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A Partnership for Health in China
Reflections on the Partnership Between the
Government of China, the World Bank and DFID
in the China Basic Health Services Project

Gerald Bloom, Yunguo Liu and Jianrong Qiao
May 2009

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A Partnership for Health in China

Reflections on the Partnership Between the Government of China, the World Bank and DFID in the China Basic Health Services Project

Gerald Bloom, Yunguo Liu and Jianrong Qiao

Summary

This practice paper is one of a series, in which development practitioners reflect on their own experiences. Its aim is to contribute to efforts to understand China's successful management of very rapid change and development. It explores the relationship between central and local governments in the implementation of change and the role of partnerships between the Chinese government and international and bilateral organisations. It focuses on the health sector, which has experienced major challenges in adapting to the many changes associated with the transition to a market economy. By the mid-1990s, policymakers had recognised the need to address these challenges, but they did not have a clear understanding of a practical way forward. One government strategy to build this understanding was to collaborate with the World Bank and the Department of International Development of the UK in the design and implementation of a project which encouraged a large number of poor rural counties to test strategies for strengthening their health service. The end-of-project evaluations documented the many changes they had put into place and the contribution this project made to national policy processes.

The authors played different roles in the project. This enabled them to gain first-hand knowledge of the relationship between levels of government and between officials of the government and the international agencies. When the project came to an end they decided to reflect on what they had learned. This practice paper presents the results of this reflection. It provides unique insights into the way China is managing health system change and into the working of partnerships between the Government of China, the World Bank and bilateral donor agencies.

Keywords: health sector reform; development partnerships; institution building.

Gerald Bloom, a Fellow of the Knowledge, Technology and Society Team at IDS, has worked for many years on issues related to health system reform in contexts of rapid social and economic change. He has been involved in several major studies of China's management of health system transition in partnership with a number of China's leading research institutes. His recent projects include the EU-funded POVILL project and the DFID-funded Future Health Systems Consortium, which are studying illness-livelihood links, the impact of new government health financing arrangements on household coping strategies and lessons for systematic approaches for building effective rural health institutions. He was involved in the rural health project between 1996 and 2007 first as a member of the design team and then as a member of the core supervision team. He is the co-Chair of the China Health Development Forum.

Yunguo Liu started his medical career in 1975 as a village 'barefoot' doctor in Hubei Province of China. In 1982 he graduated in Medicine in Tongji Medical University, Wuhan, China. He continued his clinical and research work in the university in reproductive health and got his doctor degree in 1988 and a master degree in public health in the University of California at Berkeley in 1994. From 1989 to 1993 he worked in the Maternal and Child Health Department, Ministry of Health, People's People's Republic of China. Since 1994 Dr Liu worked in the Foreign Loan Office, Ministry of Health, China, as a director of a series health projects funded by the World Bank, the Department for International Development of UK Government and other donors on Maternal and Child Health, Primary Health Care, Rural Health and Disease Prevention and Control. He also led a number of studies on gender and health equity, medical insurance and financial assistance for the poor, health care performance assessment and health reform policy. He has published a number of books and articles in Chinese and English on China rural health reform, primary health care, reproductive health and rural health financing and service delivery.

Jianrong Qiao is currently the Health Advisor for the China Office of the UK Department for International Development. She has over a decade of experience working closely with a wide range of partners in China including the Government of China, the World Bank and UN agencies. She has worked on projects for strengthening and reforming the rural and urban health systems and for supporting disease-specific programmes for the control of tuberculosis and HIV and AIDS. She was originally trained as a biologist and holds a masters degree in ecology. Before she joined DFID in 1999, she worked for the rural water supply and sanitation programme of the Chinese Ministry of Health. During her time with DFID, she has gained international experience in the region.

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Acronyms

CCCPC	Central Committee of the Communist Party of China
CMS	Cooperative Medical System (rural health insurance scheme)
CST	core supervision team
DFID	Department for International Development
DOTS	directly observed treatment of tuberculosis
FLO	Foreign Loan Office
GoC	Government of China
IDA	International Development Assistance
MA	Medical Assistance
MCA	Ministry of Civil Affairs
MDG	Millennium Development Goal
MFA	Medical Financial Assistance
MMR	maternal mortality rate
MoF	Ministry of Finance
MoH	Ministry of Health
NCMS	New Cooperative Medical System
NDRC	National Development and Reform Commission
NEP	National Expert Panel
RC	Resource Centre
RMB	renmibi (unit of currency in China)
SARS	Severe Acute Respiratory Syndrome
TA	Technical Assistance
UHPP	Urban Health and Poverty Project
WB	World Bank

1 A Partnership for Health in China

Reflections on the Partnership between the Government of China, the World Bank and DFID in the China Basic Health Services Project

Gerald Bloom, Yunguo Liu and Jianrong Qiao

This practice paper is one of a series, in which development practitioners reflect on their own experiences. Its aim is to contribute to efforts to understand China's successful management of very rapid change and development. It explores the relationship between central and local governments in the implementation of change and the role of partnerships between the Chinese government and international and bilateral organisations. It focuses on the health sector, which has experienced major challenges in adapting to the many changes associated with the transition to a market economy. By the mid-1990s, policymakers had recognised the need to address these challenges, but they did not have a clear understanding of a practical way forward. One government strategy to build this understanding was to collaborate with the World Bank and the Department of International Development of the UK in the design and implementation of a project which encouraged a large number of poor rural counties to test strategies for strengthening their health service. The end-of-project evaluations documented the many changes they had put into place and the contribution this project made to national policy processes.

The authors played different roles in the project. This enabled them to gain first-hand knowledge of the relationship between levels of government and between officials of the government and the international agencies. When the project came to an end they decided to reflect on what they had learned and identify lessons for China's management of health system change and for future partnerships for health system development in other countries. This practice paper presents the results of this reflection. The authors presented their main conclusions to a workshop organised by DFID in London in January 2008 and they published them in a DFID Policy Briefing Paper.

This practice paper is organised as separate reflections from different perspectives. The first is by Gerald Bloom, a researcher from the IDS, who was a member of the core supervision team. He introduces the project and the partnership which managed it. He brings the perspective of an engaged outsider. The second is by Yunguo Liu, who was a government official and the project manager. In preparing his reflection, he organised a workshop of experts who had played a technical leading role in the project and it takes their comments into account. The third is by Jianrong Qiao, a Chinese citizen and the DFID Health Advisor. She combines both perspectives in providing recommendations for future partnerships in China and other countries. The reader can build a more complete picture by combining these perspectives.

2 Reflections of a Researcher and Member of the Supervision Team

Gerald Bloom

2.1 Introduction

Between 1998 and 2007 the Government of China implemented the Basic Health Services Project in 97 poor rural counties in which 45 million people live. Its aim was to test innovative approaches for implementing major health system changes to improve access to competent care and reduce the impoverishing impact of major illness. The final evaluation concluded that the project was successful in meeting many of its objectives and influencing government policy (MoH, World Bank and DFID 2007; MoH 2007b).

The project was jointly funded by the Chinese government, a World Bank credit and a grant from the British Department for International Development. Officials from the three institutions worked together in project design, implementation and evaluation. This paper explores how this partnership functioned with the aim of learning lessons for future development partnerships in China and in other countries.

2.2 The author

I am a researcher who has undertaken a number of studies of the management of health system change in China and other countries. I was also a participant in the Basic Health Services Project. This paper is based on my observations and reflections as a project participant. Although I have used my research skills to analyse these experiences, my understandings have inevitably been influenced by the role I have played (Eybin 2007). The purpose of this section is to make this position clear to the reader.

In 1996 I was invited to join a team that would identify and design a rural health development and reform project to be financed by a World Bank credit. I was recruited because of my previous research on health finance in rural China. I was pleased to accept this opportunity to test some of the ideas that had arisen from the research. I brought to the project a commitment to pro-poor health system development and a belief that interventions had to be grounded in their local context. My role in the team was to support the design of the component on rural health finance. This focused on support for rural health insurance (CMS) and a health safety net for very poor people.

It became clear during project design that the inter-government arrangements for financial management, whereby local governments in poor counties were responsible for repaying a high proportion of the loan, meant that very few resources would be available for technical assistance and supervision by project

managers. We prepared a request for co-funding, which I presented to DFID. At that time DFID was rethinking its programme of development assistance to China and I was asked to join a team of DFID officials, who were identifying health sector priorities. They became convinced that participation in the Basic Health Services Project would provide a good opportunity to learn the realities of rural health reform and establish relationships with key actors. The final strategy proposed that the first DFID health project would support implementation of that project by funding Chinese and international technical assistance and pilot testing of pro-poor interventions in a small number of project counties. I led the team that designed the DFID project.

I was subsequently asked to be a member of a three-person core supervision team (CST) for the project. Each team member had been part of the design process and we continued to be responsible for different project components. The CST was answerable to both the World Bank and DFID with a mandate to support project supervision. Our main role was to participate in six-monthly supervision missions. I participated in every supervision mission between 1998 and 2007. I also participated in several meetings aimed at bringing the experience of the project to policy debates.

My role on the CST changed over time. At first I worked closely with the Chinese experts responsible for the technical aspects of the project components on rural health insurance and a health safety net. The CST were the members of the supervision team with the closest contact with Chinese technical experts. The officials from the World Bank and DFID spent most of their time working with the project managers at national and provincial levels. The CST helped the officials of the funding agencies with the identification and resolution of technical problems and supported the supervision process. The role of the CST changed as the focus of supervision shifted from the implementation of individual components to cross-component issues, policy influence and post-project sustainability. We increasingly acted as facilitators of partnership processes. We also played a role in flagging emergent issues for future attention.

The shift in my role was brought home to me during the mid-term review. I suggested to the project manager that the CST could help the internal review team finalise their technical reports. He declined the offer, explaining that he saw our role as a bridge between Chinese and non-Chinese partners rather than as technical experts/advisors. I came to view my role as a facilitator of a development partnership. The CST helped when conflicts arose between partners. We were the only non-Chinese members of the supervision team whose involvement extended throughout the project. We identified strongly with the project and with the efforts of the project managers. At times we were perceived by one or another of the international agencies as having 'gone native'. We saw things differently. Our job was to observe and identify problems and facilitate the achievement of the project objectives. We were outside the partnership and inside the project.

I did not perceive a major conflict between my roles as researcher and CST member. I was excited by the idea of a project that could test reform strategies and influence policy. I was fascinated by the implementation process, both itself and what it told me about relationships between the national and local levels of

government in China and the implications for the implementation of health system change. I saw the project as a laboratory for the management of health system change in the context of China's economic transition. I had a strong commitment to the project and to the positive aspects of the tripartite partnership that made it possible. The project also provided opportunities for me to establish new links with researchers and government officials.

My position provided a unique opportunity to observe and participate in a constantly evolving partnership between officials of the Chinese Ministry of Health, the World Bank and DFID at a key moment in China's development. The Basic Health Services Project was only a small element in China's massive Western China Development effort. But, it was a window into the way the government was testing alternative reform strategies as it began to contemplate major reforms.

The information presented in this paper is largely based on personal observations. I have drawn on a number of documents collected over the life of the project, including the very thorough internal and external end-of-project evaluations. I benefited greatly from many conversations with project personnel all over China and with insightful officials from the World Bank and DFID. I have borrowed many ideas from Liu Yunguo, the project manager, Qiao Jianrong, a DFID health advisor, and Chris Scarf and Vivian Lin, fellow members of the CST. It was a great privilege to work with this excellent group of people as we grappled with the challenges this highly complex project presented. Despite all these influences, I take full responsibility for the opinions expressed.

2.3 The project

The Basic Health Services Project was the eighth World Bank project in China. Previous ones had focused on issues of particular policy concern such as regional planning, human resources, disease-specific programmes or health promotion. The Basic Health Services Project was the first to address health system development as a whole. This reflected a change in the priorities of health policymakers, who were increasingly convinced of the need for systemic reforms.

By the early 1990s it was clear that the health sector was experiencing problems in adapting to rapid economic, institutional and demographic change (Meessen and Bloom 2007). The problems were particularly acute in poor rural areas. Many health facilities were run-down and poorly equipped. Government budgets and the cooperative medical system (CMS) had previously been important sources of rural health finance, but township health facilities now financed 90–95 per cent of their expenditure from payments by patients. Village and township health workers mostly had limited training and were working with little supervision. The cost of care was rising rapidly, largely because of unnecessary prescriptions of drugs and the growing use of diagnostic tests. The coverage of preventive services was not improving quickly enough and these services were unable to respond effectively to a growing burden of chronic illness associated with demographic change.

The attention of policymakers was drawn increasingly to health-related issues. Many health facilities were in financial trouble. There was growing concern about the quality and cost of services. Surveys showed that many people could not

afford hospital care and that major illness was an increasingly important cause of household impoverishment. In 1991 the government set ambitious targets for reducing infant and maternal mortality. In early 1997 it issued a policy document that included a commitment to establish by 2010 an effective public health system appropriate to the socialist market economy. The document outlined strategies for improving health services that included investment in health facilities, upgrading the skills of health workers, strengthening management, improving preventive services and reforming health finance. A subsequent document focused on the potential role of a modified version of the CMS in rural health finance. The government faced major challenges in translating broad principles into practical strategies for reform and development and effective ways to help governments of poor rural counties manage health system change. The Basic Health Services Project was designed to address these challenges (Liu and Bloom 2002).

