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Designing a rural health reform project: the negotiation of change in China

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Summary

This paper describes the design of a World Bank funded rural health rehabilitation and reform project. The project was designed between 1995 and 1998. During the same period, there was an intense debate about health policy that culminated in the organisation of a national conference and the announcement of a new government policy in early 1997. The paper traces how different components of the project were agreed between Ministries and between the national and provincial levels. It suggests that the final design of the project reflects the state of policy discussions at the time the loan agreement was signed. It foresees continuing changes as the problems of implementation become clear and the perspectives of actors at county and township levels become increasingly important.

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List of abbreviations

CHRP	county health resource plan
CMS	cooperative medical system
DPF	Department of Planning and Finance (of Ministry of Health)
DSP	Department of Social Development (of State Planning Commission)
FLO	Foreign Loan Office (of Ministry of Health)
MCH	maternal and child health
MFA	medical financial assistance
MOA	Ministry of Agriculture
MOF	Ministry of Finance
MOH	Ministry of Health
PLG	Project Leading Group
RHP	regional health planning
SDPC	State Development Planning Commission (new name for State Planning Commission)
SPC	State Planning Commission

1 Introduction

1.1 China's transition to a socialist market economy

China has been in transition to a market economy since the late 1970s. This has involved the implementation of major economic and institutional changes, such as a shift to household production, the transformation of the communes into a new tier of local government, the devolution of government powers and radical changes to the relationship between enterprises, government and individual employees. During this period China's economy has grown rapidly and household incomes have risen substantially.

Other ex-command economies have not had such positive experiences. Nolan (1995) argues that the government's management of transition contributed to China's success. The Chinese leadership combined a desire to maintain social and political stability with a willingness to encourage experimentation. This led them to reject a blueprint approach to change. Policy-makers gave more attention to transition management than to debates about the eventual structure of the 'socialist market economy' (Rawski 1999). There was extensive inter-ministerial discussion about every aspect of reform (Lampton 1992).

One factor that has strongly affected the transition has been the relative influence of local political leaders (Shue 1988). This was enhanced by a radical devolution of government powers. The national level retained authority over the overall reform strategy, but, local governments were given a great deal of autonomy. Many of the most significant innovations began locally (Kelliher 1992). The national government has encouraged local governments to test reform options before it has announced national policies. Even after a new policy has been formulated, local governments have had considerable leeway in implementation. For example, local governments have varied considerably in their enforcement of new financial regulations (Lichtenstein 1993).

The transition to a socialist market economy has involved a complex and continuing negotiation. The government has been able to test different points of view regarding the impact of alternative reform strategies. There has been considerable scope for variation between regions, depending on the local situation. This has been important because the attempt to establish a market economy rapidly, whilst protecting the population against excessive dislocation and suffering, has been a complex process for which there are few precedents.

China has actively sought exposure to international experience. It has used its membership in international organisations, such as the World Bank, to gain access to relevant expertise (Jacobson and Oksenberg 1990). The World Bank has supplied technical advice and helped Chinese institutions improve their capacity to undertake economic analyses. The government has not always accepted the advice of external advisors. Decisions about reform strategies have been largely an internal matter.

The conservative approach to reform has had benefits and costs. China has experienced great economic success, and the government has managed to avoid catastrophic mistakes during a period of complex change. The number of people living in poverty has diminished greatly. This has provided a relatively stable

environment, within which stakeholders could develop strategies for adapting to change. It has facilitated the construction of a political consensus in favour of reform, and permitted people gradually to revise their views of possible ways of ordering social relationships. It has allowed the development of an understanding of how a market economy works.

On the other hand, interest groups have had opportunities to retard change and individuals and institutions have been able to profit from the exploitation of incentives provided by partially liberalised markets. Woo (1999) argues that the gradualist approach to change has resulted in substantial economic losses. It may have contributed as well to growing differences between localities with competent local administrations committed to reform and those with weak and/or less accountable local governments (Wang and Bei 1991). Faster growing localities have been able to limit the amount of tax revenue they have been required to transfer to other areas.

The government acknowledges that these problems are serious. It has launched major initiatives to reduce corruption and announced policies to reduce subsidies to state enterprises, rationalise public sector employment and reform the social sector. These major changes will alter the economic circumstances of many people substantially. The negotiation of change may be particularly difficult during this phase of reform, as potential losers protect their interests. The cost of strategic errors could be high, in terms of decreased well being and loss of support for reforms. This makes it important to understand how change has been managed and how this process could be improved during this next phase.

During the first 15 years of the transition, the government focused mostly on the promotion of economic growth. During that period economic and institutional reforms profoundly affected the health sector and the rest of the social services. The cost to individual families of health care rose substantially. Health facilities in poor areas found it increasingly difficult to fund their activities. There was a perception that the quality of services and coverage of preventive programmes were at risk. Serious illness became a major cause of household impoverishment. By the late 1990s, the problems in the health sector had risen high on the government's list of priorities.

The aim of this paper is to contribute to an understanding of China's management of the transition in the health sector. It also explores the relationship between the World Bank and its largest client ($2.5–3.0 billion a year of IDA credits and loans during the late 1990s). It uses the experience of a single project to shed light on the process of reaching agreement on strategies for reform. It will be of interest to Chinese health policy-makers, managers and researchers and international readers with an interest in health system reform and the transitional economies.

1.2 The structure of the paper

Between 1994 and 1997 the Government of China and the World Bank prepared a project to help poor rural counties rehabilitate and reform their health systems.[3] Section 2 discusses the context within which the project was designed. Health facilities had been adapting to economic and institutional changes in a piecemeal fashion for years. The pressures for systematic reform grew and in 1996 the government announced a new health policy. The Government and the World Bank agreed in 1994 that the next project should systematically address issues of rural health development in poor counties. Section 3 provides a short description of the project and outlines the chronology of events that linked project preparation to health policy debates. It also describes the stakeholders involved in the design process.

Section 4 describes the complex discussions between Chinese stakeholders during project preparation. The Government and the Bank agreed that systematic reforms of rural health services were needed. They produced project concepts that embodied different understandings of the way reforms could be implemented. These concepts were modified, as various parties became involved. Several Ministries brought points of view that reflected their perspectives on transition. The process was strongly influenced by the decentralised nature of the Chinese government.

Section 5 discusses the implications of the design process for project implementation. It points out that the design phase mostly involved national and provincial stakeholders. The points of view of county and township governments will become increasingly important, as implementation proceeds. Project managers will also need to take the perspectives of rural residents into account. The policy environment has changed considerably since project launch. A flexible approach to project implementation is needed. Project managers need to ensure that the points of view of all relevant stakeholders inform project implementation and they need to feed lessons from this experience to national policy debates.

