



# Technical Assistance Report

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Project Number: 40646  
May 2007

## People's Republic of China: Assessment of the Rural Health Services System

Asian Development Bank

## CURRENCY EQUIVALENTS

(as of 30 April 2007)

Currency Unit	–	yuan (CNY)
CNY1.00	=	\$0.13
\$1.00	=	CNY7.7223

## ABBREVIATIONS

ADB	–	Asian Development Bank
CHEI	–	China Health Economics Institute
GDP	–	gross domestic product
MOH	–	Ministry of Health
NDRC	–	National Development and Reform Commission
PRC	–	People's Republic of China
PRG	–	policy review group
RCMS	–	Rural Cooperative Medical System
RHSCDP	–	Rural Health Services Construction and Development Program
WHO	–	World Health Organization

## TECHNICAL ASSISTANCE CLASSIFICATION

<b>Targeting Classification</b>	–	Targeted intervention (TI-M)
<b>Sector</b>	–	Health, nutrition, and social protection
<b>Subsector</b>	–	Health systems
<b>Themes</b>	–	Inclusive social development, capacity development
<b>Subthemes</b>	–	Human development, institutional development

## NOTES

- (i) The fiscal year of the Government and its agencies ends on 31 December.
- (ii) In this report, "\$" refers to US dollars.

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## I. INTRODUCTION

1. Improving people's health is one of the strategic priorities of the People's Republic of China (PRC) as outlined in the 11th Five-Year Plan for National Economic and Social Development (2006–2010) and the Rural Health Services Construction and Development Program (RHSCDP) endorsed by the State Council in March 2006. In December 2006, the Government of the People's Republic of China requested Asian Development Bank (ADB) technical assistance (TA) to support the assessment of the initial phase of RHSCDP implementation.<sup>1</sup> ADB undertook TA fact finding in February 2007 and reached agreements with the Government regarding the TA impact, outcome, outputs, terms of reference for consulting services, cost estimates, financing plan, and institutional and implementation arrangements.<sup>2</sup> The design and monitoring framework is in Appendix 1.

## II. ISSUES

2. Before the economic reforms initiated in the late 1970s, the PRC was renowned for its impressive gains in public health, reflecting a commune-based rural health system characterized by an equitable allocation of public resources and a focus on highly cost-effective preventive health services. However, following economic reforms and the dismantling of rural collectives, and despite improvements in some areas, progress in rural health care and health outcomes has lagged behind the PRC's rapid economic growth and urbanization. In recent years the Ministry of Health (MOH) and other Government agencies have increasingly recognized that there are problems regarding access to affordable health services.<sup>3</sup> Rapid increases in total expenditures on health care have outpaced public expenditure for health, which declined as a share of total health costs from 40% in 1980 to 17% in 2004. Low levels of health insurance have led to a sharp increase in out-of-pocket expenses for individuals, which reached 54% of total national health expenditures in 2004, compared with 20% in 1980. The share of out-of-pocket health expenditures is even higher in poorer rural areas, where local government health-care budgets are most strained and where health insurance coverage is very low.

3. Since the 1980s the introduction of market reforms and the devolution of public finance has had a serious impact on the quality of rural health services. County and township hospitals and village clinics face dwindling public budgets, and are managed like private enterprises attempting to maximize revenues. In some cases this is achieved through excessive sales of expensive drugs and supply-induced demand. The rural health care system increasingly resembles a poorly regulated market. Total health care expenditures represented 5.6% of gross domestic product (GDP) in 2004 and are projected to reach 7% by 2010.<sup>4</sup> Limited mechanisms for controlling costs and improving quality mean that this increase will not necessarily improve the quality of care.

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<sup>1</sup> Following the launch of an initial phase in 2004 in certain localities and endorsement by the State Council in March 2006, the RHSCDP was formally announced in August 2006 to address key rural health problems. RHSCDP investments from the central level will end in 2009 and local implementation by 2010.

<sup>2</sup> The TA first appeared in *ADB Business Opportunities* on 15 February 2007.

<sup>3</sup> At the 2005 National Health Working Conference, Health Minister Gao Qiang cited accessibility and affordability as key issues for the health sector.

