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Partnerships for development – lessons from a health project in China

Since the mid-1990s the Chinese Government has been implementing a development programme of historic proportions in the western part of the country. Its success in reducing the number of people in poverty and achieving Millennium Development goals has stimulated a lot of interest. China is increasingly involved in the development efforts of a number of low-income countries. There is a lot of uncertainty about how its increasing prominence will affect development partnerships in these countries. The Chinese government has built highly effective partnerships with DFID, the World Bank and other agencies in its Western China Development Programme. This policy brief describes the experiences of a three-way partnership in the Basic Health Services Project and explores lessons for partnership-building elsewhere.

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A partnership approach to project supervision. Chengdu, Sichuan Province

Between 1995 and 2005 the Chinese Government invested a lot of money in the development of the Western parts of the country. It also undertook a major review of its development policy that culminated in decisions to increase greatly the size of fiscal transfers to poor localities and support the development of social services, including health. It has worked closely with DFID and the World Bank in the Western China Development Programme, including in the Basic Health Services Project. This policy brief outlines lessons from that project, which tested innovative ways to strengthen and reform the health systems of poor counties. It reflects the views of the three people, with different roles in the project, listed in the credits on the last page and the conclusions of one-day workshops in Beijing and London.

By the mid-1990s China had been managing a transition to a market economy for more than a decade. It had experienced sustained economic growth and a rapid fall in the number of people living in poverty. However, the rural health system was experiencing serious problems. Many facilities were run-down and overstaffed with unqualified personnel. Poorly designed price controls were encouraging overuse of drugs and diagnostic tests. The public was worried about the high cost of medical care and the danger that a major illness would drive their family into poverty. Government leaders were increasingly aware of the magnitude of the problems but did not know how best to address them. The Basic Health Services Project was designed during the run-up to a conference on health policy in late 1996, at which many national ministries and all provincial governments were represented. The resultant policy statement outlined broad approaches for addressing demand and supply-side problems. Before the political leaders would agree to invest substantial financial resources and political capital in the new policy, they needed to be convinced that the proposed solutions were realistic and the risks were well understood. The project helped 97 poor counties, with a population of 45 million, test reform strategies with funding from government, World Bank and DFID. It faced the following challenges:

- to support major health sector changes in counties with big financial and human resource constraints in a highly devolved government system,
- to create an effective partnership for project implementation between officials of the Chinese Government, the World Bank and DFID,
- to build a coalition for reform involving local government leaders, local and national experts and officials of relevant government departments and
- to produce and disseminate systematic evidence about what works well and what does not.

Implementing the unimplementable

Several foreign experts declared the project unimplementable, when they observed the many inter-connected problems of the health sector. One could have said the same of China's transition to a highly dynamic market economy. The government does not have a blueprint for reform. It uses the metaphor of crossing a river by feeling for the stones to describe its approach. This involves defining broad development priorities, devolving economic decisions and gradually establishing rules-based institutions to formalise ways of doing things shown to work.

This approach has worked well in establishing markets and stimulating economic growth. It has worked less well in building institutions for an effective health system. People need to trust health workers to act in their interests and health workers need to believe that good performance will be rewarded. People also need to believe that contributions to a health insurance scheme will yield benefits many years in the future. Government officials need to understand their roles in supporting new institutions. A deputy governor of a project municipality summarised the challenge of building an effective health system in terms of three imbalances:

- between investing in facilities and training and creating appropriate institutions for an effective health system,
- between health worker attitudes inherited from the command economy and the need to attract patients and win the community's trust and
- between new ideas for a future health system and local understandings of the possibilities for change.

The Basic Health Services Project was organised to address this challenge. A recent workshop of key project people identified the following lessons for supporting health system transition in poor counties.

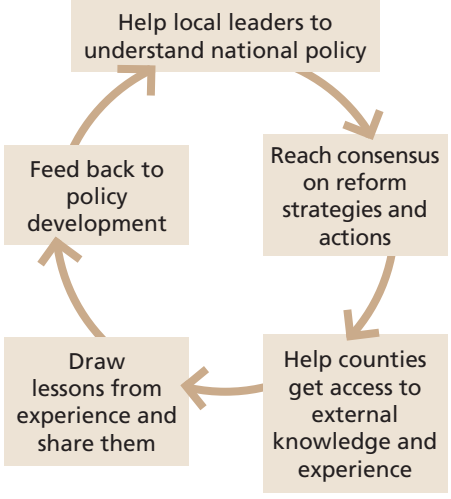
Local government leaders had to be convinced that their health systems could be improved and that the risks of failure were manageable. The project achieved this by organising meetings between these leaders and officials from national ministries to discuss health sector problems and the strategies for addressing them. This helped local leaders improve their understanding of the policy environment, provided opportunities for counties to exchange experiences and encourage dialogue between different levels of government.

