

Complex Structures: Meaning Formation Amid China's New Rural Cooperative Medical Scheme

MOHAN J. DUTTA
KANG SUN

National University of Singapore, Singapore

The culture-centered approach (CCA) foregrounds meanings from the margins as entry points for interrogating structures of health care. Through a culturally centered ethnographic examination of the ways in which family members left behind in a village in China make sense of their (in)access to health services, we seek to develop an understanding of China's new rural cooperative medical scheme (NCMS). Although structures have been theorized in earlier CCA projects, this article specifically focuses on the interpretations of health services under a newly introduced health policy framework. To our knowledge, this is the first culture-centered study of negotiations of health services in rural China amid the ongoing health reforms as China opens up to a global market economy and undergoes market reforms in the public sectors (e.g., health, education). Voices of community members point toward the inequities constituted in the structures of NCMS, corruption introduced by the transformation to a monetary economy from a cooperative-based economy of health care, and agentic expressions that imagine alternative structures of organizing health and care.

Keywords: culture-centered approach, structure, China, health policy, rural, new rural cooperative medical scheme (NCMS), meaning

The culture-centered approach (CCA) to health communication foregrounds the role of meanings in making sense of the structures that constrain and enable health (Basnyat, 2014; Dutta, 2004; Dutta & Basu, 2008). Structures, the patterns of distributions of resources and frameworks of organizing these resources (Giddens, 2007), are intertwined with meanings of health, shaping the everyday constructions of health meanings and being shaped in turn by the flows of meanings in local communities (Dutta, 2004; Murphy & Dingwall, 2003; Vindrola-Padros & Johnson, 2014). Extending the overarching framework of the CCA to policy structures, a meaning-based framework to health policy articulates everyday meanings as the anchors for interpreting health policies and the effects of these policies in the lives of community members, embodied in their lived experiences with health services. How community members make sense of a health policy is mediated through their accounts of everyday health seeking.

Mohan J. Dutta: cmmohan@nus.edu.sg

Kang Sun: kangsunbg@gmail.com

Date submitted: 2015-09-08

Copyright © 2017 (Mohan J. Dutta and Kang Sun). Licensed under the Creative Commons Attribution Non-commercial No Derivatives (by-nc-nd). Available at <http://ijoc.org>.

In this article, we coconstruct everyday meanings of seeking health amid structures of health services in the rapidly changing economic context of rural China, reflecting the larger scale economic and health care reforms nationally (Lei & Lin, 2009). With the transition of the Chinese rural economy from a collective system to the Household Responsibility System in 1979, the commune-funded Rural Cooperative Medical System (CMS) that covered 90% of all villages until mid-1970s, ensuring that farmers had access to basic health services in rural China, started collapsing. With the collapse of the CMS, by 2003, 96% of rural households in China lacked medical insurance, and health care providers were privatized, funded by fee-for-service revenues and with increased autonomy to “generate, retain, and manage surpluses” (You & Kobayashi, 2009, p. 6). The new rural cooperative medical scheme (NCMS), a voluntary insurance program, financed through flat-rate household contributions and government subsidies, was introduced in 2003. In the backdrop of these transformations in the local structures of health care delivery since the economic reforms initiated in 1979 (Wagstaff, 2007; Wagstaff, Lindelow, Gao, Xu, & Qian, 2009), we explore the local interpretations of health structures and articulations of health-seeking behaviors in a village in China. Suggesting that locally situated meanings of experiences with health policies grounded in the voices of community members depict the complexities that are otherwise absent from quantitative evaluations of the effects of health policies (Lei & Lin, 2009; Wagstaff, 2007; Wagstaff et al., 2009), we study the ways in which community members understand health seeking amid structural changes. Drawing on the CCA, we examine how the NCMS is understood and negotiated by community members in their everyday coconstructions of health seeking. To our knowledge, although the CCA has drawn attention to the interplay of structures and local health meanings, there have not been studies of culturally situated accounts of experiences with health policies. Moreover, by extending the CCA to the context of health services delivery in rural China, we hope to contribute to a growing body of health communication work on health services delivery across global contexts and specifically in China.