In early 1995 the Government of China and the World Bank agreed to develop a project for strengthening basic healthcare in poor rural areas. There was a long design process leading to the launch of the project in September 1998. That year the Department for International Development of the UK decided to support China's health sector development. Its first project was the Health 8 Support Project whose objective was to strengthen implementation of the Basic Health Services Project by funding additional technical assistance and intensive innovation and lesson-learning.

The project's stated aim was to help the government achieve sustainable health improvement for the residents of poor rural counties through a combination of supply-and demand-side interventions. It initially included 71 counties with a population of 32 million in seven provinces; eventually the health component of the Qinba poverty reduction project in 26 very poor counties in three more provinces was integrated into it.

The project was organised in four components. The first focused on health resource planning, the construction of rural health facilities and the strengthening of the health management information system. The second focused on improving the quality of medical care and strengthening a small number of cost-effective health interventions. The third was aimed at testing innovative models for rural health insurance and establishing a medical financial assistance scheme for very poor people. The fourth component provided technical support and supervision to enhance the capacity of counties to manage the implementation of major health system changes.

2.4 A partnership for the management of change

The implementation of the project involved a number of actors. This section argues that their understanding of the project components reflected the level of government and government department in which they worked. It suggests that one reason for the project's success in both achieving targets at county level and influencing policy was that project managers at the Foreign Loan Office (FLO) of the Ministry of Health (MoH) and the officials of the World Bank and DFID worked together as strategic partners in negotiations with other actors.

2.4.1 Context

The Chinese government combines vertically organised sector organisations and highly devolved local governments (Saich 2001; World Bank 2002). This structure strongly influences the policy process (Liu and Bloom 2002).

During the mid-1990s government officials increasingly recognised the serious problems in the rural health sector, but they differed on how government should address them. The MoH was concerned about the financial problems of health facilities and the consequences for health workers. It wanted investment in rural health infrastructure and staff training. A few forward-looking officials had come to the view that systematic reforms were necessary and that they would have to combine measures to improve the quality of health services and reduce unnecessary costs with those aimed at reforming health finance. This group of officials played an important role in the debates that ultimately led to major health reforms. They were also instrumental in the design of the Basic Health Service project.

Chinese policymaking is very conservative, giving priority to the preservation of social stability and avoidance of major errors (Liu and Bloom 2002). It can take a long time for government statements of intent to evolve into concrete commitments to use government funds and regulatory powers. This happened with regard to rural health services. The government issued its first major policy statement in 1997 but took six years to make significant commitments of money for them. It is still formulating other health policy initiatives. Throughout this time there has been a continuing negotiation between stakeholders about detailed policy options.

In many parts of government there was a perception that the MoH paid more attention to employees' interests than to the needs of the public. Health facilities were overstaffed and public health budgets were very constrained. Health facilities were allowed to compensate by charging for drugs and diagnostic tests. This was associated with rapid increases in the cost of medical care. This fed a growing perception of health workers as opportunistic. This perception seems to have influenced government departments. For example, the Ministry of Agriculture opposed the introduction of compulsory health insurance on the grounds that household contributions would not necessarily result in commensurate benefits (Du 2000). The same mistrust of the health sector led the government to assign responsibility for the development of urban health insurance and urban and rural health safety nets to the Ministries of Labour and Social Security and Civil Affairs, respectively. There were also signs of public mistrust of health facilities, including reports of physical violence against health workers (Harris and Wu 2005). In 2005 senior policymakers publicly criticised 'opportunistic hospitals'. One response to disquiet about the behaviour of health workers was the decision in the late 1990s by the Rectifying Incorrect Professional Ethics Office of the Disciplinary Inspection Committees of the Communist Party to focus on reducing the practice of accepting informal payments from patients, drug companies and other health sector players (Fang 2008). This was part of a government-wide effort to reduce corruption and increase trust in the public sector. The MoH needed to convince these stakeholders that it could use additional resources to improve services for rural people. This was one of its objectives for the Basic Health Services Project.

The Chinese government is devolved into national, provincial, municipal, county and township levels, each of which is responsible for financing its own health facilities (World Bank 2002). The structure of each level of public administration mirrors the sector organisation at national level. While the project was being implemented, higher levels of government made modest fiscal transfers to poor localities, but they did not provide enough money to finance even employees' pay. Local governments tended to resist policies that implied major responsibilities without additional resources. Provincial governments were important stakeholders in policy discussions. The organisation of the repayment of the World Bank credit mirrored the prevalent arrangements for financial management by making county governments responsible for repaying a large proportion of the credit and provincial governments responsible for repaying the balance. Central government had little direct financial leverage over the use of project funding by provinces and counties.

By the mid-1990s the central government was making substantial investments in infrastructure, particularly in the poor Western Provinces. This was largely the responsibility of the State Development and Planning Commission (subsequently renamed the Development and Reform Commission). During the early 1990s the government had organised a programme of investment in rural health infrastructure. Following the general pattern of government investment, central funds were only released if matched by local resources. An evaluation of the programme indicated low take-up by poor localities because they could not provide matching funds (Liu and Bloom 2002). The Commission hoped that the project would enable poor counties to invest in their health facilities. It opposed the use of credit to subsidise recurrent costs, reflecting the government's resistance to the use of central government funds for similar purposes.

This perspective changed in 2003, when new political leaders gave higher priority to meeting the needs of the rural poor and improving social services, such as health. Soon afterwards, the government announced it would provide fiscal transfers to poor provinces, earmarked for rural health services (Zhang *et al.* 2008).

China's highly devolved government system influenced the implementation of both government reforms and project components. The counties were responsible for repaying most of the World Bank credit, and their government leaders strongly influenced the use of funds. Project managers had to convince them that interventions were useful and feasible and that the project could provide appropriate technical support to help them implement change (Liu and Bloom 2008). This worked well for some counties, which undertook ambitious reforms. Others were much more conservative, focusing mostly on upgrading facilities and training health workers.

The tension between the perspectives of the national and local levels is an important reality in China. The government's transition management strategy has been to permit localities to experiment with new approaches and encourage widespread imitation of successful innovations. Some innovations have emerged out of local experiences and others have been imported from abroad. Although local government leaders can improve their career prospects by implementing successful reforms, the cost of failure can be high. One major influence on the

performance of new institutional arrangements is the understandings of different stakeholders and the behavioural norms they internalise. One can view the management of China's transition process, from this perspective, as one of mutual learning and co-creation of new institutions.

The different perspectives were neatly summed up in a reflection by a deputy mayor of a municipality which contained several project counties. He referred to three imbalances: between investment in hardware (facilities and training) and software (systems); between passive approaches to service provision inherited from the command economy and actively seeking patients; and between visions of future institutional arrangements on the part of national project managers and understandings of the complexities of implementation by local government officials.

Major debates were underway about the health sector's future, while the project was being implemented. The project was designed to encourage local governments to test alternative interventions and identify the difficulties to be overcome in managing change. One expected outcome was a better understanding of how government could translate broad health development objectives into realistic strategies for change in poor rural counties. Government policy commitments became clearer and more focused over the life of the project. In 2003 the government announced its support for the rapid spread of county-level rural health insurance schemes called the New Cooperative Medical System (NCMS) and began to transfer public funds to these schemes. Many counties competed to implement national pilot schemes and several project counties were selected.

2.4.2 Partners

The three partners had different interests and understandings of the project.

The *Foreign Loan Office (FLO) of the MoH* managed the project. It was established to manage World Bank projects and was answerable to the Department of Planning and Finance of the MoH. As with many government agencies, its budget could hardly pay the basic salaries of its employees and it relied on projects to supplement its revenue. Since the national government did not repay any of the World Bank credit, the FLO had to negotiate a management fee from the participating provinces. This influenced power relationships within the project. The DFID grant provided additional funds for FLO activities.

The FLO was part of the MoH. It had a reputation for competence and its financial viability depended on future World Bank projects. Its leadership had a strong interest in the smooth implementation of the project. They also had incentives to test new approaches to health system development and participate in internal policy discussions. The FLO had no direct control over the use of the World Bank credit. It had to rely on other sources of influence such as the authority that central government officials were seen to possess by officials in lower levels of government, the agreed rules in the loan agreements with county governments and their access to World Bank and DFID officials.

The project established a *national expert panel (NEP)* responsible for the

implementation of each component. Its members included both researchers and ex-government officials. Over time, they became committed to their components and were highly visible in the project. Several benefited greatly from their role in this national project within their organisations and as authorities in particular aspects of rural health reform and participants in national committees. In one or two cases they became champions of specific reforms.

The project was implemented by officials in *project offices* within the provincial and county health bureaux. They were answerable to the health bureaux and through them to the provincial and county government. They mostly responded to local priorities.

The *World Bank* has a long history of collaboration with the Chinese government, which has regarded it as an important source of international expertise (Jacobson and Oksenberg 1990). The Basic Health Services Project was an important departure for the World Bank as the first health project to take a system-wide view of reform. Some actors at the World Bank viewed it as a major opportunity to implement certain ideas of health reform. This was clear in the negotiations about project design (Liu and Bloom 2002). There was a lot of interest in the project in Washington. However, the project's reputation fluctuated. It was named one of the best-designed projects of its year, several years later it was labelled a failure and the final project review was, again, strongly positive. This interest in Washington created difficult challenges for the task team leader. On the one hand, it was important to take into account the changing views of the technical people in Washington. On the other hand, it was important to avoid a major conflict with the Chinese government, one of the most important borrowers from the Bank. One key role of the task manager was act as a bridge between the project and the World Bank bureaucracy.

In 1997 after the election of a new government in the UK and in anticipation of the return of Hong Kong to China, DFID undertook a major review of its involvement in China and decided to focus largely on pro-poor projects in a few sectors, including health. The launch of the Basic Health Services Project came at an opportune time. Its project team submitted a request to DFID for additional support for technical assistance. DFID responded because the project provided a good opportunity for its officials to become familiar with the health sector. DFID emphasised its particular concern to ensure that poor people benefited from the project.

DFID faced a very steep learning curve in establishing a productive partnership with the FLO. The process of project design and the early years of implementation revealed quite different understandings of partnership. From the Chinese point of view there was a common understanding of the broad project objectives on which they would deliver. They understood that DFID had a special interest in poverty issues and they took this into account, to some extent, in developing agreed activities. DFID understood partnership as the development of consensus between project actors. It also saw its mission as representing poor people.

2.5 Project supervision

One notable feature of the project was the degree to which officials of the FLO and the two funding agencies created a partnership for oversight of implementation. Each party had a strong stake in the success of the project and in the success of this partnership. The MoH valued the flexibility to test new approaches to reform and demonstrate effectiveness to policymakers. China is an important borrower from the World Bank and this created an incentive for success. In addition, there was a strong desire by World Bank experts to participate in the reform process in the largest country in the World. DFID had launched a new programme of support to China subsequent to the election of a new government in 1997 and the return of Hong Kong to China. It decided to support the project as an effective way to establish good relationships with the MoH. It also had an institutional mission to influence policy for meeting the needs of poor people.

The partners had different understandings of partnership. This became clear to me when I led a team that designed the DFID project. DFID and its consultants understood partnership as a sharing of objectives and a consensus approach to decision-making. It emphasised consultative approaches to project planning. The Chinese view was that each organisation had a shared interest in the successful implementation of the project but also had its own institutional objectives. They tended to view project supervision and the oversight of implementation as a means whereby the three partners collaborated in negotiation with provincial and county-level implementers, while negotiating how each partner could achieve at least some of their individual agendas.

2.5.1 *Partnership rituals: the supervision mission*

Supervision was organised in six-monthly missions. The rituals of these missions reflected the relationships between the key actors and influenced partnership construction. The work began well in advance of the mission with the preparation of progress reports by each project province and by the national project team. These were substantial reports that summarised activities and the degree to which agreed targets were met. All the reports were translated into English. The mission began with the delivery of at least eight volumes with several hundred pages. Members of the mission team had little time to read the reports.

The mission began with a field trip lasting three to four days in the host province. This would consist of visits by joint teams of national experts, officials of the FLO, members of the CST and officials from the funding agencies to two or three counties. These visits followed a standard pattern. Officials from the provincial project office accompanied the team to the counties. Each county visit began with a presentation by senior officials from the government and the Communist Party. This meeting was attended by many local government officials. Early in the project these presentations were very lengthy and full of detailed quantitative information. As the project progressed, county and provincial project officers learned more effective ways of summarising progress and identifying problems. They also made increasing use of PowerPoint and DVDs. In each county the team visited several county-level health institutions. They also visited township health centres and a few villages in each township. The visits were relatively short and everyone was

well prepared for the visitors. They were well-choreographed events.