<sup>4</sup> "Unprecedented urbanization, rural reform and industrialization, and the rapid aging of the PRC's population will all add to the demand for health care. Assuming continued growth of the PRC's economy at an average annual rate of 7%–8% and continued growth of the PRC's total health expenditure at an average annual rate of 12%, total health spending will reach 7% of gross domestic product in 2010" (United Nations Health Partners Group in China. 2005. *A Health Situation Assessment of the PRC*. Beijing).

4. Public officials at the highest level have expressed concern about inadequate access to affordable and good quality health services and the need to narrow the gap between rural and urban areas in terms of access.<sup>5</sup> Several major initiatives are underway that are expected to have an important impact on the provision of rural health care services in line with the objectives of the 11th Five-Year Plan. Among these is the RHSCDP. Following the launch of an initial phase in 2004 in selected localities,<sup>6</sup> and endorsement by the State Council in March 2006, the RHSCDP was formally announced in August 2006. It is the largest investment program in public health, and the broadest in scope, since the founding of the PRC in 1949,<sup>7</sup> Investment from the central level will end in 2009 and local implementation will end in 2010.

5. Assessment of past performance is critical to identifying key bottlenecks and obstacles, and to feeding back evaluation results into evidence-based policies. Building on existing research,<sup>8</sup> the TA will support an assessment of the RHSCDP initial phase so work plans can be adjusted and policies improved. The TA builds on previous ADB support to the PRC<sup>9</sup> in the health sector, including research that helped to catalyze the Government's pilot-testing of the new Rural Cooperative Medical System (RCMS), and follow-up work on expanding services (especially basic preventive services) and establishing mechanisms for community participation to enhance system management and guide implementation at the grassroots level. It also builds on ADB cooperation with the National Development and Reform Commission (NDRC) in public nutrition and non-communicable diseases.

### III. THE TECHNICAL ASSISTANCE

#### A. Impact and Outcome

6. The impact of the TA will be improved access of rural communities to good quality local health services. The outcome of the TA will be a policy note issued by NDRC on improving equity, efficiency, and effectiveness of rural health services, which will form the basis for a review and possible revision of the RHSCDP.

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<sup>5</sup> The landmark Decision on Major Issues for Establishing a Socialist New Countryside, issued following the Sixth Plenary Session of the 16th Communist Party of China Central Committee in October 2006, calls for "Solidifying the public goods nature and quality of public health, deepening medical and health system reform, strengthening government responsibilities, strictly supervising management, constructing a primary health care system to cover all urban and rural residents, and provide to the population safe, effective, convenient, and affordable public health and basic medical services".

<sup>6</sup> Localities were selected based in part on participation in the Rural Cooperative Medical System (RCMS) and other national health-related programs.

<sup>7</sup> The RHSCDP includes measures to improve infrastructure and equipment of rural health facilities, management and operating systems of health facilities, human resources development and deployment, and related policy measures such as the new RCMS; medical aid for rural areas; aid for rural areas from cities; integration of rural health resources to optimize efficiency of resources; adjustment of health facility infrastructure, equipment, and personnel to population base and actual utilization; establishment of a rural health network; development of multiple systems of ownership; definition of service packages by level, rational pricing of services, and securing resources for rural health, especially for poorer communities.

<sup>8</sup> Includes the Report of the National Health Services Survey of 2003, the findings of the joint WHO—Development Research Center (DRC) project on health, a study on the Progress and Outcomes of the New Cooperative Medical Scheme implemented by the MOH — Center for Health Statistics and Information, and the recent findings of the China Rural Health Survey organized by DRC.

<sup>9</sup> ADB. 2000. *Technical Assistance to the People's Republic of China for Policy Support for Social Security Reform under Tenth Five-Year Plan*. Manila; ADB. 2003. *Technical Assistance to the People's Republic of China for a Fund for Strategic Policy Conferences and Studies for Poverty Reduction*. Manila; and ADB. 2004. *Technical Assistance to the People's Republic of China for the Facility for Policy Reform Support*. Manila.