2 Rural health services in the transition to a socialist market economy

2.1 Impact of economic and institutional changes on rural health services

By the mid-1970s China had established an effective health system throughout most of the country. The majority of villages had a health station with several part-time barefoot doctors and village midwives. Village health stations organised public health campaigns and provided basic health services. Each commune (now called townships) had a health centre, with several doctors and assistant doctors. These facilities coordinated and supervised public health programmes and provided medical care. The health bureau of the county, the lowest level of government at that time, had overall responsibility for the performance of the local health services. It prepared five-year plans and allocated the annual government budget. County-level institutions

[3] Other funding agencies have joined the project after the design phase with which this paper is concerned.

supervised the performance of township and village facilities and provided referral services. The so-called three-tier health system (village, township and county) made a substantial contribution to major health improvements.

The management and finance of the health sector reflected the context within which it had developed (Tang *et al.* 1994). Village personnel were paid a share of collective production, like other local residents. Health centre personnel were either paid government salaries or a share of collective production. Village and township health facilities charged patients a small fee to cover non-salary costs and sold them drugs and other consumable items. People paid for care at the county hospital. Most communes established a cooperative medical system (CMS), which derived funds from household contributions and collective welfare funds. These schemes provided some services free of charge and reimbursed a proportion of other medical costs.

The transition to a market economy during the 1980s and 1990s affected rural health services in a number of ways. The economy grew rapidly and household incomes rose, particularly in the more developed localities. Inter-regional differences in average income grew over time. Public sector pay rose considerably, reflecting the general rise in household income in the more rapidly growing regions. The government devolved financial management to lower levels during the 1980s (Bird *et al.* 1995; Wong 1995). The size of fiscal transfers between richer and poorer regions decreased, relative to total public expenditure (Ahmad 1997). Governments of poor rural areas experienced increasing financial problems and many spent over 80 per cent of their budget on salaries (Zuo 1997). Government health budgets no longer covered basic salaries in many localities. Although the real value of government health expenditure rose, its share of the total, excluding subsidies for its own employees' health care, fell from 32 to 14 percent between 1986 and 1993 (World Bank 1997).

Health facilities had to find alternative sources of revenue. The government price bureau kept charges for medical consultations and hospital bed-days low. However, it allowed facilities to charge a mark-up on drug sales and impose substantial fees for new tests. This encouraged them to shift to an increasingly expensive style of curative care (Bloom and Gu 1997). As health facilities focused on achieving financial targets, relationships between them became more competitive and supervision and referral diminished. These changes resulted in a rapid increase in the cost of care. The impact on households was exacerbated by the collapse of CMS schemes in 90 percent of villages (Feng *et al.* 1995). By the early 1990s most of the rural population paid almost the entire cost of medical care in cash.

2.2 Pressures for reform

During the 1990s there was a growing sense that something had to be done about the problems in the rural health system. The immediate pressure for action came from health facility managers, many of whom had to decide between allocating scarce resources for pensions, salaries, maintenance and operating costs. A survey of rural health facilities found many in an advanced state of physical decay. A 1995/96 study found 1/3 of

rural health centres in poor counties in debt and a further 1/3 with financial difficulties. Government grants no longer financed salaries fully. The more successful facilities generated enough revenue to pay bonuses on top of basic government salaries. The less successful ones paid as little as 60 per cent of basic salaries. One consequence was that few of the better-trained personnel stayed in facilities in poor rural areas (Gong *et al.* 1997).

In 1991 the government launched the three items construction programme, which provided central government funding for rehabilitation and/or reconstruction of county public health institutions and rural health centres, purchase of equipment and retraining of health workers. Other levels of government were expected to co-fund the investment. A mid-term review in 1995 found that total expenditure came from national government (2.7 per cent), provinces, prefectures and counties (28.5 per cent), townships (20.9 per cent), individual facilities (40.9 per cent) and others (7.1 per cent) (Department of Planning and Finance 1996). This review found the take-up of national government funding by poor counties was very low, largely because local governments and facilities could not afford their share of the cost. The government recognised that special measures were needed to address the problems of health services in poor counties.

During the late 1980s and early 1990s, the government became increasingly interested in measures to reduce poverty. China had made substantial progress in reducing the number of people living below the poverty line, however, the absolute numbers were still considerable. The government established ambitious poverty reduction targets (Cook and White 1998). A large proportion of poor households was located in so-called 'poverty counties'. The government established large poverty alleviation programmes to finance infrastructure development and provide soft loans for small-scale productive investments.

During the early 1990s the government supported several major studies of health status, service utilisation and health expenditure. These studies found that health improvement had slowed and there were widening differences between rich and poor areas. They revealed that poor households found it difficult to pay for health care. They showed that many people declined hospital admission, despite a doctor's recommendation. The studies also found that the serious illness of a household member could impoverish a family (Yuan *et al.* 1996). There was an increasing willingness to view measures to reduce the impact of ill health as an integral component of an anti-poverty strategy (Chen 1994).

2.3 New health policy

In 1996 the government organised several meetings on health problems, culminating in a national conference, hosted by the highest political leadership. The following year the government published a major health policy statement (State Council 1997a). It gave priority to the rural areas. Health development was to be based on existing primary health care plans. The statement covered rehabilitation and upgrading of health facilities, strengthening of preventive programmes and basic care, and improvement to systems of management, supervision and referral. It advocated rises in government health expenditure and the re-establishment of

CMS, as a source of health finance. It also advocated improvements to personnel policies, certification of health workers, rural placements for urban hospital staff, better supervision, and a stop to the recruitment of unqualified staff. The document referred to the special needs of poor counties, and proposed special government support for them. The aim was to establish a system capable of providing access to cost-effective services at an affordable cost and protecting people against the impoverishing impact of major illness.

The publication of the policy document indicated a change in government priorities. It signaled that local government leaders would now be judged on the performance of their health services. The national conference was followed by a series of provincial and then county ones, aimed at securing political support from all levels of government. The policy document was not a blueprint for health sector transition. Some of the policies represented definite commitments to change, whilst others indicated the perspective of the health sector in ongoing policy negotiations.

2.4 Evolving World Bank support strategies

The World Bank has been involved in China's health sector since the early 1980s. By the early 1990s it had supported sector studies and several projects. It had also funded training and capacity building, through the World Bank Institute. One aim of the latter activities was to strengthen training and research in health economics, through the establishment of the National Health Economics Network.

During the early 1990s the World Bank reviewed its international health sector activities and presented a new strategy in the 1993 *World Development Report* (World Bank 1993). During the same period, it supported studies of national health accounts and health finance in China. These studies provided a systematic analysis of the economics of the health sector. The findings were presented at briefing sessions for decision-makers. They were published in 1997 (World Bank 1997). The World Bank was eager to support a project that would help the government implement health reforms.

