The Functions of Participation in a Village-Based Health Pre-Payment Scheme

What Can Participation Actually Do?

Andreas Wilkes

IDS Bulletin Vol 31 No 1 2000

1 Introduction

When communities identify their own problems, make all key decisions on goals and means, and mobilise to carry out their own plans, this is commonly recognised as representing 'a high degree of participation'. This is often shown diagrammatically at the top end of a 'ladder of participation', in contrast to lesser degrees of participation, such as 'consultation', 'delegation', or 'passive participation' (e.g. CPGUKAN 1991; Pretty *et al.* 1994). In the experience of the author, such criteria are widely accepted among development workers. This article analyses a participatory evaluation of one village-based health pre-payment scheme in a poor village in China. The main focus of the article is on issues concerning participation ***at a micro-level***, both in the scheme and in the evaluation. Analysis of the process points to the influence that different interests, different channels for voicing interests, and unequal power relations have in determining the outcome of decision-making processes. The article concludes that participation, as widely understood by development workers, is not a sufficient condition for ensuring the accountability of health scheme managers and providers at the micro-level.

Section 2 provides an introduction to and evaluation of the health pre-payment scheme. Section 3 analyses the key issues revealed by the evaluation in terms of the impact of different modes of participation on the outcomes of decision-making processes. The conclusions are presented in the final section.

2 Background to the Laba Village Community Medical Scheme

Laba village is an administrative unit consisting of four hamlets, close to the border with Myanmar. Laba village is inhabited by 2,595 people, all of whom are Lahu, an ethnic minority. Most of the villagers are Christian, and regularly attend church services. The village is 18 km. from the nearest township, where there is a health centre, a journey that takes a half-day walk. There has been a formal village doctor since the 1960s when Zhang Zhaqi, a traditional Lahu herbal doctor, was trained in simple Western medicine as a 'barefoot doctor'. In the 1970s and early 1980s two other health workers were trained (one male and one female), who are now responsible for prevention and

immunisation, and maternal and child health services respectively within the administrative village. They also provide simple curative treatments in the outlying hamlets where they live.

During the Cultural Revolution, Laba village implemented a health pre-payment scheme (referred to as a Cooperative Medical Scheme, or CMS) like almost all other villages in China. The CMS provided free outpatient treatments to villagers. Unlike schemes in most other villages in China, the CMS in Laba survived after the introduction of the household responsibility system in the early 1980s.[1] Until the mid-nineties, each villager still contributed two yuan each year for the CMS. But with rising drug prices, the Laba CMS could no longer sustain service provision at a level of subsidy satisfactory to villagers.

Laba village began implementing income generation projects funded by Oxfam Hong Kong in the early 1990s. In 1995, Oxfam HK provided funds for villagers to establish a traditional medicinal herb plantation. In 1996, villagers expressed their interest to Oxfam HK in reviving the CMS. Among other support, Oxfam HK provided 10,000 yuan as a seed fund to purchase drugs.[2] Two additional newly trained health workers began to serve in the village clinic under the direction of Zhang Zhaqi, who became also 'senior advisor' and *de facto* head of the CMS Fund Management Committee. With the formulation of a series of new management regulations in Spring 1998, the Laba CMS was implemented by villagers under the direction of the committee and village cadres. Details of the new scheme are outlined in Box 1.

2.1 The participatory evaluation

In March 1998, the author accompanied Oxfam HK staff to investigate the CMS project in Laba village. Although it was clear that the villagers welcomed the CMS, some issues were raised. After several discussions, the Health and Ethnic Studies Group of the Yunnan Participatory Rural Appraisal (PRA) Network developed a proposal with Oxfam HK to carry out a participatory evaluation together with Laba CMS fund committee, the villagers and other relevant agencies. The evaluation took place in late 1998.

The first activity of the evaluation was to hold discussions with around thirty village and brigade cadres[3] representing villagers in each of the four hamlets. The cadres raised several issues and problems with the CMS. These issues included: whether the level of household contributions was sufficient, problems with drug stock management, and the level of technical skills of the health workers. On the basis of these discussions, the village cadres suggested several objectives for the evaluation and asked the evaluation team to help them meet the objectives. Fortunately, the objectives set by the cadres largely overlapped with those set by Oxfam, and so could be worked on together.

The evaluation activities in the village lasted eight days, and activities took place in each of the four hamlets. In each hamlet, separate group discussions were held with men and women. Semi-structured interviews were undertaken with members of poor households about ability and willingness to pay the membership fees, and with village health workers about their medical knowledge, practices and training needs. A simple household questionnaire was designed and administered in each of the hamlets in order to estimate utilisation rates and the level of funds needed. Evaluation team members also calculated the average cost per visit through a review of past prescription forms in order to estimate CMS fund needs together with the results of the questionnaire.

