

China: Regional Health Planning An Interventional Case Study

Background and Rationale

Waste and duplication of physical and human resources in health continues to drive cost escalation and ties up resources needed to upgrade essential public health functions, move into community services and fund basic care for the poor. Problems of competing parallel health services provided by the formal health sector, family planning, state owned enterprises (SOEs) and sectors such as railways, mining, police and the army are well known, and are now being compounded by rapid growth in private facilities and services. With help first from the World Bank and more recently interest from other development partners, the Government of China has tested and developed the approach of Regional Health Planning (RHP) to help rationalize resource allocation for health, focusing on city or prefecture level, for populations of 3-5 million people in the city and surrounding counties, as well as more recent application in bigger cities.

Regional Health Planning is an integrated, decentralized planning system that aims to coordinate health services to meet the basic health needs of the population and to ensure efficient allocation of resources to the health sector. As an integrated planning mechanism for the health sector, Regional Health Planning should be a management tool to coordinate all resources and efforts to address the current health development problems, in both urban and rural areas

RHP is now fully integrated into Government of China's (GOC) health policy. Following the 1997 National Health Conference recommendations, National Guidelines for Regional Health Planning was formulated by the SDPC, the MOF and the MOH published in March 1999 after approval by the State Council, and is also the subject of one of 13 urban health policy papers released in 2000. The administrative unit for Regional Health Planning is the prefecture.

In China cities are now responsible for arranging health insurance for their populations and it has been clearly shown that cities which have introduced RHP as a way of improving efficiency and cost control and broadening the service base have a greater chance of viable health insurance schemes. However, with very strong and ongoing work on principles and policy, the current challenges to useful RHP application appear to be related to: capacity for local analysis, the implementation process which needs to engage key decision makers in city government and other constituencies; and availability of a suitable methods and tools for this type of planning at city level. Therefore the Government has endorsed this proposal for a case study to address these matters; in fact the Government requested a modification of the original proposal for a more hands-off study, to address the planning process and practical mechanisms.

Record and Rationale for Bank involvement.

The Bank has a strong record of assistance in the area of RHP over the last 12 years, through the following activities:

- (a) The Integrated Regional Health Planning Project (Health III), Cr. 2009-CHA piloted RHP in three cities, Jinhua, Jiujiang and Baoji. The experience was disseminated to 27 other cities during the project, and led to the adoption of RHP by the State Development Planning Commission (SDPC) as a mandatory framework for new city planning, and the formation of a RHP Research Association (involving provincial and city governments and technical institutions) and an expert advisory group on RHP to SDPC (ref. ICR, June 1998).
- (b) Using an IDF grant for Capacity Building in RHP (IDF Grant TF27548), SDPC and MOH consolidated the project experience, prepared policy guidelines and conducted

comparative study of RHP in China, Japan and Australia (Completion memo, March, 2001).

- (c) The Bank's major sector study, *Issues and Options in Health Financing*, 1997, noted addressed the link between RHP and ability to influence supply side health financing issues.
- (d) Recent ASEM funded work in Wuhan on options for divestment of health assets as a part of SOE reform has generated interest and requests for assistance from other cities.

This year, at the request of SDPC, EASHD with EACCF and WBI, is conducting two seminars on RHP, using the GDLN facility, with support from the Australian Government's Department of Health and Aged Care. The first, in April, discussed a recent analysis of RHP experience in 30 cities, and experience of RHP in Korea, Eastern Europe and Australia. At this seminar city and province level participants in Western China identified current barriers to implementation of RHP, and the need for a process-oriented case study, focusing on specific health problems or system improvement needs as a starting point and involving key stakeholders in the learning process. It is intended that the second seminar, due in September, will, among other topics, review the methodology of the proposed case study before implementation.

Link to WB strategy in China. The subject is in line with the current China CAS, which supports improving resource allocation and essential services in the social sectors, as a contribution to better services for the poor, with a focus on central and western provinces.

The RHP case study will complement Bank's work in urban development, and will be conducted in a city which is participating in the city development strategy (CDS)¹. It also strengthens the cooperation between social and urban development in the Bank's country team, which has rather lapsed since the much earlier Medium Cities Project closed in the early 1990s, and has been to some extent fostered through the Lagging Regions sector studies. The results of the case study are expected to be applicable to western provinces which are expecting rapid investment as a result of the western development initiatives.

Problem analysis and approach of the Study

At the local level, the implementation of RHP has encountered a range of difficulties, including conceptual, technical, and political issues. SDPC's recent review of experience of 30 cities, and group discussions in the GDLN seminar found that RHP had been instrumental in some adjustment of health resources (particularly in relation to growth limits and equity of resource allocation), but that there were many remaining implementation challenges, including:

- Different definitions of health resources in use and a myriad of planning methods
- Limited information base
- Focus on quantity of health resources rather often without a development perspective
- Absence of framework for monitoring and evaluation
- Structural barriers to rational planning – including multi-sectoral and multi-level government involvement in health care, exclusion of the private sector, and lack of role clarification
- Lack of a shared view on key health system problems and underlying factors, and therefore possible solutions
- Conflict between equity and efficiency goals
- Inadequate responsiveness to cultural expectations

¹ The CDS studies will address environment, urbanization and migration, transportation, economic development, and poverty, and will be completed over 12 months. It is possible that they could lead to other urban projects.

- Unacceptable service quality
- Inadequate regulatory framework
- Inadequate political commitment

There was an emerging view amongst some key players that RHP should no longer be concerned with providing a blue print for the entire system but take a more step-by-step approach, starting from priority policy concerns or programmatic areas. There was also an appreciation from many seminar participants that the plan is only good if it is implementable, thus recognizing the importance of the planning process. Seminar participants also expressed the desire for World Bank assistance in piloting different approaches to planning. These considerations summarized above have shaped the proposed approach for the city-level case study.