County project managers needed to be confident that their team had the technical capacity to implement complex interventions. The project organised training and provided technical support. It established provincial and national panels of experts, who became a source of new ideas for project counties. These ideas came from fast-developing parts of China and from abroad. The project helped poor counties test the relevance of these ideas to local circumstances.

Active supervision by project managers and World Bank and DFID officials made an important contribution. All counties agreed to the project objectives but some components were much easier to implement than others. Investment in infrastructure and health worker training brought almost no political risks, while some aspects of reform affected the interests of stakeholder groups. The project organised regular supervision meetings to review progress. The three-way partnership enabled project managers to respond to delays in addressing the more difficult aspects of implementation by referring to the agreements with the World Bank and DFID.

It was important to document reform experiences and enable county leaders to present lessons to policy-makers. This provided an incentive for counties to perform well. It also contributed to the development of realistic strategies for managing change. Towards the end of the project there was a major effort to prepare a systematic analysis of the lessons for policy makers and policy implementers. The design of the project had not fully anticipated the usefulness of this kind of analysis and there was agreement that future interventions should pay more attention to evaluation and ways to increase learning from project experiences.

DIAGRAM 1 ***The circle of health reform***



Managing a partnership for change

The Chinese Government has invested a lot of effort to develop a follow-on health project with the World Bank and DFID. This was not to gain financial benefit, since China is ineligible for subsidised loans. It was due to other benefits of partnership projects such as the capacity to experiment with new uses of public funds without creating precedents, the reduction of the risk to local government leaders in testing innovative approaches, the chance to test reform strategies before introducing them nationally and the opportunity to experiment with ideas from abroad. The following paragraphs present some lessons from the Basic Health Services Project about the management of a partnership for change.

One major challenge was to build a strategic partnership between project managers and officials of the World Bank and DFID. Each partner had different priorities. Project managers were strongly influenced by national policy discussions. World Bank officials tended to view project components in terms of global debates about health finance. DFID officials were particularly concerned to demonstrate benefits for the very poor. When the project was functioning smoothly, the different viewpoints stimulated a learning approach to implementation, but they sometimes threatened to disrupt the project. The box summarises lessons that the DFID Health Advisor distilled from eight years of managing the construction of a strategic partnership.

Tips from a DFID Health Advisor for managing a tripartite relationship in China

- Agree the principle objectives and keep these objectives in mind as problems emerge
- Partners should reveal their objectives and an action plan should be agreed that takes all objectives into account
- There should be an agreed decision-making process, open and inclusive communication and no secret bilateral agreements
- Ensure that local managers take the lead
- Foreign partners should think carefully about the value-added of an intervention before deciding to act
- Problems should be discussed openly and resolved quickly
- Trust needs to be built; project managers need to demonstrate a commitment to implement the project and other partners need to demonstrate their commitment to the achievement of project objectives and their willingness to defend the project against disruptive interventions by their own organisation
- Partnership is a mutual learning process

A second challenge was to build local capacity. The project invested in strengthening county-level planning and management. It encouraged counties to integrate project activities into routine work and into efforts to implement government policies. Counties mostly used resources from the project and other sources in a coordinated manner One example is how project counties strengthened implementation of a new national maternal health care programme and achieved better outcomes than comparable non-project counties. This was the conclusion of an end-of-project external evaluation.

A third challenge was the sequencing of different aspects of reform. For example, there was little purpose in pushing counties to allocate a lot of money to demand-side initiatives while health facilities were overstaffed with many untrained personnel. Local governments faced strong political and ethical pressures to retain people, who had begun work when medical schools were closed. By the turn of the Century, many rural health workers were reaching retirement age and simultaneously graduates of an expanded training system were seeking jobs. The project helped counties strengthen human resource management. The demographic and skills profile of rural hospital employees changed dramatically and it became easier to reform health finance. The follow-on project will focus on this reform.

A fourth challenge was to encourage counties to test new approaches in anticipation of future opportunities for policy reform. This required patience and an understanding that the construction of appropriate institutions takes time and mutual learning by many actors. The need to think long-term sometimes put a strain on the partnership. It conflicted with the understanding of a project as a means of testing the impact on beneficiaries of an intervention with a clearly defined design. The box illustrates how the project contributed to the most dramatic health policy development during the life of the project: the decision to provide fiscal transfers to poor counties earmarked for health insurance and a health safety net for the very poor. It illustrates the advantages of taking a longer view of change management.