Culture-Centered Approach to Health Communication

Building on health communication scholarship that emphasizes meanings as anchors of health experiences (Dutta, 2004), the CCA suggests a framework of communication grounded in local meanings of everyday health constructed at the intersections of culture, structure, and agency (Basnyat, 2014; Dutta, 2007; Dutta & Basu, 2008). Meanings of experiences negotiating health resources, health services, and policies (Dutta & Basu, 2008) offer anchors for understanding the nature, role, and impact of policies on the lives of everyday people (Basnyat, 2014; Dutta, 2007; Dutta & Basu, 2008). Structures depict the ways in which health resources are distributed in local communities (Giddens, 2007) and are reflected in local, national, and global policies. The voices of community members depicting health seeking in their everyday lives offer insights into the constitutive policies (Dutta, 2007). In other words, policies such as the Household Responsibility System and the NCMS in China can be understood from the descriptions offered by community members of their experiences of seeking health care in their local contexts. In the realm of health policies, we argue that the CCA offers a framework for exploring local processes of sense-making amid everyday experiences of health seeking that are constituted by economic and health policies (Dutta & Basu, 2008). The sense-making narratives shared by communities at the margins offer frameworks for interpreting policies such as the NCMS as understood from the standpoint of community members experiencing the policies in their everyday negotiations of health.

From CMS to NCMS

From the 1950s through the 1970s, the CMS, or *hezuoyiliao*, was an integral part of a comprehensive cooperative system in China (Liu, Hu, Fu, & Hsiao, 1996; Liu, Zhao, Zhang, Hu, & Meng, 2015; You & Kobayashi, 2009). The CMS had a three-tiered structure: The first tier was formed by the village "barefoot doctors," who provided basic preventive services and primary care. The second tier was formed by the township doctors who were stationed in commune medical centers in the towns to provide primary care. The third tier was formed by county hospitals, and only in rare cases of very critical diseases that none of these three tiers would handle could patients be referred to urban tertiary hospitals (Liu, Hu, Fu, & Hsiao, 1996).

The term *barefoot* in the 1970s came from the namesake political posters that featured doctors (usually women) paying medical visits to patients in their homes by walking barefoot in the rain. The doctor had limited training and usually carried her medical equipment in one bag to pay fellow villagers visits when she was asked by the patients' family members. In Fukong, the doctor provided basic medicines for cold, headache, simple first-aid sets, and syringes for shots. After the barefoot doctor was married into another village, no new barefoot doctors were trained to take her place before the CMS collapsed. People in the village then went to the township medical center, a 20-minute walk for treatment. There were two doctors in the center in the 1970s. For each visit, the patient offered a coupon with the township stamps as the token of payment for doctors. At the end of the accounting session, doctors presented the tokens of payment to the township administration for grain rations, cloth and oil stamps, and other life resources. Doctors from these two tiers usually were natives of the villages and still were registered as peasants. Their tasks of treating patients were seen as differences only in division of specific labor tasks while they served the same overall goal of building a socialist village as peasants who worked the land.

With the Communist Party Plenum of December 1978, China's agricultural reform started. The then-newly installed Household Responsibility System redistributed socialist communal land to the use and disposal of individual peasants, who signed contracts with village communes for agreed agricultural taxation. As Liu et al. (1995) summarized, "the two principal components of China's rural reforms were the de-collectivization of Chinese agricultural production and gradual moving the pricing and production of agricultural commodities toward a free market" (p. 1086). With the reforms, "80% of agricultural commodities were bought and sold in competitive markets in 1990 compared to 8% in 1978" (Liu et al., 1995, p. 1086). Such a change in pushing agricultural commodities to the market had its structural impact on the communal funding of the CMS, essentially leading to the collapse of the CMS, with its funding base disappearing.

With the spread of the Household Responsibility System that let peasants use the communal land on contract, allowing them to keep the surplus after paying the assigned agricultural tax, the labor duty point that once worked for village commune collective farming lost its social context and local support. Peasants did not need to work anymore for the village commune to earn labor duty points to be changed into grain rations. They only needed to work on their assigned farmland. They paid agricultural tax, keeping the surplus for themselves. The usual practices of paying doctors with a small paper card with the

village administrator's stamp on it so that the doctors could exchange living resources lost its foundation because the village no longer had the right to redistribute grains and other resources. Thus, the medical services provided by these three tiers of doctors under the CMS, which had been regarded as a necessary social welfare function of the village commune, were left unfunded and soon collapsed.