These visits provided an opportunity for the supervision team to obtain a snapshot of the state of the project. In many cases, the project managers had already identified issues to be followed up in the field. The team would identify major constraints to implementation or problems and issues that had arisen. It would also highlight issues that reflected the concerns of the partner institutions. The supervision team provided a formal feedback to the county, which identified issues to be addressed during the next phase of implementation. These visits and feedback sessions provided opportunities for the key actors to air their views and flag the topics for discussion at the workshop. The supervision workshops involved several participants from each project province and were hosted by a different province each time. After the field visit and before the commencement of the workshop the officials from the FLO, World Bank and DFID discussed the key issues, agreed an agenda and identified areas for decisions. Many of the issues had already been discussed during the field visits. The FLO might also bring forward concerns about the performance of a specific province and other partners might bring concerns from their side.

When the partnership was working well, the workshop was structured around negotiations between the three partners and the project implementers. It began with statements by each partner about progress to date and the key issues to be addressed. The World Bank task manager would refer to the loan agreement and the project objectives, the DFID health advisor would refer to the priority given to meeting the needs of poor people and the Chinese project manager would refer to new health policy developments. Each province would then present a report and the national experts would report on progress with each component and comment on priorities for strengthening implementation. The provinces would listen to these comments and respond to them by revising their plans.

Often the project managers would identify one province that was lagging behind or experiencing other difficulties with project implementation. The problem would be identified publicly and one purpose of the mission was to agree on corrective measures. During the latter part of the project some of the more innovative counties were invited to send representatives to the workshop to present their experiences. This provided positive feedback for good work and enabled other provinces to learn from these experiences.

Towards the end of the workshop each province would make a short presentation on how it had adjusted its plans. The presentations might include an acknowledgement by the 'problem province' of its errors and an assurance it would do better. The CST usually made a short presentation that focused on emergent issues during the next phase of project implementation or on tasks that had been particularly well done. This was a ritual acknowledgement of the role of foreign experts and of ideas from abroad. The workshop ended with speeches by the World Bank and DFID, commenting on decisions made during the workshop, and it ended with a presentation by the Chinese project manager who often affirmed his agreement with the comments by the representatives of the funding agencies and sometimes added comments on particularly problematic issues. The main decisions were recorded in the World Bank aide-memoire and presented to

the Minister of Health a couple of days later. The project team circulated the *aide-memoire* to all provincial project offices.

The ritual described above affirmed the shared understanding of the three partners. One of its main aims was to strengthen the Chinese project managers in discussions with the provinces about the use of resources and achievement of project objectives.

2.6 Transition management and institution-building

2.6.1 Implementing the unimplementable

After the first two and a half years the project commissioned a team of consultants to undertake a mid-term review. The team identified a number of problems such as the overstaffing of health facilities with many unskilled personnel and the perverse incentives arising from the price control system and weaknesses in health management, and concluded that the project was unimplementable. This underlines the problems with blueprint approaches when new institutional arrangements need to be constructed in contexts of rapid change.

These conclusions mirrored the response that most social scientists would have given in exploring China's options for development in the early 1980s. The complexity of the task of managing a transition to a market economy while maintaining social stability was great, and few predicted the kind of success China has experienced. A recent book by North (2005) argues that China has created appropriate incentives for key actors in its emerging market economy, but that it will need to strengthen its rules-based institutions for tasks requiring high levels of trust between organisations and between organisations and the population. Yang (2004) extends this analysis to explore how China is gradually establishing an institutional framework to support a sophisticated financial system. This is relevant to the health sector, which relies on high levels of trust between providers and users of services and between insurance schemes and their beneficiaries (Gilson 2003). The managers of health system transition are overseeing changes to institutional arrangements and to the behavioural norms to which health system actors are expected to adhere. The process of change management is at least as important as the vision of a possible endpoint.

2.6.2 Testing new ideas and encouraging local innovation

The Chinese health policy community often couches debates about health system reform in terms of forms of health sector organisation in different OECD countries. At one point, for example, there was a great deal of interest in the so-called Singapore model. More recently there is discussion about combining 'British trousers with a German shirt' to signify an interest in fully funded general practitioners and hospital insurance. This understanding of reform as a selection from a menu of organisational forms mirrors much international discourse on health system reform, which focuses on the impact on performance of alternative arrangements for health finance, payment of providers and so forth. The World Bank typifies this approach and it presented it to Chinese researchers and

government officials through its China-based health economics flagship course. The project's experience illustrated the many challenges in adapting ideas from one context to another.

One characteristic of World Bank projects in China has been that the credit is on-lent to counties. The county governments are reluctant to spend their money on costly national or international consultants. Consequently, projects have relied on modest inputs from international experts, complemented by inputs from the health economics flagship course. This was not a major concern in previous projects with rather narrow objectives. It was a much greater worry in a project aimed at testing options for reform. The decision by DFID to fund additional technical assistance provided an opportunity to make greater use of national and international experts.

One use of the funds was to increase the inputs by national experts and provide more supervision visits. The final evaluation by an external team highlighted supportive supervision as a major contributor to project success. This appears to have been an effective mechanism for transmitting ideas and new approaches to rural counties.

The arrangements for importing ideas and expertise from outside China were less successful. This reflected the different understandings by the different players. Access to foreign expertise was organised in two ways. First, a three-person core supervision team was established to participate in all supervision missions. Its members made visits to project counties and worked with the national and provincial experts during the twice-yearly supervision missions. This provided very limited opportunities to explore ideas in a systematic way. The team's focus was on how ideas from abroad could be adapted to the needs and possibilities of the project. I was a member of this team.

Second, the project established a resource centre to provide technical experts to the project. This did not work well and the experiences illustrate the challenges inherent in China's attempt to import ideas to inform its transition process. One problem arose from the inability of many international experts to understand the challenges of transition management. A project manager told me that around a third of consultants were useful, a third were a serious burden and a third had little impact. The typical 'failed' consultant would discover that health facilities were overstaffed and service providers faced perverse incentives, and either conclude that the reforms were unimplementable or attempt to teach project managers what they knew only too well. At times, these consultants tried to influence project implementation through their links with a funding agency. This was perceived by the project managers as inappropriate interference in government business. The approaches the Chinese favoured for importing new ideas were either to send a group of people on a study tour to view different ways of doing things in another country, or to invite a foreign expert to present a series of lectures to local experts. The local experts were then expected to decide on the applicability of particular ideas to the local situation. These approaches made it very difficult for project experts to form long-term relationships with international experts. This limited the fruitfulness of the exchanges of expertise and knowledge.

These problems arose from a model of knowledge transmission, which assumed there are well-known approaches to health system reform that international

experts can bring to a country. This model assumes that the role of these experts is to inform health system actors about this approach and support implementation. This model is inconsistent with China's approach to the management of change, where there is no blueprint for reform and there is an acknowledgement that effective strategies for institution-building can only be identified through mutual learning.

The following sub-sections explore how the project reflected this approach to change management and institution-building and how this influenced the functioning of the three-way partnership. It draws on lessons from two project components concerning the reform of health finance. This choice was influenced by three factors. First, both components involve the importation of ideas from outside and a great deal of local innovation. Second, the major policy development during the project's life concerned this issue. Finally, I was responsible for supervising these components and I have a deeper understanding of this aspect of the project. The discussion of the design and implementation of the project draws on a paper and book chapter by Liu and Bloom (2002 and 2008) and the discussion of the development of policy draws on a recent book chapter by Zhang *et al.* (2008).

2.6.2.1 Making visions real: new CMS

During the 1960s and 1970s China developed the so-called collective medical system which both reimbursed a part of the cost of medical care and helped pay the salary of health workers. The collective medical system was organised by the communes, the units of collective agriculture. This system strongly influenced international debates about strategic health system development.

A large proportion of these schemes were disbanded during the shift to household production. However, a number of counties retained their schemes. During the 1980s and 1990s there was a growing interest amongst researchers and some MoH officials in possible strategies for reviving these schemes. The interest of ministry officials was strengthened by the growing financial problems of many rural health facilities. During the 1990s three departments of the Ministry of Health collaborated with research institutions to undertake studies of existing schemes and test new ones (Zhang *et al.* 2008). I was a member of one of the research teams.

One contribution of the World Bank to health policy analysis in China was its support of the creation of a network of health economists linked to a flagship course organised by the World Bank Institute. The purpose was to create a cadre who were familiar with the discipline of health economics. This discipline has developed a set of understandings of the design of health insurance schemes. The members of the network tended to share these understandings and view CMS through this framework. They shared a vision of health system reform as a combination of demand- and supply-side measures that would include some form of compulsory rural health insurance. This network was linked to the Department of Planning and Finance of the MoH, which was the ministry's point of contact with the World Bank.

The early discussions during project design were dominated by a simple vision of a future health system with improvements to the supply side and a well-established rural insurance scheme. This view was held by senior advisors from the World Bank and key supporters of the project in the MoH. When DFID designed its project to support implementation of reforms, its economist was also enthused by this vision.

The vision was rapidly modified as it confronted reality during project design (Liu and Bloom 2002). There was substantial opposition by several ministries to compulsory health insurance because it contradicted the policy of reducing the levies imposed by local governments and the central government could not ensure that local schemes would provide commensurate benefits to their members. There was also opposition to the use of World Bank credit to subsidise project schemes, reflecting government's unwillingness to earmark fiscal transfers for recurrent health expenditure. The final project design was for project counties to test new schemes in a few townships and gradually expand successful ones. The schemes were voluntary and local governments were asked to match the household contributions. This mirrored the 1997 policy statement by the Central Government and State Council: 'The establishment of cooperative medical schemes should work under the organization and leadership of the government, with the principles of running by the local people with public assistance and voluntary participation'. The most notable aspect of this policy statement was the lack of commitment by central government to provide financial support.

The health economics literature opposes voluntary insurance because of problems with selection bias. It also opposes the rather high levels of co-payment the schemes required. During my work with Chinese colleagues I gradually came to understand the degree to which debates about CMS and local taxation were linked. The central government was faced with resistance to a rising burden of tax on rural people that was not leading to commensurate benefits. There was a lot of distrust in local governments. The challenge for government was to build trust in the management of funds collected for CMS and ensure that the services they subsidised were cost-effective. CMS could be understood as one aspect of the reform of the tax system. In this context it would have been highly risky for government to support compulsory contributions until it was confident that rural people were strongly in favour.

The project team encountered big problems with implementing schemes. They found it difficult to convince households and local governments to contribute. After the mid-term review the project managers decided to focus on a few relatively successful schemes to learn lessons in anticipation of a policy change. The project undertook a study to understand the reasons for these difficulties and identified several factors (Wang *et al.* 2001). The most important was the lack of a clear national policy to support these schemes. The study found that people were not confident that money they contributed would be used for the intended purpose and that the cost of healthcare would be controlled. The project team concluded that the project would need to give much more emphasis to local governance and the establishment of trusted and trustworthy schemes.

Meanwhile, people in Washington were asking the World Bank task manager difficult questions about these schemes. There were signs that the World Bank

had lost its enthusiasm for CMS. This may have been influenced by the well-known problems associated with voluntary insurance. After some time, the World Bank suggested that this component could be dropped. The project managers strongly opposed dropping this component. They were aware of a change in the national policy environment in favour of greater inclusion of poor people and a strengthening of the social sector, including health. There was a growing perception amongst policymakers that serious illness had become a major precursor of household poverty. In 2003 the government announced its support of a new kind of CMS, to be organised by county health departments focusing largely on reimbursing a share of the cost of hospital care. The central government stated it would transfer 10 yuan per beneficiary, contingent on both local governments, and the households themselves, making matching contributions.

The implementation of the new policy began with the selection of counties to implement pilot schemes. Several project counties were selected. The government encouraged a rapid spread of these schemes and by 2008 almost all counties were included. Meanwhile the government increased its contribution and the matching contribution by local governments to 40 yuan per beneficiary.

The rural health insurance schemes are still evolving. During the first years, the government's focus was on financial audit and ensuring that the payment of benefits was fair and seen to be so. Many issues remain to be resolved concerning the design of benefit packages, the system of payment of service providers and the equity of access to benefits. The main contribution of the project was to the understanding of the need to win the trust of the community. The government requires schemes to create a supervisory committee that includes stakeholders from local government departments, the Communist Party and local representative bodies. These committees could play an increasing role in addressing these problems over time.

One can learn several lessons from this experience. The first concerns the role of external partners as a source of ideas. The World Bank and other agencies had played an important role in introducing the concepts of rural health insurance through funding training and research and then supporting a large-scale experiment in the Basic Health Services Project. As the schemes experienced difficulty, the project supported studies and a series of meetings to explore the implications of its experience. This enabled national and provincial experts and local governments to deepen their understandings. At a certain point the World Bank became engaged in internal debates about the design of these schemes. It did not communicate the details of its concerns or engage in the debates in China. Consequently its announcement of a wish to discontinue the component was experienced as a disruption of the project and there was little engagement with the issues that may have been raised.

