bank (ADB), the African Development Bank, the Inter-American Development Bank (IDB), the International Monetary Fund (IMF), CGD, Brookings, the Overseas Development Institute (ODI), evaluation offices), and gray literature sources (SSRN, Devex, consultancy reports, working papers,

* The last was published in 2014.[15] Sridhar et al. have, however, published several academic analyses of the Bank's health financing.[13,16,17]

and other unpublished or non-peer-reviewed materials). A total of 260 papers were initially identified, with an additional 44 added through forward and backward citation chaining. From the 304 papers we identified, we assigned each a relevance score and identified 286 as relevant, of which 50 were highly relevant. Papers classified as highly relevant were those that provided direct, substantive evidence on the World Bank's engagement in health, including financing mechanisms, lending trends, trust funds, and evaluations of effectiveness.

A structured data analysis of the World Bank's health portfolio to understand the scope, structure, distribution, and content of Bank health operations. We began with 27,943 projects in the World Bank Projects & Operations dataset and narrowed the sample to all 382 Bank projects with a health component active in 2025, identifying how the Bank is *currently* funding health. The focus on a snapshot of the active 2025 portfolio is deliberate: the paper's central question concerns the potential future role of the Bank in health financing, and the most recent full year of available data helps us to determine the Bank's priorities based on what it is currently funding. The Bank's health lending was analyzed at the country level, project level, in comparison to government health expenditure, and before and after IDA graduation.

Semi-structured key informant interviews with 42 stakeholders explored thematic perceptions of and experiences with the World Bank's role and performance in health. Stakeholders interviewed represented a wide range of views and experience, including current and former Bank staff, partners at other GHIs, country counterparts within national governments, and donor and shareholder governments. Current Bank staff consulted include health financing experts, health specialists, health economists, regional strategy and operations experts, outcomes leads, and GFF staff. Donor countries and World Bank shareholders consulted include France, Japan, Canada, Germany, Norway, and the UK. Regional and health financing experts at WHO and Africa Centres for Disease Control and Prevention were also interviewed, along with current and former staff of the Global Fund and Gavi. Staff with relevant expertise were consulted at the Rockefeller Foundation, the Gates Foundation, and the Children's Investment Fund Foundation. Health financing experts at the IDB and the ADB were also consulted. Finally, staff from ministries of health and finance in South Africa, Zambia, Rwanda, and Nigeria with experience working with the Bank were consulted. Additional stakeholders were identified during interviews using a snowball approach to help ensure representation across stakeholder groups.

Interviews explored stakeholders' experiences working with the Bank, understanding of the Bank's comparative advantages, and perceptions of key practical considerations that would affect the Bank's ability to take on a larger role in funding and supporting health systems. Other topics included the Bank's capabilities as a grant-maker, the Bank's role in LICs, the Bank's governance model and strategic orientation as they relate to health, and experiences with the Bank as a development partner. The premise of the World Bank taking on a larger role in global health financing does not assume the Bank would do more on health while everything else within the global health architecture remains the same. Rather, the analysis that follows rests on the supposition that the Bank takes on

more of the financing, functions, and operations on which other GHIs currently lead, assuming the number of GHIs decreases (i.e., some GHIs sunset) while the total share of available DAH remains the same. Stakeholder views expressed and issues raised in interviews are in that spirit.

The paper proceeds as follows. In the first part, we present an overview of how the World Bank works, including the types of windows and instruments the Bank offers and key features of the Bank that affect its health funding, such as the broader corporate structure in which it sits. In the second part, we present a descriptive analysis of the World Bank's portfolio in health, including country- and project-level analyses. In the third and final part, we present a thematic analysis of how the Bank engages with the health sector, informed by the literature and stakeholder interviews. This paper takes stock of the World Bank's current role in health to inform discussions on the future of global health financing, aiming to surface key tradeoffs—between country ownership and earmarked priorities, loans and grants, scale and selectivity—that are central to any future redesign of the global health financing architecture.

Part 1. Overview of how the World Bank works

1.1 World Bank Group structure and model

The World Bank Group (WBG) consists of five institutions with complementary roles in development. Its two core lending arms are IBRD, which lends to middle-income and creditworthy lower-income governments,[18,19] and IDA, which provides grants and low- or zero-interest loans to the poorest countries.[20] The International Finance Corporation finances private sector projects through loans, equity investments, and advisory services in developing countries; the Multilateral Investment Guarantee Agency offers political risk insurance to encourage foreign investment in emerging economies; and the International Centre for Settlement of Investment Disputes provides arbitration facilities for investment disputes. In common usage, "the World Bank" typically refers to IBRD and IDA together, whereas "the World Bank Group" refers to all five institutions. All five entities share the overarching goal of creating "a world free of poverty—on a livable planet."[21,22]

Membership. The World Bank's lending arms are cooperatives owned by their member governments, which act as shareholders. IBRD has 189 member countries, while IDA is a separate legal entity with 175 member countries.[23] Each member's influence is exercised through voting power tied to shareholding and financial commitments.[24] Under the IBRD Articles, voting power is composed of basic votes plus share votes linked to shares held. Major institutional decisions, including amendments to the Articles of Agreement, require an 85 percent supermajority of total voting power.[25] The US is the single largest shareholder and holds 16 percent of IBRD voting power as of 2025, giving it an effective veto over decisions requiring the 85 percent threshold.[24] The US is also the largest shareholder of IDA with 10 percent of voting power, followed by Japan at 8 percent and the UK at 7 percent.

Governance model and leadership. The World Bank's day-to-day governance is handled by the Board of Executive Directors, a resident board of 25 officials representing all member countries.[25] The five largest shareholders each appoint their own Executive Director, while other countries are grouped into constituencies that elect the remaining directors. The Board of Executive Directors reviews and approves Bank projects, policies, and strategies on an ongoing basis. Above it, each member country appoints a Governor, usually its finance minister or central bank governor, to the Board of Governors.[26] This is the Bank's highest decision-making body and meets once a year, typically during the World Bank-IMF Annual Meetings. By long-standing tradition, the World Bank's President is a US citizen nominated by the US, reflecting the US's role as the largest shareholder. The President is selected by the Executive Directors for a renewable five-year term and oversees the Bank's management and operations, as well as chairing the Board. Ajay Banga has served as the President since 2023. The President and Bank staff manage the project lending portfolio, research, and TA, subject to Board oversight.[24]

How the World Bank is funded. The World Bank's financing comes from a mix of market-based capital and donor contributions. IBRD is financed mainly through borrowing on international capital markets, with member capital backing its borrowing. When shareholders want IBRD to lend more, they can approve capital increases; the most recent was the 2018 Capital Increase Package.[27] Since then, the Bank has mainly relied on balance-sheet and policy reforms to expand lending headroom.[28] IDA, meanwhile, provides grants and highly concessional financing that cannot be sustained through repayments alone.[29] It is funded largely through its own internal resources: reflows from past credit repayments and borrowing on international capital markets, topped up by donor replenishments negotiated every three years (IBRD reflows also contribute to IDA's funding). Donor contributions now make up only around a quarter of the total.[30] These negotiations are conducted by IDA deputies from donor countries, a separate non-governing body convened specifically for replenishments.

FIGURE 1. IDA21 donor pledges

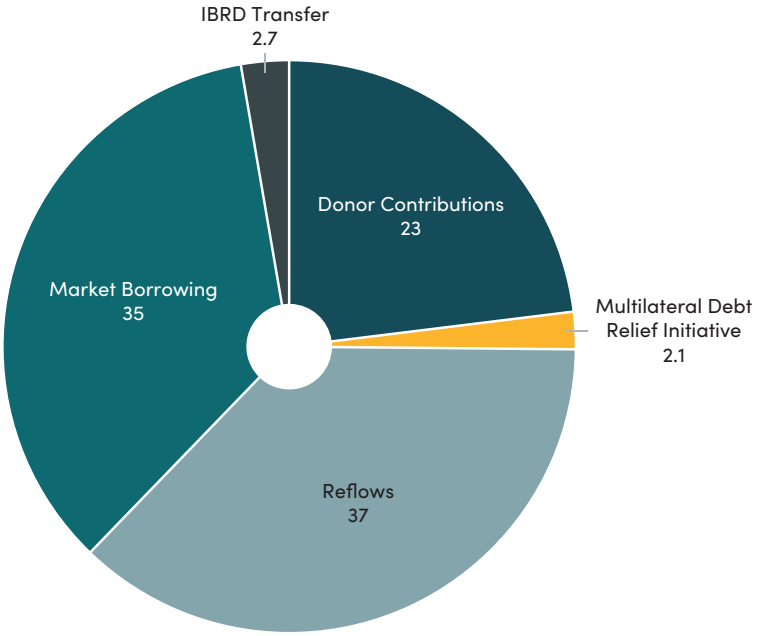
Donor	IDA21 Pledge (USD Millions)	% of Total
US	3,200	15%
Japan	2,772.14	13%
UK	1,781	8%
Germany	1,758.04	8%
France	1,345.77	6%
Canada	1,197.6	5%
Italy	794.2	4%
G7 Donors	**12,848.75**	**59%**
Remaining G20 Donors	**7,520.27**	**34%**
Other Donors	**1,437.82**	**7%**
Total Pledges	**21,806.84**	**100%**

Source: IDA21 Deputies Report.

In the IDA21 round in December 2024, donors reportedly pledged $23.7 billion, supporting a total financing package of $100 billion through IDA's hybrid model of contributions, internal resources, and market borrowing.[31] However, with reductions in the US and UK pledges, alongside the absence of pledges from several other countries, this headline number has fallen to $21.8 billion. The G7 donors accounted for 59 percent of all pledges, the remaining G20 donors 34 percent, and other donors contributed 7 percent (see Figure 1). Since 2018, IDA has also issued bonds to help stretch donor resources. Notably, reflows—repayments on existing loans—constitute the largest source of funding, closely followed by market borrowing (see Figure 2). Since 2005 (IDA's 14th replenishment), donor pledges have stayed fairly consistent in absolute terms while representing a declining share of overall IDA funding, reflecting the growing role of reflows and market borrowing (see Figure 3).

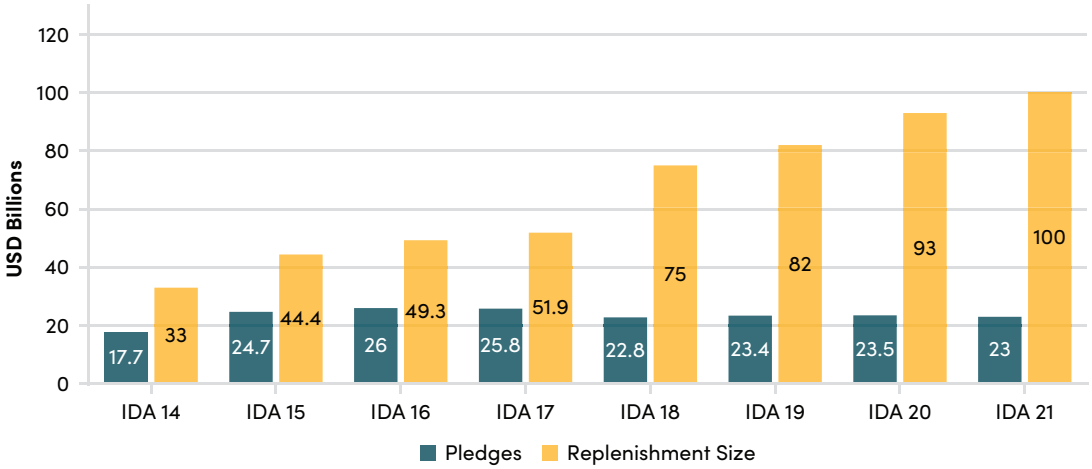
FIGURE 2. IDA's main funding sources are donor contributions, reflows, and market borrowing

Estimated sources of funding for IDA21, in USD billions



Source: IDA21 Deputies Report, CGD staff calculations.

FIGURE 3. Donor pledges represent a declining share of overall IDA funding
IDA 14–21 donor pledges vs. total replenishment size, in USD billions



Source: IDA Deputies Reports.

Country eligibility. Countries access World Bank financing mainly through IBRD and IDA, and eligibility depends on income and creditworthiness. IBRD lends to governments the Bank considers creditworthy, most often MICs and some creditworthy LICs. There is no hard income cutoff, but wealthier developing countries "graduate" from IBRD lending.[32] IDA eligibility, on the other hand, is anchored to an operational income cutoff of $1,325 GNI per capita for FY2026, but also includes some countries above that threshold that cannot borrow on IBRD terms.[33] As of 2023, 78 countries are IDA-eligible (including 59 IDA-only and 19 IDA Blend countries)—mostly LICs or LMICs, many in Africa.[29] Some countries are blend borrowers and can access both IBRD and IDA during transitions.

IDA uses a formula-driven allocation system to determine how much each eligible country can receive. This performance-based allocation model takes into account a country's population, its income level (GDP per capita), and the quality of its governance and policy performance (measured by the Bank's Country Policy and Institutional Assessment scores).[34,35] Using the Bank-IMF Debt Sustainability Framework, IDA also adjusts the mix of grants and loans based on debt sustainability assessments so that countries at higher risk of debt distress receive a larger share of financing as grants or on more concessional terms to mitigate the risk of the poorest, most vulnerable states accumulating unsustainable debt from IDA.[36] In addition to these country allocations, IDA provides dedicated windows for certain priorities—for example, extra allocations for fragility and conflict, crisis response, and regional projects—allowing eligible countries to access additional resources when needs are acute or cross-border. These supplements mean that while each IDA country has a base "country envelope" allocation from the formula, they can access additional funds for specific needs.[29]

IBRD loans, conversely, are not governed by a single allocation formula, and countries do not receive a fixed entitlement.[32] MICs negotiate IBRD financing based on their development programs

and the Bank's lending capacity. They can request project or policy loans up to limits set by their creditworthiness and the Bank's exposure limits. There is no fixed country envelope for IBRD, though the Bank may set indicative lending amounts in each country's partnership strategy. IBRD has a hard lending limit each year based on its capital and risk management, but in practice it strives to meet as much country demand as possible within those financial constraints. In general, IBRD-eligible countries do not borrow up to set limits or indicative lending amounts, in contrast to IDA-eligible countries, which tend to use their full IDA allocation, partly due to the nature of a competitive market for non-concessional lending.

1.2 Description of IBRD and IDA portfolios and financing instruments

IBRD loans are non-concessional loans, mostly to MICs. They carry interest rates near market levels—often slightly above the London InterBank Offered Rate—plus a small margin for the Bank's administrative costs. Because the Bank has a triple-A credit rating, IBRD's borrowing costs are low, so the rate charged to borrowers is typically below what many countries would face in commercial markets. IBRD loans usually have maturities of about 12–20 years with grace periods of about 3–5 years before principal repayment begins. IBRD lending is designed to be financially self-sustaining, with loans expected to be repaid in full with interest.

IDA credits are highly concessional loans with interest-free or low-interest rates available to the poorest countries. Repayment periods are very long, often around 30–40 years, and typically include grace periods of about 5–10 years before principal repayments begin. IDA may charge a small service fee—often 0.75 percent—far below market borrowing costs. IDA also provides grants, especially for countries at high risk of debt distress or emerging from conflict, which do not have to be repaid. In FY2025, about $8.2 billion (24 percent) of IDA's $33.8 billion in commitments were grants.

IDA allocations, windows, and crisis financing

IDA21 has $100 billion in total resources, divided between country allocations and a set of thematic channels (see Table 1). Most health lending flows through country allocations—primarily Performance-Based Allocations (PBA) and the Fragility, Conflict, and Violence (FCV) Envelope—and is supplemented by additional resources from a range of more targeted "windows."