## **B. Methodology and Key Activities**

7. **Key Outputs.** The TA will have three components, aimed at delivering three core outputs: (i) a tool for assessing the RHSCDP, (ii) an assessment of the implementation of the initial phase of the RHSCDP, and (iii) policy recommendations for improved Government investment decisions for rural health.

8. **Component 1. Assessment Tool Design and Pilot Testing.** To develop an assessment tool for the RHSCDP, the TA will review relevant national and international experience of evaluating health systems. The TA will define the objectives and scope of the assessment; identify information needs and users of the findings; and determine data collection methods and instruments, quality control measures, data processing and analysis, and reporting method. The extent to which the RHSCDP addresses the specific needs of the rural poor and vulnerable will be assessed. The TA will pilot-test the assessment tool and prepare an implementation plan of the assessment to be carried out under component 2. The TA team will report to the Policy Review Group (PRG, see para. 13) on the results of the review of experiences, the assessment tool and the pilot-test results, and the assessment implementation plan.

9. **Component 2: Assessment of the RHSCDP Initial Phase (2004–2006).** Following finalization of the implementation plan in component 1, component 2 will support selection and training of interviewers and other persons who will be engaged to carry out the assessment, prepare the logistics of the assessment exercise, and implement the assessment. Under component 2, the data will be processed and analyzed, and the report of the assessment prepared.

10. **Component 3: Development of Final Policy Recommendations.** Component 3 will prepare draft policy recommendations and proposals for further central and local government investments in rural health based on the findings of the assessment. The draft policy recommendations will be presented to the PRG and discussed during a workshop in association with international partners. Under component 3, the policy recommendations will be finalized after consensus has been reached and circulated by NDRC to the agencies concerned for their consideration.

## **C. Cost and Financing**

11. The total cost of the TA is estimated at \$500,000, of which \$400,000 will be financed on a grant basis by ADB's TA funding program. The TA will finance consulting services, including external resource persons for draft reviews and other focused inputs, office equipment and supplies, workshops and training, field trips, and activities related to the implementation of the assessment (e.g., the survey, focus groups, and reviews). The Government's contribution, estimated at \$100,000 equivalent, will be in-kind through the provision of office accommodation and venues for meetings, counterpart staff and allowances, miscellaneous administration expenses, and local transportation for field visits. The detailed cost estimates and financing plan are in Appendix 2.

## **D. Implementation Arrangements**

12. The TA will be implemented over a period of 15 months from July 2007 to September 2008, with core policy recommendations to be identified by month 12. NDRC will be the Executing Agency for the TA. The China Health Economics Institute (CHEI) will be the

Implementing Agency. Under the supervision of NDRC, CHEI will be responsible for day-to-day oversight of and support for the consultants' work, including coordinating the development of the assessment tool, implementing the assessment of the RHSCDP initial phase, and producing the assessment findings and policy recommendations by June 2008.

13. The PRG will be established to build broad support for the TA across key agencies and local administration. It will also disseminate major outputs to relevant ministries and agencies for consideration. NDRC will chair PRG meetings and the Ministry of Finance will co-chair. NDRC will invite MOH, State Administration of Traditional Chinese Medicine, Ministry of Civil Affairs, Ministry of Education, Ministry of Personnel, Development and Reform Commission of the State Council, and other central and local partners to join the meetings. NDRC will be responsible for convening (and CHEI for organizing) three inter-agency meetings of the PRG at (i) inception, about 1 month after the start of the TA, to discuss the objectives, scope, and coordination of the work of CHEI and the consultants; (ii) about 4 months after the start of the TA, to present the assessment tool and discuss its implementation; and (iii) about 12 months into the implementation, to discuss the assessment findings and policy recommendations.

14. ADB will establish an advance payment facility for NDRC and/or CHEI to support agreed cash expenditures, including workshops and the implementation of the assessment in the field. Costed activity proposals will be submitted via NDRC to ADB for approval. The amount of advance and eligible expenditures for advance payment will be arranged in line with ADB's *Guidelines for Disbursement of Technical Assistance Grants* (1992).