The second issue concerns the sequencing of reforms. During the early years of the project the counties invested substantially in improving their health facilities and training health workers. During this period there was a marked change in the attitudes of health workers who increasingly recognised the need to attract patients. Meanwhile the passage of time was resolving one of the most serious problems. During the late 1960s and early 1970s many highly trained health

workers were transferred from the cities to work in rural health facilities. These facilities also hired many people who had little professional training. During the transition to a market economy, when it became possible for people to change jobs, most of the skilled health workers left the rural health facilities. These facilities were largely staffed by relatively unskilled personnel. They had great difficulty recruiting trained doctors partly because they were in short supply and partly because they could not pay competitive salaries because they had to ensure that their unskilled employees were also paid. This situation changed quite quickly towards the end of the 1990s when many of the unskilled health workers reached retirement age. At the same time, the number of trained doctors was growing and rural health facilities reported much less difficulty with recruitment. By 2003, when the new rural health policy was announced, the age profile of many rural health facilities was much younger and the average level of skills was higher. It was now much easier to implement many reforms.

2.6.2.2 Making policy by making things work: Medical Financial Assistance

China has had no experience with widespread government provision of a health safety net for poor people. This was not important during the period of the command economy, because units of collective agricultural production were responsible for the wellbeing of their members. However, during the transition to a market economy rural households became increasingly vulnerable to shocks, including serious illness.

The idea for a health safety net was imported from abroad. During project negotiation, the World Bank made it clear that it needed to demonstrate to its Board arrangements to ensure that very poor people would benefit. There was agreement on the inclusion of medical financial assistance for very poor people and the design was copied from an existing World Bank poverty alleviation project. The State Development and Planning Commission strongly opposed the use of World Bank credit to finance this component on grounds of financial sustainability (Liu and Bloom 2002). Eventually it was agreed that local governments would provide a defined amount of money per capita for this purpose for any township that used World Bank credit to improve its health centre. This was a new departure for local government.

The person in charge of this component focused on supporting rapid implementation. Amongst the issues addressed were the selection of beneficiaries, measures to ensure the money was used for the agreed purpose, and measures to monitor the quality and cost of services. The major implementation constraint was the reluctance of cash-strapped local governments to allocate money to schemes which did not have central government support.

The implementers of this component became increasingly committed to the creation of an effective safety net for poor people. The project managers became aware of the very serious problems poor people were experiencing. There were heated debates about the relative merits of subsidies for hospitalisation and for outpatient care and eventually it was agreed that counties could experiment with the latter. Qinghai Province extended its scheme to other counties. The project supported several studies that documented the problems of poor people and the

degree to which they benefited from the health safety net. In fact, the funding of the safety net was very modest and the studies were better at demonstrating that most of the resources reached poor people than at showing a major change in household livelihoods.

When new political leaders came to power who were looking for ways to make a visible difference to the life of poor people, they were strongly attracted to the demonstration by the project of an intervention that successfully channelled money to very poor people. In 2003 the government policy supported the creation of a national MFA scheme. The government gave responsibility for developing it to the Ministry of Civil Affairs, possibly because of its lack of confidence in the degree to which health facilities would use additional resources to meet the needs of poor people. The project organised activities to assist that ministry in learning from its experience. In practice there have been long delays by that ministry in developing institutional arrangements to support a safety net.

2.7 Conclusions

This project provided a small window through which I could catch a glimpse of China's approach to transition management. It showed some of the approaches the government is employing to oversee rapid changes and institution-building. The most striking finding is the degree to which local innovators and central policymakers have to collaborate to co-construct the institutional arrangements for an effective health system. This involved continuous negotiations between officials at different levels of government.

It is difficult to pin down the role of outside agencies in this complex environment. China has recently negotiated a new World Bank project to follow up the Basic Health Services Project. This involved a major input of time and effort by many officials to design a project that is financed by a loan that must be repaid at commercial rates. DFID has agreed to provide a grant to cover the cost of technical assistance and also to reduce the interest rate. The Chinese government is allocating very large amounts of money to the development of Western China and it has made rural health reform a major government priority. It could have financed the project out of its own funds, but it chose to involve both outside agencies. It is useful to explore why it might have made this decision. Perhaps the answer lies in the functioning of the development partnership described above.

One advantage in the project approach is that although it is embedded in the government system, it can experiment with new ways of doing things, without creating firm precedents. It also makes possible the establishment of an expert team without the need to create major new institutions. Furthermore, it creates an environment that encourages innovation by local governments and reduces the political risk to them of failure. But why not simply establish a project using Chinese funds?

One reason may be the lack of internal mechanisms to create such a special organisational structure. Also, the existence of a loan agreement with the World Bank seems to have shielded project managers from political pressure from

provincial governments, and the availability of DFID grant funding provided them with the ability to employ a team of experts and provide intensive supervision. The partnership with officials from international organisations may have given project managers a greater degree of autonomy from the routine politics of financial management. It also provided them with privileged access to counterparts in the Ministry of Finance, which manages the link with the World Bank.

The link with these agencies was also seen as a mechanism for gaining access to international experience. However, as discussed above, foreign experts were not perceived to hold the answer to the challenges of China's health system reform. Rather, the project provided a means whereby Chinese experts could become familiar with a variety of approaches and then select those most appropriate to local realities. In practice, it proved difficult to link international experiences with those responsible for managing local change processes. There is a need for more learning by both sides of this relationship.

The Basic Health Project was a small aspect of China's very large Western China Development Programme. This was the largest international development investment effort of the decade. There is growing interest in other countries in learning lessons from that experience. China is becoming involved in the development efforts of other countries and there is a growing interest in how to involve its officials in development partnerships in those countries. The creation of a ten-year development partnership between the Government of China, the World Bank and DFID provides useful lessons that could be applied to the construction of new kinds of partnerships in other parts of the world.

3 Reflections of the Project Manager

Liu Yunguo ¹

3.1 Introduction

In China the government is organised into national, provincial, prefecture, county and township levels. Each tier of government has its own health bureau. Township governments consolidate several social sectors into a single department. At each level from the national to the county level there are a number of health institutes under the administration of each tier's health bureau, including a centre for disease prevention and control, a health inspection and monitoring centre, a maternal and child health institute, one or several general and specialised hospitals, a traditional Chinese medicine hospital, a blood supply station, etc. Township health centres and village clinics are the major healthcare providers at the grassroots levels but family planning is an entirely separate vertical system in most counties.

Such a decentralised structure leads to a number of health policy and operation consequences. (1) The State Council and national ministries set the health policy framework and provide technical instructions to their counterparts in lower levels of government, but they do not have direct administrative authority over them. Local health bureaux report to their head of government and have considerable autonomy within the policy framework in implementation. (2) Each level of government controls its own budget and largely finances health institutes at its level. As poor counties have less revenue they depend more on fiscal transfer from higher tiers of government. When the transfer is limited, external resources like World Bank loans and bilateral grants become the main way to deal with health financing gaps and health status lags. (3) In most previous World Bank health projects the national level on-lends World Bank credit funds to lower levels of government. As counties have to repay the loans, their preference is to spend money on local health infrastructure and services, rather than on joint activities and shared external technical assistance with other counties.

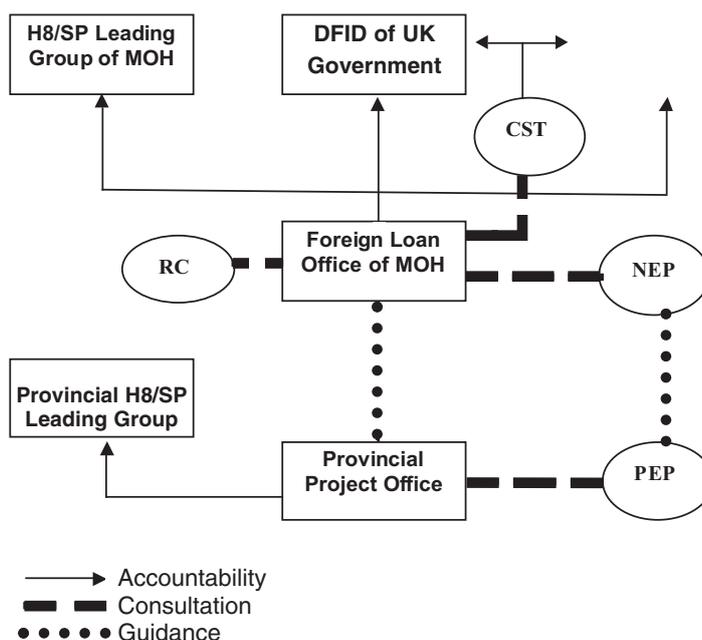
Therefore, the ability of county governments to translate national health reform policy into practice, the opportunities for them to get proper and timely technical support in policy implementation, and their managerial capacity are determinants of their success in health reform and development which, in turn, has significant impact on the health status of the local population. In the China Basic Health Services Project (H8/SP) the co-financing of DFID has added a great deal of

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value to and differed widely from a traditional World Bank loan project, as its grant has been largely spent on capacity-building of governments at all levels, provision of technical assistance to poor counties, operational studies on rural health policy, encouragement of health system innovations and reform pilots, pro-poor health services and priority public health interventions. These were carried out on top of the World Bank loan which was mainly spent on strengthening basic health infrastructure, health planning and workforce development, improving health information systems, and public health and medical service delivery. In brief, H8/SP aimed at improving the health of rural people by strengthening service provision and reducing financial barriers to access to basic care. It covered 97 rural poor counties in ten north-western provinces with a population of 46.8 million. Its cost was US\$128 million (\$85 million from a World Bank loan and the rest from local governments), and a grant of £21 million from DFID.

The national government is accountable to the World Bank and DFID for the agreed use of funds and puts in place a system to supervise and monitor the project implementation. The Foreign Loan Office (FLO) under the Ministry of Health bears full responsibility for the design and management of H8/SP. It liaises with related sectors and line departments of MoH, supervises provincial project management offices and reports to the Project Leading Group of the MoH, to the World Bank and to DFID. A national expert panel (NEP) is contracted to provide technical consultancy to FLO, and similar panels are established at provincial, prefecture and county levels. FLO also works with the core supervision team (CST) which acts as a consulting body to DFID and the World Bank, and with a Resource Centre that organises international technical assistance to the project with the DFID grant. These relationships are shown in Figure 3.1.

Figure 3.1 Relationship of FLO with donors and provinces



CST – Core Supervision Team
 NEP – National Experts Panel

RC – Resource Centre for the Project
 PEP – Provincial Experts Panel

3.2 Lessons for implementing change in a highly decentralised system

In the mid-1990s the Government of China was increasingly concerned about the rising costs of medical care, inter-regional inequalities in the availability of basic health services, the low coverage of rural health insurance and the rising incidence of illness-related poverty. It responded with a series of studies, policy debating and a national health reform conference at the highest level in December 1996. The central government issued an important health policy, the *Decisions on Health Reform and Development* in early 1997 (CCCPC and the State Council 1997), which set specific objectives for health reform and development. These objectives included rehabilitating the health infrastructure, improving service quality, providing basic health insurance for all urban employees, rationalising health resource allocation, encouraging community healthcare, deepening reform of the personnel and payment system, giving health institutions more autonomy, establishing the rural cooperative medical system, strengthening the three-tier rural health delivery network and reinforcing public health services.

This was a comprehensive and important health policy. However, its implementation depended on a number of factors in a highly decentralised system. Firstly, given the large diversity of different regions, the national policy could not define detailed strategies and implementation measures. It was left to local governments to translate the policy into feasible strategies and actions suitable to their local situation. Secondly, the national policy was not linked with a health budget that was mainly allocated by local governments according to their financial capacity. Thirdly, the comprehension and interpretation of the national policy by local authorities could differ according to their experience and the challenges they faced. Fourthly, the introduction of reform and changes needs innovations that rely on proper incentives, knowledge management, technical assistance and additional investment which were not available to many counties.

Although local governments attached importance to the *Decisions on Health Reform and Development*, convened local health conferences, issued official documents expressing determination to execute it, and did make some progress in health reform at local levels, in many regions the policy has been largely translated into paperwork and political gesticulation.

Five years after the *Decisions on Health Reform and Development* came out, the central government issued the *Decisions on Further Strengthening Rural Health Work* (CCCPC and the State Council 2002). This new policy document admitted that though notable achievements had been made, the rural health work remained weak. It suffers from such problems as delayed system reform, insufficient capital investment, shortage of medical personnel, backward infrastructure, problematic rural cooperative medical care services, and serious epidemic and endemic diseases in some areas, which lead to clear evidence of farmers in poverty or returning to poverty. Party committees and governments at all levels must pay immediate attention to these problems.

The 97 poor counties in ten provinces covered by H8/SP experienced a different health reform process from other counties. The project was launched in October 1998, reviewed in mid-term in 2002 and completed in June 2007. Its first phase

from 1998 to 2002 was focused on implementing the *Decisions on Health Reform and Development*, and the second phase from 2003 to 2007 was spent on carrying out the *Decisions on Further Strengthening Rural Health Work*. The H8/SP mid-term review, the completion report, its external evaluation and the related ministries consistently acknowledged that the project counties have been much more advanced in implementing the national health reform policy in comparison with non-project counties at the same socioeconomic level. These counties have substantially improved the health status and health equity of the poor rural population and contributed to national rural health policy development. The project assisted poor counties to implement national health reform policy in five main ways: (1) translating national health policy into specific strategies and actions; (2) providing dialogue opportunities between county implementers and national policymakers; (3) constructive and timely supervision; (4) continuous technical assistance; and (5) encouraging innovations and learning from others. The latter two will be discussed in the following sections.