IDA allocations can be delivered as grants or concessional loans, depending on a country's GNI and vulnerability. Overall, the IDA portfolio split is roughly 24 percent grants and 76 percent loans.[37] IDA windows and crisis facilities enable additional resources to flow when shocks are large, cross-border, or linked to displacement. The Crisis Response Window (CRW) can be used to support responses to major emergencies, including public health shocks. The Global and Regional Opportunities Window (GROW) provides top-up financing for eligible regional investments and is explicitly intended to facilitate collective action and the provision of regional and global public goods. The Window for Host

Communities and Refugees (WHR), now a subwindow within GROW, is also health-relevant because it supports service delivery and system capacity in refugee-hosting settings, where basic services are often under severe strain.[31]

TABLE 1. IDA21 allocations and windows

IDA Allocations & Windows	IDA21 Amount (USD billions)	Description
Country Allocations (PBA + FCV + IDA-GFPP)	$67.2	**Performance-Based Allocations (PBA):** These allocations depend on several factors: the overall availability of IDA's resources, individual country needs, their policy performance and institutional capacity, and each country's performance relative to others. The PBA system is designed to provide resources where they are likely to be most helpful in reducing poverty. **Fragility, Conflict, and Violence (FCV):** Enhance support for eligible countries facing different FCV risks **Grant Facility for Project Preparation Envelope (IDA-GFPP):** Provides resources to support IDA21's focus on building client capacity for delivery
GROW	$15.9	**Global and Regional Opportunities Window (GROW):** Scales up action on priority global and regional challenges to help countries address policy priorities with cross-border externalities; includes subwindow for Host Communities and Refugees (WHR)
CRW	$3.7	**Crisis Response Window (CRW):** Provides additional resources to help countries respond to major natural disasters, or public health emergencies and severe economic crises so that they can return to their long-term development paths; includes CRW Early Response Financing (ERF) subwindow to enable IDA countries to intervene earlier in response to slower-onset crises, namely disease outbreaks and food insecurity
SUW-SML	$3.0	**Concessional Scale-up Window (SUW) – Shorter Maturity Loans (SML):** Provides additional concessional resources with an allocation of $3.0 billion in eligible countries, i.e., IDA countries at low or moderate risk of debt distress, as well as Gap and Blend countries
PSW	$3.2	**Private Sector Window (PSW):** Mobilizes private sector investment in IDA-only countries and IDA-eligible Fragile and Conflict-affected Situations (FCS)
Total	$100	

While IDA channels 90 percent of its financing on-budget through government systems,[38] a meaningful share of the World Bank's financing—particularly in FCV settings—is implemented through third-party arrangements involving UN agencies, NGOs, and CSOs. The Bank increasingly relies on these modalities where government capacity is weak, state presence is limited, or fiduciary and security risks constrain direct implementation. According to the Independent Evaluation Group (IEG) evaluation of the World Bank's FCV Strategy, third-party implementation (TPI) accounted for approximately 10 percent of IDA and IBRD commitments in fragile and conflict-affected countries during 2020 to 2025.*

* A portfolio-wide figure for off-budget IDA/IBRD implementation is not publicly reported. The 10% figure cited here applies to FCS countries only; given FCS countries represent approximately 23% of the total IBRD/IDA portfolio, the implied share of total commitments implemented off-budget is considerably smaller.

TPI is used most intensively in high-conflict and Remaining Engaged in Conflict Allocation settings such as Yemen, South Sudan, and Afghanistan. In some cases, a substantial share of the portfolio is implemented through UN agencies including UNICEF, WHO, and the United Nations Development Programme. These arrangements are especially common in health, nutrition, social protection, and emergency service delivery operations, where maintaining continuity of essential services is a priority despite weak or disrupted state systems.

This stands in contrast to broader DAH flows. Approximately two-thirds of all DAH globally was channeled off-budget in 2023, with the share higher in LICs (68 percent) than LMICs (59 percent), based on OECD Creditor Reporting System means from 2018 to 2022.[39]

Financing instruments

The World Bank provides financing through three main sovereign financing instruments: Investment Project Financing (IPF), Program-for-Results (PforR), and Development Policy Lending (DPL). IPF supports medium- to long-term investments and institutional strengthening, and in health it often finances packages spanning infrastructure, workforce development, supply chains, health information systems, and service-delivery improvements. IPF is also the modality where the Bank is most directly involved during implementation, with close supervision of how funds are used and requirements to comply with environmental and social safeguards. PforR links disbursements to verified results using country systems, making it well suited to reforms in areas such as provider payment, facility performance, primary care quality, and health system management. PforR builds on the Bank's post-2010 expansion of Results-Based Financing (RBF), promoted in part by the Health Results Innovation Trust Fund.[40] DPL provides rapid-disbursing budget support tied to policy and institutional actions and can shape health systems even when an operation is not coded to the health sector, for example, through reforms in public financial management, insurance design, purchasing, or social sector governance. Contingent instruments such as the Catastrophe Deferred Drawdown Option extend this approach by providing quick-disbursing support following disasters and other shocks, including health emergencies.

Trends in IBRD and IDA financing over time

The volume of IBRD and IDA financing has grown substantially over the past decade, especially in response to global crises. In FY2025, combined IBRD and IDA commitments totaled $80.8 billion, nearly double the FY2014 level of $40.8 billion and about 17 percent above the FY2024 level of $68.8 billion. The scale-up over the past year reflects both borrower demand and an institutional strategy—backed by shareholders and reinforced in G20 processes—to expand lending headroom through capital-adequacy and balance-sheet reforms, rather than relying solely on new paid-in capital.[41] At the WBG level, the institution delivered $118.5 billion in grants, loans, equity investments, and guarantees in FY2025, against total commitments of $161.9 billion.

Trust funds in health beyond IDA and IBRD

Beyond core IBRD and IDA, trust funds supplement financing when needs are acute, cross-border, or otherwise difficult to address through country envelopes alone.[42] Subcategories of trust funds include financial intermediary funds (FIFs), Bank-executed trust funds (BETFs), and recipient-executed trust funds (RETFs), all of which involve varying levels of Bank involvement.[16,43] FIFs are a specialized subset of trust-fund-based arrangements that support global partnerships under separate governance structures allowing for formally distinct decision-making from core Bank country financing. The World Bank typically provides financial and administrative services as trustee but does not control allocation decisions. The World Bank is trustee to 27 FIFs[44] and an implementing entity for 20; FIFs collectively hold $37.2 billion in trust. The Global Fund and Gavi are the largest health FIFs, together accounting for over 90 percent of health FIF disbursements in most years.* Because FIFs are independently governed and therefore not part of Bank operations, they are out of scope for this analysis.

Crucially, trust funds also allow non-sovereign donors, including philanthropic organizations, to contribute, and they give donors considerably more control over how resources are allocated than core IDA or IBRD lending. These funds are also frequently claimed to "leverage" core IDA by influencing how IDA resources are allocated. The GFF, for example, incentivizes countries to direct part of their IDA envelope toward health, as GFF grants are only available to countries that include health allocations as part of their IDA spending.

Trust funds

World Bank-managed trust funds provide earmarked, partner-financed grants that can co-finance sovereign operations, support TA and analytics, pilot innovations, and expand engagement where lending is constrained, particularly in fragile or emergency settings. Trust funds finance roughly two-thirds of the Bank's advisory services and analytics. Across all sectors, the World Bank's trust fund portfolio as of FY2024 includes 229 standalone trust funds and 67 large, multi-donor "umbrella" trust funds.[45,46] In FY2024, trust funds received $7.2 billion in contributions from over 100 donors and disbursed $10.1 billion, holding $18.9 billion in trust. The GFF is a notably large, multi-donor trust fund in health that disbursed $211 million in 2024 (see Box 1).

1.3 The World Bank's analytical, technical, and convening activities

The World Bank's engagement in global health extends well beyond its financing operations. Through knowledge production, TA, global monitoring, and convening, the Bank shapes health policy and the global health architecture in ways that are difficult to quantify but often as consequential as its lending.[12] Scholars studying the Bank's influence on global health have argued that it operates

* The Global Fund, Gavi/the International Finance Facility for Immunisation, and the Pandemic Fund are largely beyond the scope of this review due to their formal separation from Bank governance and operations.

through what can be understood as "expert" and "discursive" power—shaping what policymakers consider legitimate knowledge and the language through which health challenges are framed—alongside its more visible financial role.[12] We briefly touch on some of these activities below as they emerged as important considerations in our thematic analysis; however, this discussion is highly abbreviated and should not be taken as a thorough review of the World Bank's analytical, technical, and convening functions.

The Bank has been a major producer of health economics research and global health guidance since the 1990s. Its Disease Control Priorities series—first published in 1993 as the World Development Report and now in its fourth edition—was among the first systematic efforts to apply cost-effectiveness analysis to health interventions in developing countries at scale and has been widely used to inform the design of essential health benefits packages and plans across LICs and LMICs. Most recently, the Bank launched the Government Resources and Projections for Health series, an annual macro-fiscal health financing report. The Bank also co-produces with WHO the biennial Universal Health Coverage (UHC) Global Monitoring Report, which tracks progress on service coverage and financial protection against out-of-pocket health spending across countries. The Bank delivers a substantial volume of TA and advisory services in health, much of it financed through trust funds rather than core lending, as discussed further below. The Bank also plays a prominent role in convening regional health financing forums and various forums on UHC.

Part 2. Portfolio analysis of the World Bank's engagement in health

At present, the World Bank's estimated 2025 health commitments account for approximately 18 percent of total DAH disbursements.* While this overstates the Bank's share of annual flows, the Bank is an important source of financing for health given its breadth of country coverage, on-budget financing, and ability to blend loans and grants.

Methodology

We began with 27,943 projects in the World Bank Projects & Operations dataset and narrowed the sample to all 382 Bank projects with a health component active in 2025, identifying how the Bank is *currently* funding health. The active portfolio represents a relatively small subset of the full historical dataset. As a result, the health-focused statistics below describe the current operational portfolio rather than the Bank's full historical engagement in health. Rather than counting new approvals in a single fiscal year, which may then be spread over many years, we estimate the Bank's health financing footprint in 2025 by spreading each project's total health commitment evenly across its duration, then summing the portion attributable to calendar year 2025. All figures are based on

* Institute for Health Metrics and Evaluation. Financing Global Health 2025: Cuts in Aid and Future Outlook. Seattle, WA: IHME, University of Washington; 2025. https://www.healthdata.org/research-analysis/health-financing.

commitments from project-level data, rather than disbursements, because disbursement data is not reliably available and tends to lag by several years as projects are implemented. The exception is trust funds, which are recorded as disbursements in the World Bank dataset. Additionally, using project-level commitment data allows for detailed operational and sectoral analysis that accounts for health sector shares of multi-sector projects. Project-level analyses are disaggregated by financing source (IDA, IBRD, trust funds), whereas country-level analyses assign countries to categories based on FY2026 country lending eligibility (IDA-eligible and IBRD). IDA Blend countries are grouped with IDA-eligible countries because they retain IDA access. Detailed methodology notes are available in the accompanying workbook.

2.1 Project-level overview

What volume and share of overall Bank funding goes to health?

Based on our portfolio analysis at the project level, the World Bank committed an estimated $7.0 billion to health in 2025 across 382 active health operations, accounting for approximately 7 percent of the total $94.2 billion active portfolio.

How is health financing split across lending types?

Of the $7.0 billion in estimated 2025 health commitments,* IDA leads at 50 percent ($3.5 billion) and IBRD accounts for 40 percent ($2.8 billion), with trust fund grants contributing the remaining 10 percent ($713 million) (see Table 2).† Trust funds should be seen as a modest but useful top-up, mostly attached to IDA and IBRD operations rather than standing alone.

TABLE 2. Health commitments by financing source

Financing Source	2025 Health Commitments	% of Total
IDA	$3,459,805,418	50%
IBRD	$2,814,327,342	40%
Trust Funds	$712,793,938	10%
	$6,986,926,698	100%

* Health commitments are calculated as the total World Bank commitment for each operation multiplied by its health sector allocation percentage, capped at 100%. Health sector shares are drawn from the sector percentage column in the "Sectors" sheet, and a project is classified as being in the health sector if its sector name contains "health." Projects are then categorized as "majority health" (health share > 50%), "minority health" (health share >0%–50%), "any health" (health share >0%), and "non-health" (health share = 0%). The exception is trust funds, which are recorded as disbursements in the World Bank dataset.

† An additional ~$540 million in parallel co-financing from other multilateral development banks—primarily the Asian Infrastructure Development Bank, the Islamic Development Bank, and ADB, concentrated in the Indonesia Health Systems Strengthening Project—flows alongside World Bank health operations but is excluded from these figures as it originates outside World Bank financing sources.

Trust fund health financing is concentrated in several funds, including the Afghanistan Resilience Trust Fund ($257 million across 34 projects) and the GFF ($181 million across 58 projects), which together account for over 60 percent of 2025 trust fund health commitments. These are followed by the Ukraine Relief, Recovery, Reconstruction, and Reform Trust Fund ($29 million), the Ethiopia Health PforR MDTF ($23 million), and the Health Emergency Preparedness and Response MDTF ($18 million across 18 countries) (see Table 3).

TABLE 3. Largest health trust funds

Trust Fund	2025 Health-Adjusted Trust Fund Disbursements	Project Count
1. Afghanistan Resilience Trust Fund	$256,850,819	34
2. Global Financing Facility	$180,622,418	58
3. Ukraine Relief, Recovery, Reconstruction, and Reform TF	$28,882,928	11
4. Ethiopia Health Program for Results Multi-Donor Trust Fund	$23,339,568	1
5. Health Emergency Preparedness and Response Multi-Donor Trust	$17,869,482	18

Health-related FIFs—including the Global Fund, Gavi, and the Pandemic Fund—provide additional financing that flows through the Bank but is largely managed outside its core lending operations. While some FIF co-financing appears in the Projects & Operations database alongside other trust fund grants, the majority of FIF resources operate through separate channels and are not captured in core World Bank project reporting and are therefore excluded from our analysis.

How are health commitments distributed across dedicated vs. multisectoral projects?

The Bank overwhelmingly funds health through dedicated health projects. Of the $7.0 billion in 2025 health commitments, 87 percent ($6.1 billion) flows through projects where health is the majority sector share (above 50 percent), versus just 13 percent ($925 million) channeled through projects where health is a minor component (>0–50 percent). This concentration is broadly uniform across all three financing sources, with IDA (89 percent), trust funds (85 percent), and IBRD (84 percent) channeling the vast majority of health funding through majority-health operations (see Table 4).

TABLE 4. Health commitments by sector classification

Category	2025 Health Commitments	% of Total
Any health (>0%)	$6,986,926,698	100%
Minority health (>0–50%)	$925,004,070	13%
Majority health (51–100%)	$6,061,922,628	87%
Category	**2025 IDA Health Commitments**	**% of Total**
Any health (>0%)	$3,459,805,418	100%
Minority health (>0–50%)	$371,827,842	11%
Majority health (51–100%)	$3,087,977,576	89%
Category	**2025 IBRD Health Commitments**	**% of Total**
Any health (>0%)	$2,814,327,342	100%
Minority health (>0–50%)	$449,005,347	16%
Majority health (51–100%)	$2,365,321,996	84%
Category	**2025 Trust Fund Health Commitments**	**% of Total**
Any health (>0%)	$712,793,938	100%
Minority health (>0–50%)	$104,170,882	15%
Majority health (51–100%)	$608,623,056	85%

How is health financing distributed across lending instruments?

IPF is the instrument used most widely across the health portfolio, accounting for 67 percent ($4.7 billion) of 2025 health commitments and 78 percent of operations. PforR represents 27 percent ($1.9 billion) of health commitments and 15 percent of operations, with a much larger mean size of $32.9 million, more than double the mean IPF operation ($15.8 million). As a result, when the Bank uses RBF for health, it does so at significantly larger scale. DPL accounts for just 7 percent of projects (28) and 6 percent of commitments ($410 million), with a mean project size of $14.7 million. This relatively low DPL share may suggest that the Bank invests more heavily in health projects than in health policy, which has implications for health financing reform.

When we consider this by financing source, we see that IBRD leans more heavily on PforR. IBRD PforR financing accounts for 39 percent of its health commitments and 25 percent of operations, compared to 19 percent of IDA commitments and just 11 percent of IDA operations. IBRD projects are also substantially larger across every instrument: the mean IBRD IPF health operation ($20.1 million) is 36 percent larger than IDA's ($14.7 million), and the mean IBRD PforR operation ($40.6 million) is 57 percent larger than IDA's ($25.8 million). This reveals that IBRD health financing operates at a larger per-project scale, consistent with the larger economies and higher borrowing capacity of IBRD borrowers. Trust fund health financing flows primarily through IPF (85 percent of commitments), with the smallest mean project sizes across all instruments, reflecting their role in financing targeted, project-level interventions. Overall, the Bank's health portfolio remains heavily reliant on IPF as a project-based financing instrument. PforR remains underutilized within IDA and trust funds, where just 41 of 302 health operations use RBF (see Table 5).