15. In consultation with NDRC, ADB will engage a team of national consultants (20 person-months) and an international consultant (1.5 person-months), who will report to CHEI and ADB, and as requested to NDRC. Also in consultation with NDRC, ADB will recruit the consultants on an individual basis in accordance with ADB's *Guidelines on the Use of Consultants* (2007, as amended from time to time). The national consultants will include a specialist with expertise in policy and evaluation, public health management, health services delivery, human resources development, rural health insurance, and pharmaceuticals. This specialist will act as the overall team leader for the group of national and international consultants. The other national consultants will have experience in health economics and financing, and health infrastructure and equipment. Short-term resource persons needed for the design and implementation of the assessment will be proposed to ADB and recruited under the team leader as required. The international consultant will (i) serve as advisor to CHEI and the national consultants; (ii) have broad international expertise in evaluation systems, policy processes and health economics; and (iii) review the outputs submitted in English.

16. The consultants will (i) review international and national literature and practices on evaluation and health system reform, (ii) contribute to the development of the evaluation tool for the RHSCDP, (iii) organize and participate on-site in the assessment of the initial phase of the RHSCDP, (iv) produce the report of the findings of the assessment and help to formulate recommendations for RHSCDP implementation until 2010 and for general health reforms to improve access to affordable and good quality rural health services, (v) carry out field visits, (vi) prepare and organize workshops, (vii) liaise with government agencies as needed, and (viii) collaborate closely with CHEI and NDRC. The Terms of Reference (Appendix 3) outline their tasks and reporting requirements. Consultants' reports will be prepared in Chinese and English.

17. The consultants, through CHEI, will submit to the Government (in Chinese) and ADB (in English) four reports, which should include the conclusions of the PRG (except if decided otherwise by ADB). The reports are as follows:

- (i) an inception report within 1 month of commencement of services for discussion during TA launching, proposing a firm implementation plan, the description of the division of labor among consultants for the execution of the TA, a coordination mechanism with CHEI, and an indicative outline of the assessment tool;
- (ii) an interim report, to include the review of national and international experience on evaluation systems, the proposed assessment tool, the result of the pilot exercise and the implementation plan;
- (iii) a draft final report to include (a) the review of international and national best practices in evaluation systems and lessons for the PRC; (b) the assessment tool, including methodology and implementation process; (c) the assessment report, with findings and policy and operational recommendations; and (d) a separate 10-page summary, targeting PRC key decision makers, of key findings on rural health, lessons in assessing the RHSCDP, and recommendations for the governments to strengthen rural health systems; and
- (iv) a final report, which will include the finalized items (a)–(d) above. An outline of the final report is in Appendix 4.

18. The World Health Organization (WHO) has expressed a strong interest in participating in the assessment process and policy dialogue on rural health within the framework of the TA. NDRC and ADB both recognize the value of technical inputs from WHO and welcome its participation. This will build on WHO's long-term involvement in the PRC's health sector, and ongoing cooperation between ADB and WHO in the PRC and regionally.

19. In addition to systematic dialogue with CHEI and ADB throughout the TA implementation period, WHO will provide complementary technical inputs under the guidance of NDRC and CHEI. Specifically, WHO will (i) participate in the preparation of the workshops planned under the TA, in coordination with CHEI and the consultants hired under the TA; (ii) provide input to the review of international experience on health evaluation systems as proposed in the TA; and (iii) comment on the draft assessment tool and the policy recommendations.

#### **IV. THE PRESIDENT'S DECISION**

20. The President, acting under the authority delegated by the Board, has approved the provision of technical assistance not exceeding the equivalent of \$400,000 on a grant basis to the Government of the People's Republic of China for Assessment of the Rural Health Services System, and hereby reports this action to the Board.