3 Preparing the Health VIII project

3.1 The basic health services project

The project, which emerged out of years of discussion includes 71 counties in Qinghai, Henan, Guizhou, Gansu, Anhui, Shanxi Provinces and Chongqing Municipality. Its stated purpose is to achieve sustainable health gains by improving allocation and management of health resources, upgrading township health facilities, improving the quality and effectiveness of health services, and increasing risk-sharing and affordability of essential health care for poor families. The total cost is $107 million over five years. Various levels of government will provide 35 per cent and a World Bank credit will provide 65 per cent of the total.

Around 60 per cent of project funds are allocated to township health centres for strengthening their service capacity. Over a quarter of the budget is for improving supervision and referral, implementing

standard case management for common health problems, improving drug prescription behaviour and extending coverage of specific interventions such as maternal and child health services, tuberculosis control and immunisation. A sixth is budgeted for the start-up costs for local health prepayment schemes and the funding of a targeted health benefit for the very poor. The remainder is allocated for strengthening rural health planning and management and measures by the MOH and Provincial Health Departments to support health sector reform and assist project counties with project implementation.

The project was designed during a period of intense national debate about health policy (Table 1). In early 1994 the MOH applied to the State Planning Commission (SPC) for permission to develop an eighth health project using World Bank funds. Later that year the SPC exchanged views with a World Bank mission and listed Health VIII as a candidate project for 1995/97. In February 1995 the Minister of Health and officials of the Bank formally agreed to develop a project that would systematically address the problems of the health sector in poor rural areas. Based on this agreement, the Government and the World Bank developed their different project concepts in 1995.

Table 1 Chronology of project preparation

Activity	**Date**
• MOH notified SPC of interest in health project	01/94
• SPC and World Bank agree to list Health VIII as candidate project for 1995–1997	11/94
• Discussion between Minister of Health and Division Chief of World Bank	02/95
• Initial concept note approved by Minister of Health	07/95
• World Bank prepares outline project preparation plan	11/95
• Project identification mission	(05–06)/96
• Completion of World Bank report on China: Issues and Options in Health Financing	08/96
• Project preparation mission	(10–11)/96
National Health Conference and new policy statement	**12/96–01/97**
• MOH prepared revised project proposal	02/97
• Project preparation mission (preparation of guidelines for county health resource plans)	05/97
• Publication of State Council policies on CMS	05/97
• Project preparation mission	09/97
• Project appraisal	01/98
• Final negotiations	03–04/98

Project preparation included four missions, of two–three weeks each, during which the Government and World Bank reviewed progress and agreed the next steps. Two occurred in 1996 and two in 1997. They provided a forum for discussion of project strategies and resolution of areas of disagreement.

During 1995 and 1996 the Chinese Government and the World Bank supported a substantial amount of analysis of options for addressing problems in the health sector. The Government held a National Health Conference at the end of 1996 and released a major policy statement in early 1997. The World Bank funded a study of 'Issues and Options in Health Financing in China' in mid-1996 and published a modified version of this report in 1997. The final project design was strongly influenced by the outcome of the national health policy negotiations. The project was appraised at the beginning of 1998 and the final negotiations took place in Washington in late March to early April of that year.

3.2 Participants in project design and policy formulation

A large number of stakeholders were involved in project design. Figure 1 describes the principal Chinese participants. It is divided in two tiers to represent the separation between those principally involved in design and those mostly responsible for implementation.

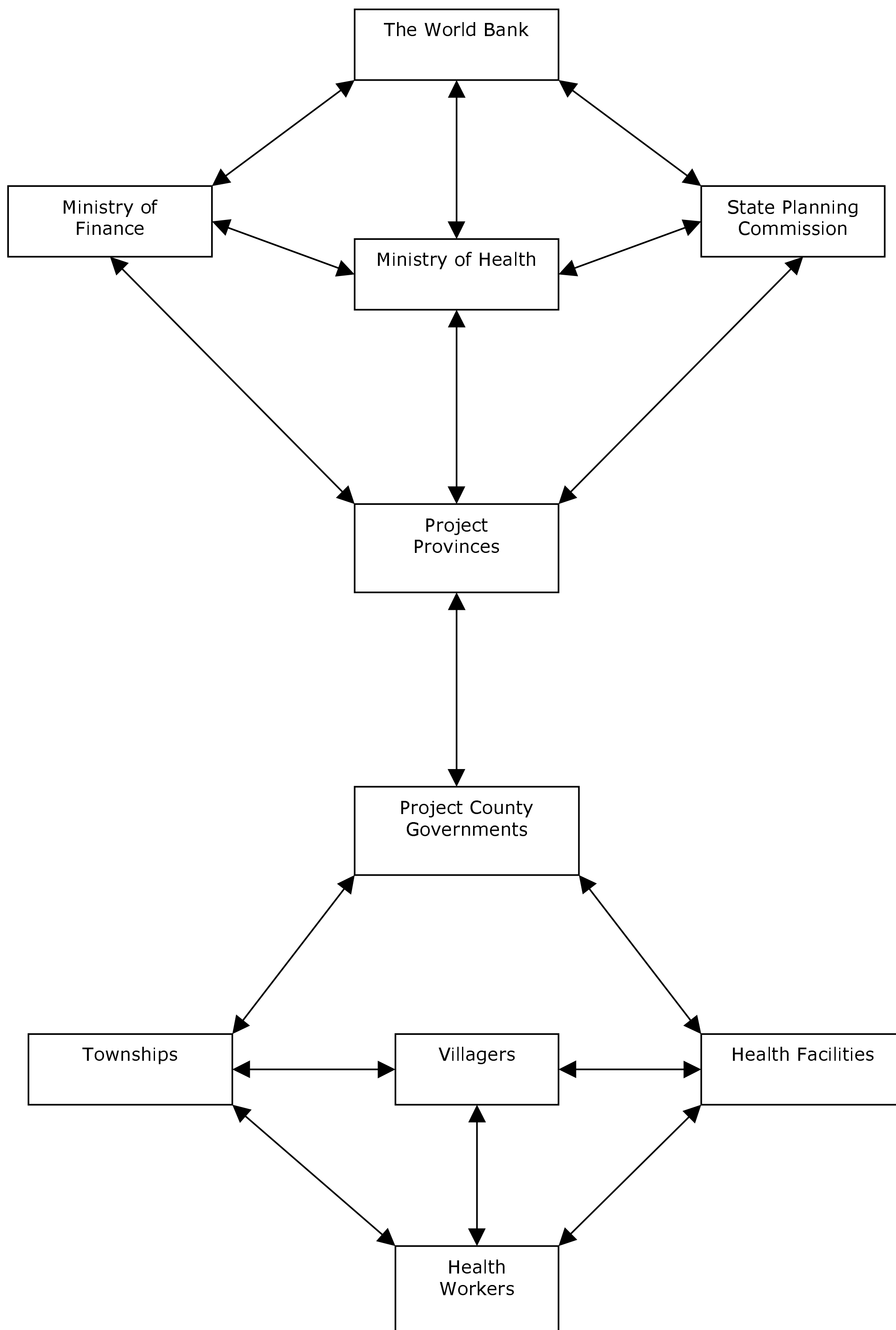
The government is organised into national, provincial, prefecture, county and township levels. Each tier of government is organised similarly. For example, provinces, prefectures and counties have their own health departments. Township governments consolidate several social sectors into a single department.

