



Governance in Maternal and Child Health Care in Rural China

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Main Contents:

- Introduction
- The State Regulated Model (SRM): the model before the late 1970s
- The Dual Institution Model (DIM): the ongoing model
- The Participatory Governance Model (PGM): an alternative
- A Case of PGM in MCH
- Conclusion



Introduction

- **1. The Aim of the research:**

To explore the role the Participatory Governance Model can play in contributing to more effective governance in MCH, and finally to the improvement of MCH outcome in rural China.

■ 2. The objectives of the research:

- To review and assess two operational models of the MCH system (SRM and DIM) in the past and at present, and the major challenges for them;*
- To explore whether an alternative – the Participatory Governance Model (PGM) can tackle the problems of SRM and DIM in theory;*
- To operationalize the PGM model in the field of MCH in rural China;*
- To investigate empirically the contribution of PGM to the performance of MCH in selected counties in rural China;*
- To analyze the major influencing factors that could contribute to the successful practice of GPM in MCH in rural China;*

■ 3. The Key research questions:

Whether the Participatory Governance Model (PGM) could be used to tackle the major challenges that the MCH system is now facing in rural China?

By which pathways could PGM contribute to better performance of the MCH system, and finally to an improvement of MCH outcomes in rural China?

What are the potential influencing factors that might contribute to the successful application of the PGM model in MCH in rural China?



- **5. Theoretical Framework:**

Participatory Governance;
Civil Society;
Social Capital

- **6. Methodology:**

Case study
Expert interviews;
Document analysis;
Historical comparison

The State Regulated Model (SRM)

----the model in use before the late 1970s

- ❖ Major features of SRM before the late 1970s
- ❖ The operation of SRM
- ❖ The problems of SRM



1. Major features of SRM before the late 1970s:

Hierarchy in administration

Broad coverage of health services

Low cost to individual users

Low-level of the quality of provision of health services

Urban-rural difference in the financing mechanism

2. The operation of SRM:

Areas	Administrative Organizations	Financing Source
Urban	Provincial and city level Bureau of Health, MCH Organizations, and CDC	State funded
Rural	Local government; County level Bureau of Health, MCH center, Hospital; Commune Hospital; Production Brigade Health Center	County level: State funded; Below county level: Funded by the three tiers of the collective economy: commune, production brigade, production team



3. The problems of SRM:

Low level of funding

MCH supply cannot meet demand

Low efficiency of budget allocations

Low work incentives

Large inequality between urban and rural areas

The Dual Institution Model (DIM):

---- The ongoing model

- ❖ Why the reform?
- ❖ Operation of DIM
- ❖ Major challenges to DIM

1. Why the Reform?

Disadvantages of SRM

...(stated above)

Impact of economic reform

- The implementation of the household responsibility system
- A rapid disintegration of the rural collective economy
- A rapid collapse of RCMS (rural cooperative medical system)
- The emerging of market-oriented MCH provision