3.3 Translating national health policy into specific strategies and actions

The H8/SP preparation was in parallel with national health reform debating before 1997. When the policy was decided and issued, all counties prepared a review of their health systems and incorporated the national policy contents into their county-specific project design. The project preparation was a process of local health problem identification and analysis, setting up objectives, and digestion of national policy by counties. The Foreign Loan Office engaged a large number of international and local consultants, organised many workshops and conducted a wide range of negotiations with provinces and counties to reach agreement on the project framework. The process helped provinces and counties translate the national health policy into project strategies and achieved consensus among stakeholders (Table 3.1). These strategies actually formed the components of the project.

Table 3.1 Key health reform policy and H8/SP strategies

Key national health reform policies	H8/SP strategies
<ul style="list-style-type: none"> ● Improve health economic policy and increase governments' health allocation. The central and local governments' allocation to health should increase annually in line with economic growth, and the range of increase should not be less than that of government fiscal expenditure. ● Strengthen rural three-tier health system and improve county-township-village service network. Rationalise the size and distribution of health institutes and readjust their functions. 	<p>(1) Develop and implement County Health Resource Plan. Promote rational deployment and readjustment of health resources, and support personnel management reform.</p>

<ul style="list-style-type: none"> ● Consolidate and upgrade rural health manpower at grassroots levels. Solve the problem of their reasonable payment and strictly prohibit unqualified personnel from occupying technical posts. 	<p>(2) Rehabilitate township hospitals and install basic medical equipment for township and village institutes.</p> <p>(3) Strengthen management health information system.</p>
<ul style="list-style-type: none"> ● Improve drug administration and promote balanced development of health services and medicines: set up national essential drug system, classified drugs as either prescription and over-the-counter drugs, and establish drug storage systems at the central and provincial levels. ● Develop an essential drug list for township and village levels. 	<p>(4) Improve service delivery: develop and implement clinical protocols; create an essential drug list for townships and villages; develop hospital procedures and a mutual referral system; evaluate and improve service quality; and train health workers.</p>
<ul style="list-style-type: none"> ● Government at all levels should bear full responsibility for the provision of public health services and care, strengthen preventive institutes and ensure funds for the prevention and control of severe diseases. ● Centred on improving people's health status, take the provision of basic services as a priority and ensure social equity, to gradually meet the diverse needs of the people. ● Strengthen prevention, care and public health. 	<p>(5) Priority interventions: based on the major health issues of a county, to fund cost-effective public health services and disease control.</p>
<ul style="list-style-type: none"> ● Actively and steadfastly develop and improve cooperative medical system (CMS). ● The establishment of CMS should be led and organised by government, and follow the principle of being run by local people and subsidised by public, voluntary participation, mainly funded by individual premiums with collective and government support.* ● Intensify the The People's Congress role in CMS supervision.* 	<p>(6) Conduct CMS pilot and provide financial support from the project funds.</p>

<ul style="list-style-type: none"> • Pay particular attention to health services in poor and minority group areas. 	<p>(7) Initiate Medical Financial Assistance Programme: provide free essential public health services and subsidise in-patient care for the poorest, identified beforehand.</p>
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* Abstracted from the State Council's *Circular About CMS* issued in 1997. Other policies are abstracted from CCCPC and the State Council 1997.

Within these strategies each project county developed a County Health Resource Plan and a project implementation plan, which further helped them to put the strategies into a feasible local plan of action at the project implementation stage. These plans provided systematic guidance regarding implementing national policy and linking it with resource allocation, including the project inputs. From 1998 when the project was launched, some project counties started full-scale health reforms and inaugurated an entirely new phase of health development. Many others made modest progress with the implementation of change. A few found it impossible to initiate any health reforms, keeping themselves busy building hospitals and expanding services without foresight and originality, and managing the health sector in a traditional way.

3.3.1 Dialogue of county implementers with national policymakers

The overall design of H8/SP was included by the World Bank in a worldwide list of ten excellent project designs in 1998. It was fully in line with the national health reform policy and based on the experience of previous projects and on adequate local participation. However, this could not ensure the success of the reform and the project because it would be implemented in a very dynamic environment. China was moving from a command economy to a market system. Principal county government leaders were changed from time to time and each new leader had a different understanding of the national health policy and held different political aspirations. New health challenges emerged in the process of reform.

In order to carry out the health policy in a consistent manner while adapting to a changed environment and responding to new challenges, H8/SP organised a series of workshops, seminars and conferences to enable continuous dialogue between county implementers and national policymakers. These also provided opportunities for counties to exchange their experiences in health reform and for central ministries to get feedback on health policy development and readjustment. The subjects, participants and contents of some important policy dialogues are listed in Table 3.2.

Table 3.2 Important meetings of implementers with policymakers

Time and subject	Participants	Key contents
13–15 October 1998 H8/SP launch conference	MoH Vice-Minister, MoF, NDRC, all county governors, health directors, finance and planning officials from all project counties and provinces	<ul style="list-style-type: none"> • Introduction of H8/SP objectives and contents • H8/SP implementation plan and management rules • Explanation and discussion of national health policy – <i>Decisions on Health Reform and Development</i>
4–12 November 2001 H8/SP (in 2 groups) implementation strategy workshop	Project county governors, health directors, planning and finance officials from counties and provinces, MoH Vice-Minister	<ul style="list-style-type: none"> • Rural health reform progress and analysis – MoH • Health policy for poor areas and health financing • Western development and social security • National poverty reduction policy and its relation to H8/SP • Priorities of H8/SP in next phase
18–24 September 2003 H8/SP management training workshop	H8/SP managers from all counties, prefectures and provinces, NEP and FLO team members	<ul style="list-style-type: none"> • National rural health reform direction and issues • International health reform trends and lessons • Health planning and human resources development • Health service quality and operation management • New CMS and health financing • Primary healthcare and community health • Health system performance assessment • How to promote health reform with the project
8–11 April 2005 H8/SP management review workshop	County governors, county health and financial bureaux directors from 33 lagging counties, managers of 10 provinces, MoH and MCA officials	<ul style="list-style-type: none"> • Priorities of current rural health work • Analysis of medical costs escalation • Progress of national medical assistance • Experience of health reform in Qianjiang District of Chongqing and Huangzhong County of Qinghai • H8/HP progress review and solutions to problems

These large-scale activities involved county governors, health bureaux directors and project managers, and officials from planning and finance sectors. Local government officials and project managers from prefectures and provinces also participated in these events. At the central level, presentations were usually made by a Vice-Minister of Health (the Head of the Project Leading Group), senior officials from line departments of the Ministry of Health, the Ministry of Finance,

the State Planning and Reform Commission, the Ministry of Civil Affairs, and the Poverty Reduction Office of the State Council, and experts from the national research academy. These policy dialogue opportunities were organised in such a way that: (1) ministries at the central level made presentations on specific topics of health reform policy and progress; (2) selected project counties presented their experiences of health reform and implementation of the project; (3) participants discussed common health issues and how they found suitable solutions to address them through the project practice and experiment; (4) participants provided feedback to policymakers and made recommendations on policy development; and (5) agreement was reached on actions for the next stage of the project implementation and health reform process.

The important value of this kind of policy dialogue is to reduce the separation of policymakers and implementers, inform county officials about national health reform progress and lessons drawn from elsewhere, and encourage them to test and discover their own ways of implementing national policy. These opportunities helped counties to link the national policy objectives to their local reality, translate the strategies into concrete activities and project measures, and keep health reform moving forward on the right track. For many newly appointed county governors and health directors these often became the first detailed and comprehensive lessons they learnt about health. At the time of the H8/SP final evaluation in 2007 many county government officials and health managers appreciated such direct communications with central government sectors and still had fresh memories of workshops they attended and the key messages they obtained.

3.3.2 Constructive and timely supervisions

H8/SP organised 17 regular and formal joint supervisions by MoH, World Bank and DFID, according to the Project Agreement, and numerous irregular supervisory visits by the central and provincial project management agencies and experts at the request of counties.

The regular joint supervision is conducted twice a year; one early in the year to systematically review project progress and achievements, and the later one to approve annual plans at county, province and national levels for the next year. A supervision mission consists of officials from DFID, the World Bank, the Ministry of Health, sometimes the Ministry of Finance and Ministry of Civil Affairs as needed, specialists from the core supervision team, and national and provincial expert panels. Normally a structured joint supervision has to fulfil the following tasks: review annual or semi-annual project progress reports by the central government, provinces and selected counties; make field visits to counties, health facilities and households to get first-hand information on the project and discuss health reform issues with various stakeholders; and conclude with a workshop involving all provinces and selected counties to exchange experiences of and lessons drawn from rural health reform, decide on important project issues and agree on actions for the next stage.

The irregular supervisory visits made by the central or provincial project management agencies are more focused on specific technical issues and

locations where special attention and support are requested. The team consists of senior project managers, national and provincial experts and sometimes international consultants. This type of supervision is less systematic but more hot issue-focused and problem-solving. It helps counties to adapt health reform strategies and service techniques that have proven effective in other places, helps them coordinate with other sectors and brings in the technical assistance they need.

When visiting a county the supervision mission usually meets together with county governors, The People's Congress and Political Consultative Commission leaders, and officials from all related government sectors such as planning, finance, health, poverty reduction, civil affairs, women's federations, education and agriculture, etc. It provides a good opportunity to analyse local health issues together, discuss health plans, review project activities and impacts, and reach consensus on health reform actions. It is also an important opportunity for health leadership development, inter-sector coordination and public mobilisation. Unlike traditional administrative check-ups these supervisions have been constructive and supportive. They are organised intentionally not to jeopardise county ownership of the project and health reform, and not to instruct them what to do. On the contrary the supervisory missions assist project counties to make decisions about and choose health reform paths suitable to the local reality. It is a mentoring rather than a teaching process. The supervision also monitors how much rural poor people benefit from the project and health reform through case studies – allowing poor people to be heard – and through the analysis of routine project monitoring indicators.

3.4 Continuous technical assistance

One feature of H8/SP that differs from other health projects is its stable technical assistance system delivered from the central to the grassroots levels. The system is largely financed through a DFID grant. As shown in Figure 3.1, the project set up a core supervision team (CST) consisting of international specialists to create a bridge between DFID, the World Bank, the national project office and the national experts panel. It continuously brought in new ideas and international experience of health reform and development and provided various options that the project teams at the central and provincial levels could choose from to address issues confronting them.

At the central level seven principal experts were contracted by FLO to provide consultancies on each sub-component of the project, including county health resource planning, health infrastructure, management information systems, service delivery and quality improvement, public health interventions, cooperative medical scheme development and medical financial assistance. Each principal expert formed a technical team. At province, prefecture and county levels similar technical groups were set up and contracted by the project management office at that level. All expert panels and groups report to their contractor only but maintain a cooperative relationship amongst themselves.

In addition to these expert panels and groups, a large number of international and

local consultants were recruited at the request of ministries, provinces and counties to deal with special tasks. This technical assistance system formed a chain allowing knowledge and skills learning and transfer. When CST and international consultants bring in new ideas and recommendations, FLO organises project team and NEP members to first digest these notions, then pick up those useful to counties, translate them into understandable terms and operational guidelines for the counties to use, and provide training as necessary. The central and local experts work together with county health managers and providers to test and expand new approaches and techniques.

A good example is the introduction of social assessment to the project, which was later widely used by project counties to design and evaluate health reform pilots. Until the late 1990s social assessment had not been used in the Chinese health sector. In September 1999 H8/SP sent eight experts and project managers to the Institute of Development Studies (IDS) of Sussex University in the UK for two weeks' training in the basic theory, methods and application of social assessment. Each delegate was assigned to work on a specific topic including practical guidelines for social assessment, stakeholder analysis, survey methods for health project monitoring and evaluation, the methodology of public health service quality studies, gender analysis, and cost-effective analysis of health services. The team sorted out their training notes, referred to additional materials available at IDS, discussed with trainers and compiled a booklet on *Social Assessment for Health Programs* in Chinese (Foreign Loan Office 1999). During the two weeks in the UK the team also developed a fieldwork plan to conduct an experimental social assessment in five H8/SP counties in October 1999 immediately after they returned to China, which tested the methods and skills they learnt. Based on their experience the booklet was further revised and used as training material for the pilot counties of Chongqing Municipality and Gansu Province, which then conducted social assessment for their pilot design and evaluation. With the experience accumulated by the pilot counties the booklet was developed into formal training materials (Foreign Loan Office 2002a) and used for expanded training for all project counties. In the second phase of the project most of the project counties applied social assessment to their health planning, health reform consultation, design, and evaluation.