In health, as in other sectors, the national leadership of the Communist Party and the State Council establish the broad policy framework. They mostly involve national ministries and provincial governments in policy formulation. For example, the key participants at the 1996 National Health Conference were ministers and provincial governors.

Local government leaders must take national policies into account. Their success in meeting national priorities influences their prospects of promotion to higher levels of government. Lower levels of government have considerable autonomy within the policy framework. National ministries set the policy framework and provide technical advice to their counterparts in lower levels of government, but they do not have direct administrative authority over them. Local health departments report only to their head of government. Each level of government controls its own budget. Although the richer localities transfer resources upwards and poorer localities are net recipients of fiscal transfers, the volume of these transfers is relatively small (Wong 1995). Also only a very small share of total fiscal transfers are earmarked for specific sectors. The organisation of World Bank supported projects mirrors the underlying relationships between levels of government.

Government policy is that the national level on-lends most World Bank credit funds to lower levels of government. This means that the design of projects must reflect the preferences of local governments, who will have to repay the money. The national government is accountable to the World Bank for the agreed use of funds and puts in place a system to supervise and monitor project implementation. It does not have direct control over resources because of the on-lending arrangements.

Figure 1 Principal stakeholders in negotiation of project design and implementation



The preparation and final design of Health VIII was strongly influenced by the decentralised government system. The principal participants in project design were the World Bank, national ministries and provincial governments. They agreed upon broad guidelines for the use of project funds and established the overall framework for project implementation. County governments applied these guidelines in formulating their project proposals. The counties have a great deal of flexibility in implementing the project, within the agreed policy framework and guidelines. This section focuses on the top half of the figure.

The design of World Bank supported health projects principally involves three ministries. The Ministry of Health (MOH) provides technical leadership, the Ministry of Finance (MOF) is responsible for the financial agreement and loan repayment and the State Planning Commission[4] (SPC) ensures that the project is consistent with the government five-year plan and with national priorities for the use of World Bank credits. The following paragraphs describe the system at the time the project was prepared. These ministries were subsequently restructured.

The MOH assigns the principal responsibility for each project to one department. The Department of Planning and Finance (DPF) was put in charge of Health VIII. This Department was also responsible for agreeing the annual central MOH budget with the MOF. It also played an important role in the analysis of reform options in the period leading up to the formulation of the new national health policy.

The MOH established a Project Leading Group under the Chairmanship of the Deputy Minister responsible for foreign credits. All relevant departments are represented on this group. Each department is responsible for different aspects of rural health services covered by the project. Representatives of these departments participated in project design.

The primary contact between the World Bank and the Government of China is through the MOF. Two departments were involved in the Health VIII project. The World Bank Department[5] was responsible for the relationship between the government and the World Bank. It did not interfere with the details of project design except to ensure they were consistent with national financial rules and procedures. It also negotiated loan agreements with lower levels of government. The Social Security Department was in charge of budget allocations to the health sector at the central level and of earmarked transfers to provinces for purposes such as the three-item construction programme. It linked to the MOH through the Department of Planning and Finance.

The SPC coordinates the preparation of the five-year plans. These plans are now largely concerned with public sector investment. Within the SPC, the Department of Social Development (DSD) was responsible for planning health infrastructure. The Foreign Capital Utilisation Department allocated World Bank funds between sectors and ensured that the broad purposes of projects were consistent with national priorities.

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4 The State Planning Commission has subsequently been renamed the State Development Planning Commission.

5 The World Bank Department has subsequently been merged with the International Cooperation Department.

As a result of the comprehensive nature of health VIII a number of other ministries were consulted on different aspects of design. For example, the Ministry of Civil Affairs was involved in discussions of targeted benefits for the very poor, the Ministry of Agriculture had an interest in CMS and the Poverty Alleviation Office had an interest in inter-sectoral approaches to poverty reduction. Their role is described where relevant.

The Provincial Governments were key players in project design. The project could not go ahead without their support. The key players at provincial level were the Health Department, the Finance Department and the Planning Commission.

The MOH has established a Foreign Loan Office (FLO) to manage its relationship with the World Bank. The FLO coordinates all aspects of project management from design to evaluation. It receives funding from a government grant and payments by provinces for management services. This means that the FLO is not exclusively funded by one level of government. It manages health projects through local authorities, within a framework of national technical guidelines. Its position between line departments of the MOH, project provinces and the World Bank gives it a unique perspective as a facilitator of negotiations.

4 From project concept to final design

4.1 Project concepts and policy debates

The MOH and the World Bank broadly agreed on the objectives of the project. However, they differed on how to achieve them. One area of disagreement was the strategy for encouraging and enabling counties to implement change in a highly decentralised system. The government wanted to adapt an ongoing investment programme to the needs of poor counties. Its ideas for addressing other health development problems were under negotiation. The World Bank envisaged the project as an opportunity to introduce and test major reforms, using the transfer of funds from higher levels of government as an incentive to change. These differences reflected, to some extent, alternative views about how to implement health reforms. They also reflected the contrasting viewpoints of direct participants in the transition and an external agency with wide international experience. This section discusses how these points of view were reconciled against the backdrop of the ongoing development of national health policy.

The Government and the World Bank agreed, in November 1995, to a preliminary project concept. The project would be an integral part of the poverty alleviation component of the ninth five-year plan. Its objective would be to achieve sustainable health improvements in poor rural counties through reform and upgrading of township and village health services and measures to increase access to these services. The project would include measures to improve health services, strengthen health management, reform rural health finance and ensure access to health services by the very poor. However, at this point the Government and the World Bank had substantially different views on project design.

The MOH began to develop the project in early 1995, while it was undertaking a mid-term review of the three-item construction programme with the MOF and SPC. Its original project ideas were aimed at overcoming financial constraints to programme investment in poor counties (Section 2.2). The DPF and the FLO jointly prepared a briefing document for the Minister of Health in July 1995, which proposed a project covering 200 poor counties in 12–15 provinces. Most of the funds would be used to rehabilitate and re-equip health facilities and train health centre managers and clinicians. The strategy proposed for diminishing financial barriers to access to health services was to establish CMS schemes. The MOH hoped that these schemes would mobilise substantial additional resources for health. This simple model reflected the Ministry's thinking about health development strategies at that time. Its ideas changed during the negotiations leading up to the 1997 publication of the new government health policy. In April 1996 the MOH proposed that the project allocate 70 per cent of funds for construction and training, 20 per cent for CMS start-up funds and a small amount for health management development and targeted health benefits for the very poor.