The findings of these activities were presented at open meetings held in each hamlet. During these meetings, the evaluators presented issues raised by the men and women's groups, members of poor households and service providers. The villagers were asked to validate which issues were problems that should be discussed further. Those issues that were validated by the ordinary villagers were then presented to a second meeting of the village and brigade cadres. The cadres were again asked to validate issues that should be resolved, and were facilitated to formulate an action plan of who would be responsible for discussing and deciding solutions to the issues.[4] Of the twelve actions listed in the action plan, ten were to be resolved by villagers, through discussions organised by the cadres, with final decisions either to be made by the cadres or the CMS Fund Management Committee. The action plan has since been fully implemented by the villagers.[5]
According to widely used criteria, the scheme and evaluation activities represent examples of 'high

Box 1: Description of Laba village Cooperative Medical Scheme

SOURCES OF FUNDS

Villagers

- Da Laba Hamlet: Villagers contribute Y5 per person, plus 300 kg. of grain grown on collective land
- Other hamlets: Y6 per person.

County Health Bureau (CHB)

- Initial grant of Y1000 used for the purchase of drugs and simple equipment. These funds came from earmarked funds for the national CMS policy[6]
- Funds for training of 2 new Village Health Workers (VHWs)
- The CHB pays a cash subsidy of Y20 per month to all VHWs in the county
- The CHB pays for all vaccines.

Oxfam HK

- Y25,000 towards the acquisition of the clinic building from the Marketing and Supply Cooperative
- Y10,000 provided for a drug fund, used to purchase 44 types of Western drug (before Oxfam funding, drug supplies were provided by the doctor himself out of his own pocket).

Township government

- Y7000 towards acquisition of clinic building.

SERVICES COVERED BY MEMBERSHIP

(a) Outpatient clinic services: Drug costs at the central clinic and those provided by the two additional VHWs operating in the outlying hamlets are fully reimbursed. Villagers have to pay out of pocket for the registration fee (Y0.20) and injection fee (Y0.50). These fees are in accordance with the standard fees set by the Provincial Health Dept.

(b) Immunisations: No special fund allocations are made for immunisations from the CMS. Vaccine costs are borne by the CHB. Immunisations incur the injection fee.

SERVICES NOT COVERED BY MEMBERSHIP

(a) MCH services: Ante- and post-natal check-ups are not included in the scheme. Neither are they provided by any of the health workers, since they lack the skills to do so. The township health centre is supposed to send MCH staff to the villages to assist in providing consultations and checks, but as they have no funds for this they rarely do so.

(b) Non-essential drugs: Villagers must pay out-of-pocket for non-essential drugs such as intravenous tonics.

PAYMENT OF SERVICE PROVIDERS

- The 2 VHWs receive 150 kg. of grain each per year, and a cash subsidy of Y20 paid by the CHB. The VHWs also earn Y30 per month paid by the CMS fund. This is taken from the fees paid by villagers for registration and injection. (Fees earned in excess of this are paid to the CMS Fund.)

COOPERATIVE MEDICAL SCHEME MANAGEMENT

CMS management regulations detail the sources of fund revenue, benefits of membership, composition of the management committee, their remuneration, and management procedures. The Fund Management Committee comprises a director, deputy director, accountant, cashier and senior advisor.

levels of community participation'. The initiative to revive the scheme came from community members, the major decisions were made by them, and villagers were responsible for implementing their own scheme with the support of external resources. Likewise, the evaluation aimed to meet objectives set by villagers' representatives, large numbers of villagers in each hamlet were involved in the discussions, and decisions resulting from the evaluation were made and implemented by villagers themselves.

3 Participation in the Scheme and in the Evaluation

Three key issues emerging from the evaluation relate to the impact of different modes of participation on decision-making outcomes: lack of representation in decision-making structures, lack of exemptions for poor households and lack of services for women's special needs. This section focuses on explaining why these issues had not been resolved

prior to the evaluation, why they were raised in the evaluation (rather than raised during the implementation and management process), and why the evaluation led to different decision-making outcomes about the same issues.[7]

3.1 Lack of representation in decision-making structures

The origin of the composition of decision-making structures can be traced from the origins of the scheme as a whole. The idea of reviving the CMS was raised by the doctor in discussions with Oxfam staff, with whom he was already co-operating in growing medicinal plants. The doctor's primary motivation in seeking Oxfam's support was to secure additional financial and human resources for health service provision in the village. An outline proposal was devised in discussions between the doctor, village cadres and Oxfam staff.

