Concept Paper for a Tibet Health Human Resource and Management Program

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Acronyms and Abbreviations

AusAID	Australian Agency for International Development
CDC	Centre for Disease Control and Prevention
HRD	Human Resource Development
TAR	Tibet Autonomous Region
THSSP	Tibet Health Sector Support Program
TRBH	Tibet Regional Bureau of Health

1. Introduction

The Tibet Autonomous Region (TAR) occupies more than one eighth of Chinese territory. It has large strategic significance because of its undeveloped mineral and water resources and its long southern border with Kashmir, India, Nepal, Bhutan and Burma. As the source of some of Asia's major rivers it is also a bellwether for climate change across Asia.

Despite its massive size, the TAR's inhospitable terrain (average elevation over 4000 metres above sea level) and climate means it has only 2.87 million people. Its remoteness also inhibits economic development with farmers and nomadic herders accounting for more than 70% of the total population[1]. There are only two urban centres with a population greater than 100,000 in all the TAR. Tibetans are therefore relatively poor. In 2008, average annual income per capita in rural households was RMB 3,251(less than A$530 at current exchange rates).[2] Between 2001 and 2008 almost 94% of TAR revenue was provided by the central government in Beijing.

2. Contextual Analysis

2.1 TAR Health Status

The TAR has the poorest health status of any part of China. In 2008 maternal mortality in the TAR was 234 per 100,000; in China overall it was 34.2 per 100,000.[3] The TAR hospital delivery rate was 44% while the Chinese national rate was 94.5%.[4] Reports suggest that in some remote areas malnutrition and stunting among children are common.

Health statistics in the TAR are improving but progress is limited by a health workforce that is too small, has low skill levels, and is located predominantly in the larger population centres. Relatively few health workers have bachelor degrees and service centres in rural and pastoral areas, where most Tibetans live, are poorly staffed and equipped.

2.2 Australian Government Support to the TAR

The Australian Government has provided assistance to the TAR since 1991. The Australian Agency for International Development (AusAID) and the Australian Agency for International Agricultural Research (ACIAR) have been the main implementers but in Australia there is a strong whole-of-government interest in the TAR's development. Assistance has covered research in agriculture and animal husbandry, small community development activities and scholarships.

[1] Tibet Statistical Year Book 2009 p.42
[2] Tibet Statistical Yearbook 2009 p.107
[3] China Health Statistics Yearbook 2009 p.197 and p.201
[4] China Health Statistics Year Book 2009 p.200

The most significant investments have all been by AusAID and include: a A$2.25 million primary health care and water supply program in Shigatse from 1997 to 2000; and a A$2.9 million Region-wide iodine deficiency disorders program from 2000 to 2003. Over the last six years AusAID's flagship in the TAR has been the A$19.3 million Tibet Health Sector Support Program (THSSP) which will finish in June 2010.

2.3 International Donors in the TAR

Australia's development cooperation relationship with the TAR of nearly 20 years standing has been matched by few other donors. In an environment characterised by political sensitivities, sometimes limited engagement with government counterparts, and high transaction costs – all of which can limit development effectiveness - the number of foreign development actors is dwindling.

Donors such as the European Union, the United Nations Development Program, Germany, Japan, and the Canada Fund support relatively small-scale, often localised activities in environment, poverty alleviation and primary health care. Many are implemented through international NGOs and are scheduled to end in 2010 and 2011. Donors cite difficulties in engaging with TAR counterpart agencies and increasing flows of national government finances for the TAR's development as reasons for not planning new interventions.

While Germany has probably committed more funds than Australia to the TAR over the last 10 years (through a variety of relatively small activities and programs targeting several provinces in Western China) no other donor project is as large as THSSP.

2.4 THSSP: ***Achievements and Main Lesson***

THSSP is essentially a capacity building program directed at making the TAR health system more effective. It has built managerial and clinical skills at systems, organizational and individual levels, by facilitating training for over 500 health staff. It has helped develop protocols and procedures in areas such as infection control and blood supply and it has introduced modern cost and performance management systems to several hospitals. The Deputy Director of the Tibet Regional Bureau of Health (TRBH) considers that THSSP has been instrumental in raising service delivery standards which have contributed to recent falls in infant and maternal mortality rates.