The World Bank envisaged a very different project. It proposed that responsibility for credit repayment be largely shifted from county to provincial governments. This would have the dual effect of reducing the financial burden on poor counties and giving more influence to higher levels of government. It suggested that only 30 per cent of the credit should be used for components of the three-item construction programme and the rest should be spent on improving high priority health services. It proposed that county governments transfer their health budget and credit funds into a consolidated health account and set targets for increased expenditure on essential health services. They would pilot far-reaching reforms, including the devolution of personnel management to health facilities. The project would include 40 counties, using some elements of competitive selection, including the quality of their health sector development plans. Counties that did not meet performance targets would not automatically be retained in the project; that is continued support would depend on progress.

The World Bank concept implied substantial changes to the system of public sector finance. Higher levels of government fund a relatively small share of the cost of capital works, as in three items construction. The World Bank envisaged major transfers of funds from higher levels to project counties to fund investment and some service subsidies. This could be seen as a precursor of future increases in fiscal transfers earmarked for health services. This proposal became entangled in negotiations about tax reform between different levels of government. These negotiations were linked, in turn, to debates about changes to public sector pay and employment practices; a decision to increase financial flows to poor localities would have to be linked to measures to limit the government salary bill. These are amongst the most difficult and politically sensitive issues in the current phase of transition. They were not resolved at the time the credit agreement was signed.

The Bank also proposed a modification to the relationship between government levels. Based on its experience in other countries, it envisaged that the project would increase the ability of provinces to encourage county governments to implement substantial reforms, including some with ramifications beyond

the health sector. Provinces would be able to provide more funds to counties that performed well and withhold funds from those that performed poorly. This would be a major departure from existing arrangements where counties signed on to their full credit allocation at the beginning of the project. These arrangements reflected the government system of devolved financial management.

The MOH responded to the World Bank concept with a proposal to include 60–70 counties in the project. It also argued that provinces could not be asked to repay the proposed 50 per cent of the credit and suggested that 20 per cent was more realistic. In subsequent consultations with provincial governments in April 1997, two provinces only accepted to repay 10–20 per cent of the credit. All provinces preferred to allocate project funds mainly to civil works and the start-up costs of CMS and they strongly objected to the imposition of conditions regarding personnel management. The MOH also rejected the suggestion that counties be invited into the project only when they produced acceptable implementation plans and be subject to ejection if they did not perform. The reason given was that the SPC would not approve the credit agreement before it had determined the allocation of all funds and identified the authorities responsible for repaying them.

The decision by provinces to repay a share of the credit and their subsequent decision to provide a share of government counterpart funds was a major departure from previous projects. It probably reflected the 1997 policy statement, which called on higher levels of government to provide financial support to health services in poor localities. The statement did not specify the level of support they should provide.

At the time the credit agreement was signed local governments still provided most government finance for rural health services. This situation was mirrored in the credit agreement in which local governments took the primary financial responsibility for repayment. This had a number of consequences. It meant that provinces could not choose the poorest counties, since they were likely to have the greatest difficulty with repayment. It also set limits on the use of credit funds. The government emphasised the need to invest in tangible assets, reflecting the SPC's view that counties should only incur debts to finance productive investments. The final agreement was that counties would spend half of credit funds on infrastructure.

The SPC was also concerned that increases in recurrent health expenditure be sustainable. The lack of firm commitments by higher levels of government to finance health services in poor localities meant that the original ideas for demand-side reform had to be rethought. If CMS schemes had to depend mostly on local sources of finance, they were much less likely to become a major mechanism for reducing financial barriers to access to health care in the near future (Section 4.3). This led to a search for complementary strategies to improve access to the most effective health services. The final project design allocated around a quarter of the budget to a few high priority interventions. It also provided support for the establishment of CMS and targeted benefits for the very poor. However the SPC insisted that local governments finance these components out of their own contributions to project finance.

The government and the Bank also had to reach an understanding on the role of pilot activities in the development of reform strategies. The World Bank preferred to limit the number of project counties, whereas the government wanted to spread gains and the burden of repayment more widely. If there were fewer counties, the World Bank argued, it was more likely that some would succeed in implementing change and that good supervision and learning by higher levels would take place. The government focused mostly on the need to limit the amount of money each county would have to repay.

A key to successful transition is that relevant stakeholders discover their new role in the emerging market economy. This involves a major change in perspective. A pilot project can help people achieve this by exposing them to new ideas and enabling them to test new ways of doing things. However this takes time. Project design needs to balance the pressure to make an immediate impact against the time it takes for people to adapt their own thinking. Also, the transmission of expertise is two-way. Experts from outside the local milieu are unlikely to have enough information to predict the outcome of reforms, in the context of changes to all aspects of social organisation. The Chinese government has dealt with this problem by enabling local governments to test alternative models so that other localities can learn from successes. The designers of the Health VIII Project had to reconcile the need to allow local personnel to find their own strategies for change, with the benefits of exposing them to alternative ways of understanding health system development. These tensions influenced all aspects of project design.

The remainder of Section 4 discusses the negotiations that led to the final design of the project. Some decisions involved intense negotiations and others were made quite easily. The latter mostly shared the following characteristics: everyone accepted the rationality of the decision, they were included in the 1997 national health policy statement, they were to be implemented by county or township governments and their feasibility could not be tested until project implementation.

4.2 Improving the supply side: health service rehabilitation and reform

The SPC coordinates the production of regular five-year plans. The health chapter of the plans sets quantitative targets for the construction of health facilities and training of personnel. It also establishes general goals for service delivery. Since the government only funds a small share of total expenditure by health facilities, these latter goals are mostly general exhortations to good performance. The existing health planning system was created when the view of the SPC was that the priority was to establish a network of health facilities and overcome absolute shortages of trained personnel. This section describes the efforts to modify this system for a project aimed at improving the performance of existing health facilities and personnel.

When the World Bank and MOH began to discuss Health VIII the government was already exploring how the newly developed regional health planning (RHP) methodology could contribute to the control of health costs. This methodology was developed as part of a World Bank project in three urban prefectures, which formulated and implemented hospital rationalisation plans between 1989 and 1998 (World Bank 1998).

The SPC and the MOH had agreed to draft national RHP guidelines and the 1997 health policy statement proposed that local governments use them. By the end of 1996 everyone agreed to include RHP in the health VIII project, however this meant different things to different people.

The first government proposal for the project was that it would largely be a modified version of the three-item construction programme. In this case, counties would produce a RHP in order to avoid duplication of facilities. The World Bank, on the other hand, proposed that the plans should also include the identification of community health needs, definition of the roles and functions of facilities and quantification of resource requirements (financial, human, and physical).

Those responsible for project design faced a typical situation. There was general agreement on a policy, but someone had to translate it into operational reality. Local actors had to understand what they should do, or the policy would remain an empty slogan. First, they had to reconcile the points of view of the MOH and World Bank.