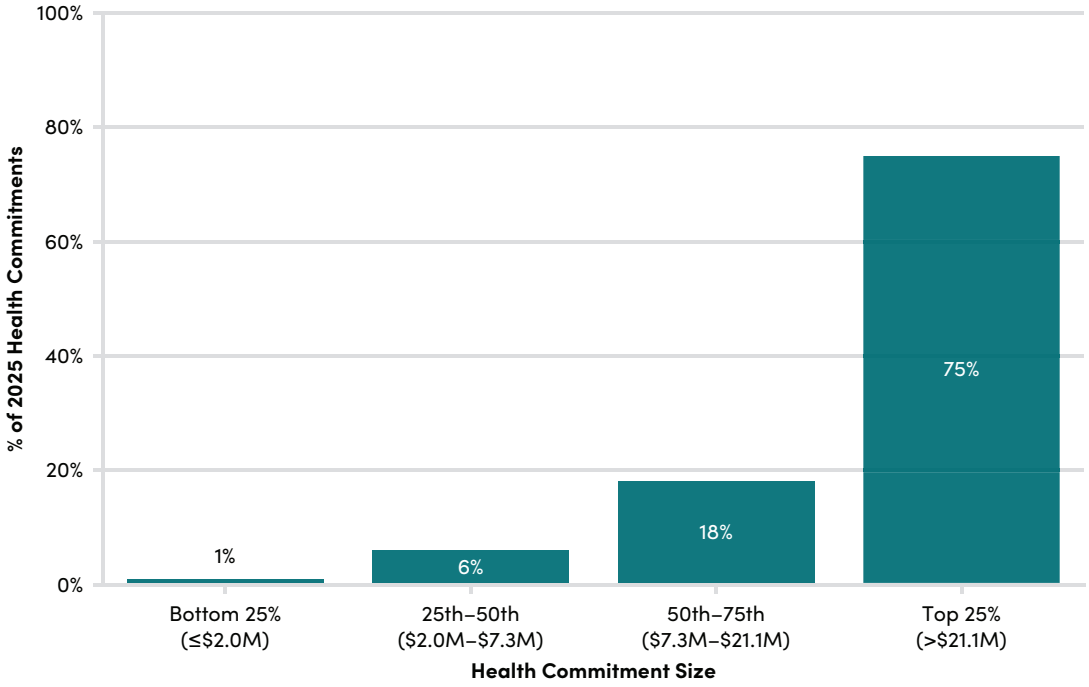
TABLE 5. Health commitments by financing instrument

Financing Instrument	2025 Health Commitments	% of Total	Count	% of Count	Mean Project Size
Investment Project Financing	$4,701,823,742	67%	297	78%	$15,831,056
Program-for-Results Financing	$1,874,844,098	27%	57	15%	$32,892,002
Development Policy Lending	$410,258,858	6%	28	7%	$14,652,102
	$6,986,926,698	100%	382	100%	
Financing Instrument	**2025 IDA Health Commitments**	**% of Total**	**Count**	**% of Count**	**Mean Project Size**
Investment Project Financing	$2,712,084,987	78%	184	81%	$14,739,592
Program-for-Results Financing	$671,303,538	19%	26	11%	$25,819,367
Development Policy Lending	$76,416,893	2%	18	8%	$4,245,383
	$3,459,805,418	100%	228	100%	
Financing Instrument	**2025 IBRD Health Commitments**	**% of Total**	**Count**	**% of Count**	**Mean Project Size**
Investment Project Financing	$1,383,957,895	49%	69	64%	$20,057,361
Program-for-Results Financing	$1,097,034,575	39%	27	25%	$40,630,910
Development Policy Lending	$333,334,873	12%	11	10%	$30,303,170
	$2,814,327,342	100%	107	100%	
Financing Instrument	**2025 Trust Fund Health Commitments**	**% of Total**	**Count**	**% of Count**	**Mean Project Size**
Investment Project Financing	$605,780,861	85%	122	84%	$4,965,417
Program-for-Results Financing	$106,505,985	15%	22	15%	$4,841,181
Development Policy Lending	$507,092	0%	1	1%	$507,092
	$712,793,938	100%	145	100%	

How is the active health portfolio distributed by project size?

Looking at project size, the Bank's active health portfolio is highly concentrated in the largest operations. The median project size based on 2025 health commitments is approximately $7.3 million. The top 25 percent of projects by size—those with 2025 health commitments above $21.1 million—account for 75 percent of all health financing ($5.3 billion), whereas the bottom 25 percent contribute just 1 percent. Even expanding to the full bottom half, those projects together account for only 7 percent of total commitments (see Figure 4). This pattern indicates that a relatively small number of large operations drive the vast majority of World Bank health spending.

FIGURE 4. Health projects by commitment size



Notes: Quartile boundaries: $2,005,028 (25th percentile), $7,312,453, (median), $21,064,291 (75th percentile).

2.2 Country-level overview

For country-level analyses, countries are grouped by FY2026 lending eligibility: IDA-eligible (59 IDA-only + 19 IDA Blend = 78 countries) and IBRD (67 countries). IDA Blend countries are included in the IDA-eligible group because they remain eligible for IDA financing.

How widespread is the Bank's health presence across countries?

The Bank has strong health presence in most IDA-eligible countries, with 90 percent (70 of 78) having at least one active health project, but its presence in IBRD countries is more limited, with only 57 percent (38 of 67) having any health projects. Among IDA-eligible countries, 82 percent have at least one majority-health project (above 50 percent) and 55 percent have at least one project with a minority health allocation (>0–50 percent). But for IBRD countries, only 43 percent have at least one majority-health project, and 33 percent have at least one minority-health project.

What share of each country's total active Bank portfolio goes to health?

Countries are free to choose how much of their allocations go to health. Compared to across-the-board World Bank investments, health represents a modest share of each country's active portfolio. Among IDA-eligible countries, health accounts for 11 percent (mean) of total active commitments in 2025 (7 percent median), and seven IDA-eligible countries have no active health lending at all (Eritrea, Grenada, Maldives, Micronesia, St. Vincent and the Grenadines, Suriname, and Syrian Arab Republic).

For IBRD countries, health accounts for 6 percent (mean) of active commitments (1 percent median), and 29 of 67 countries have no active health lending. While the project-level analysis shows that health operations tend to be dedicated and substantial, the country-level picture reveals that those same projects represent a small slice of a much larger non-health portfolio.

How many active projects does each country have, and how many involve health?

The typical IDA-eligible country has 20 active operations, of which 17 (85 percent) have no health component at all. Of the remaining three projects with any health component, roughly two are dedicated majority-health operations and one is a minority-health project. The typical IDA-eligible country thus has three health projects alongside roughly 17 non-health projects, whereas the typical IBRD country has roughly one majority-health operation alongside 14 active operations, 12 (88 percent) of which have no health component.

In the case of both IDA-eligible and IBRD countries, World Bank health financing is deep but narrow. The Bank has dedicated health projects in most countries, but health represents a small share of the overall lending envelope.

How is health financing distributed across regions?

The World Bank's financing sources target different regions, aligned with their respective mandates. IDA is heavily concentrated in Africa, with Eastern and Southern Africa accounting for 38 percent ($1.3 billion) of health commitments and 34 percent of projects, and Western and Central Africa accounting for 32 percent ($1.1 billion) of commitments and 29 percent of projects. Together, these two regions represent 70 percent of IDA health commitments and 63 percent of projects. These are followed by the Middle East, North Africa, Afghanistan, and Pakistan at 14 percent ($475 million) and South Asia at 7 percent ($259 million) of commitments, modest relative to the region's population and disease burden.

IBRD targets an entirely different subset of regions but is spread more evenly across them. The Middle East, North Africa, Afghanistan, and Pakistan, Europe and Central Asia, and East Asia and Pacific each account for 22 percent of IBRD health commitments, followed by Latin America and the Caribbean at 19 percent ($524 million) and South Asia at 12 percent ($351 million). Africa is almost entirely absent from IBRD health financing, with Western and Central Africa accounting for less than 1 percent and Eastern and Southern Africa at a modest 3 percent.

The pattern of regional distribution is also different for trust fund health financing, which is concentrated in the Middle East, North Africa, Afghanistan, and Pakistan region at 42 percent ($298 million), reflecting substantial financing flows to health projects in fragile and conflict-affected settings, followed by Europe and Central Asia at 21 percent ($150 million). Eastern and Southern Africa accounts for 16 percent ($117 million) and Western and Central Africa for 11 percent ($81 million), with the remaining regions each below 5 percent (see Table 6).

Looking at this regional distribution, we see that World Bank health financing targets fundamentally different geographies: a heavily Africa-focused IDA portfolio, a more balanced IBRD portfolio spread across the Middle East and North Africa, East Asia, Europe and Central Asia, and Latin America and the Caribbean, and trust fund financing concentrated in the Middle East and North Africa and Europe and Central Asia, reflecting flows to fragile and conflict-affected settings, with the remaining trust fund financing spread across Africa.

TABLE 6. Health commitments by region

Region	2025 Health Commitments	% of Total	Count	% of Count
East Asia and Pacific	$722,294,134	10%	48	13%
Eastern and Southern Africa	$1,509,190,767	22%	100	26%
Europe and Central Asia	$884,965,426	13%	35	9%
Latin America and Caribbean	$648,897,575	9%	56	15%
Middle East, North Africa, Afghanistan, and Pakistan	$1,403,662,840	20%	44	12%
South Asia	$618,320,716	9%	28	7%
Western and Central Africa	$1,199,595,241	17%	70	18%
Region	**2025 IDA Health Commitments**	**% of Total**	**Count**	**% of Count**
East Asia and Pacific	$80,362,409	2%	28	12%
Eastern and Southern Africa	$1,315,347,778	38%	78	34%
Europe and Central Asia	$118,980,979	3%	10	4%
Latin America and Caribbean	$101,420,164	3%	16	7%
Middle East, North Africa, Afghanistan, and Pakistan	$474,923,622	14%	18	8%
South Asia	$259,071,433	7%	12	5%
Western and Central Africa	$1,109,699,033	32%	66	29%
Region	**2025 IBRD Health Commitments**	**% of Total**	**Count**	**% of Count**
East Asia and Pacific	$606,638,100	22%	8	7%
Eastern and Southern Africa	$77,248,633	3%	9	8%
Europe and Central Asia	$616,039,357	22%	26	24%
Latin America and Caribbean	$524,100,256	19%	30	28%
Middle East, North Africa, Afghanistan, and Pakistan	$630,315,411	22%	17	16%
South Asia	$350,602,015	12%	13	12%
Western and Central Africa	$9,383,570	0%	4	4%
Region	**2025 Trust Fund Health Commitments**	**% of Total**	**Count**	**% of Count**
East Asia and Pacific	$35,293,625	5%	21	14%
Eastern and Southern Africa	$116,594,355	16%	53	37%
Europe and Central Asia	$149,945,090	21%	11	8%
Latin America and Caribbean	$23,377,156	3%	16	11%
Middle East, North Africa, Afghanistan, and Pakistan	$298,423,806	42%	13	9%
South Asia	$8,647,268	1%	5	3%
Western and Central Africa	$80,512,638	11%	26	18%

How is health financing distributed across country income groups?

IDA and IBRD health financing flow to vastly different income groups, reflecting their distinct mandates. IDA health financing is more concentrated in the poorest countries: LICs receive 49 percent ($1.6 billion) and LMICs 47 percent ($1.5 billion), with just 4 percent flowing to UMICs.

For IBRD, the pattern is reversed: UMICs receive the largest share at 52 percent ($1.5 billion), followed by LMICs at 41 percent ($1.2 billion), with no IBRD health financing flowing to LICs. This is consistent with IBRD's mandate to serve middle-income countries.

Trust fund health financing is concentrated in the poorest countries, with LICs receiving the majority at 56 percent ($396 million), followed by UMICs at 22 percent ($158 million) and LMICs at 20 percent ($141 million) (see Table 7). This pattern is consistent with the role of trust funds as a supplement to IDA financing in low-income and fragile settings.

TABLE 7. Health commitments by income group

Income Group	2025 Health Commitments	% of Total	Count	% of Count
LIC	$1,993,368,729	29%	102	28%
LMIC	$2,835,502,056	42%	169	46%
UMIC	$1,727,113,955	26%	83	23%
HIC	$209,237,799	3%	12	3%
Income Group	**2025 IDA Health Commitments**	**% of Total**	**Count**	**% of Count**
LIC	$1,597,412,819	49%	94	44%
LMIC	$1,532,636,107	47%	101	47%
UMIC	$117,885,522	4%	20	9%
HIC	$801,808	0%	1	0%
Income Group	**2025 IBRD Health Commitments**	**% of Total**	**Count**	**% of Count**
LIC	$ -	0%	0	0%
LMIC	$1,161,800,157	41%	41	39%
UMIC	$1,451,421,587	52%	58	55%
HIC	$197,337,141	7%	7	7%
Income Group	**2025 Trust Fund Health Commitments**	**% of Total**	**Count**	**% of Count**
LIC	$395,955,910	56%	51	37%
LMIC	$141,065,792	20%	62	45%
UMIC	$157,806,845	22%	19	14%
HIC	$11,098,849	2%	5	4%

Of the Bank's active IDA health commitments, how much goes to countries above vs. below the IDA income eligibility threshold?

Despite IDA's explicit focus on the poorest countries, a significant share of IDA health financing flows to countries above the income eligibility threshold. Of the $3.5 billion in 2025 IDA health commitments across active operations, 44 percent ($1.5 billion) flows to countries whose GNI per capita exceeds the FY2026 IDA operational cutoff of $1,325 (see Table 8).[47] However, the flow of

a significant share of IDA to countries above the income threshold is not unique to health. In fact, across all sectors, approximately 58 percent of FY2025 IDA country allocations flow to countries above the income threshold.[47,*] IDA health is therefore more concentrated in the poorest countries than the overall IDA portfolio.

IDA may still flow to countries that no longer meet IDA eligibility criteria for several reasons. First, country income is not the only determinant of IDA allocations; the performance-based allocation formula also weighs population and country performance ratings.[34] Additionally, some countries above the threshold may retain IDA funding if they are experiencing economic contraction or debt crises. Furthermore, projects approved while a country was below the threshold continue disbursing for years after graduation, typically 5–10 years. These patterns reflect deliberate World Bank allocation and transition policies aimed at avoiding abrupt financing cliffs for countries that remain vulnerable, fragile, highly indebted, or institutionally weak despite rising incomes.

TABLE 8. IDA health commitments by income threshold

	2025 IDA Health Commitments	% of Total IDA Health
Below $1,325 GNI per capita (30 countries)	$1,921,155,532	56%
Above $1,325 GNI per capita	$1,538,649,886	44%
Total IDA health	$3,459,805,418	100%

2.3 Real-world footprint of the Bank's lending

How much does World Bank health financing matter relative to government health spending?

We estimated the World Bank's contribution as a share of government health spending by dividing 2023 prorated health commitments by total domestic general government health expenditure (GGHE-D), using 2023 as the latest year for which WHO GGHE-D data is available.[48] World Bank health financing plays a dramatically different role depending on lending type, serving as a critical contributor for IDA-eligible countries and representing a negligible share for IBRD countries.