2. The operation of the DIM

(1) State Institution

Top-down administrative regulation

Single party (state) regulated system

Supply-side oriented MCH financing policy

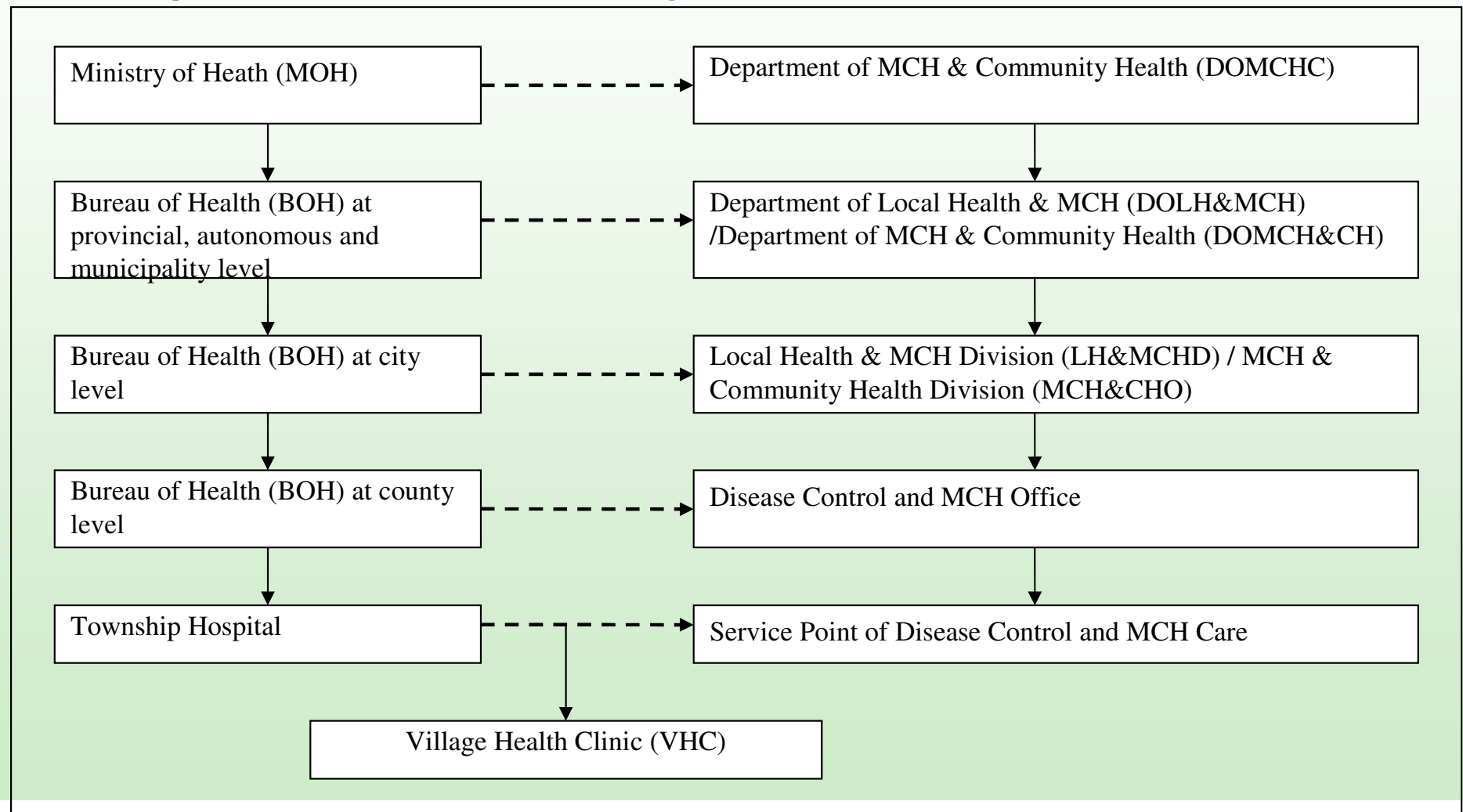
(2) Market Institution

The supply side

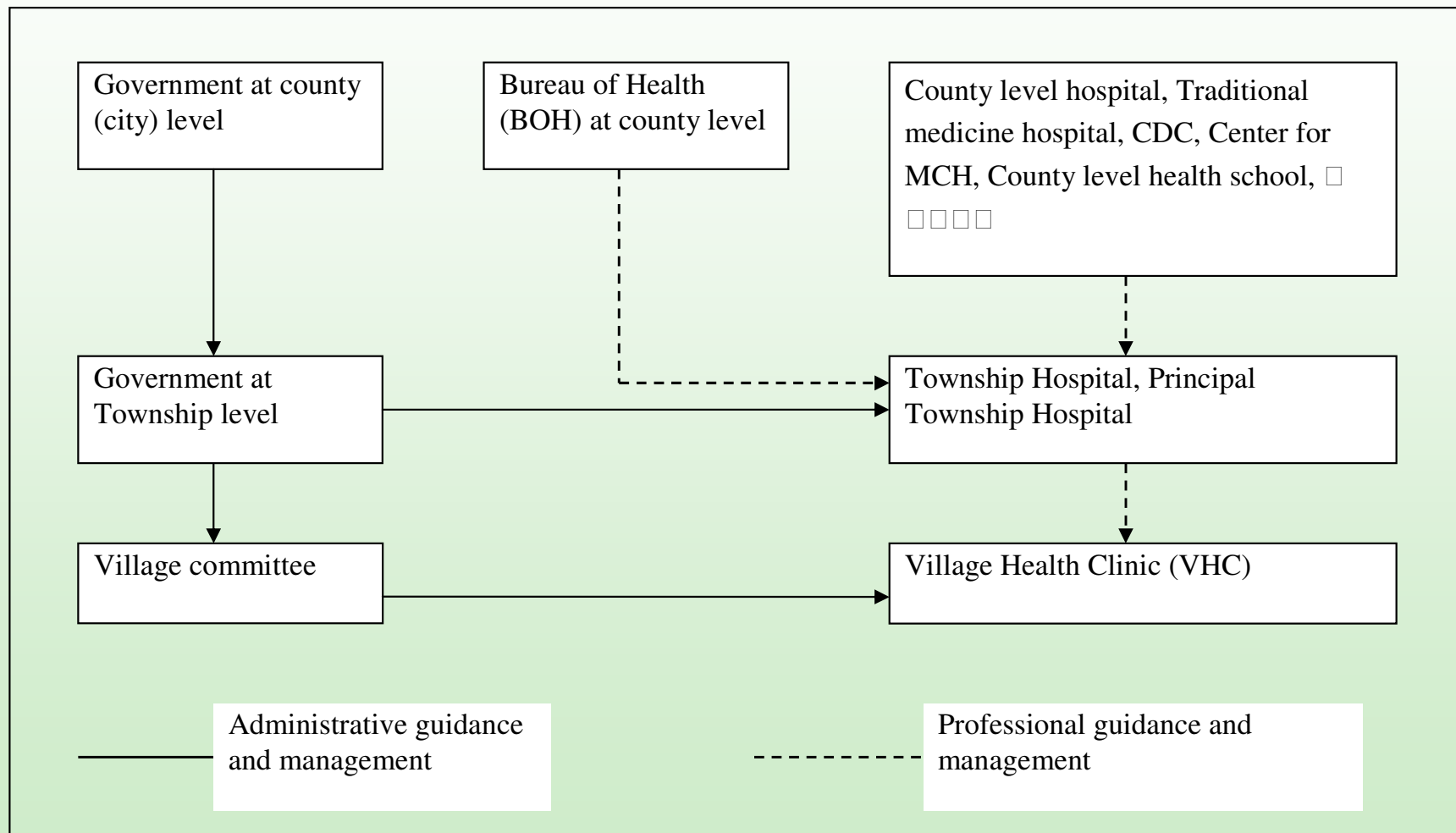
The demand side

(1) State Institution

The top-down administrative regulation structure of the health sector



The three-tier rural health care service network



Supply-side oriented MCH financing policy

Division of financial responsibility for different levels of government

Authorities	Responsibility in General	Responsibility in MCH
Central Government	Project money	The “Jiangxiao program”; The special funds for the rural MCH system construction; The special central government subsidy for NRCMS for the least developed areas, etc.
Province	Health budget for province-level institutions;	Staff expenditure and public expenditure for MCH institutions
	Project money	The special funds for MCH within the province
	Matching funds for the upper level project money	Province-level subsidies for NRCMS; Province-level Subsidies for the “Jiangxiao” program, etc.
City	Health budget for city-level institutions;	Staff expenditure and public expenditure for MCH institution
	Matching funds for the upper level project money	City-level subsidies for NRCMS; City-level subsidies for the “Jiangxiao” program, etc.