The introduction of social assessment into the health sector in China is just one example of continuous technical assistance to counties by H8/SP. A lot of other health management ideas, appropriate technologies and practical skills have been digested and adapted by the CST and expert panels at the central and provincial levels, and then transferred to counties and used by them in practice. These include health service quality monitoring and improvement, user-friendly design and construction of township health centres, utilisation of passive solar heating techniques in health facilities, performance assessment of primary healthcare institutes, collective purchase of health services by contracting, health promotion in rural areas, etc. Many of these new approaches and skills are being disseminated to nationwide programmes and non-project regions by MoH.

There have been various forms of technical assistance provision in the project. The most common are: development of technical guidelines; training for first-line health workers, managers and government officials; review of counties' plans and

reports; help with case studies and surveys; onsite mentoring; problem-solving recommendations; incorporation of health reform experience and innovations; establishment of connections and communications with external organisations; and facilitation of knowledge-sharing and experience dissemination. Linking project experts with local health workers and managers has been a mutually beneficial process. Experts get the chance to go outside their academic institutions, become familiar with the realities of health services and reform, and contribute their wisdom, while local health workers and managers are able to access knowledge and theories related to their practice and get technical support.

3.5 Encouragement of innovations and learning from others

The national health reform policy framework left considerable room and flexibility for local governments to adopt and implement according to their ability. To facilitate policy implementation and achieve health reform goals, H8/SP encouraged counties to work out their own ways of addressing local health issues, rationalising resource deployment, restructuring service delivery systems and improving health equity. This has been done through: (1) provision of innovation funds; (2) operational rural health policy studies; and (3) inter-provincial and cross-county experience exchanges.

In October 2002 the central government issued the *Decisions on Further Strengthening Rural Health Work*. At that time H8/SP implementation was accelerating after the mid-term review when project counties had gained some experience and built capacity. In order to help counties work out practical methods for health reform the project set up an Innovation Fund with RMB 6 million for which all institutes and organisations at township and village levels could apply. It was designed for innovative pilots and studies in five areas: trying new approaches to the implementation of national health policy and reform at township and village levels; improvement of basic health service utilisation by rural poor people; new forms of health institute ownership; better health management at township and village levels; and clarification of the role of the private sector in health development (Foreign Loan Office 2002b). Through a competitive evaluation process, 49 projects were funded and completed by February 2006. These projects worked out a number of innovative and practical approaches to health delivery and management, such as: a mobile tent hospital in Qinghai for nomads; mini maternity clinics for remote villages; a rural demonstration household network for promoting reproductive health and gender equity; disease case-based payment for cost control; and health promotion to prevent chronic diseases, etc. These innovations have been published in pamphlets and widely disseminated to project counties and non-project regions. The innovation fund has set up a fruitful and successful precedent encouraging people working on the front lines to carry out studies.

At national and provincial levels the implementation of *Decisions on Further Strengthening Rural Health Work* issued in 2002 was different from what happened to the *Decisions on Health Reform and Development* issued in 1997. The central government, endowed with much stronger leadership for its implementation, provided an earmarked budget, and increased fiscal transfers

from central to local authorities. In 2003 a lot of operational issues were identified in carrying out *Decisions on Further Strengthening Rural Health Work*. The experience of H8/SP caught the attention of the relevant ministries. In order to learn the lessons from the project and find solutions to the problems arising in implementation, H8/SP organised a series of operational studies with the DFID grant. Study subjects were proposed mainly by the line departments of the Ministry of Health and the Ministry of Civil Affairs. There were three areas for study: (1) the design and operation of the new cooperative medical system, (2) the establishment and management of a national medical assistance programme for rural poor people on the basis of the H8/SP pilot of medical financial assistance, and (3) efficient health service delivery, quality and cost control. In total, 27 operational studies were funded and completed by research institutes, universities and health academies. A steering committee consisting of the H8/SP national experts' panel and CST members, officials from relevant ministries and provincial health departments, and international consultants, reviewed and selected study proposals independently and guided the studies. The committee also connected H8/SP with researchers and policymakers. The findings and policy recommendations of these studies were published (Foreign Loan Office 2006) and conveyed to all the relevant sectors and local authorities through a series of workshops and seminars during the study process. These studies provided valuable information on H8/SP experience and pilots of new health institutions in a timely manner. This model of managing health policy studies has been adopted in the DFID-funded China Health Policy Support Project implemented by the Ministry of Health and in other research programmes.

H8/SP has also encouraged inter-provincial and cross-county experience exchanges. In addition to thematic workshops and seminars on rural health reform organised at national and provincial levels, county governors and health officials visited selected project counties and coastal regions to learn about specific experiences. For instance, delegates from Ningxia Autonomous Region visited Dafang County in Guizhou Province to learn how the women's federation and the family planning and health sectors were working together to improve reproductive health and promote gender equity. Officials from Gansu Province visited township and village health institutes in Zhejiang Province where competitive mechanisms were introduced to improve service quality and control medical costs. Many project counties visited Qiangjiang County, Chongqing Municipality, where public health coupons were used to better target poor people and provide favourable incentives to providers. These inter-regional experience exchanges have promoted mutual learning processes and the adoption of innovative health reform approaches by counties.

3.6 Main achievements of H8/SP and health reform

From 1998 to 2007 the H8/SP supported 97 poor rural counties in ten provinces of central and western China in implementing national rural health reform policy. A number of health indicators were set up and monitored to assess the impacts of the policy. As indicated in its completion report (Liu and Liu 2007), it achieved the objectives set at the beginning. Its main achievements are as follows.

3.6.1 Improved health resource planning and personnel management reform

Project counties developed and implemented county health resource plans and readjusted the scope and deployment of township health centres. The proportion of government funds allocated to township and public health services out of the total health budget increased from 28.28 per cent in 1998 to 37.7 per cent in 2006. Most counties carried out personnel management and payment system reform at township hospitals. Well over half of township hospitals (63.6 per cent) now recruit directors by open competitive process, 66.7 per cent engage staff on contract, and 90.9 per cent conduct routine staff performance assessment.

3.6.2 Strengthened capacity of basic health service delivery

With the project support, counties upgraded 1,107 township hospitals and built 29 passive solar heating township health centres. More than 150,000 sets of medical equipment were installed in township health centres and village clinics. The proportion of township hospitals with the proper infrastructure for obstetric services, to national standards, increased from 10 per cent in 1997 to 100 per cent in 2006. The project provided more than 960,000 attendances at short training courses for health workers (although some people participated in more than one course), and long-term training for 3,799 key staff from county institutes and 8,379 key staff from township institutes. It trained more than 33,000 health managers. The proportion of staff at township hospitals with college-level education increased from 5.1 per cent in 1996 to 28 per cent in 2006; those without professional education decreased from 48 per cent to 12.7 per cent in the same period. The proportion of village health workers meeting the eligibility criteria increased from 41 per cent to 84 per cent. The utilisation rate of hospital beds at general township health centres increased from 25.6 per cent in 1999 to 39.8 per cent in 2006, and that of central township hospitals increased from 30.5 per cent in 1998 to 44.2 per cent in 2006. In 2006 the number of outpatient visits at township hospitals in pilot counties increased by 10.9 per cent, and the number of in-patients increased by 35.4 per cent, over numbers in 1996.

3.6.3 Improved health care quality

The percentage of township hospitals using an essential drug list increased from zero in 1997 to 90.1 per cent in 2006, and that of village clinics increased from zero to 83.8 per cent in the same period. H8/SP introduced service quality assessment and improvement procedures to most townships, and provided a wide range of frequent clinical supervisions. A sample survey revealed that the percentage of outpatients using essential drugs reached 91.78 per cent in a small number of counties receiving intensive support and 85.76 per cent in other project counties, as compared to 57.6 per cent in non-project counties. The average cost per outpatient visit was 21.79 yuan in comprehensive pilot counties, 22.01 yuan in general project counties, and 31.68 yuan in non-project counties.

3.6.4 Expanded essential public health services

In order to reform the healthcare payment system, the project commenced purchasing public health services by contract in 12 counties as a pilot. The priority interventions of the project subsidised 92,816 pregnant women for hospital delivery with an average of 175 yuan subsidy per woman. It provided folic acid for more than 138,000 women and free tests for and treatment of reproductive tract infections for 536,000 women. The immunisation rate of four vaccines increased from 88.5 per cent in 2002 to 93.8 per cent in 2006; the vaccination rate of hepatitis B for neonates reached 85 per cent. In project counties 96.3 per cent of patients with detected tuberculosis were correctly managed with directly observed treatment of tuberculosis (DOTS). The proportion of rural households consuming iodised salt increased from 83.1 per cent in 1998 to 98.9 per cent in 2006. And 9,474 patients with cataracts were treated, 7,500 of whom received free or subsidised artificial crystal lenses. The follow-up survey indicated that 68.5–85.4 per cent of rural residents received education on STD/HIV prevention, and more than 90 per cent of health workers in project counties trained in STD/HIV prevention.

3.6.5 Established cooperative medical system and medical financial assistance

From 1998 the project started to re-establish the cooperative medical system (CMS). By 2002 a total of 117 townships had set up and were running CMS, covering 1.1 million of the rural population. From 2003 these old community-funded CMS schemes transformed into new CMS schemes that were substantially funded by government. By 2006 a total of 50 project counties established new CMS schemes, covering 10.48 million of the rural population.

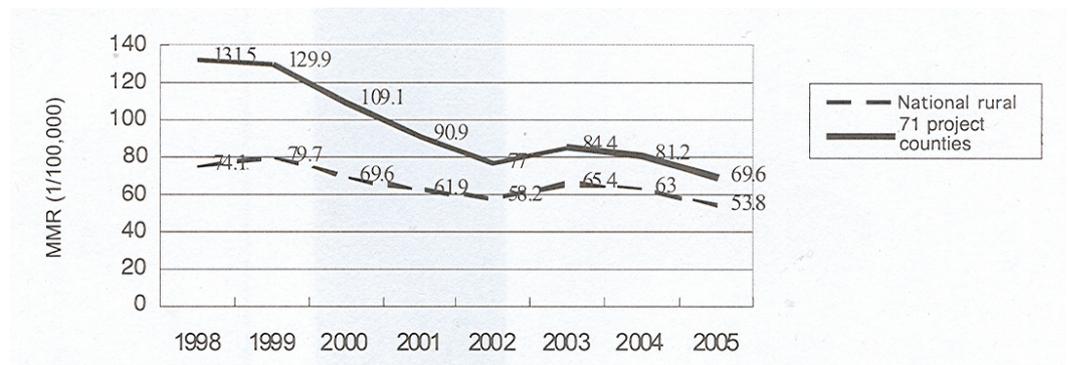
The project has systematically explored and established a medical financial assistance programme (MFA), and has developed a set of operational, managerial and supervisory guidelines and procedures. By 2005 MFAs covered 4.9 per cent of the rural population in 7 provinces and 19.4 per cent in three Qinba provinces. From 1998 to 2005, the MFA cumulatively covered 11.6 million of the poorest populations, among them 143,700 in-patients and 918,500 outpatients, and 62,800 pregnant women and 183,700 children got free maternal care and immunisation respectively. In 2002–2005, MFA subsidised 30–53 per cent of in-patient care costs; in the five comprehensive pilot counties MFA shared 68.08 per cent of the in-patient care costs and 58 per cent of the outpatient care costs for the beneficiaries. By 2006, 89 counties had converted to the national medical assistance programme (MA) which further expanded coverage and benefit for rural poor people.

3.6.6 Improved health status and health equity of the population

In project areas the proportion of residents' visits to health institutes in two weeks increased from 11.8 per cent in 1998 to 21.9 per cent in 2006; that of the fifth lowest income group increased from 11.2 per cent to 22.3 per cent. Residents' annual hospitalisation rate increased from 2.1 per cent in 1998 to 3.6 per cent in 2006; those unable to access in-patient care decreased from 60.4 per cent to 28.1

per cent. The annual hospitalisation rates of minority, low-income, and poor groups were higher than that of non-project control areas by 48.3 per cent, 75.4 per cent and 175 per cent respectively. In 2006 the average in-patient care cost was 2,678 yuan in project areas and 3,384 yuan in non-project counties. The percentage of pregnant women giving birth in hospital increased from 19.6 per cent in 1998 to 80.2 per cent in 2006, and that of the fifth lowest income group increased from 17.1 per cent to 72.7 per cent in the same period. From 1998 to 2006 the average rates of maternal mortality, infant mortality and mortality of children under five from project counties in ten provinces were reduced by more than half. As shown in Figure 3.2, the difference in maternal mortality rate (MMR) between project counties and the national rural average has been substantially reduced.

Figure 3.2 Comparison of MMR in 71 project counties with the national rural average



It should be pointed out that H8/SP was implemented in a complex and dynamic context from 1998 to 2007, a critical period of health reform in China. These achievements in health reform and health improvement should not be solely attributed to H8/SP, although the project contributed a great deal to health development in these poor counties and was regarded as a landmark in their history. Many other factors contributed to the achievements as well. After the outbreak of severe acute respiratory syndrome (SARS) in 2003, governments at all levels substantially increased their budget allocations to public health services, strengthened disease surveillance systems and improved the capacity of Disease Prevention and Control Centres at all levels. Other initiatives such as the Global Fund provided funds for the prevention and treatment of HIV/AIDS, tuberculosis and malaria. And in 2005 the China Development Research Centre published its report on health reform analysis commissioned by WHO with financial support from DFID, which provoked broad health reform debate, engaged senior political leaders, and facilitated concrete steps to reform the health sector in order to provide universal access to basic healthcare. These factors had significant impact on the project and facilitated health reform and development in counties in a synergistic way.