### DESIGN AND MONITORING FRAMEWORK

<b>Design Summary</b>	<b>Performance Targets/Indicators</b>	<b>Data Sources/Reporting Mechanisms</b>	<b>Assumptions and Risks</b>
<b>Impact</b> Rural communities have greater access to good quality local health services	Utilization of rural health facilities by 2010  Financial protection through pre-payment schemes  Quality as perceived by patients by 2010	MOH statistics  MOH statistics  MOH survey	<b>Assumption</b> <ul style="list-style-type: none"> <li>• Other Government programs in support of rural health (e.g., support to new RCMS, medical aid) are successfully implemented</li> </ul>
<b>Outcome</b> A policy note issued by NDRC on improving equity, efficiency and effectiveness of rural health services, as the basis for a review and possible revision of the RHSCDP	Policy note by October 2008	NDRC	<b>Assumption</b> <ul style="list-style-type: none"> <li>• NDRC adopts the policy recommendations</li> </ul>
<b>Outputs</b> Assessment tool for the RHSCDP  Assessment of the implementation of the initial phase of the RHSCDP  Policy recommendations for improved Government investment decisions for rural health	Assessment design by October 2007  Assessment report available by March 2008  Draft Policy recommendations by June 2008  Full final recommendations by September 2008	NDRC/CHEI minutes of meeting  NDRC/CHEI minutes of meeting  NDRC/CHEI minutes of meeting  NDRC/CHEI minutes of meeting	<b>Assumption</b> <ul style="list-style-type: none"> <li>• Local governments cooperate with the central level in assessing the RHSCDP</li> </ul> <b>Risk</b> <ul style="list-style-type: none"> <li>• Lack of coordination among agencies involved in the TA</li> </ul>
<b>Activities with Milestones</b>  1. Assessment tool for the RHSCDP (6 months into the TA) <ol style="list-style-type: none"> <li>1.1. Review relevant national and international experience on evaluation systems</li> <li>1.2. Develop an assessment protocol, including information needs and users, objectives, data collection method and instruments, processing, analysis and reporting method</li> <li>1.3. Pilot-test and review the assessment tool</li> <li>1.4. Prepare the assessment implementation plan</li> <li>1.5. Hold an inter-agency workshop (including relevant local governments) to discuss the assessment implementation plan</li> </ol>			<b>Inputs</b> ADB: \$400,000 <ul style="list-style-type: none"> <li>• Expert inputs (consultants and short-term resource persons): \$148,000</li> <li>• Equipment: \$10,000</li> <li>• Workshops: \$40,000</li> <li>• Assessment (including survey corps): \$146,000</li> <li>• Miscellaneous: \$16,000</li> </ul>

<b>Activities with Milestones</b>	
<p>2. Assessment of the implementation of the RHSCDP initial phase (10 months into the TA)</p> <p>2.1. Review and finalize the implementation plan of the assessment</p> <p>2.2. Select and train the interviewers and other persons involved in the assessment</p> <p>2.3. Prepare the logistics for the assessment</p> <p>2.4. Implement the assessment</p> <p>2.5. Process and analyze the data, and prepare the report of the assessment</p> <p>3. Policy recommendations for improved Government investment decisions for rural health (12 months into the TA)</p> <p>3.1. Prepare policy recommendations based on the assessment findings</p> <p>3.2. Hold an inter-agency workshop to discuss the draft policy recommendations</p> <p>3.3. Finalize policy recommendations and circulate to agencies concerned</p>	<ul style="list-style-type: none"> <li>• Contingencies: \$40,000</li> </ul> <p>Government: \$100,000</p> <ul style="list-style-type: none"> <li>• Office accommodation and venues for meetings: \$20,000</li> <li>• Remuneration and per diem of counterpart staff: \$50,000</li> <li>• Administrative support and local transport: \$30,000</li> </ul>

CHEI = China Health Economics Institute, MOH = Ministry of Health, NDRC = National Development and Reform Commission, RCMS = Rural Cooperative Medical System, RHSCDP = Rural Health Services Construction and Development Program, TA = technical assistance.

**COST ESTIMATES AND FINANCING PLAN**  
(\$'000)

Item	Total Cost
<b>A. Asian Development Bank Financing<sup>a</sup></b>	
1. Consultants	
a. Remuneration and Per Diem	
i. International Consultants	27.0
ii. National Consultants	80.0
iii. External Draft Reviews and Focused Inputs	15.0
b. International and Local Travel	20.0
c. Reports and Communications <sup>b</sup>	6.0
2. Equipment <sup>c</sup>	10.0
3. Assessment Implementation (survey, training, etc.)	146.0
4. Workshops	40.0
5. Miscellaneous Administration and Support Costs <sup>b</sup>	16.0
6. Contingencies	40.0
<b>Subtotal (A)</b>	<b>400.0</b>
<b>B. Government Financing</b>	
1. Office Accommodation and Venue for Meetings	20.0
2. Remuneration and Per Diem of Counterpart staff	50.0
3. Administrative Support and Local Transport	30.0
<b>Subtotal (B)</b>	<b>100.0</b>
<b>Total</b>	<b>500.0</b>

<sup>a</sup> Financed by Asian Development Bank's technical assistance funding program.