Following approval of the proposal, detailed design was undertaken, the results of which were the CMS management regulations. These were worked out largely between the doctor and village cadres with the support of Oxfam staff. The management regulations included the composition of the CMS Fund Management Committee. This included the herbal doctor (who is also the village pastor), the village leader (who is son of the herbal doctor), deputy village leader (who reports to the village leader), and the two health workers (one of whom was the herbal doctor's grandson).

When asked about the villagers' role in preparation for the CMS, the doctor emphasised propaganda activities through the church, where he is also pastor, and visits to households to persuade them to join. Almost all villagers joined the scheme.[8] Membership contributions were collected by the brigade cadres in each hamlet at the end of April, when most households have cash at hand from the sale of tea. Grain payments for the health workers' remuneration were also collected by brigade cadres along with the other grain taxes paid to the state.

However, during the evaluation, villagers in one outlying hamlet objected to the composition of the committee on the grounds that current members were all from the main hamlet in the village. When raised in the action-planning meeting, this issue was validated by the cadres and Fund Management Committee and later rectified by including representatives from each hamlet. A related issue raised by many villagers in the evaluation was that the CMS accounts had never been publicly announced. Although no villagers said that they suspected improper use of funds, they readily expressed their discomfort about the lack of transparency. Again, when the issue was raised by evaluation team members in the final meeting, the cadres and Fund Committee members decided that the fund accounts should be regularly announced in the churches in each hamlet. Of particular concern to the external evaluation team was the fact that the herbal doctor and the clinic health worker were also Fund Committee members, and thus were responsible for monitoring their own performance. However, the villagers did not find this a problem, since, as they said, these two people were well respected and trustworthy.

Because the Fund Committee members were also influential figures in other spheres of village life, ordinary villagers lacked channels through which to raise these issues concerning representation and accountability.[9] For example, since the villagers lacked channels to express their concerns, although public announcement of the accounts was stipulated in the management regulations, power relations within the village and surrounding the CMS made this impossible to enforce. However, the process of eliciting and validating concerns followed during the evaluation activities in each hamlet enabled the villagers to have a voice. This voice was then represented to the cadres and Fund Committee by the evaluation team at the final meeting. This form of representation served to inform the cadres and committee that ordinary villagers (as well as Oxfam staff who were part of the team) were concerned about the issue, which prompted them to agree to announce accounts regularly.[10]

3.2 Lack of exemptions for poor households

Prior to the evaluation, poor households were not granted exemption from membership fees. In the early stages of the project, the main clique involved was primarily interested in mobilising additional resources to support service provision. Additionally, the poor were not represented among the clique. The herbal doctor/pastor and cadres specially visited poor households to discuss membership, with the aim of

persuading them to join. Some members of poor households expressed their objection (i.e. they had 'voice'), but were in no position to influence the outcome of decisions, except by not joining the scheme (i.e. 'exit'), which was the option chosen by some.

During the evaluation, however, both poor and non-poor villagers recognised that the lack of exemptions was an issue. When raised in the final action-planning meeting by the evaluation team members, the village cadres accepted that the issue was valid, and subsequent discussions among villagers resulted in them being given partial exemptions. Additional resources had already been secured when this issue was presented, and the issue could be resolved in this manner because this did not contradict the interests of the cadres and Fund Committee members.

3.3 Lack of services for women's special needs

The evaluation also found that the scheme did not meet women's special needs in terms of services provided. The health workers were unable to provide treatment for RTIs that were said by both men and women to be particularly common, and were unable to provide ante- and post-natal check-ups, even though related medical incidents were not infrequent. The frequency of these conditions was also common knowledge to members of the Fund Committee and the herbal doctor, but relevant training for the health workers was never raised as an issue during the project design. Although not contradictory to their interests, the expansion and improvement of services to include more and better services for women's diseases were not among the immediate concerns of those involved in initiating and designing the scheme. During the evaluation, when raised in group discussions by the questioning of the evaluation team members, these issues were quickly validated (accompanied initially by embarrassed giggling) by both male and female villagers. Subsequent discussions in larger meetings also validated these issues, and at the final action-planning meeting, the importance of this issue was stressed by the male village cadres themselves.

In contrast to the poor households who were able to voice their objections, prior to the evaluation, women had no channel through which to voice their needs. Since the clique and Fund Committee were the main actors in initiating and designing the scheme, the omission of these groups (or their representation) contributed to the omission of these issues in the scheme's design and activities. But when raised by the external evaluation team (which included Oxfam staff), these issues were validated and efforts were made to address them.