3.7 Conclusions

H8/SP played an important role in helping counties to implement national health reform policy. It helped counties translate national policy into specific project objectives and strategies which reflected local health priorities and needs. It also set up measurable outputs for each stage and provided continuous supervisory and technical support. The approach of the one-decade implementation of the project was to obtain full understanding of national policy, reach consensus on reform strategies and actions, provide external knowledge and experience, draw on and share lessons learnt by counties, disseminate good practice and feed back to policy development. Undertaking health reform is risky and complex, since it will affect the interests of many different groups. Political commitment and leadership from government, the ability to manage change, the availability of resources to undertake action and the acquisition of skills to solve technical problems are key elements for successful health reform. Furthermore, health reform will not necessarily benefit poor people and it is important to establish an effective information system to monitor impacts and institutional arrangements to ensure health equity.

4 Reflections of the DFID Health Expert

Qiao Jianrong

4.1 Summary

This paper draws on the almost decade-long experiences of a Government of China/DFID/World Bank co-financed rural health reform project (H8/SP). It discusses the key factors that made the project a success and the roles that external influences played and can play in facilitating changes in China. Those key factors are:

- government leadership and ownership, as well as the role that the Foreign Loan Office (FLO) plays in bridging the communication and information gap between central and local levels;
- integration of credit and grant resources at all levels with other suitable programmes is the major strength of the project to bring about real changes on the ground;
- allowing sufficient time for changes to be nurtured and incorporated at the right pace.

The paper further argues the importance of getting implementation right with three key concerns: setting the scene with consistent messages and priorities aligned to the government's programme; techniques to ensure regular supervision and quality technical assistance; and encouraging local innovation.

Based on those discussions, the paper examines the development partnership between DFID, the Chinese Government and the WB, and the lessons and experiences gained from managing this tripartite relationship to bring about changes.

The paper ends by further reflecting on the lessons that can be applied to other contexts.

4.2 Background

In early 1998, after almost three years of design and negotiation, the Government of China and the World Bank signed the credit agreement for the China Basic Rural Health Project. The project aimed to improve health outcomes through comprehensive health system development in poorer parts of China. The project came at an interesting time when health policy was being widely debated, leading to a new national health policy announced in early 1997 (Liu and Bloom 2002).

DFID came to China to start its bilateral development programme in 1998.

Attracted by the project's strong poverty focus, design innovation, and the geographical coverage of exclusively poor counties, DFID picked up the Basic Rural Health project as an appropriate platform to co-finance. From its starting point as a purely technical assistance project focusing on two project provinces to support the implementation of the Basic Rural Health Project, the £16 million investment (increased to £21m in 2002) gave DFID a much greater return than was expected. No one could have predicted either the journey all partners were about to undertake together, or the extent of changes about to take place everywhere in China.

Between 1997 and 2007, China has moved from a low-income to a middle-income country and is no longer eligible for International Development Assistance (IDA). China's per capita Total Health Expenditure (THE) increased from 258.6 yuan in 1997 to 662.3 yuan in 2005 but the share of THE in GDP has remained relatively stable: from 4.05 per cent in 1997 to 4.73 per cent in 2005 (MoH 2007a). A major rural health policy announcement was made in 2002, which marked the launch of the NCMS (rural voluntary health insurance) and MFA (medical financial assistance for poor people). At the time of project completion in 2007, Chinese policymakers and politicians were busy figuring out where to go and how to conduct their next big health sector reform.

4.3 A decade-long journey on rural health development in poorer parts of China: an incremental change process

4.3.1 Project achievements

The project achievements were made during a decade-long period of rapid economic growth and social transition in China. The trickle-down impact on growth in poorer parts of rural China is obvious with improved infrastructure, transport, electricity and literature which all played a role in improving demand, access and affordability of health services in project counties.

Nonetheless the project has demonstrated that the gains in health outcomes are larger and quicker when there is increased financing for basic health services together with development of infrastructure and human resources, institutional capacity-building, and management and supervision. This has been shown in comparison with non-project poor rural counties that did not receive comprehensive investment in system strengthening. The most important example is the independently validated substantial reduction in maternal and child mortality achieved in project counties. The project also demonstrated that greater equity in the use of health care services can be achieved through a number of interacting interventions (Huntington *et al.* 2007).

Additionally, the broad project framework enabled the project to regularly adjust its implementation priorities to meet the demands of the national and local governments to provide evidence and advice for policy development and system reform. This led to the project and its experts playing commendable roles in new rural health policy development.

4.4 How were those achievements made?

There are many contributing factors. This paper focuses on three:

4.4.1 Government leadership and ownership make it all possible, along with the role that the Foreign Loan Office (FLO) plays in bridging the communication and information gap between central and local levels of government.

Nowadays, no development professional would disagree with the importance of government leadership and ownership. Yet it is sometimes difficult to stick to this principle either from the side of the recipient government or of the donors. In most cases, difficulties may arise on both sides. This issue will be further discussed later in this paper.

In the Chinese context, we are talking about donors working with very smart and strong national policymakers operating in relative isolation from counties. Then there are the counties themselves with their own diverse range of problems, capabilities and resources. The size and complexity of China requires central policymakers to be cautious when attempting to initiate changes across the country. Thus the project provided a convenient tool for central policymakers to demand evidence and ask for advice based on real-life testing. The pre-condition for making this succeed is that policymakers should deliver explicit demands or instructions to the project managers at all levels. In reality however, these requests are usually made through policy announcements which are vague and broad.

The Foreign Loan Office is staffed by a group of experienced project managers and has a unique role here. First, many of them have skills that make them interchangeable with policymakers and many used to be senior policymakers so they understand the incentive structures within the government system and understand what underlies the policymakers' expectations. Second, as a public service unit, unlike a government ministry, they can take greater risks and operate more flexibly with a level of authorised mandate. This was vital to managing a large and complex project that was being delivered by 97 county governments and 10 provincial governments, requiring a balance between discipline and flexibility. Thirdly, FLO acts as a conduit between central policymakers and local governments, playing a role in interpreting policy through stipulating requirements in the implementation of assistance to poor counties. As a result, FLO gathers vast field experience and provides an invaluable link with reality for central policymakers. This is what took place in the process of developing the new rural health policy.

H8/SP project experiences have shown that in the Chinese context no group or individual can force any level of government to accept anything without negotiations based on hard evidence. This holds true between donors and country governments and also between central and local authorities. This is the beauty and power of working on development programmes as externals in China and indeed the most important principle to bear in mind when carrying out one's duties, though at times these realities can bring pain and discomfort to donors.

4.4.2 Integration of credit and grant resources at all levels with other suitable programmes was a major strength of the project in bringing about real change on the ground

The project benefited from having a strong and smart central leadership that was able to integrate all available resources to work on different but interlinked technical areas. WB funds paved the way for infrastructure and facility upgrading and provided the backbone of the project activities, while the DFID grant was able to focus on increasing the quality and quantity of technical assistance, supervision, innovations and large-scale comprehensive pilots, and most importantly on providing tailored support to ensure equity concerns were addressed in the policy and implementation agenda through many local innovations. Built on the well-grounded internal integration of different donors, the project was, more importantly, able to align with major national programmes, such as the National Programme to Reduce Maternal Mortality and to Eliminate Neonatal Tetanus, the New Cooperative Medical System (NCMS) and Medical Assistance (MA). This integration and coordination was not achieved without pain, compromise or adjustment but looking back, it was indeed worthwhile. It is not certain whether coordination would still have been achieved without strong Chinese leadership and ownership. This will be further examined in the development partnership section below.

4.4.3 Give sufficient time for changes to be nurtured and introduced at an appropriate pace

It is difficult to conclude what the right pace and timescale should be for any particular project. Often funding cycles rather than design determine the planned project period. But H8/SP has a story to tell here. The decade-long timescale provided sufficient time to allow locals to test out new methods in financing, service delivery and community outreach services to poor people, all of which require a long time to see changes.

The eight years of project implementation was once the subject of criticism by externals. The author argues that this initially unplanned longer-term commitment enabled the project to be an important part of a continuous national policy refinement and development implementation cycle. Had the project closed in 2003 as originally designed, it would have lost the opportunity to help the central government to implement the new rural health policy on a large scale and its policy contribution would have been substantially weakened. System change requires long-term investment, not a quick fix. It poses challenges to donors on how long we should wait for the results to come – failure and success both have merits.

4.5 Implementation does matter and try your best to get it right

Implementation is more challenging than project design. Negotiating a common project framework and shared objectives takes time but that is only a paper exercise. Implementation is about conducting activities that bring positive changes either on the ground or at the policy level. This requires a large team's

coordinated effort over a long period of time. Hence the paper makes the following observations from DFID's perspective based on its contribution to three important areas: scene-setting, technique and approach.

4.5.1 Scene-setting: consistent messages and priorities aligned with national programme

The project's overall development objective remained constant from 1997 for both Health VIII and H8/SP. But project outputs, activities and priorities were under constant review and changed to reflect the policy environment and local demands. For example, the 2002 new rural health policy provided a new steer and incentives for local governments that were highly relevant to project implementation. The two most concrete initiatives from the new policy were the New Cooperative Medical System (NCMS) targeting voluntary health insurance for rural residents, and Medical Assistance (MA) targeting the rural poor. The project had by then been piloting both schemes on a large scale for five years. The project provided ready lessons for others to draw on in the continuing process of refining and implementing the policy. Subsequent project work-plans included activities to provide Technical Assistance (TA) and invited the Ministry of Civil Affairs to use project counties to refine the design of their own MA, and project management encouraged and authorised the counties to commence the transition from project-funded MFA and CMS to government-funded MA and NCMS.

4.5.2 Techniques: Structured supervision and quality technical assistance need to be in place to support implementation and changes

The need for this form of support tends to be underestimated by both donors and partner governments in many development programmes. Adequate funding of TA will not guarantee its success. A development programme in resource-constrained areas depends on supervision and TA to bring about positive change through focused support under a common framework in a limited time period. Over time our local project partners realised that infrastructure investment alone would not bring about necessary reform and they accepted the need for qualified people to deliver quality services. TA played a vital role in this conceptual change.

Structured and regular technical and managerial supervision backed up by focused TA played an invaluable role in project implementation. Typical activities were: helping local governments to interpret new rural health policies and translating them into localised operational manuals and technical guidelines; helping to build local capacity; helping to identify implementation problems and bottlenecks and providing solutions. Supervision went from national to province, province to county, county to township and village levels and it provided feedback focusing on problem-solving and help rather than 'inspection (with name and shame)'. Supervision and TA were managed by the Project Management Office but were contracted out to experts through both institutional and individual contracts at national, provincial and county levels, usually aligning with key institutional mandates and interests.

The project leadership was able to maintain a relatively high level of stability and

commitment of its panel of experts over the many years of project implementation. There are individual factors associated with this but more importantly the 'unwritten compact' between the project and its experts provides very interesting lessons for others to learn. The project invested in those experts and gave them new skills and exposure to other countries', knowledge and techniques. In return, the experts grew together with the project. During the life of the project, many of the experts rose to very senior positions in their own institutes but they maintained their commitment to the project due to this compact.

4.5.3 Approach: encourage local innovation and flexibility to bring positive changes at higher levels and on a larger scale

There is a strong tradition in many Chinese reform processes for local innovations to lead to bigger changes. Over time, the achievements of local innovations convince central policymakers and politicians of the need for major new policy to extend change across the country. With its shared framework and objective, the project encouraged local innovation and adjustment in many of its technical areas.

For instance, counties were able to choose two or three health interventions from a list of 11 cost-effective priority health interventions developed and agreed between the WB and the central Government of China (GoC). CMS and MA design at county level followed the central technical guidelines but with a great deal of autonomy and flexibility on design of the local service package, management, cost containment, and payment methods. This might be seen as not a very orderly technical design but it allowed counties to find their own ways of developing those schemes under very difficult circumstances (no policy environment, little government funding, and little community trust of those new schemes).

The DFID-funded pilot counties provide another example. Phase 1 started with five pilot counties in two focus provinces. Pilot county level support was subsequently expanded to all 10 provinces. The additional grant funding in pilot counties encouraged local officials to take risks and to find their own solutions to their challenges in rural health development and reform. Almost all the pilot counties chose to focus on maternal and reproductive health, township hospital management, personnel reform, and the expansion of MFA to reach poor and vulnerable people in remote areas to deepen the reform. One flagship pilot county in Chongqing ultimately became the national model of rural health reform. Those lessons and experiences were disseminated to other parts of China through internal study tours and workshops and by project experts feeding into ongoing policymaking and implementation.