In the township where the village of Fukong is located, township doctors changed into local doctors, often based out of their homes, and depended on payments for their medical services. Not only did the payment method change from stamped coupons issued by township administration to out-of-pocket cash paid by peasants, but the mechanisms of pricing underwent change. In the CMS period, the payment method by stamps for health service can be viewed as a unit payment method. That is, the seriousness of the disease was not reflected by the stamps. Each visit was paid for by one coupon, and doctors could only be compensated according to the numbers of stamps that they could collect, irrespective of the seriousness of the disease. Accordingly, the expenses for medicines were also compensated for by stamps issued to pharmacists. After the collapse of the CMS, doctors could charge for medical visits, prescriptions issued, and profit on the medicines sold. Local doctors changed from serving a branch of a broader social welfare system in a socialist structure into self-funded practitioners, now running a personal/professional business of health service delivery bearing their own financial responsibilities and driven by profits. The health care interaction became codified as a cash transaction as opposed to the coupons that were traded under the CMS.

Studies examining the transformation of the health care landscape since the economic reforms and collapse of the CMS demonstrate that medical expenses became a major underlying reason for household-level poverty in the rural areas in China (Liu et al., 1995; You & Kobayashi, 2009). Liu et al. (1995) stated that "the uninsured rural population has a significant higher risk of suffering from illness-induced-poverty than their counterparts who are still covered by CMS" (p. 1089). You and Kobayashi (2009) noted that "in 2003, 96% of rural households in China lacked medical insurance, 38% of the sick did not seek medical attention, and medical debt forced many households to reduce food consumption" (p. 2). In other words, the collapse of the CMS brought about privatization of health care, leaving the bottom tier of social groups, particularly economically poor rural populations in China, to pay for their own medical expenses.

In this backdrop and to address this challenge of health care inaccess among the poor and rural populations, the NCMS was initiated and promoted as a government-induced health scheme. In October 2002, the China National Rural Health Conference was held in Beijing, serving as the backdrop for the NCMS. The NCMS is a government-run, voluntary insurance program, funded through a combination of flat-rate household contributions and government subsidies (You & Kobayashi, 2009). With an emphasis on covering catastrophic illnesses, the NCMS is primarily designed to prevent illness-induced poverty. As opposed to the CMS that operated at the village level, the NCMS operates at the county level, with counties having considerable discretion in how they organize and finance the NCMS. The limited financing of the NCMS results in high deductibles, high coinsurance rates, typically shallow coverage, and the lack of or partial coverage of many services such as outpatient care (You & Kobayashi, 2009). By 2008, the "NCMS had expanded to include 800 million people in rural China" (Babiarz, Miller, Yi, Zhang, & Rozelle, 2010, p. 2). However, such claims can be inaccurate given that more than 200 million rural people

registered as peasants in the national household registration system actually work in cities. These working peasants' access to the NCMS, which usually requires patients to be treated in their township and county hospitals to be entitled for reimbursement, is severely limited, if not impossible, leaving them outside the scope of coverage under the NCMS. In terms of health care services provided to the local population, locally based doctors form the most basic rural medical infrastructure for rural populations. They still provide the most basic and everyday health care for most of the small illnesses and diseases in the village. The NCMS began to hire these doctors on a daily basis for carrying out large-scale physical examinations. Thus, many of the grassroots-level health care providers have been functioning within a hybrid health care structure, operating privately as well as delivering services through the NCMS.

Given the emphasis of this article on culture-centered constructions of policy, we sought to initiate a dialogue between community voices and the published literature on the CMS, the NCMS, and transition from the CMS to the NCMS. The stories of the everyday negotiations of health seeking among rural communities offer entry points for making sense of the overarching policy framework as well as for imagining transformations in them. In particular, we note the following. First, lived experiences with health care are missing in survey-based reports on the NCMS, such that most reports on the NCMS offer linear accounts of the progress of the scheme. Second, local voices presented in this article point out the discrepancies between the local government reports and the local experiences of community members.

RQ: What are the meanings of health seeking constructed by community members in rural China?