In early 1996 the World Bank funded the participation of 6 people in a training course on the analysis of the burden of disease. It hoped that they would introduce this method into the project. On their return to China, the team concluded that it was not practical to ask every county to undertake such detailed studies during project design. The idea was modified to include a parallel study on the burden of disease. This was the first stage in the formulation of planning guidelines, which 71 counties would be able to apply within the time constraint.

The MOH asked three counties to pilot project design, including the preparation of health resource plans. These counties asked the MOH to clarify the relationship between this plan, the county project document and the health section of the county five-year plan. The Government and the World Bank ultimately agreed that the plan's main functions would be to inform health resource allocation by the county government and define the roles and relationships of health facilities. The new document was called a county health resource plan (CHRP) to differentiate it from the health component of the five-year plan.

The MOH produced simple guidelines to translate RHP principles into a planning instrument for rural counties, with assistance from the World Bank. During project preparation 28 counties prepared CHRPs and county project proposals. The remaining 43 counties did the same during the first year of project implementation. The major short-term impact was to improve the quality of the investment plan by more clearly defining the function of different township health centres and linking size to probable demand. The SPC has subsequently included the CHRP guidelines in a manual on health planning (Liu *et al.* 1999). The ultimate aim is to incorporate these guidelines into future five-year plans.

CHRPs are not the comprehensive development plans the World Bank had envisaged. It was necessary to begin with the existing understanding of county level personnel, who had to formulate and formally review the plan. These people had to achieve these tasks within a relatively short time. They had a limited capacity to imagine very different ways of organising health services. Also, the plans could not address issues that were

matters for high level negotiation. For example, the government was debating its policies with regard to the management of local government employees. Therefore, the CHRP provides overall development plans for human resources, but does not deal with questions of staffing individual facilities. It will be possible to extend the scope of CHRPs and modify the planning process, as project implementation proceeds.

Several aspects of supply-side reform were included in the project with little debate. Everyone agreed that something has to be done to address negative aspects of the breakdown of relationships of supervision and referral between health facilities (Liu *et al.* 1996). The project incorporated measures for achieving this included in the government's health policy statement. There was similar agreement that health facilities should adopt an essential drug list and use clinical protocols as a means of encouraging health workers to prescribe drugs more rationally. Officials at all levels of government easily accepted these technical strategies. They left the details of how to convince health facilities and individual health workers to adopt ways of working that could substantially reduce their incomes for project implementation.

4.3 Improving the demand side: new strategies for health finance

The government and the World Bank recognised that sustainable health reforms would need simultaneously to address the financial problems of health facilities and reduce financial barriers to access to health care, whilst improving standards of service. The Government's initial project concept assumed that reconstituted CMS schemes would become a major source of rural health finance. The World Bank assumed that higher levels of government would provide substantial subsidies to health services in poor rural counties. These matters were subjects of intense negotiation and the final project represents the compromises reached at the time the credit agreement was signed.

The 1997 health policy statement calls on higher levels of government to increase funding of health services in poor localities. It does not quantify the amount of funds they should provide. This suggests that agreement had not been reached on this issue. The decision that project counties would still be responsible for repaying most of the credit was consistent with this interpretation. The recognition that health services in project counties would mostly depend on local sources of health finance, forced those involved in project design to look more closely at how project components would be financed during the project and afterwards.

The project developed a three-track approach for improving health finance: subsidising essential health services, supporting CMS and funding basic services for the poorest households. Around 25 per cent of the credit would be spent on a number of high priority health services. It was assumed that the governments of most project counties would be able to fund these services after the project by adhering to the national policy of maintaining health's share of their budget as their economies grew. Counties would encourage township governments to establish CMS. They would also create mechanisms to finance benefits for the very poor.

Originally the MOH believed that CMS had the potential to become a major source of rural health finance during the life of the project. However, the success of this component was linked to broader debates

about the system of local government finance. In particular, it depended on decisions regarding the status of household contributions to CMS schemes and the willingness of higher levels of government to subsidise them.

The debates about CMS were part of a wider discussion about local government finance (Bloom and Tang 1999; Cook 1999). Local governments collect a certain number of defined taxes. They transfer a proportion of this revenue to higher levels of government, or receive fiscal transfers, depending on a complex set of rules. Local governments also collect extra-budgetary revenue in the form of levies on households or enterprises and charges for services. Extra-budgetary revenue has become an important source of finance for the social sector (Oi 1999). Some localities finance very good infrastructure and sophisticated welfare systems from this source, but others do not. This has led to substantial discontent in areas where households feel they benefit very little from the levies they pay. The government responded in 1993 by limiting levies to five per cent of average household income.

During the early 1990s the MOH became interested in the potential role of CMS as a source of health finance. A number of counties had created quite successful schemes (Carrin *et al.* 1999). They were mostly in the richer areas, where households could afford the contributions and local governments could secure substantial extra-budgetary revenue from enterprises. The MOH encouraged several research teams to establish experimental schemes in poor counties.

The MOH began to negotiate with the Ministry of Agriculture (MOA) about whether localities should be permitted to include CMS in the list of services for which they collected compulsory levies. The MOH was motivated by the need to address the financial problems of the health sector. The MOA wanted to prevent rises in the financial burden on peasant households. The 1997 health policy and subsequent guidelines on CMS (State Council 1997a&b) reflected a compromise between these objectives. Local governments cannot impose compulsory CMS levies, however, they are enjoined to establish voluntary schemes. The status of CMS in the future social security/welfare system is still a matter for debate.

Health VIII reflects the ambiguous status of CMS. It became clear early in project preparation that national and provincial governments would take very little financial responsibility for credit repayment. This meant that county and township governments would have to finance almost all government contributions to CMS. The project guidelines suggested that these contributions should amount to 1–2 yuan per capita. This was consistent with the government policy that households should be the primary source of funding for CMS (State Council 1997b).

The original project documentation had estimated that rural health services would cost around 30 yuan per capita. The proposed government subsidies were a small fraction of this. It would be difficult to convince households to contribute substantial sums to a new and untested institution. Also, the young and fit and richer households, who preferred to bypass local facilities, had little incentive to join. It became clear that CMS would only be able to reimburse a modest proportion of total health costs and would not provide substantial

risk sharing. The major objective of the CMS project component became the demonstration that effective and trusted schemes could be established and sustained in poor counties. The longer-term hope was that local residents and different levels of government would be convinced that these schemes could manage money well and play an important role in sharing financial risk. This would contribute to the ongoing negotiations about local health finance.

Once it became clear that CMS would only reimburse a small proportion of total health expenditure, another strategy to protect the very poor had to be found. For many years the MOH had been trying to endow a medical relief fund and use interest payments to finance major medical expenses of the very poor. It had not convinced the MOF or donor agencies to support this scheme. The MOH asked the World Bank to allocate project funds for this purpose. The World Bank did not respond directly, but re-affirmed the need to establish some kind of medical relief. This component was included in the project, but the two parties did not have a common understanding of what it meant.