The pilot county experience provides a good illustration of how China's policy development process operates. Macro-level policy is first locally tested to find out practical methods and evidence for policy adjustment. In most cases guided local innovation of a particular policy is carried out to develop operational manuals but sometimes new policy initiatives can be generated from this process. That is discussed in the next section.

4.6 How to facilitate policy change through solid evidence and smart advocacy

Government leadership and ownership, strong and stable management at national level, structured regular supervision and technical assistance all contributed to the smooth and solid implementation. This created a good foundation for externals to play a useful role in facilitating policy changes.

4.6.1 Role of pilots and local innovation in providing large-scale evidence

H8/SP as a whole provided a wealth of lessons and experiences in implementing rural health reform. The scale, scope and timeframe of this project's implementation are rare in externally funded projects. This added weight to its potential to influence policy. It acted as a big pilot, usually one step ahead of government policy announcements but always compliant with the main government priorities. This in turn provided evidence for the government to make 'bigger' decisions. The case of NCMS and MFA discussed earlier is only one example of how the project as a whole was able to generate evidence and lessons for policymakers.

At the operational level, grant financing provided the flexibility for project implementers at all levels to design small-scale pilots to address specific operational issues that arose in the process of rural health policy implementation in areas such as payment methods, cost containment among CMS service providers, county-wide health planning, and service subsidies for the rural poor.

4.6.2 Role of international experts and exposure to other contexts

Many international consultants have worked in this project, especially in the initial stage of project implementation. Their roles consisted more of challenging and reminding implementers about policy and acceptable practice, offering technical skills, rather than hands-on filling-in of implementation gaps, as often occurs in other developing countries. With many technical advisors not having had prior China experience, the effectiveness of international experts in this project relied greatly on their individual capacity to be a good listener and an effective learner as well as a modest collaborative partner with their Chinese counterparts.

The exceptional success related to the core supervision team (CST). This model is interesting and it shows the importance of both continuity and people skills in the delivery of technical assistance. Having been involved in project design, three international consultants in different technical areas were contracted to provide supervision support to the World Bank and DFID. Eventually they managed to develop a strong collaboration with their counterpart National Expert Panel (NEP) and played a quality assurance role with their partners in the NEP and through the NEP to project implementation. The three parties kept a clear understanding of their role which was to advise task managers in the WB and DFID on technical matters but not to become involved in managerial issues with the Chinese side. Towards the later years of the project, following the request of the Chinese manager and the clearance of the donors, the CST role was expanded to include more direct involvement in project implementation and in advising Chinese managers.

In summary, in the Chinese context, international experts should focus on technically challenging areas and quality assurance functions. It is a mutual learning process not a one-way of flow of ideas. The CST model was a big success and draws attention to the need for continuity and people skills among international consultants.

4.6.3 Role of the NEP in feeding back experiences with implementation of changes to policy development processes

The committed and stable NEP acted as the technical sounding board for both central and local levels as an extension of the managerial role of the FLO. They were also one of the key channels enabling the project to influence policy. Drawn from key national research institutes and universities, they underwent personal transformation. They received training from the project and gained new skills, were exposed to other countries' achievements in implementing rural health reform, were mentored by and learnt through international experts, and more importantly, were directly involved in advising local authorities on rural health development and reform. This made the group a valuable source of advice for the central government.

Many of the NEP members were in the drafting team for the 2002 rural health policy. Later on they acted as the advisors to the government on implementing and managing the rural health reform process.

More recently, towards the end of the project's implementation, the Chinese government has been working on a further major health sector reform to meet the demands of the people. The Project Director and some of the NEP members have been actively involved in developing the consultative papers on primary healthcare, CMS and MFA.

4.6.4 Role of donors in facilitating dialogue to make greater use of project learning and to accelerate change

Direct action by donors is unusual but appropriate on occasions. H8/SP provided one such example. In 2003, a new Department was set up in the Ministry of Civil Affairs (MCA) to take responsibility for managing welfare benefits for all urban and rural poor and vulnerable groups. This included providing financial support for their medical care needs. Establishing the department led to a major change in personnel and the old contacts DFID had established within the MCA were no longer there. The new department leadership knew little or nothing about H8SP or DFID's Urban Health and Poverty Project (UHPP) (a bilateral project also piloting MFA but for the urban poor). Project officers from both H8SP and UHPP made initial efforts to explain their projects' now extensive experience in design and delivery of MFA but the new departmental leadership in the MCA was sceptical and defensive. This was understandable in the context of them wanting to develop their own models and claim their own success based on welfare experience, rather than take advice from the health sector. We firmly believed that we had something substantial to offer in our two projects and it was strategically important to get MFA re-engagement with our efforts in these important health-related

poverty reduction strategy projects. So after several rounds of calls, we persuaded the MCA to allow us to give them an overall introduction on both what DFID was doing in the health sector and how this interlinks with their mandate. We also invited the MCA to closely examine the projects to see what help they could provide to the MCA's work. Subsequently, by working jointly with key members of the H8/SP NEP, and the National Project Management Office of UHPP, and through our ability to allocate some small resources to MCA to help them design and evaluate their own pilot in project counties, a very positive result was achieved. MA designs in urban and rural settings are directly benefiting from project lessons and models, and there has been a smooth transition from project-funded MFA to the government-funded schemes in both projects.

Lessons learned from this experience are that once an opportunity arises, we need first to let others work on it, but we should be prepared to step in and facilitate dialogue with many stakeholders. Where necessary, we should make use of the flexibility of our grant resources to go out of our way to offer project lessons and experiences to them in a neutral and non-threatening way. We were seen as neutral rather than as trying to take a share of power or resources which is the usual concern in negotiations between government departments. Our achievements in 2004/05 illustrate DFID's capacity for strategic intervention.

In summary, external actors' role in China is not to fill in implementation gaps – it is most appropriately equipping Chinese policymakers, implementers, think-tanks, and researchers to bring about changes more effectively and speedily through ideas transfer and adaptation to suit different contexts. This is a challenging, technical function for external actors to play. Our effectiveness depends on us being well informed, highly selective in our actions, and able to deliver high-quality support.

4.7 Development partnership in China: a rewarding experience for DFID in the rural health project

In recent times, the approach to development partnership has been discussed much more than it was decades ago. It is encouraging to see more reflections and corrections from traditional donors influencing the way development partnership has been managed. The progress towards the Millennium Development Goals (MDGs) in developing countries now provides one of the measurable outcomes of development partnership. Many new approaches and instruments have been developed to deliver aid under a more equal and effective partnership.

Here are some reflections and observations gained from the partnership with the WB and GoC in the rural health project. The H8/SP caused DFID and others to consider: (1) how to put the good development partnership principles into effective practice; (2) how to measure the effectiveness of the partnership; (3) how to balance internal institutional pressures and priorities with the government-led approach.

4.7.1 Development requires shared objectives, common understanding and concerted action at all levels

Development partners find these concepts easy to acknowledge but challenging to put into practice. Building shared objectives and understanding takes time and requires good communication among all stakeholders. Translating these into action at all levels requires commitment, intelligence and resources. When we donors start giving well-intentioned advice and are pressing for policy changes, we need to ask ourselves three questions: is this doable in the country's own context; what are the values added; and what are the barriers to implementation?

DFID joined in the project one year after the credit agreement was signed. Though broadly happy with the project objective and approach, DFID brought its own priorities of poverty and equity. WB and FLO shared these aims but not necessarily as enthusiastically as DFID. At times DFID may have taken too much of a carrot and stick approach with the locals. Overall we got the outcome we needed but the way we pushed social assessment and community participation deserves re-examining to see if we could have found a more productive approach.

After the mid-term review the World Bank made a strong push to abolish project support to CMS based on its technical analysis. This ignored the Government's priority and policy. Fortunately, the DFID grant enabled the CMS to continue in a meaningful way in pilot counties despite our partner's disinterest. The CMS experiences in pilot counties subsequently provided useful lessons for the Government's NCMS. This is a lesson worth recalling as NCMS now covers more than 80 per cent of the rural population and continues to be finding ways to overcome its deficiencies.

4.7.2 Development partnership is a mutual learning process requiring respect for cultural and value differences

Arrogance or ignorance among external agencies may lead them to only think about 'giving' rather than 'learning' in the development partnership. In present day China, the opportunities for donors to learn are probably now greater than those to give useful advice. To effectively bring positive changes in a development partnership, all parties need to proactively engage in learning from each other. Another potentially damaging behaviour of donors is jumping in to give advice before properly understanding the demands on the partner government.

The success of the core supervision team provides a nice example to illustrate cooperative learning. The CST members had considerable technical knowledge and experience. They demonstrated one common quality: their ability to work with national experts, simultaneously helping them and learning from them.

The operation of the Resource Centre (RC) of this project was much less successful. This tells how important it is to be able to adjust the operation of a common development assistance methodology to suit the local context. In a country with a strong implementation capacity, an RC's role is not to implement the project on behalf of donors; but to provide high-quality TA to transfer new ideas under the leadership and management of local managers. This behavioural

change proved to be difficult in H8 and the RC was quickly relegated to a minor role by the project managers.

From the Chinese side, it requires the leadership to encourage risk-taking and to be more open to new ideas and new ways of doing things. This is not always easy. The work and negotiation on gender mainstreaming was challenging and will continue to be a challenge in the new rural health project. When an issue has not been firmly placed on the agenda, there tends to be much less willingness for it to be pursued.

The extent to which externals can influence or facilitate changes in China depends first on the approach made and the way in which ideas are presented, and subsequently the quality and content of the ideas. To work successfully in China externals must demonstrate a very practical commitment to mutual learning between themselves and the Chinese team and show full respect for Chinese culture and values, while providing new ideas and concepts.

4.7.3 Building trust and relationships takes time: managing the tripartite relationships to maximise added value

In the early years of H8/SP, DFID was going through a steep learning curve in China: learning country knowledge including the institutional and governance system, learning how to work with the WB and GoC, learning how to effectively promote DFID priorities and objectives with soft power rather than monetary incentives.

There are naturally different priorities, pressures from management, and quite different institutional cultures among the WB, DFID and the GoC institutions. For the WB, though attracted by the extra grant resources, it adds another layer of consultation, and another decision-maker in the process that occasionally presents a different approach or priority. It is not bilateral between the WB and GoC any more. For the Chinese side, they need to manage their relationship with each of the WB and DFID, and also manage the tripartite relationship and the joint decision-making process. To succeed, this requires a Chinese manager with excellent negotiating and people skills and with vision.

Here are a few tips based on the principles that have made this tripartite relationship management a success, despite its ups and downs.

- 1 Let our Chinese manager take the leading position in the driver's seat. This is the most effective way to manage the complex relationship between donors.
- 2 Have an open and inclusive communication with all parties concerned (no secret bilateral deals).
- 3 Agree on a clear communication and decision-making process between the WB and DFID and with Chinese partners.
- 4 Think three times about your own values (individual and/or institutional) before you attempt to intervene and always keep the final objectives in mind.
- 5 When a relationship problem arises, put it on the table and don't wait for it to

become a bigger headache. Revisit the 'code of conduct' to see whether there is a gap needing to be covered.

4.8 Conclusions: lessons learned and implications for other contexts

The decade-long H8/SP experiences have many lessons to offer to others working in development programmes in China and elsewhere.

As for DFID or more broadly the Sino-UK partnership, H8/SP nicely illustrates the process of DFID's journey in China. DFID has moved from knowing little or nothing to being a respected player in development, earning a positive image of the UK at lower levels in the Chinese system. This has required genuine respect for country knowledge, leadership and ownership and has put those principles into practice in the daily operation of the development programme. It has also taken patience to nurture changes over a long period. After all, development is about giving people more freedom and the ability to make their own choices. Enhancing capability and freedom to make such choices speeds up the development process (Sen 1999). All of this is not achieved overnight.

As for donors more generally, if you really care about value for money and the outcomes of development, then it is essential to examine whether you get your development partnership right. Do you have an equal, balanced, mutual learning partnership with shared objectives and measurable outcomes? DFID's experiences demonstrate that even in a country as large and independent as China, if money is spent in a smart, focused and accountable way, it can bring about changes both on the ground and at the policy level with desired outcomes. Even though they may largely rely on the recipient partners' capability, donors can make life messier if they do not get the basic principles right. We must remain constantly on guard against acting as *Bad Samaritans* (Ha-Joon Chang 2007) in the development partnership business, even though it is always hard to accept our own potential for imperfection.

As for developing countries, at the heart of this, it is about having your own vision, plan and priority that suits your own context and meets the demands of your own people. Solutions will most likely come out of your own local innovation and initiatives. H8/SP offered one example of how to effectively use external support to speed up the changes and to get new ideas but without compromising ownership and leadership.

The development of China over the past decades offers much hope to other parts of the world. It paints a picture of achievement that has, by and large, utilised the nation's own intellect and resources while borrowing and learn from others' failures and successes. It has been open to new ideas and has transferred them to the Chinese context in travelling on its own development journey. It is important to reflect this so as to shed light for others. How China will deliver its own development assistance to others will undoubtedly attract increasing attention and examination.

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