

Do health sector reforms have their intended impacts? The World Bank's Health VIII project in Gansu province, China

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Abstract

This paper combines differences-in-differences with propensity score matching to estimate the impacts of a health reform project in China that combined supply-side interventions aimed at improving the effectiveness and quality of care with demand-side measures aimed at expanding health insurance and providing financial support to the very poor. Data from household, village and facility surveys suggest the project reduced out-of-pocket spending, and the incidence of catastrophic spending and impoverishment through health expenses. Little impact is detected on the use of services, and while the evidence points to the project reducing sickness days, the evidence on health outcomes is mixed.

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1. Introduction

Remarkably little is known about the impacts of developing-country health sector reforms on key outcomes, such as health status and protection against the financial risks associated with ill health. In part, this is simply a reflection of the fact that most policies and programs in the sector

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have not been subjected to rigorous evaluation.¹ But it also reflects the fact that the rigorous health sector evaluations to date have, for the most part, not been concerned with broad health sector reforms but rather with the impacts of inputs in the health production function, or with the effects on health outcomes of policy changes outside the health sector. Examples of the former include the paper by [Jalan and Ravallion \(2003\)](#), which looks at the effects of piped water on diarrheal disease among Indian children, and the paper by [Miguel and Kremer \(2004\)](#), which looks at the effects of deworming treatment in Kenya. Examples of the latter include [Case's \(2002\)](#) study of the effect of South Africa's old age pension program on the health of members of the pensioner's household, and the study by [Galiani et al. \(2005\)](#) of the effect on child mortality of Argentina's privatization of water services.

There are exceptions. [Gertler \(2004\)](#) reports the effects on health outcomes of a conditional cash transfer program in Mexico that required mothers to take their children for regular health checks to receive the cash supplement. [Newman et al. \(2002\)](#) report impacts on child mortality of health facility infrastructure investments in Bolivia. [Saadah et al. \(2001\)](#) report the impacts on utilization of Indonesia's health card introduced after the economic crisis of the late 1990s. [Wagstaff and Pradhan \(2005\)](#) examine the effects on health utilization and health outcomes of Vietnam's social health insurance program. And [Yip and Eggleston \(2001, 2004\)](#) examine the effects of provider payment reforms on Chinese hospitals. Such studies are, however, relatively few. Furthermore, all concern a relatively small policy adjustment—none looks at a system reform of the type where several changes are introduced together, possibly operating on the demand and supply sides simultaneously.^{2,3} And yet much of what national governments and donors do in the health sector involves making broad changes to health systems. Over the period 1995–2005, for example, 40% of the World Bank's health sector lending was classified as being directed at “[improving] health system performance”.⁴

One factor explaining the lack of impact evaluations of broad-brush health sector reforms is the fact that reforms are often implemented across the country simultaneously, substantially complicating the job of constructing a counterfactual. This paper reports the results of an impact evaluation of a World Bank-financed health sector reform project in China, known officially as the World Bank China Basic Health Service Project but more often referred to simply as ‘Health VIII’. In line with China's policy of piloting reforms locally before implementing them nationwide, Health VIII was implemented only in certain counties. China has nearly 3000 administrative units at county level, with an average of 450,000 people living in each.⁵ The Chinese county thus provides a reasonable sized population for a health reform pilot.

¹ A recent review ([Kapoor, 2002](#)) of impact evaluations conducted by the World Bank's independent Operations Evaluation Department (OED) over the last 25 years found that neither of the two health sector projects that had been evaluated had been done so in a rigorous way.

² As of April 27, 2005, the World Bank's impact evaluation database listed 41 impact evaluations of relevance to the health, nutrition and population sector. Not one of these fell into the category “Health Reform and Financing”. The database is available online at <http://www1.worldbank.org/prem/poverty/ie/evaluationdb.htm>.

³ See [Ravallion \(2005\)](#) for a recent review of impact evaluations, including those in the health sector.

⁴ In middle income countries eligible only for support from the International Bank for Reconstruction and Development (IBRD) rather than the International Development Association (IDA), the share rises to 50%. The classification system is not, it has to be acknowledged, watertight. Some projects concerning communicable disease control are listed under this subheading, though this may be due to the fact they contain components aimed at health system strengthening. It is also possible that some projects that involve health system reform get classified under non-health heads in the Bank's system, such as private sector development. My thanks to Lucia Kossarova for providing the breakdown of World Bank lending.

⁵ See 2005 China Statistical Yearbook.

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