Both sides agreed that special arrangements were needed to finance basic health services for the very poor, but the MOH was thinking of an endowed fund, whilst the World Bank was thinking of a mechanism funded by the community. In May 1996 the World Bank confirmed that it could not permit the MOH to use a credit to establish an endowment fund. The MOH gave this idea up. Medical relief remained a project component, but there was no idea what form it would take.

In early 1997 the World Bank proposed that the MOH think about adapting an approach that another project had developed to ensure access to MCH services by reimbursing the cost of a defined package of services for poor households. The FLO subsequently proposed that each project township establish a fund to finance essential preventive services and reimburse a proportion of the cost of inpatient care for the poorest 1–5 per cent of households (Foreign Loan Office 1997; Lin and Liu 1999). It still had to identify a source of finance for this fund. The MOH did not have a budget for this purpose and the project team discussed the issue with other ministries, with little success.

The SPC strongly opposed borrowing money to subsidise services, except small scale tests of a strategy. According to its Department of Foreign Capital Utilization, foreign credits should be used principally for construction, the purchase of equipment and importation of new technologies. Its Department of Social Development strongly opposed the use of credit funds for medical relief, arguing there were many higher priorities, the effectiveness of this intervention was unproven and there were grounds to doubt its sustainability.

The Ministry of Civil Affairs, which is responsible for social relief, acknowledged the links between major illness and poverty. However, it did not have a specific budget for medical relief. Local departments of civil affairs assist sick people and/or finance bad debts in hospitals, on an *ad hoc* basis. The amounts of money are usually small, depending on the availability of funds at the end of the year. This Ministry did not offer to finance medical relief in project counties.

The Office of the State Council Poverty Alleviation Leadership Group, which coordinates poverty alleviation programmes in poor provinces, agreed that medical relief was needed. However, it did not have a budget for activities in a single sector.

In April 1997 the MOH discussed medical relief with the project provinces. They said the health sector should not accept financial responsibility for health care for the very poor, since there was no clear national policy on this issue and they did not have a budget for such purpose. They were concerned that health facilities would have to fund this kind of benefit out of their own resources.

The project team had come to feel that they had been asked to cook a delicious meal (medical relief) without rice. People mostly accepted the potential value of a medical relief provision. However, there had been no decision about how to fund it when formal negotiations commenced in Washington in March 1998. The World Bank proposed, once more, that credit funds should be used to purchase services for the very poor. The Chinese team rejected this. It was finally agreed that government counterpart funds would be used to finance medical relief. In practice, these funds mostly come from county and township governments. The project made the release of credit funds for civil works conditional on the establishment of a county medical relief fund. This was a notable step forward in linking provision of investment funds to specific measures to address the health needs of the poor. The name of the component was changed to medical financial assistance (MFA) to differentiate it from the original idea of an endowed medical relief fund.

5 Project implementation and the policy process

5.1 Health development and reform in poor rural counties

The design of the Health VIII project was a new experience for the Government and the World Bank. Most other projects had focused on specific aspects of health development, whereas this was a comprehensive programme that addressed many aspects of health system development. Another innovative aspect was its focus on poor counties.

The World Bank had a great deal of credibility in China, as a result of the successful implementation of a number of health projects. It had also supported policy-oriented studies involving a number of Chinese researchers. The study findings had been widely disseminated to policy makers. Nonetheless, it is difficult to determine the degree to which the World Bank influenced project design.

The government had a strong sense of project ownership. It viewed World Bank credits as advances on government funds, which had to be repaid. This perception led it to subject the use of project funds to the same scrutiny it applied to the use of its own resources. Stakeholders at national and provincial levels invested a considerable effort to ensure that their perspective on project strategies was taken into account.

The project was designed during a period of intensive inter-ministerial discussion of health policy. All stakeholders had to reach a consensus before a strategy could be included in the project. Each stakeholder

assessed proposals in terms of their consistency with national policies in health and other sectors, their acceptability to local governments and possible risks. For some issues it was necessary to go through several iterations of inter-ministerial discussion and detailed review within key ministries. The final project reflected the state of health policy discussions at the time the credit agreement was signed in early 1998. The Government views the project as a means of testing strategies for implementing the new health policy.

At a meeting in May 2000, the deputy mayor of a project prefecture stressed the importance of subjective factors in project implementation. He referred to *three imbalances*: (i) progress made in rehabilitating infrastructure contrasted with delays in implementing organisational change; (ii) differences in understanding of the project between officials at various levels of government and (iii) the persistence of attitudes relevant to a command economy in the face of competition from a variety of service providers. This was a succinct statement of the challenge of managing health system change in a period of radical social, institutional and economic transition.

Health sector analysts agree that unregulated markets for health services tend to be inefficient and inequitable. Health systems need mechanisms to insure people against health risks, regulate the technical performance of providers and influence health facilities to provide effective and affordable services. They achieve this through the actions of trusted and trustworthy institutions embedded in a regulatory framework (Evans 1997; Chernichovsky 1995). Chinese policy-makers hope to establish this kind of arrangement in the context of rapid change. This involves creating new institutions and convincing relevant stakeholders to accept new rules and norms of behaviour. This is a major challenge particularly in counties with weak administrative systems and/or arrangements for democratic supervision of rural institutions.

Stakeholders have different understandings of the possibilities for change. Senior government officials are aware of institutional arrangements in different regions of China and abroad. They can imagine alternative ways of organising health systems. Those living and working in poor counties have different expectations and perceptions. They are strongly influenced by their experience of the recent past and their knowledge of the constraints to change. Senior political and government leaders formulate transition strategies, however they need to convince stakeholders to implement them.

Information and understanding of opportunities for change does not only flow from national to local levels. Many innovations during the transition to a market economy began as local initiatives. Policy-makers have a limited amount of information about the situation in poor rural areas, and much is out of date. They find it difficult to predict the impact on health system performance of particular organisational changes. Poorly conceived reforms could have a major negative effect. As change accelerates and the problems of transition become more complex, there is a growing need for knowledge of how existing arrangements work and how they respond to interventions. The following sections explore the implications of these issues for project implementation and health development and reform.

5.2 From design to implementation

Discussions about project strategy mostly took place between national ministries and with provincial governments (Figure 1). As implementation proceeds, the provinces will have more influence than the MOH on project activities, since they have access to resources from the World Bank credit, whilst the national level does not. The national level will continue to influence broad project strategies. This division of roles reflects the relationship between these levels of government; the national level formulates policy and lower levels control resources.

County governments did not directly participate in project design, but the national government employed several methods to ascertain their point of view. It supported large-scale surveys of rural health and health services. It invited three county governments to prepare pilot project proposals as a means of testing ideas for project design against local realities. It supported a social assessment study to consult providers and users of services at grassroot levels. The participating counties prepared county health resource plans and project documents, with support from the provinces. These documents focused largely on the formulation of a capital works plan. Their description of other project components largely reflected national guidelines.