Method

The data reported here were part of a culture-centered project among community members in Fukong in China between 2012 and 2014, resulting in community-driven solutions such as community-based dialogues with providers, health information materials on prevention as well as on health care resources, and culturally based health resources such as local cultural performances for promoting health and well-being. Fukong was chosen for several reasons. First, it is located in Shaanxi Province, one of the less-developed provinces in northwestern China that is economically marginalized. Second, because our overall ethnographic research design aimed to promote culturally centered social change through community dialogues, the village's economic hardships offer structurally situated contexts for social change communication. Finally, because one of us (KS) grew up in the village and is native to the language and culture in the village, he can draw more contextual connections.

The culture-centered method uses advisory board meetings, participant observations, in-depth interviews, focus groups, and community-wide consensus-building meetings to develop locally articulated problems and the range of solutions to these problems. Given the emphasis of the CCA on developing locally based problems and solutions, the entire village of 126 households (with family sizes of two to eight people) was involved in the project. The "human subject approval" for the project was secured from the institutional review board of a large public university, accompanied by approval secured from the local village leadership for the study. We used the following questions to guide the cocreation of community-grounded health solutions to locally voiced health problems (Dutta, 2004, 2007; Dutta & Basu, 2008): "What does health mean to you?" "What are your key health challenges?" "Please describe your

experiences in seeking health?" "What are the barriers to health seeking you experience?" "How do you negotiate the barriers you experience in seeking health care?" "What changes would you suggest to address the challenges you face?"

Data Collection

During our ethnographic fieldwork, the concept of the NCMS as a health structure started emerging from our everyday conversations on the meanings and experiences of health and health seeking. Responding to these emergent conversations, we looked through both the published literature and public records on the NCMS, putting the everyday conversations about the NCMS in the village in conversation with the key threads emerging from the data. We conducted participant observations, 62 in-depth interviews, and 12 focus group discussions (with six to eight participants each) in open-ended and semistructured format. The interviews and focus group discussions lasted 45 to 90 minutes each, generating 340 single-spaced pages of transcripts. Whereas the interview questions (described above) focused on the individual and household experiences of health seeking, the focus group questions asked participants to describe the collective changes in health experiences in the village and collective solutions that were envisioned by villagers.

For the initial stage of the research, one of us stayed in Fukong for two months, followed by subsequent one-month to two-month long visits, spending approximately eight months during this two-year period. During that period, we approached prospective participants in public spaces of the village to recruit interviewees and/or focus group participants for our project. As delineated by the CCA, we also recruited advisory board members ($n = 18$), asking villagers whether they would be interested in participating in a broader project of community-driven change grounded in their experiences of health and local understanding of health needs. The participants were older than 20 years of age and included peasant workers ($n = 23$) and their adult family members ($n = 60$), as well as clinic doctors ($n = 6$) and township hospital doctors ($n = 3$), recruited through the snowball sampling method.

One of the researchers grew up in rural China and is proficient in Chinese (KS); he conducted the interviews in Chinese and also translated and transcribed the interview and focus group data from Chinese to English. Initially, 10 of the interview transcripts (10%) were checked by another coder who is proficient in Chinese. The other researcher, not proficient in Chinese (KS), worked on the study design, data analysis of the translated interviews, and iterative design of the CCA intervention on the basis of the emerging data, comparing and contrasting the emerging codes from the data with the literature and reformulating questions for the interview protocol throughout the interviewing process. We also conducted participant observations at homes of peasant workers' families, village clinics, and township hospitals, completing a total of 94 hours of observations over the two-year period.

Data Analysis

To make sense of structures of health care, we concentrated on data that delineated experiences of seeking health services and health care. We read through the translated transcripts and conducted sentence-by-sentence open coding. Drawing on the principle of the coconstructivist grounded theory

approach, we then organized the open codes into selective codes around the framework of the uses of health care services organized under the NCMS, and put in conversation with the literature and policy statements on the NCMS, as well as in conversation with the advisory board in Fukong.¹ In our analysis, conducted side-by-side with our ongoing ethnographic work, we paid special attention to the discrepancies of meanings between the policy statements and everyday accounts of lived experiences, and worked through such discrepancies to foster entry points for further investigation.

Results

The voices of the participants point to the inequalities that are written into contemporary organizing logics of economics and health in China, the “asking” game of the physical exam as an example of the gap between the rhetoric and practice of health care, and corruption as an organizing feature of the rural health care structure in China. In the backdrop of these inequalities, participants suggest strategies for enacting their agency that reimagine the organizing logics of the structures.