For IDA-eligible countries, World Bank health financing represents a substantial share of government health spending, with a median of 16 percent. A small group of countries are almost entirely dependent on World Bank health financing: Afghanistan (699 percent), South Sudan (413 percent), Comoros (159 percent), The Gambia (123 percent), and Somalia (105 percent) all have health commitments that exceed their own government health spending, reflecting extremely low domestic health budgets. Even among more stable IDA-eligible countries, the Bank contributes meaningfully: Central African Republic (91 percent), Democratic Republic of the Congo (86 percent),

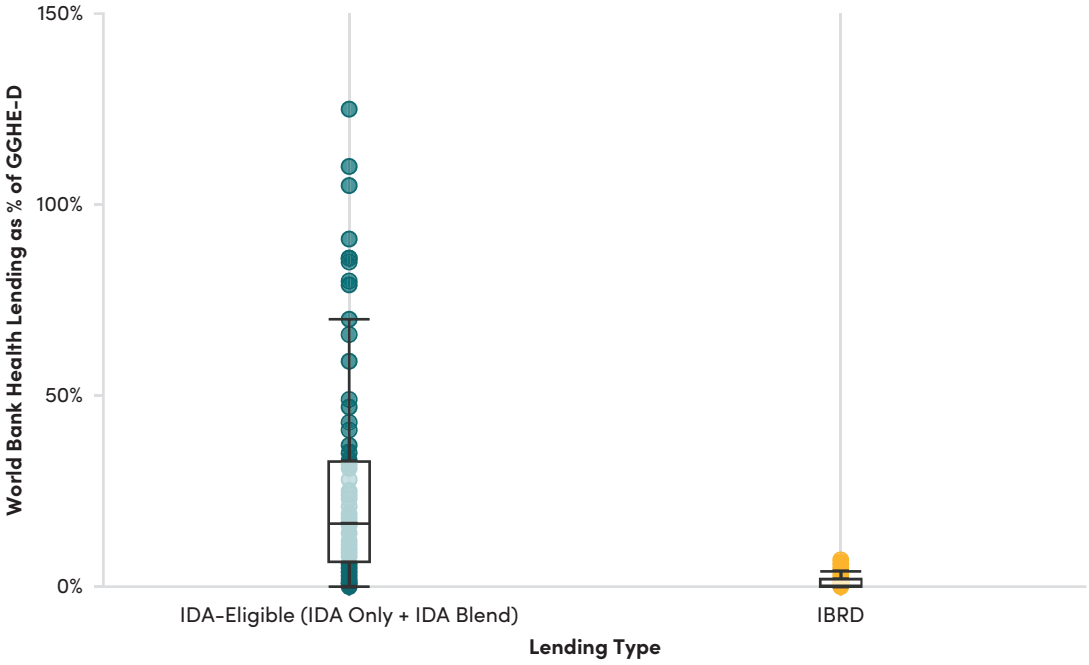
* Authors' calculations based on FY25 GNI per capita and IDA country allocations data from the World Bank. Note that the IDA-wide figure uses FY25 IDA country allocations, whereas the health figure uses 2025 IDA health commitments from the authors' portfolio data analysis.

Burundi (86 percent), Benin (85 percent), Malawi (80 percent), Yemen (79 percent), Togo (70 percent), St. Vincent and the Grenadines (69 percent), Haiti (61 percent), and Madagascar (59 percent) all see ratios exceeding 50 percent of government health spending. Values above 100 percent reflect extremely low domestic government health budgets relative to World Bank commitments, particularly in fragile and conflict-affected states.

Meanwhile, Bank health financing represents a negligible share of total health spending for IBRD countries, with a median of 0.4 percent of government health spending and most countries falling below 5 percent. Large economies like China, Brazil, Mexico, and India are all at or below 1 percent. Georgia (7 percent), Angola (6 percent), Indonesia (6 percent), and Morocco (6 percent) are the highest among IBRD borrowers. This reflects the fact that IBRD countries exercise full ownership over their borrowing priorities, spend substantially more on health domestically, and have access to multiple financing sources beyond the Bank.

The decline in World Bank health engagement from IDA to IBRD—from a median contribution of 16 percent of government health spending to under 1 percent—primarily reflects growing domestic health investment and country borrowing choices. The median IBRD country spends $314 per capita on health domestically compared to $25 for the median IDA country. The higher cost of IBRD lending may also play a role, making loans a less attractive way to fund health: only 57 percent of IBRD countries have any active health lending, compared to 90 percent of IDA-eligible countries (see Figures 5 & 6).

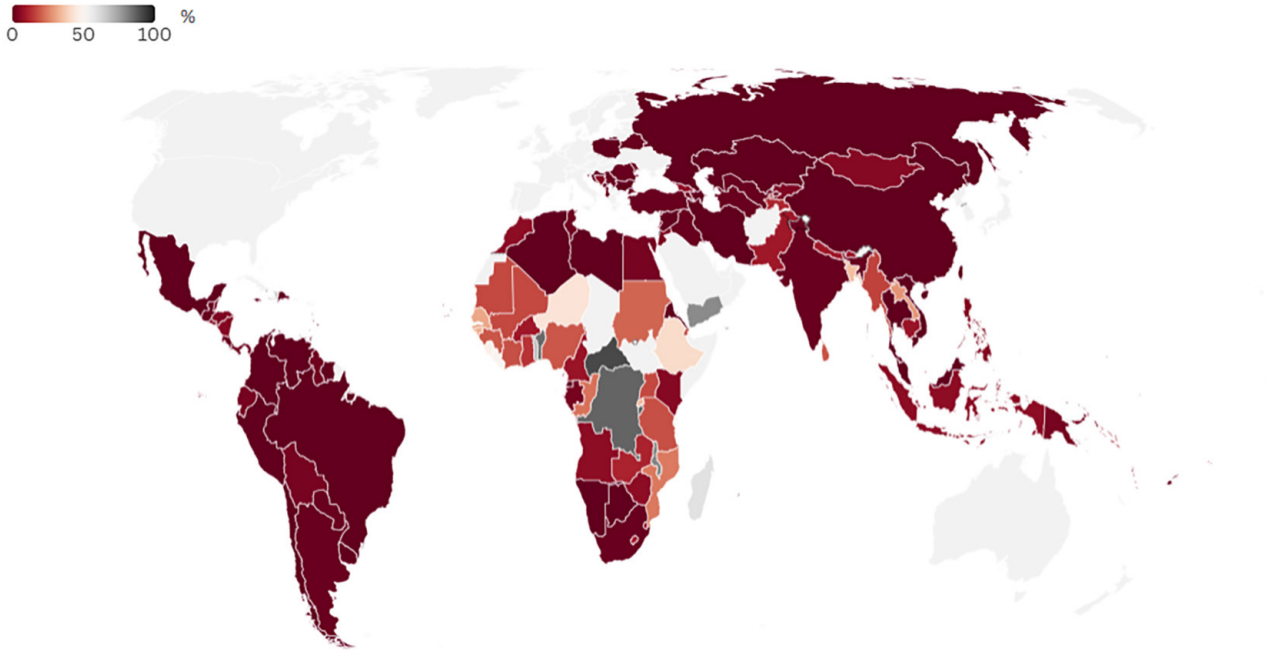
FIGURE 5. World Bank health lending as share of GGHE-D (2023)
Domestic general government health expenditure (GGHE-D)



Notes: Y-axis capped at 150% for readability. Afghanistan (699%), South Sudan (413%), and Comoros (159%) exceed this threshold and are excluded as outliers.

FIGURE 6. World Bank health lending as share of GGHE-D for IDA-eligible countries (2023)

WHO Domestic general government health expenditure (GGHE-D)



Notes: The color scale is capped at 100% for readability. Six countries exceed this threshold: Afghanistan (699%), South Sudan (413%), Comoros (159%), The Gambia (125%), St. Vincent and the Grenadines (110%), and Somalia (105%).
Source: WHO Global Health Expenditure Database.

What happens when countries transition?

As noted above, the decline in World Bank health engagement from IDA to IBRD largely reflects growing domestic fiscal capacity and country borrowing priorities. Nevertheless, the transition period itself merits examination, since the shift from concessional IDA terms to costlier IBRD lending coincides with a period when some countries' health systems may still be building capacity. The question is not whether the Bank provides adequate resources, but whether the transition produces uneven patterns of health lending continuity across countries. To investigate, we analyzed health lending patterns before and after IDA graduation across the 35 countries that have graduated from IDA.[49]

IDA commitments generally cease once a country graduates from IDA eligibility or at the end of the relevant replenishment cycle. However, disbursements from previously approved IDA projects continue for several years afterward as projects are implemented. In practice, IDA disbursements often continue for 5–10 years after graduation, depending on the size and duration of the active portfolio. Since IDA17/IDA18, the World Bank has also provided transitional support to recent

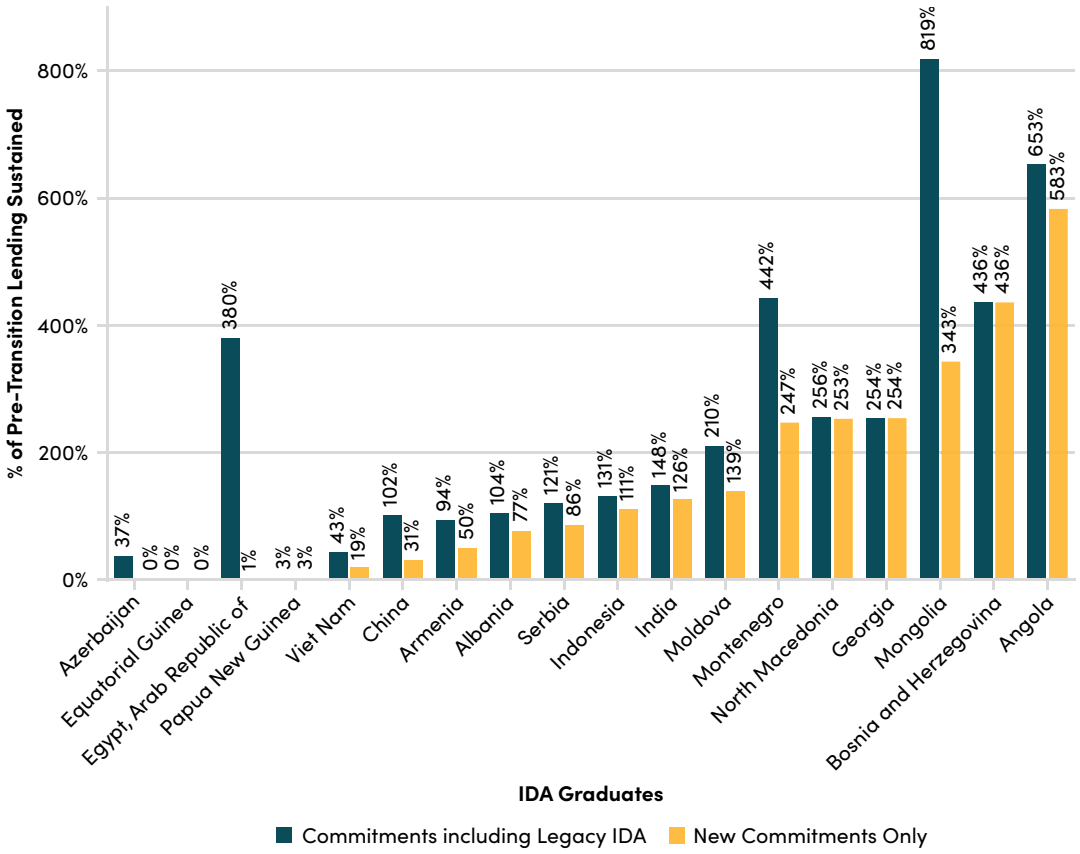
graduates, typically for up to three years, to help smooth the shift away from concessional financing. IBRD financing begins before or at the time of graduation, allowing countries to access blended financing to ease the transition.

Across the 35 countries that have graduated from IDA, we analyzed health lending 10 years before and after each country's final IDA credit. Of the 35 graduates, 16 transitioned before the Projects & Operations dataset begins, leaving 19 countries with usable data. Post-transition lending was measured in two ways: total health commitments after the transition year (including IDA operations continuing to disburse), and new health commitments only from projects approved after the transition year.

Health lending continuity after IDA graduation is highly uneven across the 19 graduate countries with usable data. The majority (10) successfully mobilized new health lending above pre-transition levels, including Bolivia (2,036 percent), Angola (583 percent), Bosnia (436 percent), Mongolia (343 percent), Georgia (254 percent), North Macedonia (253 percent), Montenegro (247 percent), Moldova (139 percent), India (126 percent), and Indonesia (111 percent), though several of these high ratios are inflated by small pre-transition baselines. A further three countries—Serbia (86 percent), Albania (77 percent), and Armenia (50 percent)—show partial sustainability, with new post-transition lending replacing at least half but not all of pre-transition levels. On the other hand, six countries show sharp declines in new post-transition health lending relative to pre-transition levels: Egypt (1 percent), Azerbaijan (0 percent), Equatorial Guinea (0 percent), Papua New Guinea (4 percent), Vietnam (19 percent), and China (31 percent). Notably, Egypt shows 380 percent overall sustainability but 1 percent sustainability for new commitments, meaning all post-transition health lending came from legacy IDA operations with almost no new commitments approved after graduation. When including legacy operations, 14 of 19 countries fully sustain or increase the level of pre-transition health lending, but this masks the distinction between countries actively securing new IBRD health financing and those simply running down existing IDA commitments.

Whether health financing holds up after graduation depends on a combination of country demand and IBRD availability as legacy IDA operations wind down. India's IBRD health portfolio grew to $2.9 billion post-transition, making it the clearest case of sustained Bank engagement. Georgia's IDA fell from $70 million to zero while IBRD lending reached $139 million, supplemented by $47 million in trust funds. Indonesia's transition followed a different pattern: IBRD health lending held roughly steady ($337 million pre-transition to $346 million post-transition), but trust funds scaled up dramatically from $4 million to $217 million. Meanwhile, trust fund contributions remain marginal in most other transition countries. Taken together, post-transition health lending fared well in the majority of countries, but countries like China and Vietnam saw sharp declines in Bank health lending after graduation, likely reflecting borrowing priorities that shifted toward other sectors as domestic health spending grew, rather than a failure of Bank financing to keep pace (see Figure 7).

FIGURE 7. Health lending sustainability post-IDA graduation



Notes: Sustainability ratio = post-transition health commitments divided by pre-transition levels, measured over 10-year windows anchored to each country's last IDA credit. 18 of 35 IDA graduates shown. Y-axis capped at 900% for readability. Bolivia (2036%) exceeds this threshold and is excluded as an outlier.

Part 2: Portfolio analysis key takeaways

- With an estimated $7.0 billion in 2025 health commitments across IDA, IBRD, and trust funds, the World Bank accounts for approximately 18 percent of the $39.1 billion in total DAH disbursements in 2025.
- The World Bank committed an estimated $7.0 billion to health in 2025 across 382 active health operations, accounting for 7 percent of the Bank's IDA, IBRD, and trust fund portfolio. Health is a meaningful but relatively small part of what the Bank does. IDA contributes 50 percent ($3.5 billion) of health commitments, IBRD 40 percent ($2.8 billion), and trust funds 10 percent ($713 million).
- The Bank primarily funds health through dedicated health projects (87 percent) rather than across multisectoral operations (13 percent).
- IPF is the instrument used most widely across the health portfolio, accounting for 67 percent of 2025 health commitments. PforR represents 27 percent, and DPL accounts for just 6 percent. IDA (78 percent) and trust funds (85 percent) are especially reliant on IPF.

- The Bank's health portfolio is highly concentrated in the largest operations. The top 25 percent of projects by size account for 75 percent of all health financing, while the bottom half account for just 7 percent of total commitments.
- The Bank has broad country coverage: 90 percent of IDA-eligible countries have active health projects, versus 57 percent of IBRD countries.
- The typical IDA-eligible country has three health projects alongside roughly 17 non-health projects. Health represents just 11 percent (mean) of IDA countries' active portfolios (7 percent median), and even less in IBRD countries (6 percent mean, 1 percent median).
- Different financing sources target different regions. IDA has a heavily Africa-focused portfolio, IBRD has a more balanced portfolio spread across the Middle East and North Africa, East Asia, Europe and Central Asia, and Latin America and the Caribbean, and trust fund financing is concentrated in the Middle East and North Africa and Europe and Central Asia, reflecting substantial flows to health projects in fragile and conflict-affected settings.
- Reflecting their different mandates, IDA health financing is more concentrated in poorer countries: LICs receive 49 percent ($1.6 billion) and LMICs 47 percent ($1.5 billion), with just 4 percent flowing to UMICs. For IBRD, the pattern is reversed: UMICs receive the largest share at 52 percent ($1.5 billion), followed by LMICs at 41 percent ($1.2 billion).
- A significant share (44 percent) of IDA health commitments flow to countries with a GNI per capita above the $1,325 IDA eligibility cutoff. However, this pattern is not unique to health—across all sectors, approximately 58 percent of IDA country allocations flow to countries above the income threshold. IDA health is therefore more concentrated in the poorest countries than the overall IDA portfolio. This reflects IDA's performance-based allocation formula, ongoing disbursements from pre-graduation projects, and deliberate transition policies.
- World Bank health financing is a critical contributor for IDA-eligible countries, representing a median of 16 percent of government health spending, with several fragile states exceeding 50 percent or even 100 percent. For IBRD countries, the median is negligible at just 0.4 percent. This gap largely reflects rising domestic spending capacity and country borrowing choices—the median IBRD country spends $314 per capita on health compared to $25 for the median IDA country—rather than a withdrawal of Bank support.
- Health lending continuity after IDA graduation is highly uneven. Of 19 graduate countries with usable data, the majority sustained or increased health lending through new IBRD commitments, but six saw sharp declines. Legacy IDA disbursements can mask the distinction between countries actively securing new IBRD health financing and those simply running down existing IDA commitments.