At project launch the governors, and senior managers from the health, finance and planning departments of the participating counties attended a briefing meeting on project strategies. They raised few problems or issues with regard to the strategy for structural reforms. This response reflects the approach of lower levels of government to discussions with policy-makers. The project allowed them to secure low cost loans for their county and it was consistent with national policy. They may have felt the same way about the project as about national policies. They accept them and then use their financial autonomy to gain leeway over implementation.

There are major differences between officials at different levels of government in their understanding of the project purpose and strategies. This partly reflects the time it takes to transmit new ideas from national to local levels. The national government organised a health policy conference at the end of 1996. The provinces organised similar ones during the following year. Prefecture and county governments need to follow these activities up at local levels. The different understandings also reflect different levels of knowledge about the local situation. Two challenges during project implementation are to increase the understanding of local stakeholders of the possibilities of change and of high level project managers of the particular problems and priorities of poor counties and townships.

The perspectives and assumptions of planners and experts were influential during project preparation. Their main consideration was to improve the quality, efficiency and affordability of health services. They assumed that almost everyone *could* benefit if more resources were attracted to the health system and if the cost of medical care were decreased without reducing the income of health workers. They did not consider the possible response of potential losers such as unskilled health workers and drug suppliers. Nor did they pay much attention to the process whereby those responsible for implementing change could be convinced they *would* benefit. Peasants have to trust that a CMS will use the money it collects in the interest of its members.

Health workers have to be convinced they will not lose income if they only sell items on an essential drug list. Local governments have to believe that money they allocate to MFA will benefit the poor. The points of view of these stakeholders did not greatly influence project design, but they will strongly influence implementation.

Project implementation will involve continuing negotiation, as more stakeholders become involved. County governments have the major responsibility for project finance. They have to repay a substantial share of the World Bank credit and provide at least 20 per cent of total project costs as counterpart funds. They formulated their own project proposals and are responsible for organising project activities in their territory. About 60 per cent of project funds will be spent at township level and 11 per cent at village level on infrastructure, training and service subsidies (FLO 1999). The main stakeholders at this level are managers of health facilities, health workers, local officials and rural residents (Figure 1). County governments do not have direct control over them.

The social and economic situation in project counties is changing quickly. The government is introducing many reforms that will affect the health sector. It has also embarked on a systematic restructuring of the health system. In 1998–99 the MOH reduced its staff by almost 50 per cent and reorganised its departments. The provinces will implement similar changes in 2000 and lower levels of government will follow in 2001. The government has shifted responsibility for urban health insurance to the Ministry of Labour and Social Security, which has launched a major reform of urban health finance (*China Daily* 2000). It has begun to reform health facility finance and management, personnel management and the system of price control (Wang Yantian *et al.* 2000; MOF, SDPC and MOH 2000). The magnitude of these changes underlines the need to enable counties to adapt the project to local needs.

5.3 Project monitoring and evaluation – feedback to decision-makers

One can view project monitoring and evaluation as a tool that senior managers use to ensure that implementation accords with the agreement between the Government and the World Bank. They monitor progress to identify problems and assist those responsible for implementation to overcome them. They evaluate the overall strategy less frequently to assess whether major changes need to be made. Health VIII includes measures to strengthen the health management information system and make relevant information available to decision-makers, including those involved in the project.

It is difficult to define a 'decision-maker' in China's highly decentralised health system. One cannot characterise the direction of influence in Health VIII as either top-down or bottom-up. On the one hand, the national government formulates strategies and policies and is accountable to the World Bank for the use of credit funds. On the other hand, lower levels of government control resources. County and township governments finance only a small share of total health expenditure. Health facilities depend heavily on payments by service users to finance health worker salaries. One reason health centres have financial problems is they cannot attract enough patients. These stakeholders all play a role in determining project

implementation. This leads to the following questions. Who needs what kind of information about the performance and views of each stakeholder? What kind of information does each kind of stakeholder need?

Health VIII project managers are important users of routine information. First, they need to monitor whether counties take the project guidelines seriously. The national government is accountable for project implementation but it does not control resources. One of its strategies for influencing county governments is through reviewing monitoring indicators. Counties have formally agreed to certain targets and are under pressure to attain them. Also, it will take a considerable effort to translate project guidelines into practical strategies for establishing new and trusted institutions and changing stakeholder behaviour. One gap in knowledge concerns the perceptions and behaviour of local stakeholders. Project managers could use this kind of information to identify implementation constraints and strategies for overcoming them.

The project was designed within the health policy framework published in early 1998. Since then the social and economic situation has changed and the discussions have moved on. These changes are relevant to project implementation. The project midterm review provides an opportunity to reassess implementation strategies. However, the pace of change is so rapid, that it may be necessary to reassess some strategies more frequently. It would be possible to review problems and incorporate agreed modifications into annual project activity plans during the twice-yearly supervision missions. Special policy workshops, case studies and evaluation of selected subjects could provide additional opportunities for this kind of discussion. However, project managers have to balance the pressure to adapt strategies to a rapidly changing environment against the need to allow localities time to establish new institutional arrangements.

Health VIII was designed to test strategies for implementing the Government's *Decisions on Health Reform and Development*. The project management team needs to evaluate the impact of innovative strategies systematically. This will involve documentation of the impact of various interventions in terms of the achievement of project objectives. The project has mechanisms for providing information to government decision-makers. The project leading groups (PLG) at each level of government level make annual reports to the corresponding People's Congress about progress and plans. The PLG at each level of government includes directors or representatives of all related departments. The annual reports could include comments about issues identified and constraints to health system improvement within and outside the health sector.

The project also needs to provide relevant information to local decision-makers. One of the greatest challenges is to convince peasants, health workers, and other local stakeholders that they will benefit from changes to the organisation of the health system. One project strategy for achieving change that meets local needs is to strengthen 'democratic supervision' of local institutions. In order for this supervision to be effective, the participants need to have information on the performance of local institutions. One way to make this information meaningful is to compare the performance of different local health systems. Where health systems perform particularly well, it would be useful to document the reasons why. This would provide a concrete illustration that project goals are attainable.

The project organises a number of activities aimed at influencing decision-makers. Visits to the field by national or provincial project managers provide informal opportunities to brief local government officials and project workshops provide more structured opportunities to exchange experiences. Annual and semi-annual reports of the project are another source of information for policy makers. Articles have been placed in national magazines and provincial project newsletters to convey messages to interested people, including government leaders. More needs to be done to ensure that these channels are used effectively.

The government took a major step in establishing Health VIII to test its health reform strategy. The project provides an opportunity for county governments to experiment with innovative approaches to the implementation of change. It also enables project managers and national experts associated with the project to develop new ways to work with stakeholders to implement major structural reforms. The lessons learned will provide important lessons for the major task of rehabilitating and reforming rural health services in the poorer counties of China.

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