<sup>b</sup> Including translation costs.

<sup>c</sup> Including computers, printers, and other small office equipment to be procured using shopping procedure in accordance with ADB's *Procurement Guidelines* (2007, as amended from time to time). The equipment will be handed over to the Executing Agency upon completion of the technical assistance.

Note: Unless otherwise agreed by the Executing Agency, and with the exception of assistants for consultants, technical assistance funds for budget lines A2–A5 will be administered by the Implementing Agency.

Source: Asian Development Bank estimates.

## OUTLINE TERMS OF REFERENCE FOR CONSULTANTS

1. The technical assistance (TA) will require the services of four consultants for a total of 21.5 person-months, comprising three national consultants (20 person-months) specializing in (i) policy and evaluation, covering aspects related to public health management, health service delivery, human resource development, and pharmaceuticals; (ii) health economics and financing; and (iii) health infrastructure and equipment; and one international consultant (1.5 person-months). The national consultant on policy and evaluation will be the team leader of the group of consultants. The international consultant will serve as advisor to the Implementing Agency, China Health Economics Institute (CHEI), and the national consultants. In close consultation with the Executing Agency, the National Development and Reform Commission (NDRC), and CHEI, the consultants are responsible for effectively producing the TA's outputs, and for organizing and carrying out the TA activities, including any specific task as may be reasonably requested by NDRC and the Asian Development Bank (ADB).

2. The team leader will coordinate the consultant team and will report to CHEI and ADB, and as requested to NDRC. The consultants will be responsible for delivering three core outputs: (i) a tool for assessing the Rural Health Services Construction and Development Program (RHSCDP), (ii) an assessment of the implementation of the RHSCDP initial phase, and (iii) policy recommendations for improved Government investment decisions in rural health to be produced in Chinese and English. In addition to their specific duties, consultants will contribute to collective tasks such as preparing, facilitating, and following up on tasks for workshops and reports, and the preparation and on-site implementation of the assessment.

### **A. Team Leader and Senior Policy and Evaluation Specialist** (national, 10 person-months)

3. The team leader will have substantial experience in country-wide evaluation, policy analysis and development processes. He or she will also have experience in public health management, health service delivery, human resource development, rural health insurance, and pharmaceuticals. The specialist will have demonstrated superior ability in leading a team of experts implementing large-scale evaluations from the design phase to the production of the final report, organizing national workshops, and have excellent analytical and writing skills. The specialist will also be very familiar with current challenges in the health sector of the People's Republic of China (PRC), and have been involved in policy dialogue and development. A background in health economics and good English skills are also required.

4. The specialist will do the following tasks.

- (i) Serve as the team leader of the national and international consultants and report to CHEI and, as requested, to NDRC on all aspects of project implementation, ensuring timely implementation of all TA activities according to the terms of reference, and any subsequent instructions or guidance that may be provided by NDRC, CHEI and/or ADB.
- (ii) Submit to NDRC/CHEI and ADB an inception report at TA within 1 month after the beginning of TA implementation. This report will include (a) details of a coordination mechanism with CHEI; (b) a firm implementation plan, detailing each member's input (to be updated periodically as needed) into designing the assessment tool, implementing the assessment, preparing the report of the findings of the assessment and the formulation of policy recommendations for the RHSCDP implementation until 2010; (c) a proposal for the scope of the assessment; and (d) indicative outlines for each of the three output reports.