Division of financial responsibility for different levels of government (con't)

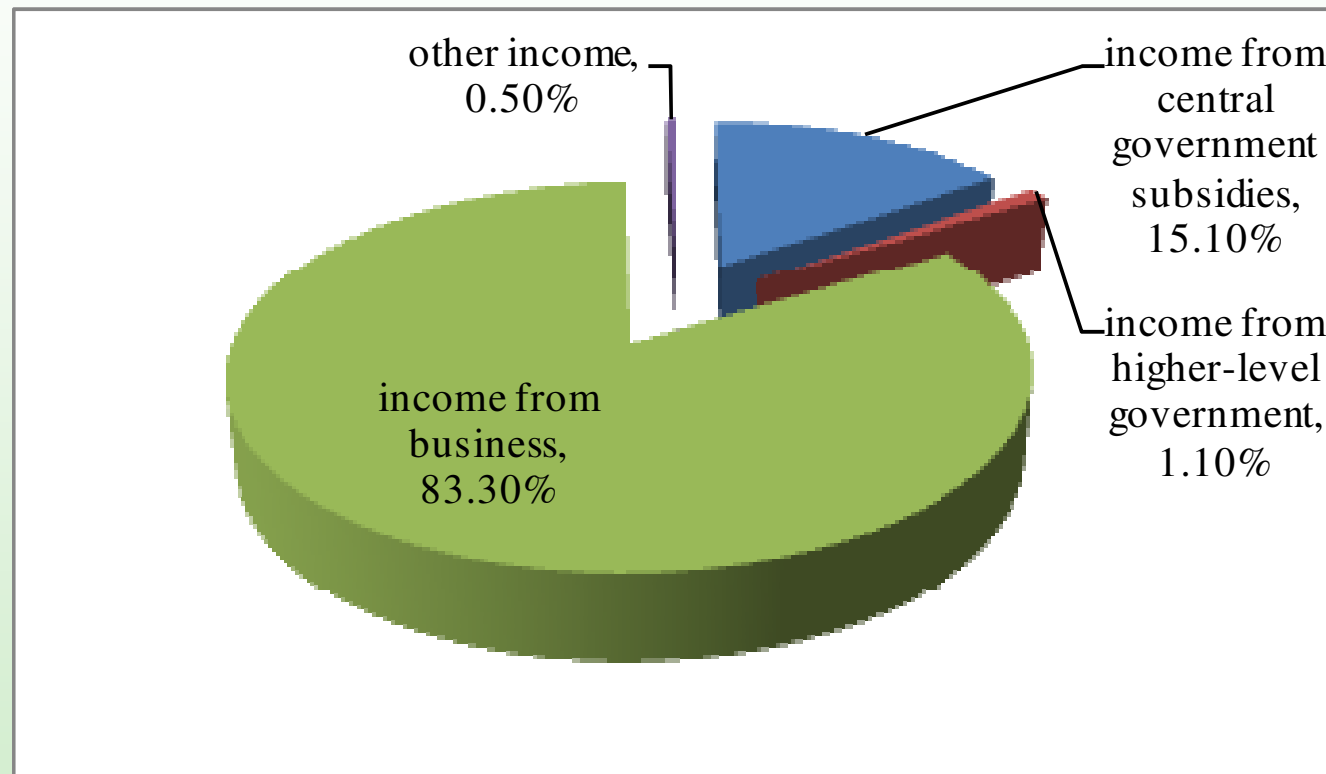
Authorities	Responsibility in General	Responsibility in MCH
County	Health budget for county-level institutions;	Staff expenditure and public expenditure for MCH institutions
	Matching funds for upper-level project money	County-level subsidies for NRCMS; Subsidies for the “Jiangxiao” program etc.
	Partial health budget for township-level hospital	MCH Staff expenditure
Township/ Street	Subsidies for the township/street-level MCH staff	The subsidies for MCH, Preventive Care and birth control staff;
	Part of the public expenditure;	MCH public expenditure (Eastern region is quite good, central/western China is basically unsubsidized.)
	Subsidies for Village Clinics and community clinics.	MCH worker in Village or community clinics (Very little subsidization)