Proposed Approach

A number of options have been canvassed with key Chinese experts and officials and ruled out:

- 1) A review of experiences and difficulties has already been undertaken (by Prof Hu Shanlian for SDPC) and should not be replicated
- 2) The development of monitoring and evaluation approaches at city level will be supported by the AusAID Capacity Building Program and need not be duplicated
- 3) A model plan document based on technical analyses would have limited impact and value given the implementation bottlenecks related more to process than to technical issues

If the RHP case study is going to help move the RHP agenda forward, it needs to demonstrate a pathway to break the implementation bottleneck. Critical ingredients will be: engagement with municipal leaders, consultation with all stakeholders, elucidation of priority issues amongst leaders and the community, and sound evidence. A link with current World Bank urban sector work would assist with both cross-sectoral engagement and access to broader social, economic, and environment data and forecasts.

On that basis, the case study will be undertaken in a city which is participating in the CDS program, and will be done in 2 stages, with stage 2 being dependent on both result of stage 1 and on further funding possibilities. Broadly, Stage 1 would entail analysis and consultation and documentation of the process and tools used. Analysis would cover:

- 1) major health problems, risk factors, and their distribution in population groups and communities
- 2) all health resources (preventive and curative, public and private, health and other sectors) and their distribution and utilization in the region (i.e. city and its rural areas)
- 3) demand side issues (cost, quality, access, health priorities) using, on social assessment methods
- 4) urban development trends and implications for future health needs and health system development

Consultation will be held with stakeholders including community leaders, city leadership, health bureau leadership, providers of health services (hospitals, community health services, CDC, private sector) and users, to identify shared concerns, and to derive a range of options for the future development of the health system

The outcome of Stage one would be the identification of the key issues in the local health system, development of a vision for the future shape of the health system (in line with broader urban development plans), and agreement on priority issues and key strategies, along with documentation of the methods, tools and procedures used. It would also contain a proposal for Stage 2.

Stage 2 of the study would be the development of a document for community information and education, plus be more interventional in terms of technical assistance to the appropriate city level personnel to undertake further marginal analysis of those priorities and option appraisal, and to help secure agreement on implementation strategies.

Client Participation and Leadership. Since the successful Health III project, GOC has actively endorsed and often initiated the Bank's involvement in RHP related activities. The proposal to include a study on RHP in the AAA program for FY02 was strongly supported by MOH and SDPC, first in May 2001. Their support was confirmed when the subject was approved for study in January 2002, although with a reduced budget. As a result of deliberations during the first GDLN seminar, members of the RHP research association and MOH have concluded that the study should focus on the process and mechanisms for RHP at city level, as the priority at this stage. The study will be guided by a steering committee made up of representatives of SDPC, MOH, MOF and leaders of the city and province selected. Two technical experts will act as reviewers of the study, and senior members of the study team work will all be experienced Chinese experts, except for the international team leader.

Timeliness and Phasing of the Study. As noted the study is appropriate at this time given (a) the recent summary of RHP experience and the identification of current bottlenecks in application of RHP; (b) the current initiatives in CDS in urban development; and the ongoing health policy work for both rural and urban settings. The study is proposed to be completed in two phases, due to budget constraints. This proposal covers the first phase, including collection of data, completion of consultations, agreement on priority issues and key strategies for the health plan, documentation of the process and of the tools and mechanisms used so far, and an outline of the actions for Phase 2, including a dissemination plan. Phase 2 would involve at the city level addressing more detailed short term work planning for the short term, and the dissemination of the findings and experience of the case study.

Interest of other Development Partners. Although the Bank was the first development partner to work with GOC on RHP, others are now becoming involved. As mentioned, the Australian Dept. of Health and Aged Care, under a Memorandum of Understanding with MOH, has supplemented TA for the GDLN seminars. Separately AusAID and SDPC have a comprehensive program of analysis and capacity building in RHP, focusing on policy level and monitoring mechanisms. DFID supports an urban health project in three western cities, and has expressed interest in the proposed case study.

Relevance to Possible future lending. China is not presently borrowing for social sectors unless the IBRD is blended with grant funds. However, the linking of the case study with the CDS studies gives the chance of obtaining improved health resource planning in any future urban development project. At the same time, keeping contact with DFID and their current efforts in urban health reform, will enable dialogue on possible cooperation on future co-financing for prefecture based health improvement projects.

Audiences for the Study and Expected Benefits. The intended audiences for the study are: (a) city and province officials and leaders of other key constituencies in the study area; to understand the process, give feedback and through their involvement strengthen the relevance and chance of implementation of the plan. (b) city and province officials in other parts of China, as potential users of the report and the planning process of the case study; (c) central level officials in SDPC, MOH and MOF and institutions involved in policy and policy research on RHP, for its contribution to policy development and for dissemination through their existing networks; (d)

World Bank/WBI staff and managers in sectors and country teams, sectoral and intersectoral theme groups etc., as a contribution to Bank’s knowledge and experience in health planning at city level, and for dissemination; (e) development partners, especially those engaged in support of health and urban development sectors in China, for assessment and possible use in relevant activities they support in China and for possible future related joint work.

Tasks and Proposed timing

TASKS	TIMING
1. Contracting with Study team; city selection and negotiation with city officials.	May/June
2. Development of detailed methodology	June
3. Collection and analysis of statistical information	July
4. Social assessment and stakeholder consultation, using selected information from the analysis	August
5. Workshop to present findings and derive issues, vision, priorities, and key strategies.	September
6. Documentation of results, processes and proposal for Phase 2, including dissemination	September