- (iii) Ensure a clear delineation of responsibilities among the members of the team and national government counterparts in implementing the TA, and assign tasks to the team of consultants in line with their terms of reference and as required to meet the objectives of the TA.
- (iv) Propose to ADB, supervise, and coordinate the use of (a) administrative assistants; (b) short-term data collectors and quality supervisors, survey trainers, and assistants for data entry and analysis; and (c) other short-term resource persons as needed.
- (v) Carry out a review of relevant national and international experiences on evaluation of health systems and draw the lessons for the PRC.
- (vi) Design the assessment tool by, among other things, (a) defining the objectives and scope of the assessment; (b) identifying information needs and users of the findings; and (c) determining data collection methods and instruments, quality control measures, data processing and analysis, and reporting method. The assessment tool should remain realistic and its design should take into account budgetary constraints, operational feasibility, and the deadline for submitting the assessment results to NDRC. Data collection methods will be determined after studying the nature of the information and data needed, and by choosing the most appropriate method, such as household and institutional surveys, case-studies, data extracted from routine information systems, and other quantitative and qualitative methods as required.
- (vii) Organize and oversee the pilot-testing of the different elements of the assessment tool and fine tune the tool based on the pilot results.
- (viii) Prepare instruction and training material required for the implementation of the assessment.
- (ix) Prepare an implementation manual and plan of the assessment, which will include (a) detailed activities and their timing; (b) resource persons and interviewers (information collectors) to recruit; and (c) detailed logistics plan of the assessment, sampling procedure, list of sampled survey units, quality control measures, data collection methods and instruments, data processing, and analysis and reporting methods (including format of the report).
- (x) Ensure the timely execution of all administrative tasks related to the implementation of the assessment. This will include overseeing selection of, training for, and inputs by, local information collectors and supervisors.
- (xi) Prepare the assessment report and draft policy recommendations and proposal for further Government investments in rural health based on the findings of the assessment.
- (xii) Prepare the inputs for the meeting of the policy review group as outlined in para. 13 of the main text.
- (xiii) Prepare and organize a minimum of three workshops to present and discuss each of the outputs of the TA, inviting potential users of the information produced by the assessment and, in association with international partners, present and discuss major elements of the TA (as detailed in the TA report).
- (xiv) Finalize the policy recommendations and investment proposals after reaching consensus, and support NDRC in formulating policy notes for endorsement and circulation to agencies concerned.
- (xv) Prepare a 10–15-page summary, targeting PRC key decision makers, of key findings regarding rural health, lessons in assessing the RHSCDP, and recommendations to the Government for strengthening rural health.

- (xvi) Ensure the timely submission of the inception, interim, draft final and final reports to the Government and ADB as described in the TA report. An outline of the final report is in Appendix 4.

5. The two other national consultants will strongly support the team leader in carrying out the tasks of the policy and evaluation specialist in designing, implementing and reporting on the assessment. The inputs of the consultants will consist of specific tasks related to their field of expertise and general tasks in designing, implementing and reporting on the assessment. The delineation of responsibility, the detailed tasks and the timing of the inputs of the consultants will be specified in the inception report and discussed during the TA launching workshop.

**B. Health Economics and Financing Specialist** (national, 6 person-months, intermittent)

6. The expert will have extensive familiarity with the PRC's public health financing systems and issues at central and local levels, including budgeting and allocation to local administration and health facilities; and experience in analyzing and formulating policies, having worked in government or in an attached policy research institute. Demonstrated skills in health insurance, social protection (especially for poor communities), planning, and evaluation methodology are strongly desired. Basic English skills will be an advantage.

**C. Health Infrastructure and Equipment Specialist** (national, 4 person-months, intermittent)

7. The expert will have extensive familiarity with the RHSCDP, especially with the detailed guidelines related to the implementation of the construction and equipment aspects. Skills in evaluating the functionality, quality, and safety of construction and equipment; the effect of their acquisition on users and patients; utilization levels of facilities and equipment; performance of maintenance systems, planning, design, and construction management are essential. Previous involvement in similar evaluation exercises is required.

8. In addition to the specific requirements outlined in paras. 6–7 above, the two national consultants will:

- (i) actively participate in the preparation, organization and implementation of the workshops described above;
- (ii) support the team leader and CHEI in preparing the inputs of the PRG meetings;
- (iii) meet ADB missions as requested.