Part 3. Thematic analysis of the World Bank's engagement in the health sector

To complement the descriptive analysis above capturing some of the key quantitative dimensions of the Bank's engagement in health, we undertook a qualitative exploration of the World Bank's role in the health sector by conducting a literature review and stakeholder interviews. The aim of this thematic analysis was to surface qualitative aspects of the World Bank's operations, engagement with other partners and countries, and structural features that are likely to be strengths, opportunities, or possible challenges for a larger future role of the Bank in health.

What follows is a discussion of key themes surfaced through the literature review, stakeholder interviews, and portfolio analysis. Themes are grouped into four broad categories: governance, strategy, and prioritization of health; financing modalities; operational issues; and relationships and partnerships.

3.1 Governance model, strategic fit, and prioritization of health

The World Bank mobilizes about the same amount annually in health investments as the Global Fund and Gavi combined, with $7.0 billion in 2025 health commitments through IDA, IBRD, and trust funds. However, the Bank—unlike the Global Fund and Gavi—has a global reach, with operations in 145 countries and health projects in over 100 of them. Beyond this core feature which differentiates the Bank from other health actors, other aspects of the Bank shape the kind of health actor it is and can be. These aspects present potential challenges and risks, as well as opportunities, should the Bank expand its role in health financing, which are discussed in greater detail in the following subsections.

Governance, mandate, and country alignment

Aspects of the World Bank's governance model may require intervention were the Bank to take on an expanded role on health in the future. Broadly, perceived limited transparency, donor dominance, and weak recipient country participation are frequently cited in the literature as leading governance challenges.[16,43,50] Power asymmetries between donor and recipient countries persist, leading to donor-driven agendas that undermine country ownership, alignment, and coherent health financing strategies, according to the literature.[50] These challenges are not unique to MDBs but are pervasive across the global health aid landscape. For the Bank specifically, relative shareholder power was a prominent concern. Since shareholding status (the "one dollar, one vote" rule) determines voting power, the largest shareholders exert the most influence on voting decisions. In practice, this means that richer donor countries such as the US, Japan, China, Germany, France, and the UK have the potential to exert significantly more influence over the agenda and priorities of the institution while Global South countries that receive World Bank financing exert relatively less. Stakeholder interviews surfaced similar concerns around the potentially outsized influence on agenda- and priority-setting in global health in a future scenario of fewer financiers. The dynamic created by the Bank's voting structure raises concerns about accountability to countries that receive World Bank

lending, a worry made more salient by the potential scenario of a greater concentration of financing through the Bank.

Several structural features of the World Bank, however, help balance concerns around outsized donor influence on Bank governance. First, LMIC constituencies have Executive Directors, and countries, not donors, choose what they finance. Second, the Bank, as with other MDBs, works with national governments and directs funds through on-budget channels (i.e., Bank funds are part of the national budget), typically with the ministry of finance as its counterpart. Consequently, Bank financing is generally aligned with national budgets and strategic priorities, while health investments compete with other sectors such as infrastructure, energy, and governance within the broader lending envelope. Third, the World Bank's mandate increases the degree of country ownership through its Articles of Agreement, which stipulate that IDA and IBRD are partnerships with countries.[51] In a recent survey conducted by ODI, 80 percent of government officials rated the World Bank's support for country priorities as either "very well" or "well" (scoring third highest after the IDB and ADB).[52] These figures reflect a general trend that the MDBs broadly, including the World Bank, are responsive to country priorities, though with the caveat that the governance challenges outlined above persist.

There were divergent views among stakeholders on the magnitude of the US government's influence and the severity of the risk that US politics will hinder Bank operations and financing decisions. The US is the largest shareholder of the World Bank (holding about 16 percent of IBRD voting power and nearly 10 percent of IDA voting power), the only shareholder with de facto veto power over IBRD structural and policy decisions (which requires an 85 percent majority of voting share), and the member country that has historically appointed the institution's President. The current US administration's dissolution of key commitments on climate, gender, and other topics it has deemed ideologically unattractive could potentially undermine an expanded agenda on health, particularly one that prioritizes health equity and incorporates a focus on marginalized populations. Other GHIs that rely on US contributions, such as the Global Fund, face similar questions. In fact, the Global Fund is expected to be 33 percent funded by the US, and thereby comparatively more dependent on US financing and in turn US policies. Although the US holds 10 percent of IDA voting power, IDA-eligible countries collectively hold 15 percent of IDA voting power.[53] While each IDA Executive Director represents multiple countries, only three of the 25 Executive Directors are from IDA-eligible or IDA Blend countries (Cabo Verde, Tanzania, and Nigeria, collectively holding 9 percent voting power). In other words, IDA-eligible countries' voting power is distributed across constituencies represented by each Executive Director rather than concentrated in a single constituency. By comparison, seven of 20 Board seats are allocated to developing country representatives on the Global Fund's board (35 percent),[54] while Gavi's Board reserves five seats out of 28 for "implementing country" representatives (18 percent).[55]

The Bank's proximity to the center of US politics has in some cases negatively influenced the perceived trustworthiness of the Bank, while there is concern that the US could exert influence on projects tagged with anything the current administration opposes. Although project-specific objections have reportedly increased on climate and gender-related grounds, US veto power does not extend

to project-level decisions, and institutional governance arrangements among Bank shareholders do not directly determine country demand for Bank projects. Some stakeholders interviewed were skeptical that the US could realistically impose its will carte blanche on Bank operations, as it is still only one among 25 Executive Directors. In the current political climate, if the Bank were to expand its focus on health, it would need to develop a model that can accommodate current geopolitical tensions and divergence of ideologies. In practice, this may mean providing the broadest support to the health sector, then letting LMICs implement their own health priorities, since any high-level specification of priorities by the Bank will provide a target for geopolitical disagreement.

Finally, stakeholders noted that the Bank should consider how to increase the contributions of CSOs in the health sector. The World Bank's governance model and overall orientation have limited mechanisms for direct CSO participation, which has implications for engagement with and representation of marginalized populations. By contrast, the governance model of disease-specific GHIs explicitly incorporates CSOs. The bylaws of the Global Fund, for example, stipulate that five representatives from CSOs and the private sector, including a representative with lived experience of one of the three diseases on which the Global Fund focuses, will be voting members of the Board.[56] The Bank's governance model, as currently constructed, does not allow for a comparable level of representation. Without this representation in health financing governance structures, there is a real risk of losing focus on marginalized populations (e.g., sex workers, people who inject drugs, and men who have sex with men) and backsliding on health equity were the Bank to absorb operations of GHIs that focus on these groups. Incorporating Board-level engagement with CSOs would involve substantial changes in how the Bank works and would substantially increase the complexity of governance of health funding.* Alternative models, such as requiring increased CSO engagement at the country level, should therefore be considered.

Key takeaway: At a macro governance level, the Bank's voting structure is based on contributions, and so is donor-controlled and US-influenced, with no civil society participation. This is balanced, however, by the meso level, where the Bank provides a relatively high degree of country autonomy over use and prioritization of funds through a country-led mandate, on-budget financing, and working through national governments. At the project level, its multisectoral nature offers country autonomy and the potential to tackle the social determinants of health, yet it also means health funding is always competing with other sectors. (Notably, health receives substantial off-budget assistance, unlike other sectors, a trend of which ministries of finance are aware.)

Fit with current Bank strategy

Before 2025, World Bank reform debates increasingly assumed that the institution could use its existing financing architecture to pursue a widening range of development and cross-border objectives.[57,58] IDA, in particular, was often treated as a vehicle for advancing an ever-wider set of

* World Bank trust funds do allow for some variability in governance structure.

priorities—climate action, pandemic preparedness, HSS, gender, and fragility[59]—with the Evolution Roadmap process explicitly framing pandemics, climate change, and fragility as core cross-border challenges shaping the institution's future operating model.[57,58] Use of disbursement-linked indicators (DLIs) as part of PforR financing and other results-based approaches were seen as ways to embed these objectives within country operations. Research on aid architecture during COVID-19 identified increased earmarking and loan-based modalities as pressures that constrain flexible health financing in countries facing tighter fiscal space.[60,61] Together, these dynamics help explain why pandemic preparedness and broader "global public goods" financing became central to debates about how the Bank should deploy its balance sheet, convening power, and trust-fund infrastructure in health.[16,58,62]

Yet this expansive vision has become more contested since 2025, particularly as US pushback has raised questions about how far the Bank can continue layering additional objectives onto IDA and related instruments. Perhaps in response to these debates and pressures, the Bank has been pursuing an agenda of selectivity, a move intended to help increase effectiveness and reduce administrative burden. More specifically, since 2025, the Bank has updated its process for formulating Country Partnership Frameworks (CPFs), the central tool used in engagement with countries. The Bank has implemented "selectivity filters" intended to link CPFs more systematically to WBG Scorecard indicators and to focus on fewer outcomes. The three filters are as follows: (1) the country's key development challenges using World Bank diagnostics, among other sources; (2) the country's key priorities using national plans, sector-specific strategies, and dialogue with government counterparts; and (3) the World Bank's comparative advantage in the specific context, including knowledge and financing. On the third filter, this involves reviewing Bank strategic areas of focus, past performance, and level of understanding and engagement in the sector, along with identifying what other partners might be doing in the same space to ensure complementarity of efforts. Resulting CPFs vary considerably based on country needs and contexts and are, in theory, highly tailored to countries' highest priorities. In countries with competing priorities across multiple sectors, this emphasis on greater selectivity with fewer indicators could inadvertently crowd out health, though at this early stage of implementation, this risk has not materialized.

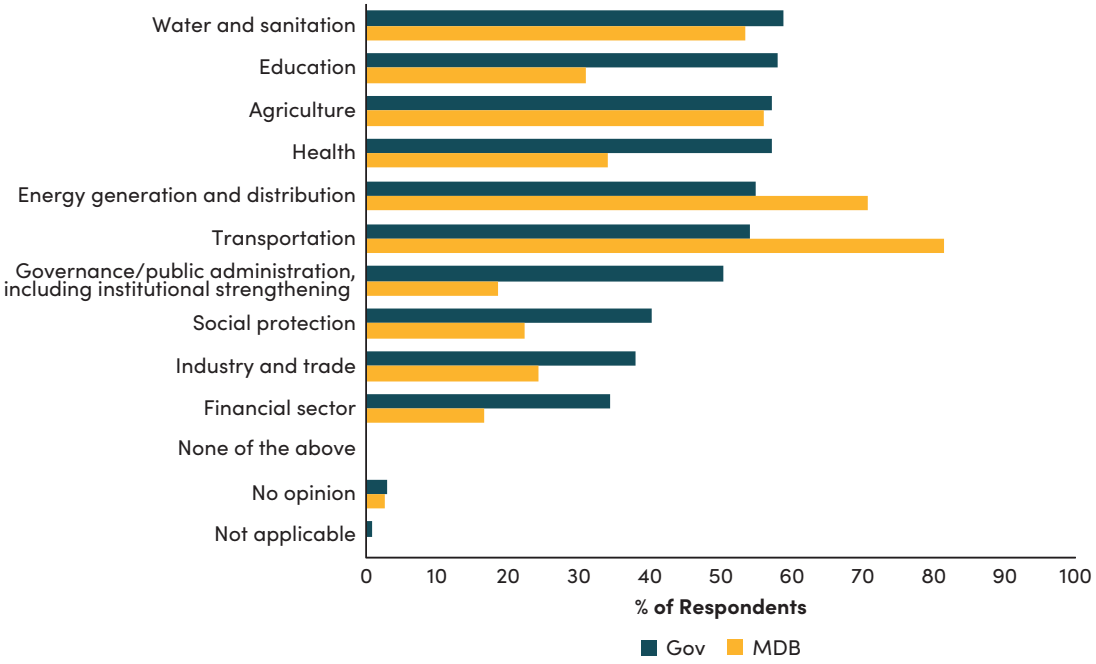
At a higher strategic level, in 2024, the Bank announced a goal of reaching 1.5 billion people by 2030 with basic health care services, defined somewhat narrowly as service contact rather than access to essential health products and services more broadly.[63] In late 2025, the Bank also launched the first National Health Compacts at the UHC High-level Forum in Tokyo, high-level strategy documents intended to align resources for health and improve primary health care delivery platforms. These compacts frame health less as a standalone social sector and more as a cross-government reform agenda linking primary health care expansion, affordability, workforce investments, and economic growth, thereby reinforcing the Bank's broader shift toward embedding health within its evolving agenda on resilience, human capital, and development effectiveness.[64]

While stakeholders generally viewed the Bank's current leadership on health positively—such as President Banga's positioning of health as a priority, both external and internal to the Bank—it

remains to be seen how other aspects of the Bank's current strategy under Banga's leadership will influence the Bank's prioritization of health. Some aspects of the reform agenda and current strategic direction were seen as potentially undermining a greater focus on health. Job creation is the Bank's current overarching strategic aim, which includes three pillars: (i) building the workforce in fields such as health care, infrastructure, and education; (ii) creating an enabling regulatory environment for businesses; and (iii) mobilizing private capital. While health is encompassed by the first pillar, it is a relatively small part of the overarching focus. Multiple stakeholders expressed concern that the jobs focus would divert attention and resources from health. External pressure from the US to get "back to basics" of macroeconomic development is also building.[65]

Notably, there is a disconnect between how government officials prioritize the health sector and how World Bank staff perceive health as a government priority. In a survey of 417 government and 46 World Bank officials conducted by ODI, more than half (57 percent) of government officials want the Bank to prioritize health, yet just over a third (34 percent) of Bank officials consider health a government priority (see Figure 8).[66] IDA-eligible and IBRD-eligible countries also had diverging views on the priority of the health sector: IDA-eligible countries prioritize health alongside a broad range of sectors, while IBRD-eligible countries tend to view the Bank as having a more concentrated role in specific sectors.

FIGURE 8. Sectors the World Bank should prioritize from the perspective of government vs. MDB officials



Note: The figure above is based on Prizzon, Zeka, et al.'s survey of 417 government and 46 World Bank official replies to the question: "If you were to choose, which sectors do you think the World Bank should prioritise in #country# in the future? Please select as many as applicable." Question for MDB officials: "Which areas do you think the government of #country# would like [your MDB] to prioritise in the future? Please select as many as possible."

Source: Prizzon A, Zeka F, Gyuzalyan H, Aghjoyan A. Reforming multilateral development banks: Perspectives from client countries. ODI Global; 2026.[66]

Key takeaway: A larger role in health clearly fits the Bank's mandate, and the President has championed health. However, this championing may be temporary, and pressures are building to focus on other priorities such as employment and jobs. Country-level engagement of CSOs, moreover, will be an important component of scaling up Bank engagement in health.

Country prioritization of health in IDA and IBRD financing

The demand-driven nature of Bank financing means the Bank currently has limited avenues for directing more financing toward health. Not all countries prioritize health when borrowing from the Bank; therefore, not all countries have health operations, as described in Part 2. There is no set health allocation for IDA, and loans cannot be earmarked for health. Trust funds and other specialized financing mechanisms do allow earmarking, such as the GFF, a multi-donor trust fund, but these are much smaller than core IDA and IBRD. Countries can access GFF grants if part of their IDA envelope is carved out for health. The GFF claims a leverage ratio of $1 of donor support to $7 of IDA.[60] Many stakeholders thought that the GFF did successfully mobilize more IDA funds for health than would have occurred absent the GFF, and that GFF resources were an effective "sweetener," though there was some skepticism around how much GFF and smaller trust funds actually leverage IDA for health. With no counterfactual for how much IDA would have gone to health without the GFF, it is not possible to empirically test this assertion (see also Box 1).

On the whole, countries do use IDA and IBRD resources substantially for health. The high variability, however, means that there is no guarantee that countries will have strong or increased appetite to borrow for health in the future, or in the event of other sources of health financing going away. Countries might decide to prioritize areas outside of health; there is consequently a risk of dilution and backsliding on immunization, HIV, tuberculosis, and malaria in particular (given that numerous GHIs have been established for the express purpose of focusing on these health areas). Additionally, because the Bank funds projects based on what countries request—that is, areas governments have identified as national priorities requiring external financing—there is no guarantee that programs serving marginalized populations, often led by CSOs and NGOs, would be taken up as a government priority. The World Bank does not seem likely to champion or prioritize these groups in the context of the current geopolitical environment; some internal Bank stakeholders indicated that the World Bank's 2023 decision to cease new lending to the Ugandan government following passage of a widely condemned anti-LGBTQ law would not happen now.[67,68] The World Bank is unlikely to fund large programs around certain vulnerable groups such as people who inject drugs and sex workers.