One of the most important achievements of THSSP is the reputation it has won from the TAR government as a practical and flexible partner that is sensitive to the Tibetan operating environment. However, as much as its work is recognised by the TRBH, THSSP has not been able to engage in a full partnership with TRBH leadership, nor reform the organisation's work practices significantly. So even where THSSP demonstration projects have clearly met priority health needs, TRBH has been slow to adopt and replicate them.

One reason for this may be that THSSP has worked in many different parts of the TAR health system, both vertically and horizontally, in response to requests for assistance. THSSP was designed to operate this way but it has meant that its energies and impact have been somewhat dispersed. A lesson of THSSP may be that a program that concentrates on fewer areas that are central to TRBH's mandate will have a greater chance of TRBH taking ownership over it.

3. The Rationale for a New Australian Health Program

3.1 Request for New Assistance

Because of THSSP's comparatively large scale and success, the TAR Government has made numerous requests that Australia stay engaged in the Tibetan health sector after the project ends. Long-term assistance to the TAR was also welcomed by the national government at the China-Australia High Level Consultations on Development Cooperation in April 2009. The Australian Government has been supportive of continued AusAID engagement in the TAR subject to development effectiveness considerations.

3.2 Threshold Criteria

A new program should meet three threshold criteria. The first is that it must be genuinely new. While recognising that continued engagement in TAR health would have to build on the achievements of THSSP, it would not be appropriate to extend THSSP again. It was extended for 15 months from April 2009 to June 2010 at TAR government request to reinforce the institutionalisation of its interventions within the health system. It is time to look afresh at working in the TAR through a full design process (that tests, among other things, the feasibility of the intervention proposed in this concept paper).

The second criterion is that a new program will have to be consistent with the *China Australia Development Cooperation Strategy*. The *Strategy* ends in 2010 and a new one will be agreed with the Chinese government by late this year. But it will not be finalised in time to guide the development of a new TAR program. There is no certainty as to what period the *Strategy* will cover and whether it will include programming in the TAR, so the timeframe for a new program should match - at least until the new *Strategy* is decided - existing contract commitments under the current bilateral program i.e. to around October 2012. If at the end of this year it is agreed that the new *Strategy* will extend to 2015, and if the Tibet program is consistent with it, then the program can be extended to 2015.

The third criterion is that a new program would have to be much smaller than THSSP. Quite apart from considerations about what level of resourcing a new Strategy might contain, when more central government money is coming into the TAR and donors are leaving because of concern about development effectiveness, it is not the time for Australia to commit another $19 million to a new program.

3.3 Outcome of Scoping Mission and Consultations

An AusAID scoping mission met a wide range of stakeholders at regional and prefectural level in the TAR in November 2009. Consultations continued in Beijing with the TRBH Deputy Director General, national ministries and other donors.

The mission was told repeatedly that the TAR receives significant fund transfers from the central government and the key challenge for the health sector is to manage those funds efficiently and effectively. It has to do this with a small number of staff whose managerial and technical skills are generally much lower than in the rest of China.

The Deputy Director General of TRBH said that the best way a new program could help the TAR resolve this problem would be to focus on human resource development (HRD), particularly at management levels. The TAR has its own *Strategic Human Resource Development Plan for the Health Sector (2006-2010)* and the central government has just released national *Guidelines on Human Resource Capacity Development in Health* (December 2009). TRBH is expected to implement these two documents and receives RMB 10 million ($A1.62 million) every year to do so. The TAR *Strategic Human Resource Development Plan for the Health Sector* is being implemented and each year a large number of health workers are recruited to work at grass-roots level health institutions. But the TRBH wants continued assistance to strengthen the health system through improvement to the management of its human resources including the professional development for health workers.