Inequalities and Structure

As LS,² a township doctor, pointed to the complex structure of hospital services, he highlights the uneven economic development in China:

The development is uneven. China’s reform and opening up is not for the whole population. It is only for a small percent to get rich and the majority is still poor. Our middle Shaanxi is ok. But the South and North Shaanxi and Gansu province are really poor.

Connecting this uneven economic development to changes in access to health services, ZX noted, “things have changed here. It is hard to get to the doctor, or to get medicine anymore.” The transformation in the health care economy with the collapse of the CMS circulated through the conversations. TY shared,

CMS took care of the basic health care, and that was guaranteed. Not now. With privatized doctors, they charge exorbitant money. And with NCMS, you have to be enrolled, and you have to make copayment. Moreover, the reimbursement is limited.

¹ To make the literature more relevant to the case of Fukong discussed in this article, we juxtapose information from other literature, which is usually based on larger scale survey data, with the village “facts” that were collected through ethnographic interviews and field notes. Such a presentation strategy is apt in showing both local particularities as well as national data.

² The names of participants are abbreviated to protect their identities. The participants felt that simply using abbreviations would work toward protecting their identities.

For XY,

Health is now something we have to pay money for. So everything has changed. Gone are the days when you could just walk in to the doctor and get your health check-up done [referring to CMS]. Now you have to pay out of pocket.

Similarly, XZ said, "Everything is an avenue for making money. Even offering health services to a poor person like me." MC said,

Under CMS, the barefoot doctor was one among us, who cared for everyone and was paid through the coupon. Now, the clinic doctors are private, and the NCMS doctors are practicing in private on the side. They want to make money, not care for the patient.

Participants in our interviews voiced their lack of access to the NCMS as they went to work in the cities in search of a living. QS noted, "In the city, I don't qualify for services. So I have nowhere to go in a health need except to pay out of pocket." Similarly, WY observed, "No one knows which rule applies. So it is up to the hospital administrators. In the city, they say you are not from here. And here in the county, I am no longer counted as I don't live here."

The uneven development in the structures of health care plays out through articulations of poor quality of health care. HJ, ZM, and GL expressed their dissatisfaction with the NCMS-related annual subsidies for chronic diseases. Peasants above 60 years of age are eligible to have up to 500 yuan worth of medical service or medicine for their specific chronic disease. Note the following conversation:

HJ: For 500 yuan, they give you useless, leftover, and expired medicines.

ZM: They give you a plastic bagful of medicine and give that to you for 500 yuan.

GL: This is a problem with their attitude.

ZM: No professional ethics whatsoever. And they don't care about your health.

On a similar note, JE stated,

They [pharmacists] do not count nor calculate if the medicines are up to 500 yuan. Nor do they examine if the medicines are for the specific chronic diseases. Instead, they just grab medicines that are on the shelf. What they had there is cheap medicines. They fill the bag with medicines that you cannot use and that is it. "Who's next?" [mimicking pharmacist's question]. For 500 yuan, we can actually have 300 yuans' worth of all kinds of medicine. And of the 300 yuan, only about half of the medicines are useful in everyday illness and seldom can you find any medicines in the bag that are meant for the chronic diseases that you have.

This articulation of mistrust for the prescribed medicines at the local level is contrasted with a national level discourse, where the 500 yuan per 60-year-old peasant are counted as a national measure of medical effort for health promotion and poverty relief (X. Liu, Zhao, Zhang, Hu, & Meng, 2015).

Physical examination is another area where the gap between the rhetoric of the NCMS and the lived experiences of community members becomes apparent. In 2012 when we commenced this ethnographic project, the national government announced a national physical exam for the elderly. According to LS, the local township hospital doctor, the examination was meant to be provided for free to rural people above 60 years of age. All relevant test information was supposed to be gathered and archived. However, many parts of information had been left blank, with many of the mandatory exams not having been conducted. According to SP, one recipient of the examination, "they only checked blood pressure, heart CT [scan], and B ultrasound." According to LS, "the national government gives 80 yuan to each person for the physical exam. The county hygiene bureau kept 20 yuan for themselves and 60 yuan was given to the bottom." Structurally, the national subsidy for the physical exams had been reduced by 25% at the county level; the remaining 75% was put under the charge of the head of the township hospital. How the head used the money was not known to one of his colleagues, suggesting layers of corruption in the allocation of the funds at the county level. Indeed, LS knew that only part of the money was used by the township hospital head to hire local clinic doctors for two weeks to perform part of the exams.