4 Conclusion

The case study reported in this article demonstrates that it is possible for a 'community' to be making all the decisions regarding a health scheme, but for there to be no accountability to service users. In this case, the initiation of the scheme was motivated by a desire to increase the resources available for health service provision (as much as utilisation) in the village. This reflected primarily the interests of the herbal doctor and the clique over which he had influence. Without this interest, the scheme may never have been re-established.[11] Furthermore, it would have been difficult to mobilise financial and labour resources within the village without enlisting the support of the village cadres. However, this constellation of interests also led to the omission of marginal interest groups' concerns in the design of the scheme, as well as its 'closure' to feedback and criticism from scheme members.

Initiation and implementation of the scheme through dominant power structures within the community may have the advantage of reducing the transaction costs of negotiation and decision-making. Indeed, many ordinary villagers appear to have been willing to submit to non-representative forms of decision-making, since this also minimised the transaction costs incurred by them. However, the structures and processes of decision-making did not enable accountability to be enforced. Hence, the evaluation found that certain marginal groups had significant unmet needs. In contrast, evaluation by external actors, which included Oxfam staff, enabled the opinions of marginal groups and ordinary villagers to influence the subsequent decisions of the Fund Committee and cadres. Thus, representation of these groups' voice by (relatively powerful) external actors had a positive effect on the ability of the marginal groups' voice to influence the outcomes of decision-making processes.

Some generalised lessons can be drawn from this case study by examining what goes on inside partic-

ipatory decision-making processes. Participation in decision-making can be understood as a process involving both 'voice' and 'influence'. Voice means to be able to share knowledge or opinions relevant to a certain decision. Voice can improve the technical quality of some decisions, and potentially can improve the fairness of some interest-related decisions. Having influence means being able to effectively contribute to the outcome of a decision-making process in order to secure one's own interests.

However, the case study showed that having voice is not a sufficient condition for influencing the outcomes of a decision, since the outcomes of a decision-making process are often more determined by interests and relative power. Influence may be achieved either through direct participation or indirect forms of participation, such as representation. However, it is not necessary that either direct or indirect (representative) participation leads to effective exercise of influence. Under the structures of existing power relations, it may not be possible to institutionalise channels for exercising either voice or influence if decisions are made by 'the community' alone. In the absence of channels for exercising voice it is likely that the interests of marginal groups will be ignored. And if marginal groups find their interests and needs are not met, they may choose 'exit' as a form of (non-)participation.

These lessons lead us back to a common critique of popular usage of the term 'participation', namely that the concept of 'a homogeneous community' needs to be deconstructed, and more attention paid to power relations between groups within the community. Formulations of 'ladders of participation' have been critiqued for similar reasons. While these critiques are by no means new, they should not be forgotten in the present discussions about the relationship between participation and accountability in health services.

Notes

1. Discussions of the health system in China can be found in recent publications of the IDS Health and Social Change Programme. They are not summarised here as the scheme operates virtually independently of the public health system.
2. This is referred to locally as a 'revolving drug fund' in the sense that drugs are restocked using funds from annual household contributions.
3. Village and brigade cadres are leaders at the administrative village and natural village or hamlet level. They are mostly elected by villagers but also represent the government in many dealings with villagers, such as tax collection, mobilisation of labour etc. There is a women's cadre in each hamlet.
4. The evaluation findings and details of the action plan are not presented in this article except where relevant to the argument.
5. No details are available of how the discussions were undertaken in practice.
6. National policy now requires that by the year 2000 80% of villages have a CMS scheme.
7. Ideally, this section would be based on ethnographic data. In their absence, it is based on the author's interpretation of the situation, from observations, interviews and other available information.
8. The few exceptions included several poor households, who, despite visits from the herbal doctor/pastor to persuade them, were unwilling to pay, claiming that they were unable to pay.
9. From the perspective of new institutional economics, repeated interactions or multiple social roles can increase trust and/or increase costs of non-compliance, thus offering economies of scale in transacting, or negotiating and arriving at decisions.
10. Due to lack of information it is not known with certainty that the committee has since actually announced the accounts.
11. The creation of new institutions also incurs transaction costs. The initiators of new institutional arrangements would be motivated to maximise the gains from the new arrangement while minimising the costs of negotiation and decision-making involved.

References

CPGUKAN (Community Participation Group of the United Kingdom for All Network), 'Community Participation for Health for All', cited in R. Loewnson, 1999, 'Public participation in health systems in Zimbabwe', paper for Accountability through Participation Workshop, Brighton: Institute of Development Studies.

Pretty, J. *et al.*, 1994, 'Alternative systems for inquiry for a sustainable agriculture', *IDS Bulletin* 25 (2).