A fifth challenge was to ensure that project-related improvements were sustainable. Two factors strongly influenced the outcome. First, was the rise in the income of rural households, most of whom had a family member working away from their village. Second, was the government decision to provide substantial fiscal transfers earmarked for health. These changes had a significant impact on the utilisation of health services and the income of health facilities. Despite these positive outcomes, there are causes for concern. The government invested heavily in hospitals at the same time as the project supported local health centres and it is difficult to assess the overall impact on the latter. Also the demand for health services in rural counties will be strongly influenced by trends in economic development and the continuing flow of people to urban areas. The final outcome of project investments is still uncertain.

A learning approach to the management of change

Making visions real: the spread of rural health insurance

The early discussions during project design were dominated by a vision of a future health sector financed by compulsory health insurance. The achievement of this vision had to confront reality. Rural residents strongly opposed compulsory contributions, fearing they would not benefit. Government departments opposed the use of World Bank credit to subsidise these schemes, reflecting existing policies against large fiscal transfers for recurrent expenditure. During implementation the governments of project counties had difficulty convincing rural residents to contribute to voluntary schemes and they were reluctant to contribute much money, themselves. This led the project team to focus their attention on ways to make schemes more trusted and trustworthy. There was some pressure from the World Bank to drop this component because the design tended to favour the better off. This did not happen because the policy environment changed. The Government decided to give higher priority to meeting the needs of the poor and strengthening health services and viewed rural health insurance as a way to achieve this. It allocated a fixed amount of money per beneficiary to schemes in poor regions, if local governments and individual households matched the contribution. Within a few years almost all counties had a scheme and the government had increased its contribution to them. The schemes are still evolving and many issues are unresolved concerning the design of benefit packages, the arrangements for paying service providers and the equity of access to benefits. The main project contribution was to emphasise the need to make schemes accountable to beneficiaries and the government. The new schemes are required to establish supervision committees that include many key stakeholders. These committees could have an important influence on the development of rural health insurance.

Influencing policy by demonstrating success: a health safety net for the poor

The Chinese Government does not have a history of large-scale financing of health care for the very poor. During project negotiation, the international partners argued that the project should provide some benefits to them. The government agreed that project counties would finance a health safety net. The person in charge of this component focused on ensuring that the money was used for the agreed purposes, the selection of beneficiaries was fair and facilities provided acceptable services. The project built a constituency in favour of policy change. The people working on this component were strongly affected by what they saw and became advocates for reform. One province extended the safety net to non-project counties. When the government was looking for ways to improve the life of the rural poor, it was attracted by the project's demonstration that it could channel funds to people in desperate need. It assigned responsibility for establishing a nationwide health safety net to the Ministry of Civil Affairs. The project organised activities to enable that Ministry to learn from its experience. The international partners created opportunities for enhanced communication between the two ministries through informal channels. Much more needs to be done to translate a commitment to help poor households cope with major illness into a well designed national programme.

Building development partnerships

The project experience was discussed at a one-day workshop in London in January 2008. The participants included officials from DFID and two Chinese Ministries and development experts. They agreed that the experiences of Western China and China's increasing involvement in many low-income countries will have an important influence on development partnerships in these countries. They also agreed that despite the apparent diversity of interests, there is a basis for building strategic partnerships based on a shared commitment to sustainable development. The workshop identified ways to build these partnerships.

- There are no simple blueprints for development and poverty reduction and it is important to question orthodoxies and accepted wisdoms. This is best achieved with an attitude of mutual respect and a willingness to learn from all successful development experiences.
- Chinese officials and researchers need to build a systematic understanding of their experience with the management of change and rapid development. In the light of China's emphasis on building infrastructure, this should include an assessment of sustainability. They also need to build their capacity to communicate the lessons from this experience to counterparts in other countries. This will contribute to international debates on effective strategies for development and poverty reduction.
- The Chinese experience of health system reform illustrates the need to understand the management of change as a process of institution building. This involves difficult decisions about the sequencing of reforms. It also involves encouraging local innovations and systematic learning from these experiences.
- Strategic partnerships between development agencies can play an important role in supporting development and institution building. However, the creation of these partnerships takes time and effort. China is a relatively new participant in development efforts in low-income countries. Substantial efforts will be needed to build effective partnerships that include China. These efforts could build on the experience of partnerships between the Chinese Government and development agencies in Western China.
- The speed of China's development experience and the newness of China's engagement in global development have generated a number of important unanswered questions. This indicates a need for investment in systematic learning of lessons from the recent past and from the many initiatives and experiments currently underway.

FURTHER READING

Building rural health systems: the experience of China's Health VIII and Health VIII support projects. Foreign Loan office, Ministry of Health, P.R. China

Health VIII (China Basic Health Services Project)/ Health VIII Support Project External Evaluation Final Report, June 2007.

CREDITS

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