Key takeaway: The Bank's country-led approach is an asset for alignment with national priorities. At the same time, the Bank's demand-driven nature risks deprioritization of health absent other health-specific financing channels. There is considerable variability in how much of countries' World Bank portfolios goes to health, and the Bank (intentionally) lacks effective mechanisms to increase it, with the exception of GFF and other grant-based resources.

3.2 Financing modalities and fit

Although the World Bank has an array of mechanisms for financing health, it is first and foremost a bank and therefore primarily offers financing in the form of loans with varying degrees of concessionality. Advantages of World Bank lending, specifically through IDA, include highly favorable terms, namely zero or near-zero interest rates, decades-long repayment periods, and long grace periods. These terms allow LMICs, particularly LICs that may not otherwise be able to access lending, to make long-term, large-scale investments in areas such as digitizing national health systems or other projects intended to be transformative for the entire health system or economy.

In addition to its lending arm, the World Bank offers grants to the poorest and most vulnerable countries through IDA and trust funds. Looking to the future, an expanded grant-making portfolio could potentially facilitate defragmentation and simplification of managing financial flows in countries. Most World Bank grants also flow through governments, which can help ensure external financing is aligned with both national priorities and budgets. Trust funds in particular can additionally provide a platform for other activities that core IDA and IBRD funds are unlikely to fund. Multi-donor trust funds are generally preferable to single-donor trust funds since they can, in theory, help align priorities across donors, thereby reducing competition, enhancing project effectiveness, and freeing up LMIC civil servant time to execute the operation rather than service individual donors.[43]

Offering both loans and grants comes with several advantages. First, countries can access financing tailored to their fiscal space and needs. Second, countries can access a larger funding envelope than would otherwise be available with grants or loans alone. Third, grants can support targeted, time-bound health objectives or TA, while loans can support larger, broader, more time-intensive projects requiring larger-scale investments. Being able to blend financing also supports a smooth transition process as countries' fiscal spaces expand. Lending and trust fund models affect financing flows and institutional capacities differently, however, with some evidence pointing to greater effectiveness of core funding over earmarked funds. Country case studies highlight the importance of tailoring financing to the country context and the national government's political will to build sustainable health financing capabilities.[69–76]

The Bank would likely need to expand its grant-making portfolio were it to take on an expanded role in health and absorb operations of existing GHIs. Stakeholders interviewed for this paper broadly welcomed the idea of the Bank providing more grants to countries, especially to the poorest and most fragile. In a recent ODI survey, nearly half (44 percent) of surveyed IDA countries considered the volume of concessional financing too low, suggesting that a significant share of countries would also welcome an increase in grants. More than a third (36 percent) of surveyed IDA countries also considered MDB grants and loans insufficiently flexible, compared to 13 percent of IBRD countries.

Donor countries, such as the US, Canada, France, the UK, and Japan, however, are likely unwilling or unable to mobilize additional funds. There is consequently concern that current funding levels for GHIs would not be sustained if redirected to the Bank, and that overall health funding would decline as a result. The legitimacy of this concern was validated by interviews with some funders of the system.

The risk of overburdening countries with debt, particularly countries already heavily indebted, informs the interest in greater concessionality and grant-making. The growth of indebtedness in LMICs and strain on public budgets from debt servicing present potential limitations for an expanded role of the Bank in loan-based health financing.[77] In the same ODI survey referenced above, however, just 17 percent of IDA countries consider loans too expensive, while about a third of all respondents thought that MDB borrowing compromised debt sustainability.[66] Stakeholders similarly had mixed views on the question of debt sustainability. Some characterized the debt burden as manageable given how soft IDA lending terms are; others viewed the current levels of debt as potentially perpetuating a vicious cycle in which servicing debt takes priority over investing in public systems. Fiscal space for additional borrowing has an upper limit in all countries, and in many of the poorest and most heavily indebted, it is unclear how much more debt can realistically and sustainably be absorbed. Consequently, some stakeholders took issue with the principle of lending to countries already highly indebted. Focusing grants on indebted countries, debt restructuring, and forgiveness mechanisms serve as possible counterbalances. IDA financing, for example, allows for shifting back to grants from loans if a country is at risk of debt distress, while risk of debt distress and level of debt more broadly are factors incorporated into IDA's design and lending decisions.[36]

Financing instruments

The World Bank offers a range of instruments, though with variable approaches to implementation, accountability, and performance incentives. While many studies in the literature underscore the promise of innovative financing mechanisms in mobilizing resources and incentivizing results, there are consistent concerns about fragmentation, donor-driven agendas, transaction costs, and sustainability. The World Bank uses three primary financing instruments in health: IPF, PforR, and DPL.

Health investments most commonly use IPF, accounting for 67 percent of health commitments and 78 percent of operations in 2025. Health projects financed through trust funds almost exclusively use IPF, with 85 percent of trust fund health financing commitments using IPF. Comparative literature on MDB financing instruments describes investment lending as the oldest and most dominant, noting that it involves the Bank deeply in design and focuses the Bank on inputs and reviewing eligible expenditures rather than ensuring development results or policy reform.[78]

Health projects infrequently use DPL, suggesting that supporting health policy reforms is potentially under-prioritized across the Bank's health financing portfolio. PforR projects are more common and have successfully supported health system reforms and institutional capacity building, exemplified by Costa Rica's experience.[70] Specific RBF schemes have demonstrated positive impacts on service utilization and quality, particularly in maternal and child health, with rigorous monitoring and verification mechanisms enhancing accountability.[74,79] However, downsides have also been reported. PforR can distort incentives, focusing on measurable outputs at the expense of less tangible but critical health system functions.[80] The overall evidence on sustainability, cost-effectiveness, and long-term health system impact remains limited, mixed, and context-dependent.[81–84]

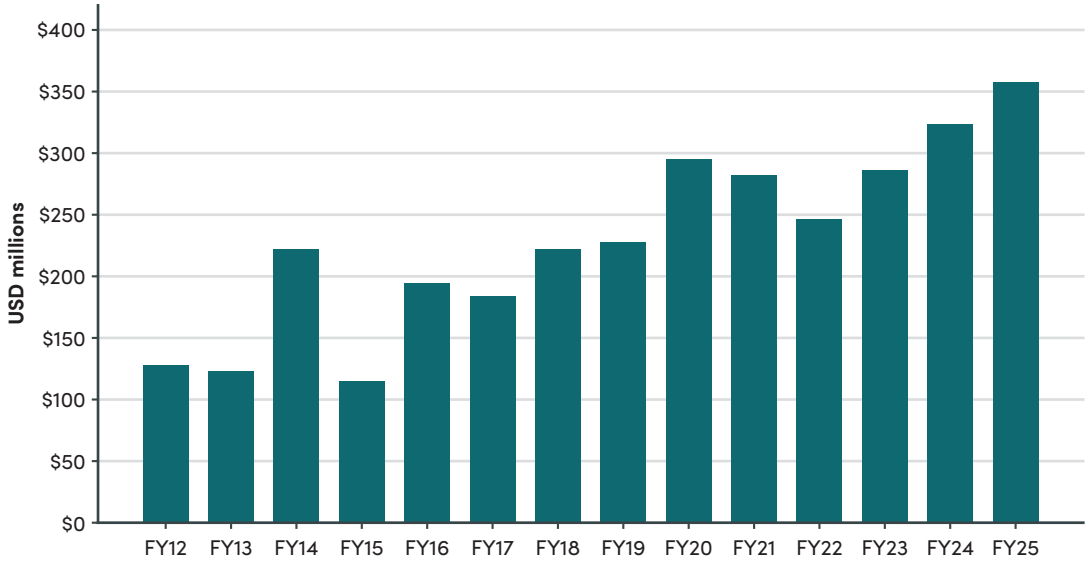
Key takeaway: Specific financing instruments such as IPF, PforR, and DPL are available to meet country needs and donor needs for accountability, control, and performance incentives.

Trust funds

Trust funds are central to World Bank health financing, used extensively to channel donor resources for targeted health initiatives. Empirical analyses show that trust fund allocations are often poverty- and policy-selective, aligning with IDA criteria in many cases.[85,86] In health, trust funds often finance the "around-the-project" functions—design, TA, piloting, learning, and coordination—rather than replacing core sovereign financing.[16] When done well, trust funds were viewed by stakeholders as transformative and enabling of large-scale and sector-wide reforms. The GFF, for example, was generally viewed by stakeholders as a useful tool for supporting investments in health systems through its leveraging effect.

Their prominence is not new. By the early 2010s, trust funds had already become a major channel for World Bank health engagement, reflecting donor preferences for earmarked financing and targeted initiatives. Health trust fund disbursement volumes have grown steadily over the past decade (see Figure 9), even as the Bank consolidated the number of funds through the Umbrella 2.0 reforms described in Section 1.2, and stakeholders view the landscape as unwieldy still. Several stakeholders suggested that if the Bank increased its grant-making for health, the Bank should decrease or consolidate the number of trust funds and use grants for transformative projects that require high upfront costs.[43] Critics likewise note that the proliferation of World Bank-managed health funds and partnerships can complicate coordination, both internally and with other agencies, if not carefully aligned with country strategies.[16] The World Bank has acknowledged this fragmentation issue, for instance, by attempting to consolidate some trust funds into broader "hybrid" funds to reduce duplication.

FIGURE 9. Disbursements through IBRD and IDA health trust funds by fiscal year



Sources: World Bank Finances One (DS00074), December 2025. Excludes accounts classified as financial intermediary funds: the Global Fund to Fight AIDS, Tuberculosis and Malaria; the International Finance Facility for Immunisation and Gavi Fund accounts; CEPI; the Pandemic Emergency Financing Facility; the Pandemic Fund; and the African Programme for Onchocerciasis Control (disbursed through its FY2015 phase-out). Programs with both FIF and IBRD/IDA accounts appear through their IBRD/IDA accounts only. May undercount health activities under non-health umbrella programs. FY2026 excluded (incomplete).

The growth of trust funds has made them an increasingly important channel of World Bank health engagement, but also raises questions about fragmentation, donor influence, and coordination. Design features influence donor participation, with trade-offs between burden-sharing and preferences shaping fund size and modality.[87] Health researchers Janelle Winters and Devi Sridhar describe the Bank's trust fund model as "earmarked, extra-budgetary 'multi-bi' aid," where bilateral donors exert influence by channeling money through the Bank for specific goals.[16] While this can mobilize resources for specific health issues (e.g., a donor might fund a trust fund for pandemic preparedness or nutrition), it can also skew the Bank's health agenda toward what donors are interested in, potentially at the expense of country-defined needs. For example, a country might need health worker salaries or primary care clinics (which are harder to finance via earmarked funds), but donors prefer to fund specific diseases or innovative pilots. By channeling many separate donor-funded initiatives, the Bank's health portfolio can become fragmented across disease-specific or priority-specific funds, potentially undermining coherent national health planning.[16] Each trust fund must also be applied for, and each has its own requirements, increasing administrative burden on countries.

The challenge for the World Bank is to mediate these influences, leveraging donor funds while maintaining alignment with countries' own health sector plans. Initiatives like the International Health Partnership and its successor UHC2030 have promoted country ownership and alignment

of external support, principles that the Bank endorses. Yet some researchers argue that the Bank's dual accountability to both donors and borrowing countries can create tension in setting health priorities.[16] Ensuring that programs like GFF or other trust fund-funded efforts complement, rather than override, national health priorities is an ongoing balancing act. Recent initiatives such as National Health Compacts are partly an attempt to manage this tension by tying external support more explicitly to nationally negotiated reform agendas, though whether they materially improve donor alignment behind national plans remains an open question.[9]

Donors themselves bear the majority of the responsibility in rationalizing the way the Bank approaches trust funds and determining the capacity of the Bank to increase its grant-making portfolio. Although donors express a desire to consolidate and defragment health financing, donors also want to earmark funds for specific purposes, which has in part contributed to a proliferation of trust funds. Consolidating financing modalities and mechanisms therefore requires greater donor coordination and alignment, together with willingness of donors and shareholders to change. Importantly, for the Bank to increase the scale of its grant-making, donors would most likely need to increase their commitments to the Bank.

BOX 1. The Global Financing Facility: A test case for an increased World Bank role in health

The GFF is the World Bank's most institutionally integrated health trust fund and the closest existing test case for an expanded Bank role in global health financing. Its Secretariat is embedded within the Bank's health practice, its grants are linked to IDA and IBRD operations, and its model rests on the claim that relatively modest donor grants can mobilize substantially larger public financing toward health. A decade into its operation, the GFF offers the strongest evidence available on whether a Bank-hosted, donor-funded trust fund can credibly convene partners and channel additional financing for health, a question with direct implications for the policy options discussed in this paper, including an IDA health window.

The trust fund model helps mobilize additional donor resources

The trust fund structure has specific benefits that can attract donors: donors have more control to earmark funding to their priorities, and philanthropies (which are excluded from IDA contributions) can contribute substantial resources to the GFF. However, the GFF remains relatively small, disbursing $181 million in 2025, only 2.6 percent of the total $7.0 billion Bank health commitments in 2025, suggesting its ability to attract resources is relatively limited.

Governance: More concentrated than IDA, but with increasing LMIC involvement

The Trust Fund Committee (TFC), the GFF's decision-making body, is made up of representatives of the World Bank and donors contributing above a defined threshold. The broader Investors Group, which includes partner-country ministers, CSOs, the private sector, UN agencies, Gavi, the Global Fund, and private foundations, plays an advisory role only.[89] Responding in part to earlier critiques that it lacked any recipient-country voice, the TFC has recently added partner-country representation through the Investors Group Co-Chair seat and the Chair of the GFF Ministerial Network.[90] Even so, formal decision-making remains with the Bank and a small group of contributing donors, leaving the GFF's governance more concentrated than IDA's (Section 1.1).

Prioritization of health and increasing IDA and IBRD prioritization of health

As a trust fund with an explicit reproductive, maternal, newborn, child and adolescent health, and nutrition (RMNCAH-N) mandate, all GFF resources go to health. Stakeholders interviewed for this paper generally viewed the GFF as valuable for health system investments. Its budget, however, is small; one of the main arguments for the GFF model is that it helps draw more World Bank financing into health. The Bank claims that every dollar of GFF grant funding is linked to roughly $7 of IDA or IBRD financing.[91] But that statistic is more a factual description of the makeup of the combined GFF-IDA-IBRD portfolio than a causal statement about whether the GFF actually pulls in additional health spending. The key question is the counterfactual: how much of that IDA financing would have gone to health if the GFF did not exist? The literature does not provide a clear answer. Interviews conducted for this review revealed differing views: some stakeholders saw GFF grants as a "sweetener" that encouraged governments to allocate more IDA resources to health, while others questioned whether the effect was as meaningful as the Bank claims.

Financing mechanisms: Grant only

GFF provides grants only. This model has the advantage of avoiding adding to countries' debt, but the disadvantage of not being able to directly shift to loans in wealthier countries and thus cannot stretch the impact of official development assistance through securing reflows and raising resources from capital markets. The GFF's grant-only model therefore gives less flexibility than IDA. As countries move toward IBRD eligibility, IDA can adjust the mix of grants and concessional loans it provides, whereas the GFF can only offer grants.

Is the Investment Case worth it?

A key operational question is whether the Investment Case (IC)—the GFF's signature planning tool—adds enough value to justify the extra work involved in preparing it alongside a Project

Appraisal Document (PAD). In theory, the IC is meant to shape the PAD so that GFF and IDA financing reflects national RMNCAH-N priorities. Whether the IC actually shapes financing decisions appears to vary widely across countries. A policy analysis covering 28 GFF countries described the IC as more of an "aspirational vision" than an operational planning document. In practice, the IC often did not determine what the linked Bank operation financed: in Kenya, for example, the IC identified 20 counties as priorities for scale-up, but the project that followed was rolled out nationwide instead.[93] A 2025 independent evaluation of the GFF found many of the same issues across the 36 partner countries it reviewed, pointing to recurring gaps in how ICs were used in practice.[94] The scale of GFF grants relative to the operations they are linked to also varies widely—from 3 percent of linked IDA financing in Bangladesh to 67 percent in Cambodia, with a median of 24 percent[92]—reflecting how differently the tool is applied across settings. Where government teams or Bank staff are already stretched thin, preparing an IC can require considerable time and effort without necessarily changing funding decisions.