TRBH considers that THSSP's assistance in staff capacity building has been among the most valuable of its interventions. Its facilitation of university and vocational training and recognition of qualifications was among the most significant contribution to health HRD in the TAR over the last five years. Better trained staff are now starting to reform health management systems and this is translating into more efficient and higher quality service delivery outcomes. For example THSSP-mentored hospital management has contributed to higher hospital delivery rates in Lhasa municipality. But a lot more needs to be done.

TRBH agreed that a new AusAID program focussed on implementing national and TAR health HR plans and integrating them into the whole health system would be better placed to work in closer alignment with TRBH senior management than THSSP. It would be helping TRBH conduct its core business, which is managing human and financial resources so that the system produces better outcomes, particularly at county and township level and below. It would also be building on one of the most successful aspects of THSSP.

4. Program Description

4.1 Opportunity to Influence Change

The new program could be called the *Tibet Health Human Resource and Management Program.* It must be about management as well as HRD. In integrating HRD into the whole TAR health system, it will have to work across the intersection of HRD and change management. In helping to make decisions about who is trained, to do what, and why, the program will contribute to management of all aspects of the health system – overall management through TRBH; management of the preventative medicine network through the Centre for Disease Control and Prevention (CDC); and management of the clinical medicine network through the hospitals. In addition, HR decisions will have an impact on the internal management of these organisations themselves. In this way the program will be part of the health reform process in the TAR. It will be important to ensure in any design process that this opportunity to influence change is accepted by TAR counterparts. See **Risks** at 5.2 below.

4.2 Goal and Objectives of the Program

The **Goal** of the program is a *more efficiently managed health system delivering better quality services*.

Objective One is *a workforce better trained in health management, preventative and clinical skills*.

The first output is a comprehensive TAR HRD Plan, updated for the next Five Year Plan period (2011-2015) and consistent with the national *Guidelines* and the *Regional* Plan, which is budgeted and being implemented. The Plan is assigning existing staff to undergo training and recruiting new staff to fill gaps. Financial allocations for these purposes are based on rigorous assessment of needs at system, organisational and individual levels. Implementation of the Plan is being measured against its own monitoring and evaluation framework.

The second output is a well-functioning consultative mechanism, chaired by TRBH, that coordinates the contribution to the TAR HRD Plan that the TAR Government requires other agencies to make. The Regional Bureau of Education is revising curricula to meet TAR health workforce needs; the HR Centre of Tibet University is conducting skill surveys and needs assessments; and the Regional Bureau of HR is developing a policy for health staff placements with appropriate incentives and in accordance with the TAR HRD Plan.

Objective Two is *system and organisational reforms underway to improve service delivery.*

The first output is that the newly acquired skills are being utilised in the workplace: more and adequately trained staff are in place filling key

management and service delivery gaps such as inspection, specialised nursing and laboratory technicians.

The second output is that in one or two demonstration counties or townships which receive technical assistance and some funding from the new program: a HRD plan is in place with an adequate budget and is being used; and some evidence of system or organisational change is underway at the Bureau of Health, CDC or hospital as a result of the training the staff have received.

4.3 Anticipated Outcomes

Outcomes will be more evident if the program lasts for five years rather than just over two; however at Regional, county and township levels there should be:

- More qualified staff where they are needed
- Improved health management practices (showing that health funding is being used more efficiently) and
- A better range and quality of healthcare services available, particularly at county and township levels.

If the program lasts to 2015 it should be able to make some assessment, in the counties directly supported by the program, of its contribution to TAR government targets such as: By 2015: to bring the hospital delivery rate up to 60%, infant mortality rate below 20 per 1000 and maternal mortality rate below 200 per 100,000.[5]

HRD can be an effective entry point for building gender considerations and approaches into system reform, organisational and management planning, and individual capacity building, all of which will take place to some extent under the new program. The program will select indicators to measure progress in redressing female disadvantage in health service provision and access.

5. Delivery and Implementation

5.1 Program Management

The TRBH will lead the program since it is responsible for HRD in the TAR health sector. A program management committee will need to sit within TRBH, chaired by the Director General or a Deputy Director General and include the heads of the Planning and Finance Division, the Disease Control Division, the Rural Health Division and the Human Resource Management Division, as well as the Australian Team Leader and AusAID.