(2) The Market Institution

The supply side (MCH organizations)

Income Source	Clarification	Share (2005)
Income from providing service at a market price (Business Income)	Users' out-of-pocket payment for MCH service	83.30%
Government Subsidization	Subsidy from Department of Finance at different levels directly or indirectly (i.e. through the responsible health department)	15.10%
Subsidization from other higher level (non central) health institutions	Non fiscal budget of financial assistance coming from the higher level health organizations	1.10%
Others	/	0.50%

Break-down of sources of income for MCH institutions in 2005



Source: Calculated by the data in table 4-8-1 of China Health Statistical Yearbook 2006, MOH.

The demand side (MCH service users):

Out-of-pocket payment:

- Maternal health care
- Child health care
- Birth delivery

Some re-imburement channels in rural areas:

- NRCMS (some regions provide partial re-imburement for birth delivery in the system of NRCMS)
- Jiangxiao Program (only in the program counties of the least developed areas where Jiangxiao Program is implemented)

3. Challenges to DIM

(1) Government Failure:

Unable to provide sufficient funds for public MCH services

Unable to tackle the problem of increasing inequality within the MCH system

Lack of accountability

Lack of transparency

(2) Market Failure:

- Unable to provide essential MCH service package (EMCHSP) to everyone who are entitled to it

Access to the EMCHSP is the minimal requirement for meeting the principle of equity in MCH. However, due to inequality in social economic status and other environmental factors, not all users can access the EMCHSP under market provision.

- Unable to solve the incentive problem within MCH organizations

With market provision, people who work on clinical care usually get higher income, which in turn help to generate higher profit for the MCH organizations where they work. Therefore, people would have higher incentives to do clinical care, rather than MCH care.



The Participatory Governance Model (PGM): ---- *An alternative*

- PGM in theory
- Linking PGM to the MCH in rural China
- The advantage of PGM in MCH

1. PGM in theory

(1) A broad definition of participatory governance (PG)

Institutions and processes, both formal and informal, which provide for the interaction of the state with a range of other agents or stakeholders affected by the activities of government in attempts to engage with real problems and seek practicable solutions (Vasudha & Gerry, 2009)

(2) The history of PG: six theoretical influences

Liberal democracy, Communitarianism, Populism, Freirean Empowerment, Neoliberalism, and New Institutionalism

(3) Why PG

Governance “merges as an attractive alternative when there are manifest state failures and/or market failures” (Schmitter, 2002).

(4) The Function of PG

- **Proper functioning of democracy**
(through the accountability of government and fair representation);
- **The deepening and broadening of democracy**
(whether through direct participation, reduction of distance between the elites and the majority, or indeed, changes in a status quo of power);
- **Empowerment**
(through realizing individual freedom and fulfilling the human agency);
- **The Contestation of domination**
(through electoral competition, community-based action, conscientisation);
- **Curbing government excesses**
(through the construction of individuals as beneficiaries, clients, and users);
- **An effective way to tackle the collection action problem**
(through community-based participatory development).