Operational and partnership challenges

Because GFF-linked projects use Bank staff and instruments, countries run into operational challenges similar to those seen across the rest of the Bank's health portfolio: long project preparation times, little public monitoring and evaluation (M&E) of impact, TTL variability, and limited comparative advantage in TA and procurement.

On partnerships, part of the GFF's original purpose was to reduce coordination friction between the Bank, Gavi, and the Global Fund by giving them a single country IC around which to organize. Section 3.4 documents mixed results and persistent challenges in Bank–Gavi and Bank–Global Fund jointly financed operations, including "insufficient mutual understanding," "frustration with how to influence key processes," and "differences in internal timelines, budget cycles and reporting." The GFF's value as a convening platform depends on the IC having operational traction, but the evidence suggests the IC has limited traction even with the Bank itself.

Implications for an expanded Bank role in health

After more than a decade in operation, the GFF offers a useful window into both the strengths and limitations of a Bank-hosted health financing platform. In countries where governments were already committed to expanding health investments, GFF grants often helped keep health high on the agenda, provided additional resources and TA, and supported larger World Bank operations. In other settings, however, its influence appears to have been more limited. Key weaknesses include a governance structure that remains donor-driven, use of grants alone (which limits its scale), and high administrative costs on account of the separate IC and approval process.

An IDA health window would need to address these limitations. Much of what frustrates partners about the GFF is fixable on paper. A window built into core IDA would not need a separate trust fund, a parallel IC, or a separate TFC, and it could move between grants and concessional loans as a country's needs change. Even if those design issues were addressed, however, implementation challenges would remain. The operational strains that surface in GFF projects are not just artifacts of the trust fund; they run through the Bank's whole health portfolio, and a window would rely on the same teams and systems. A health window could address some of these weaknesses, but its success will depend on how effectively projects are implemented.

Key takeaway: The GFF shows both the strengths and limitations of the Bank trust fund model. As a trust fund, it can raise money from donors including philanthropies, earmark funds to health, and integrate projects with Bank operations. But the GFF's governance structure is dominated by a small number of donors, the GFF can only use grants and not loans (which limits its scale), and the administrative burden on all sides is high given the separate IC and approval process.

Beyond capital expenditures: Financing recurrent health expenditures

Stakeholders had a wide range of views on the Bank as a suitable home for broad health system financing inclusive of recurrent expenditures, such as health worker salaries and health commodities, in the poorest countries. Stakeholders generally accepted that the Bank finances recurrent costs in some settings in practice and generally agreed that it made sense for the Bank to finance recurrent costs in limited, time-bound circumstances in specific country contexts. Examples of situations in which financing recurrent expenditures was viewed favorably include crisis events such as infectious disease outbreaks and time-bound investments such as creating a new or temporary cadre of health workers to achieve a specific goal (e.g., disease elimination). If a Bank operation does support these kinds of expenditures, stakeholders emphasized the need to have a clear transition plan for shifting financing to the government to avoid perpetual dependency on external sources for core health system functions. These operations would also ideally be set up in a way that systematically strengthens the health system. It was also noted that there are often interactions between capital and recurrent costs that should be considered. For example, while hospitals might be a more visible investment in health, a hospital could end up functionally non-operational over time because of medical equipment in need of repair or insufficient human resources for health.

Overall, stakeholders emphasized that if health worker salaries are supported as part of a Bank operation, the support should be transitory and a stopgap measure. It was also noted that if Bank financing supports these kinds of gaps without accompanying strategic planning, this support is neither sustainable nor effective at strengthening the health system. Although the Bank and MDBs broadly were often viewed as generally reluctant to support these kinds of expenditures, in practice recurrent costs are financed by Bank operations. Multiple Bank staff indicated a trend toward

acceptance of this practice, while also suggesting that ministries of health should retain a role in stewardship and priority-setting. A minority of stakeholders, however, thought that the Bank should not support recurrent costs under any circumstances, or did not think the Bank had a track record in developing long-term human resources for health in LICs.

On the other hand, several stakeholders expressed the view that in some country contexts, there is no other way of financing these sorts of core health system components. If external financing is required, the World Bank's mix of grant and loan financing is more likely to enable a smooth transition from stopgap measure to full domestic financing of recurrent costs relative to a grant-only financing source. In other words, support for recurrent costs can initially be financed with a grant and transitioned to loans as the country's economic situation improves, until eventually the government is able to fully finance the health system.

Key takeaway: IDA and IBRD are well placed to use both grants and loans to meet country needs. Trust funds can attract more health funding, and they can incentivize specific objectives, but their proliferation increases donor control, administrative burden, and fragmentation. Despite its historic focus on investment lending, 24 percent of IDA is in the form of grants and frequently covers recurrent costs.

3.3 Operational issues

The following section summarizes some of the operational issues that could potentially derail successful expansion of Bank health operations. These potential issues include: (i) delays in disbursements and long lead times to develop projects; (ii) special considerations for operations in FCV settings; (iii) institutional incentives and reliance on individuals; (iv) potential mismatches in technical expertise and assistance; (v) weaknesses in monitoring and results tracking; and (vi) procurement challenges. Improving internal coordination across units was viewed as an additional, broader operational challenge in need of reform.

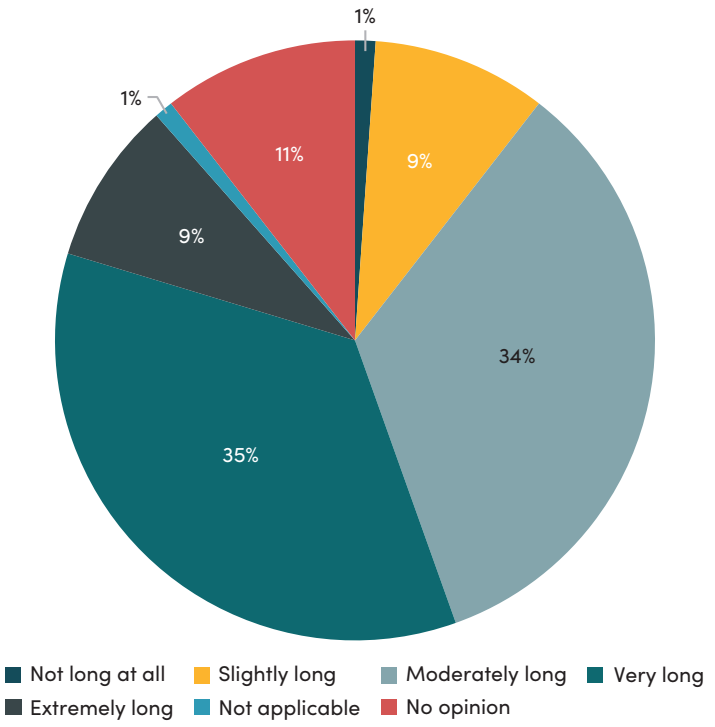
Delays in disbursements, long lead times to develop projects, and other bottlenecks

Several papers in the literature point to disbursement delays, absorptive-capacity limits, bureaucratic bottlenecks, and underutilization of funds as important constraints to World Bank health project implementation.[58,95–97] Taken together, these sources suggest a recurring pattern in which available financing is not always translated efficiently into execution, especially where administrative systems are weak or projects are overly complex relative to country capacity.[95,96] LMICs underspend their health budgets by 13 percent on average, and health execution rates are declining in LICs, especially in Africa; meanwhile, high-income countries are overspending on health.[98] Some papers also point more specifically to slow approval and implementation processes, limited institutional capacity, and fragmentation across financing channels as factors that can

weaken execution.[16,50,58] These challenges are not unique to the Bank and instead are frequent barriers to effectiveness across aid agencies.

The Bank's controls in general make it fairly inflexible and slow (though under Banga, the Bank is pursuing an organizational efficiency and effectiveness agenda to address these challenges). In a recent ODI survey, although 79 percent of government respondents rated short processing times as either very or extremely important, less than half (47 percent) thought that MDB performance in this domain was good or very good.[66] Processing times from initial project conceptualization through to board approval are considered too slow by nearly half of survey respondents, with notable differences between IDA and IBRD countries. While only 32 percent of IBRD countries surveyed reported processing times perceived as long, most IDA countries (59 percent) reported processing times perceived as long. Most government respondents perceived the project cycle length as long, with 44 percent describing the project cycle as very or extremely long (see Figure 10). Project preparation, ensuring MDB requirements, and safeguards compliance are seen as the main sources of delay leading up to board approval, while internal procedures, project preparation, and procurement requirement compliance are the primary bottlenecks between board approval and disbursement.

FIGURE 10. Perceived length of the project cycle



Note: Findings from Prizzon, Zeka, et al.'s survey based on 395 government respondents to the question: "Thinking about a typical MDB project, how long would you say it takes from conception to first disbursement in #country#?"

Source: Prizzon A, Zeka F, Gyuzalyan H, Aghjoyan A. Reforming multilateral development banks: Perspectives from client countries. ODI Global; 2026.[66]

Operations in FCV settings

As a bank, the World Bank tends to be risk averse. In health areas that require nimbleness, speed, and flexibility, such as humanitarian contexts, the Bank is not viewed as an optimal partner by numerous stakeholders. The Bank is viewed as strongest on projects requiring scale, yet weaker when it comes to pilot projects and innovation. In humanitarian emergencies and FCV settings (which frequently overlap with LICs), multiple stakeholders did not see a clear value-add of Bank operations relative to other entities active in those settings, such as humanitarian organizations. The Bank is currently in the process of revising and operationalizing its strategy for engagement in FCV settings, so this may be a space to watch in 2026 onward.[93] Importantly, the Bank has reported a marked increase in financing for FCV settings, with 33 percent of IDA funds targeted to FCV settings during FY2020–FY2024, driven by reclassification of Nigeria and Ethiopia as FCV countries.[99]

There are also contexts that governments cannot reach, where NGOs and UN agencies may have more established infrastructure to deliver services—though these organizations are themselves facing funding shortfalls and generally have limited resources for HSS. Because the Bank primarily works through governments and is not set up to partner with CSOs or UN agencies at scale, organizations designed specifically for humanitarian and fragile settings may be better positioned to operate in these contexts. Notably, however, the Bank has worked with NGOs and CSOs in limited circumstances, such as in Afghanistan (also of note, the largest health trust fund is the Afghanistan Resilience Trust Fund). The World Bank also reports that third-party implementers were used in 10 percent of IDA and IBRD FCV commitments from 2020–2025.[99] The performance of this approach, however, particularly compared to other funders, is not well documented. An external and independent evaluation, ideally covering the Bank and other GHIs, would therefore be valuable.

Institutional incentives and the role of individuals

Attributes of individuals in key positions, such as TTLs, were identified as by far the biggest operational issue by stakeholders. The experience, personality, and motivations of TTLs and other key Bank staff overseeing country operations were seen as critical determinants of whether a project or partnership succeeds or fails. These attributes were also seen as influential in the extent to which projects align with country priorities. This dynamic leads to inconsistency in the predictability and reliability of the Bank as a partner in health, which creates considerable variation in project effectiveness and impact. It was also noted that Bank staff tend to lack government experience and negotiating skills. The incentives and political economy at country level (i.e., dynamics and sensitivities around personal connections within government, such as proximity to the minister) were also noted as important factors.

Institutional incentives inform how staff interpret institutional guidance, as well as the level of engagement with other partners. In general terms, Bank staff, namely TTLs, are perceived as being primarily incentivized to disburse funds and deliver against specific project indicators rather than

optimize for long-term sustainability or domestic financing. Stakeholders broadly thought that Bank staff generally are not incentivized to engage in consultative processes with other donors and partners working in countries. For example, a bilateral donor working in a conflict-affected African LIC shared that the TTL working in the same country engaged much more enthusiastically following the Bank's issuance of an incentive to leverage more bilateral funding in its operations.

More broadly, the World Bank's health operations face internal challenges such as bureaucratic processes, the need for (and variable level of) inter sectoral coordination, and variability in expertise. Health outcomes depend on actions beyond the health sector (e.g., in education, water, nutrition), so Bank teams must coordinate across sectors. This multisectoralism is something that is conceptually embraced, as the Bank often touts its multisectoral ability, but is practically difficult in large institutions. More broadly, stakeholders expressed concern about the Bank's institutional inertia and skepticism about the Bank's capacity to change, as well as mixed views on the extent to which World Bank staff and shareholders have appetite to do more on health. Stakeholders noted the general difficulty often associated with changing large bureaucratic organizations, and specifically the challenge of changing entrenched mindsets and organizational culture. Several stakeholders expressed the view that it is very hard to change World Bank systems and incentives for just one sector, let alone a sector that may not be a top priority.

Technical expertise and technical assistance

The idea of the Bank as a "knowledge bank" was formally embraced in its 1998 World Development Report, though scholars have noted that this rebranding coincided with a period when the Bank's financial influence was waning and it sought to reassert institutional relevance through its research function.[12] In a recent survey conducted by ODI, nearly 73 percent of government respondents rated the World Bank as effective in offering policy advice and TA, while nearly three quarters rated the Bank as effective in generating research and analysis.[66] The prime advantage of MDB TA identified by survey respondents is filling technical and knowledge gaps. When drilling down into specific features of policy advice and TA that countries consider important, only 20 percent of ODI survey respondents ranked MDB-provided TA as reflective of local context and culture, and only a quarter considered TA timely and flexible.

Historically, the Bank operated disease-specific project portfolios with a cadre of technical health experts in areas such as malaria and immunization. Over the last few decades, the Bank has broadly shifted health operations away from disease-specific portfolios toward health systems, UHC, and primary health care. In terms of technical expertise outside of operational activities, a *Lancet* commentary from Ruger (2007) argued that the Bank has a genuine comparative advantage in topical areas such as health financing and financial protection, economics, financial sustainability in the health sector, and sound macroeconomic and fiscal policy, and that these strengths justify its analytical leadership while suggesting it should leave disease-specific technical guidance to

WHO and UNICEF.[100] The view that the World Bank has genuine comparative advantage in public financial management (PFM) and health financing-related topics and that it lacks technical expertise within specific thematic areas of health (e.g., immunization, malaria) was corroborated by stakeholder interviews. There was not consensus, however, that the World Bank should maintain global analytical leadership on these topics, in part due to the same concerns surfaced in the literature around potentially outsized influence. If the Bank does, it would need to do so in partnership with WHO.

Were the Bank to expand health TA alongside TA for health financing, it would potentially have to rebuild those cadres of experts within the Bank. Given the Bank's recent staffing changes, including its plan to phase out short-term consultants, who comprise roughly a quarter of the Bank's workforce, some stakeholders were skeptical that the Bank would be willing to bring on additional health experts. On the other hand, the Bank need not have all expertise in-house, and its programs would (and should) focus on broad health system support rather than disease-specific programming. The Bank can also outsource disease-specific technical expertise to external TA providers to help guide programs and operations as needed during the design stage. Indeed, the Bank should develop a strong and honest capacity to decide when to look outside when it does not have the requisite expertise to inform contextually appropriate projects.

Operationally, the Bank has relatively limited project funds for TA. Projects typically draw from BETFs to provide implementation support and TA to countries. TTLs can draw from BETFs to access more flexible project funds, including funds to undertake technical work prior to project execution. Trust funds finance roughly two-thirds of the Bank's advisory services and analytics overall. In practice, this means the Bank's TA function—supporting countries on health financing reform, provider payment design, PFM in health, insurance scheme design, and capacity building—often runs parallel to or ahead of lending relationships, providing the analytical scaffolding on which operations are later built. TA may be the primary vehicle for Bank engagement in FCV settings; consequently, this kind of support is important in countries where lending is limited. The Bank's role in generating and disseminating knowledge and best practices through TA and policy advice distinguishes it from other global health actors in ways that its financing volumes alone do not capture.[100]

How TA is delivered matters: critical researchers and others have raised concerns in the literature about over-reliance on global consultants,[101] models that travel poorly across contexts,[102] and insufficient integration of local expertise and community voice into program design[69,103]—concerns that were corroborated in stakeholder interviews. TA for health was broadly not viewed as a comparative advantage of the Bank. Numerous stakeholders also did not think that the Bank, as it currently operates, was well-positioned to provide intensive implementation support. Other donors and partners, most obviously WHO, could be better positioned to deliver this kind of support to countries, if only because other donors and partners have larger budgets specifically for TA.