9. Under the direction of the team leader and based on an agreed division of labor within the consultant team during the different phases of the TA, the two national consultants will also provide the following inputs linked to their field of expertise.

**1. Design Phase**

- (i) Study the RHSCDP, associated national and local policies, and general guidelines related to the experts' field of expertise;
- (ii) consult previous studies and evaluation reports on the PRC's rural health system;
- (iii) specify the objectives and evaluation questions that need to be answered, and specify the variables to be measured as they relate to the specific field of expertise;
- (iv) identify the data sources and propose the most cost-effective data collection methods or instruments in line with national requirements and international standards (whenever feasible);

- (v) contribute to the development of the sampling framework and identify sampling units (health facilities, local governments, health workers, farmers, etc.);
- (vi) make concrete proposals to ensure the relevance and the validity of the assessment;
- (vii) suggest quality-control measures;
- (viii) define the selection criteria of information collectors related to the specific requirements of the experts' field of expertise; and
- (ix) contribute to the development of training material for information collectors and to the overall assessment implementation plan.

## **2. Implementation Phase**

- (i) Take responsibility for, and ensure proper implementation of, the assessment plan for the specific area of responsibilities given to the expert as assigned by the team leader; and
- (ii) act as a general supervisor during the information collection phase to ensure quality measures are properly followed throughout the implementation of the assessment on-site.

## **3. Reporting Phase**

- (i) Process and analyze the qualitative information collected;
- (ii) discuss and interpret information produced in conjunction with the other consultants, CHEI and NDRC, and external resource persons as needed. And, in coordination with the team leader, refer technical questions to the international experts if needed;
- (iii) in close coordination with the team leader, and using a predefined format, report on the detailed findings of the assessment and prepare a set of relevant and realistic policy recommendations for the PRC;
- (iv) after internal agreement on the policy recommendations by the consultant team, CHEI, and NDRC, make concrete proposals on the implications of the recommendations on the further implementation of the RHSCDP; and
- (v) contribute to the summary, which will target PRC key decision makers.

### **D. Senior Evaluation Specialist** (international, 1.5 person-months, intermittent)

10. The international specialist will have global experience in evaluation systems, including substantial scientific publications, and be familiar with the PRC health sector. He or she will also demonstrate experience in policy processes and health economics. The specialist will serve as an advisor to CHEI and the national consultants during the duration of implementation of the TA. More specifically, the international expert will:

- (i) have international expertise in evaluation systems and contribute to identifying relevant lessons for the PRC;
- (ii) provide technical inputs into, and comment on the design of, the assessment tool;
- (iii) contribute to and review the formulation of the policy recommendations;
- (iv) review the summary which will be prepared at the end of the TA;
- (v) review the outputs submitted to ADB in English; and
- (vi) actively participate in the TA launching workshop (first workshop) and the dissemination workshop (third workshop).

## OUTLINE OF THE FINAL REPORT

- I. EXECUTIVE SUMMARY
- II. BEST PRACTICES IN EVALUATION SYSTEMS
  - A. Review of National and International Best Practices
  - B. Lessons for the People's Republic of China
- III. ASSESSMENT REPORT
  - A. Objectives and Scope of the Assessment
  - B. Information Needs and Users
  - C. Assessment Methods and Instruments
  - D. Quality Control Measures
  - E. Data Processing, Analysis, and Reporting Method
  - F. Limitations
  - G. Results of Pilot-Test
  - H. Assessment Implementation Plan
  - I. Report of Field Implementation
  - J. Assessment Findings
  - K. Recommendations and Proposal for Further Government Investments in Rural Health
- IV. RECOMMENDATIONS TO CENTRAL AND LOCAL GOVERNMENTS (INCLUDING FURTHER INVESTMENTS IN RURAL HEALTH)
- V. SUMMARY FOR KEY DECISION MAKERS<sup>1</sup>
  - A. Key Findings on Rural Health in the People's Republic of China
  - B. Lessons in Assessing and/or Reviewing Rural Health
  - C. Recommendations to the Government for Strengthening Rural Health

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<sup>1</sup> The summary for decision makers will be a stand-alone monograph.