[5] TAR Health Promotion Action Plan for Farmers and Nomads (2009 - 2015)

Project technical assistance and funding will only be used to supplement activities that are being implemented by TRBH, CDCs or hospitals in accordance with the TAR Health HRD Plan. The project will help Tibetan agencies implement demonstration activities in one or two counties as a means of ensuring management reforms are taking place and performance is being measured in accordance with monitoring and evaluation plans. But the program will not implement activities itself. Nor will it fund any separate or parallel activities.

5.2 Risks

Counterparts

A shared vision of the project will have to be agreed early. Full involvement in the design process from the TAR Government (Regional Department of Commerce), the TRBH, the Regional CDC and hospitals will be essential but cannot be guaranteed. If this concept is approved post will have to work with TRBH to ensure it understands the expectations of a design mission, including counterpart commitment at the highest levels.

During the implementation of the program access to engaged and skilled counterparts, government data and even project sites may be limited. A stronger commitment to access than THSSP received will have to be negotiated with TRBH before any new program can start.

Scope to Influence Change

TRBH may initially see the program as playing a narrow HR role rather than contributing to management and organisational reform of the health system. To be effective this program must operate across the interface between HRD planning and health system management. It will not be viable if corralled into just organising training courses. This must be clearly understood and agreed with TRBH in the design process.

ATL Skill Set

An Australian team leader will need a track record of initiative in health HRD and management and organisational change, as well as persuasiveness, resilience and inter-cultural nous. He or she will be one of only a small handful of Westerners resident in Lhasa. Tenderers for a new program could have trouble finding someone with this skill set available.

Instability

THSSP and other donor projects experienced major disruption and delay after the social disturbances in Lhasa in March 2008. There is always a risk that this will be repeated.

Cost

Transaction costs for any activity in the TAR are high. Management and personnel costs (including short term technical assistance) take up more than 60% of the THSSP budget. This is not unusual in the TAR, given the difficulty in attracting technical advisers and program staff, the high cost of living and transport, and the time required to conform to TAR government procedural requirements.

Isolation
Other donors are leaving the TAR and by the end of 2011 Australia could be its only substantial bilateral donor. This limits possibilities of synergy and leverage from other initiatives and can adversely affect the morale of a project team.

Compatibility with New China-Australia Development Cooperation Strategy
The current AusAID China Country *Strategy* will be completed at the end of 2010. There is some possibility that a new program in TAR would not fit easily with the approach and the activity profile of a new *Strategy*. This would have to be managed.

Hand over from THSSP
A new program will need to take advantage of the good will and relationships built up by THSSP. If a new program cannot be designed, contracted and mobilised by the end of June in time for a handover, interim arrangements will have to be put in place to ensure THSSP assets and national staff are available to hand over when a new Australian team leader does arrive.

5.3 Resourcing Implications

AusAID resourcing in the vicinity of $5m would be needed for a program lasting from mid-2010 to October 2012. A program extending to end 2015 would require around $8 million. This would fund an Australian team leader and a small project team of nationals, access to predominantly national long and short term technical assistance, and an allocation of approximately 25% of the total budget for demonstration projects. These estimates are based on the management and implementation costs of THSSP, allowing for inflation, and also draw on the expenditure pattern of the *Xinjiang HIV/AIDS Prevention and Care Project (2002-2009)* which operated in a comparable environment to the TAR.

6. Conclusion

Health needs in the TAR are likely to remain high for years to come. A key to improved health outcomes is capacity building that targets management of the health system and tracks needs and performance down to county level where service delivery and access are most critical. The national *Guidance* and TAR *Health Human Resource Development Plan* provide the authority and direction for this and Beijing is providing much of the funding, but the TAR is asking for Australian expertise to help implement it. Australia is better placed in the TAR than any other donor to assist. However, the particularity of Tibet - not only the altitude and climate - can make it an inhospitable place to operate. The decision for peer review is whether continued Australian engagement in the TAR and the planned health outcomes of this concept outweigh the considerable risks of committing AusAID to work in that environment for up to another five years.