If health financing flows were to increase through the World Bank, several stakeholders proposed that the Bank should reduce its TA to mitigate the potential for power and influence dominance. Alluding to the Bank's comparative advantage in fiduciary management and oversight, several stakeholders indicated that other agencies could take on the roles of supporting implementation and providing normative guidance, with governments setting the agenda.

Monitoring, evaluation, and results measurement

A number of weaknesses have been identified with the World Bank's approach to results M&E. Despite its role in knowledge production broadly, only a small fraction of the World Bank's health projects have been robustly assessed. In fact, only about 5 percent of World Bank projects are rigorously evaluated to determine causal effects. Many projects rely on routine monitoring or end-of-project reviews that document outputs (e.g., number of clinics built, people trained) but not whether health outcomes improved as a result of the intervention. The paucity of rigorous evaluation is partly due to funding and incentive issues, as evaluations often depend on special grants or trust funds and may not be prioritized in loan budgeting. This "evaluation gap" can mean limited learning about what works in health financing. Stakeholder interviews generally corroborated the view that the Bank's approach to M&E in health is not particularly strategic or transparent.*

There is no consolidated public reporting of health outcomes across the World Bank's health portfolio. Results are tracked at the individual project level through Implementation Status & Results Reports,[104] but these are not aggregated into a portfolio-wide view of health impact or HSS effectiveness. Additionally, the Bank's health target of reaching 1.5 billion people with quality, affordable health services by 2030[63] is a coverage metric rather than an outcomes measure, and the methodology for counting people "reached" is not publicly detailed.[105] As a result, this review was unable to systematically assess the health impact of the Bank's portfolio. An agenda to strengthen the Bank's approach to M&E overall was recommended to accompany a growth in investments in health.

The Bank's Independent Evaluation Group (IEG) has flagged weaknesses in how health project results are measured and used for course correction. In recent years, both Bank staff and external experts have called for embedding impact evaluations into health projects and reporting successes and failures more transparently.[106] The situation is slowly improving—for example, the Bank's newer projects in health often include evaluation components, and trust funds like the Strategic Impact Evaluation Fund sponsor health studies—but significant gaps remain in assessing effectiveness. Inadequate evaluation risks repeating interventions with unknown or marginal impact, while identifying and scaling more effective strategies remains elusive.

* The GFF was highlighted as an exception. See, for example, Frequent Assessments and System Tools for Resilience: https://data.gffportal.org/key-theme/FASTR.

An additional tension that surfaced through stakeholder interviews was around the kinds of results that are attractive to donors and most helpful for monitoring tangible progress in improving health systems. HSS does not lend itself easily to the kind of quantifiable, "headline" results that disease-centric GHIs like the Global Fund and Gavi report (e.g., number of lives saved). Donors tend to gravitate toward these easily understood metrics, and the Global Fund's straightforward results framing has proven effective for fundraising. Communicating the value proposition of investments in health systems, by contrast, presents challenges with generating donor commitment in the same way. The "appropriation" of the HSS agenda, in medical anthropologist Katerini Storeng's framing, by GHIs such as Gavi highlights both this communication challenge and GHIs' bias toward verticalization.[107] The World Bank would need to address both the measurement and communication challenge to convince donors, taxpayers, and policymakers to commit additional funds to the Bank.

Procurement of commodities

Stakeholders generally did not think that the Bank should procure health commodities on behalf of countries, especially in MICs, in future health financing scenarios. Instead, the Bank would be better positioned to help finance procurement and to support the development of countries' capacities to procure commodities themselves rather than building "artificial" parallel systems. Stakeholders had mixed views on the Bank's procurement functions and ability to work with pooled procurement mechanisms and generally tended to think other institutions are better positioned to lead on procurement. Overall, stakeholders had mixed views on the feasibility and appropriateness of the Bank absorbing procurement functions of other GHIs in the future, though the Bank could certainly play a role in financing procurement. Gavi's market-shaping function for vaccines, for example, was commonly viewed as a unique strength of Gavi that would be difficult to replicate. There was some skepticism among stakeholders that the Bank could aggregate demand as well as the Global Fund, and in turn enable more favorable pricing and better access. On the other hand, some viewed the Global Fund as replacing rather than aggregating demand. Because the Bank works directly with countries rather than regions, the Bank is perhaps more limited in its ability to influence regional or pooled drug pricing. Bank procurement processes can also be viewed as slow and inefficient by borrowing countries. Countries' varying degrees of capacity for procurement were also noted as an important consideration (e.g., small island countries versus large MICs).

Key takeaways:

- Expanding the World Bank's role in health financing will need to be aligned with appropriate incentives for key staff, such as TTLs, and improving the tracking of results. Better tracking and communication of results is also key to maintaining donor support. The Bank will need to overcome barriers to effectiveness, such as improving lead times in project development. Its impact will be greatest if the Bank leads on financing while working with partners to strengthen the TA and procurement ecosystem, rather than leading on those functions itself.

- Slow processes and the government-to-government approach make the Bank well-suited to stable, low-income settings, but less so to fast-moving humanitarian contexts or contexts with very low government capacity. The World Bank does have a FCV strategy with a different model in these settings: 10 percent of IDA and IBRD FCV commitments went through third-party implementers from 2020–2025. An external and independent evaluation of this approach, covering all major global health funders, would be valuable in guiding a future expansion of the Bank's role in health.

3.4 Relationships and partnerships

As a major actor supporting multiple sectors and projects within countries, aspects of the World Bank's engagement with country officials, health agencies, and other partners warrant exploration. This section discusses how the World Bank is perceived as a financier and as a partner, including areas of opportunity and potential barriers to its future impact in health.

Perceived risk of outsized influence on health priorities

Stakeholders both within and external to the Bank expressed concern about the risk of concentrating power and influence in one institution by having one main entity dictate the flow of global health financing in the future. Several stakeholders referenced global protests against the Bank and IMF in the 1980s and 1990s following the introduction of structural adjustment programs and user fees.[108] Although the Bank has undergone multiple reforms and changed in substantial ways in the last few decades, some stakeholders expressed skepticism that the Bank has changed *enough* relative to that period. In LICs that have fewer financing options, there is already some perception that the Bank exerts outsized influence over countries. Most stakeholders, moreover, did not think that the answer to the current crisis is one agency tasked with all aspects of global health. That said, the Bank remains a relatively small part of overall DAH and so the risk of dominance is low.

The need to defragment financing needs to be balanced with retaining some degree of healthy "competition" among different financing partners to avoid recreating conditions that seed distrust and foment further disillusionment with global health aid. Robust accountability mechanisms, including independent external monitoring, are needed to guard against this risk, particularly if a greater share of health financing flows through the Bank. Other suggestions that surfaced through stakeholder interviews include reconfiguring other aspects of the health financing architecture (consolidating GHIs, for example), channeling more financing through regional banks, and reducing the Bank's TA offerings.

Absent this "competition" with other financiers, the Bank could feel less incentivized to change more generally or adapt its standards, operating procedures, or internal culture. Even within the current environment, the Bank tends to hold significant power and influence, particularly in the poorest and most fragile contexts in which some countries depend substantially on the Bank to finance the

health sector. More broadly, there is a sense among stakeholders interviewed that there needs to be willingness within the Bank to engage with a wider array of stakeholders in the design of operations, including with CSOs and across government (i.e., not just ministries of finance and health, but also other ministries and departments with relevant priorities and responsibilities).

Collaboration with other agencies

The Bank's 1.5 billion target and the National Health Compacts framework do not yet specify how the Bank will coordinate with the Global Fund, Gavi, or other vertical funds in countries where these actors are already significant financiers and procurers. Given that the Bank's comparative advantage lies in systems and fiscal engagement rather than commodity procurement or disease-specific programming, the value of the new target will depend partly on whether it catalyzes a clearer division of labor across the architecture or simply adds another layer of parallel goal setting.

Due to its significant presence in countries and scale of investments, the Bank's potential function as a tool of alignment across a multitude of partners was viewed as an area of strong opportunity. There was a fair degree of consensus among stakeholders in seeing a potential role and value-add if the Bank could support greater visibility in financing flows (i.e., how much financing is coming from each partner for what purpose). Visibility would support coherence in the flows by helping to ensure resources are complementary rather than duplicative. Achieving this level of alignment and visibility, however, requires significant willingness across Bank staff and partners to collaborate in new, more flexible ways.

The World Bank's convening function is also valued by some as a way of translating analytical and financing leverage into political commitment. A CGD analysis of the new WHO–World Bank UHC Knowledge Hub noted its potential to bridge the two institutions' different ministerial relationships—the Bank's access to finance ministries and WHO's access to health ministries—to drive coordinated reform.[109] However, the Bank's track record in multilateral health partnerships highlights some areas for improvement (as can be said for other GHIs engaged in these kinds of partnerships). Findings from Gavi–World Bank jointly financed projects illustrated key issues such as "insufficient mutual understanding," "frustration with how to influence key processes," and "differences in internal timelines, budget cycles and reporting."[10] The literature also raises questions, based on previous partnership models, about whether the Bank's institutional model is well-suited to genuine coordination or whether its convening role tends to reinforce its own centrality rather than building genuinely collective governance.[45,*] These tensions have not disappeared: the more recent memorandum of understanding between the World Bank and the Global Fund, signed in December 2025 and targeting at least $2 billion in joint financing, represents renewed ambition for

* See, for example, research on the Health Systems Funding Platform, an initiative established in 2009 designed to harmonize health systems financing across the Bank, Global Fund, and Gavi, which found that the Bank showed an apparent reluctance to harmonize its funding processes with other Platform partners: https://pmc.ncbi.nlm.nih.gov/articles/PMC3607847/.

coordination, but whether it translates into meaningfully aligned country-level programming—rather than parallel operations with joint branding—remains to be seen.[110]

Stakeholders had mixed views on the feasibility of expanding co-financing arrangements between the Bank and GHIs. The World Bank currently has multiple modalities for co-financing projects or blending Bank financing with Global Fund and Gavi financing. This arrangement can look like Global Fund or Gavi grant funding passing through the World Bank for a given project, with the Bank managing the operation. Advantages of this approach include a greater overall health financing envelope and streamlined administration for countries. Although potentially politically challenging to channel other donor resources, numerous stakeholders viewed this arrangement favorably, as it would leverage the Bank's ability to bring resources onto budget for country governments. These co-financing arrangements need not be the only or ultimate model for consolidating donor financing, but rather are one option on the path toward greater consolidation.

Internally, there are challenges with managing large multi-donor trust funds, namely coordinating with multiple partners and navigating different donor priorities. Stakeholders underscored the importance of the skill profile of TTLs tasked with managing operations in these portfolios, as TTLs must balance multiple donor demands and expectations, the priorities of the client government, and Bank priorities. There appears to be some frustration on both sides: other partners with different project cycles, indicators, and expectations do not necessarily appreciate or understand what their expected contributions are in the operation, particularly over the entire project lifecycle. Broadly, stakeholders tend to describe Bank staff as not especially communicative or collaborative with other donors and partners working in health in a given country, a sentiment shared across the spectrum (though with exceptions). Numerous stakeholders, including Bank shareholders, viewed the World Bank as "opaque" in both results monitoring and its project development process, which in some cases has led to the perception that the Bank does not adequately engage with other partners throughout the project lifecycle. This challenge relates back to institutional incentives.

In terms of collaboration with other MDBs, more than half of government officials surveyed in a recent ODI survey do not think that MDBs coordinate well at the country level. Most MDB officials (57 percent), meanwhile, rate their coordination positively (well or very well). Co-financing of projects was rated as the top priority by both government and MDB officials for coordination. The World Bank has recently signed agreements with the IDB and ADB around "mutual reliance" and shared priorities, though both initiatives are relatively new and their effectiveness is difficult to ascertain. Regional banks were also highlighted in stakeholder interviews as generally more trusted within regions relative to the World Bank due to greater sensitivity to local priorities and links to other regional initiatives.

Country capacity to engage with the World Bank

Stakeholders underscored the importance of country capacity to engage effectively with the World Bank, which requires negotiating skills. Involving other ministries and departments beyond the ministry of finance and treasury along with other partners external to government could potentially help align discussions and enhance the quality of negotiations. Capacity to develop key documents such as strategic and national plans was also cited as an important determinant of the ability to negotiate; the ability to present credible evidence and implementation plans to achieve intended outcomes can enhance a country's room to negotiate. Provision of resources to support the design stage may be particularly important. Political buy-in to undertake reforms was offered as another relevant determinant.

Several potential limiting factors influence the scope for additional World Bank financing for health in countries. First, governments have only so much fiscal space to take on additional loans; increasing the availability of grant financing was viewed as preferable, primarily in LICs. Second, the flexibility of financing once legally binding agreements are in place was viewed as a potential limiting factor. For example, if a loan agreement is tied to specific health outcomes but implementation reveals unforeseen bottlenecks requiring additional funds, the original terms can constrain both engagement and effectiveness. More generally, there can be limited room to negotiate or change project scope and direction following discussions beyond the conceptualization stage. To mitigate this risk, client countries must have clarity on what works best within their context and what is feasible (i.e., what is within scope for the government to achieve) at the point of project conceptualization.

Other aspects of the World Bank's orientation and operations can negatively influence countries' perceptions of and experiences with the Bank.* First, the Bank's processes are often viewed as onerous, complicated, and excessively demanding. These attributes, when paired with harder lending terms, can make the Bank an unattractive partner for MICs. Disbursement delays and slow project start-up were also identified as major concerns. Fiduciary safeguards need to be balanced with timely implementation. One suggested way forward is conforming to countries' own systems where possible, which aligns with findings from a recent ODI survey. The survey found that 81 percent of surveyed government officials considered "use of country systems" very or extremely important, yet only 57 percent rated MDBs as good or very good in this respect. Findings from the literature reveal that alignment with national strategies varies, with some programs achieving strong integration and others operating parallel to country systems.[70,72]

Lastly, institutional incentives and "human factors" (individuals) were again cited as influential in the experience of engagement with the Bank. The role of individuals and potential "unspoken rules" of how to operationalize Bank processes, as noted by one health ministry official, warrants

* To note this section is not representative of all country experiences.

further examination. There was also some skepticism around the Bank's capacity or willingness to help countries track system improvements over time and sustain investments beyond the project lifecycle. For example, multiple stakeholders expressed the view that the Bank could and should do more to support countries with budget execution and domestic resource mobilization, which would help sustain system improvements beyond the lifecycle of the loan or grant. Stakeholders also noted that the Bank does not always engage substantively with country-prepared reports, and could do more to support medium-term expenditure analysis.

Key takeaways:

- The World Bank has an important role to play in the future of health financing and is a valued partner to countries in supporting health goals. There is a real risk of concentrating power and influence in a single institution in the event of a greater share of health financing being channeled through the World Bank. This will need to be mitigated through stronger accountability, transparency, and external reviews.

- The Bank could play a greater role in coordinating donors at the country level and could increase its co-financing with Gavi and the Global Fund. This shift will require greater transparency and flexibility, communication and collaboration, and alignment of staff incentives, alongside similar changes in how partners operate.

Conclusion

The World Bank is well-positioned to play a prominent role in the future of health financing, with several major strengths that could support an expanded role. The Bank has operations in nearly all LICs, provides on-budget financing (thereby supporting sovereignty and enhancing allocative efficiency), blends grants and loans (thereby supporting sustainable income transitions), and works through ministries of finance (thereby facilitating broad health system development). A larger role in health clearly fits the Bank's mandate, and the President has championed health.

Yet this championing could be temporary, as pressures are building to focus on other priorities such as employment and jobs. The Bank is also fundamentally demand-driven and therefore has limited influence on country prioritization of health. Operational issues including inefficient processing times, TTL variability and incentives, and limited M&E serve to potentially undermine the Bank's suitability as a health financier if not addressed. The risk of dominance over health financing is another concern. Stronger transparency, accountability, tracking and reporting of results, alignment of incentives, and support in the design phase are among key changes that would enhance the suitability of the Bank as a health financier moving forward.

Three promising policy options exist for an expanded role for MDBs in health financing. These options include taking on a greater role in country-level donor coordination, Gavi and the Global Fund co-financing of IDA operations, and creating a World Bank IDA health window open to MDB co-financing. This will require reform at the Bank, but more importantly, it will require donors and recipient-country leaders to develop a shared vision for global health financing grounded in a clear understanding of the comparative advantages of all global health agencies.

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