(5) The core of PG

- ◆ Collaboration of the “public” with the state
- ◆ Horizontal interaction
- ◆ Pressure groups
- ◆ Decision making + Policy implementation

2. Linking PGM to the MCH in rural China

(1) Dimensions:

- ◆ Participatory decision making
- ◆ Participatory financing
- ◆ Participatory management
- ◆ Participatory evaluation

(2) Participants:

A matrix of stakeholders in MCH, including:

- The government at different levels
- The service delivery organizations at different levels
- NGOs working on MCH
- Enterprises having relation to MCH
- Village community
- Representatives of users' group
- Media

(3) Institutions:

- A Standing Committee for MCH decision making, comprised by all stakeholders in MCH;
- A social cooperative funding system for MCH, jointly established by the public and the private;
- Community-based actions to tackle the problems within the community itself;
- A bottom-up training mechanism for MCH human resources
- Practical tools for the “public” to conduct monitoring and evaluation for MCH;

3. Potential advantages of PGM in MCH in rural China

- To improve accountability of the government;
- To bring about more transparent decision making and budget using processes;
- To mobilize more social funds for MCH;
- To help ensure wider access to essential MCH service package;
- To help the most vulnerable communities /families/ individuals to tackle their MCH problem through community based capacity building;
- To achieve sustainable development in MCH human resources at the community level.
- ...

A Successful Case of PGM in MCH

- Background
- Major Activities
- Examples
- Effects

1. Background:

- **County:** Jianchuan (in the least developed province of Yunnan)
- **Project:** China-Canada MCH Cooperative Project
- **Funding:** CIDA (Canadian International Development Agency),
Yunnan government (provincial, city, and county level)
- **Time period:** 1997-2003
- **Project aim:** improving local MCH outcomes;
improving performance of the local MCH system

2. Major Activities:

Participatory training for county/township/village level MCH workers;

Participatory health education in rural community;

Participatory community activities (eg. “jiaose banyan, □□□□”);

Participatory monitoring and evaluation;

Provision of necessary MCH facilities;

Establishment of twelve Child Health Care Centers

3. Examples:

(1) The establishment of the Leading Team for Emergency Referral for MCH in Xizhong Village

- Release village document for the establishment of the team;
- The team is comprised by the village head, village doctors, village worker for family planning; and five other villagers;
- Set up the objectives of the team;
- Members of the team will be responsible for sending the users to township/county hospital in emergency;
- The village committee will pay 4 RMB per person as compensation to the member who helped sending the user to the hospital.

(2) Participatory monitoring and evaluation in Xizhong Village

Participants: Head of Township Hospital; 3 Heads of Xizhong village;
4 old ladies; 8 young ladies; and village doctor

Process: Self-evaluation → Summarizing → Policy recommendation

Activities:

--Villager Group:

Self evaluate the knowledge about MCH, the service that the village doctor has provided; the way of health education that they like; the effect of the current health education methods; the expectation of the village doctor...

--Group of the Heads of Village:

Self evaluate the support they have given for the village doctor; the difficulties that the village doctor is facing while she does MCH work; the services the village doctor is providing; the expectation for the village doctor..

--Village doctor:

Self evaluate the services she is providing; factors influencing villagers health; the way to solve the village MCH problem; the help she has gotten in the village; the expectation for the future; the effect of current health education;

(3) Participatory MCH human resource training

Levels:

- County Level
- Township level
- Village level MCH doctors
- Village level home delivery workers

Activities:

- Participatory class training
- Participatory community practice
- Participatory editing of training materials

(4) The effects of PGM to the MCH outcome

- Rate of birth delivery with new scientific methods:
46.86% in 1996 to 94.65% in 2001
- Hospital delivery rate:
39.50% in 1996 to 57.47% in 2001
- Coverage rate of child care for under 7 year old:
31.22% in 1996 to 67.43% in 2001
- Coverage rate of maternal care:
53.87% in 1996 to 88.84% in 2001
- Rate of systematic management for pregnant women:
33.83% in 1996 to 70.22% in 2001

Conclusion

- In theory, PGM is useful for dealing with government failure and market failure in problem-solving/conflict-solving;
- With a prudential design, PGM could be applied to the MCH governance in rural China;
- There have already been sprouts of PGM in local community in rural China;
- Evidence thus far shows the positive effect of PGM on the MCH outcome in the county studied;
- PGM could be an effective model for achieving better governance performance and better MCH performance in rural China.



Thank you!

Comments are welcome!