The resulting exam process was filled with problems. Participants reported that the physical exam was often performed perfunctorily, with many sections of the exam not being conducted and certain sets of data not being gathered at all, at times being left out and at other times being filled in on the basis of oral reports without actually conducting the recommended tests. LS noted,

It is bad practice not to examine what was on the form. For instance, the kidney and liver functions should have been examined. They examined blood sugar by using a chemical slip. That is not accurate. Medicine has many steps and each one should be attended to meticulously.

In many participants' accounts, the mandatory blood exam was simply skipped. ZM said,

For physical exam, they [township hospital doctors] do not even draw your blood sample. They asked you to come for a blood examination. But when you go there, they ask you for the slip that shows you have completed the examination from the clinic doctors. Once they have the slip, they can claim that the blood has already been examined. Then nothing about your blood is done: The blood was not even drawn from you and how could they have done anything? So this policy of physical examination for the elderly has given hospitals the best chance to get rich. Hospitals got rich, governments paid money, but we had not benefited much from the policy.

The participants pointed toward a corrupt system of organizing health care that profits under the label of offering physical examination to patients.

The Asking Game of the Exam

In the stories shared by the participants, the physical exams funded at the national level depict the gaps between the rhetoric of a specific policy and the actual implementation of the policy, serving to reproduce inequalities of health care. In their accounts of the physical examination, participants noted how the physical tests supposed to be conducted under the policy were instead turned into what they called the asking game. Note the following discussion:

ZM: They would ask you about your heart rate.

YA: They only ask you for your health conditions.

ZM: The "ask" game is done in [doctor] DH's clinic. After that, DH will give you a slip to show that you have finished with his round of the exam. For the rest of the exam, you go to the town hospital to have it done. Upon showing the slip that local clinic doctors have examined you, the township hospital doctors will ask you again about other stuff.

YA: Right! So even the town hospital does not draw blood.

DX: The doctor told me that my blood would not be drawn because he was afraid that I could not endure it.

Rather than conducting the physical exams they were supposed to conduct, the doctors simply asked about the symptoms and then filled in the forms. For most of the participants, the blood test was not even conducted, although results of the blood tests were written up.

Because the process was not supervised and was left to each doctor's mercy, there were also instances in which the blood sample was drawn, but the procedure was not adequately followed. Consider the following focus group discussion:

SM: I have been examined for B ultrasound and blood sugar.

GL: Let me tell you, for B ultrasound, they would let you fast for 12 hours. Did you eat before you went there?

SM: Some have eaten, but some have not.

ALL: [Laughing]

GL: That does not work then. The result is not good.

HJ, one of the recipients of the physical exam, stated that the doctor in charge of performing the exam asked ambiguous questions such as "Is everything well with you?"³ He questioned the validity of such a question:

³ In Chinese, *hao* can be translated into "(physical) fit(ness), good, wonderful." HJ used *hao* first to mean his doctor's question "Are you feeling 'well'?" and then changed its meaning creatively to question the quality of the health care service—"Is the examination a 'good' one?" Through the shift of meanings of the same Chinese word *hao*, HJ actually cracked jokes about the health care service that he received and also cracked open a deep-rooted issue of the structure and infrastructure of health care service actually available in China's countryside.

The exam was just an empty process. For some illnesses or diseases, the person himself may very possibly not realize that he/she has it. But the exam doctor will take his answer by face value: The doctors will ask, "Is everything well with you?" What does that "well" actually mean? And can it show anything substantive at all?

HJ pointed out that the asking game performed by doctors was simply to finish the examination quickly without having to perform the physiological tests that are mandated by the policy. The asking game is an example of the ways in which communication is constituted in structures of health care, reifying the inequalities that are built into the overarching organizing logics of health care. Everyday forms of communication in health care interactions reflect the gaps between rhetoric and practice of health care, and offer insights into the inequalities in the organizing of health care structures.

Corruption as Structure

For the villagers, corruption was seen as a structural barrier to receiving health treatment. As WX stated,

Now the government policy is really good. It seems to cover all the necessary parts of health and it shows its care for the people in the countryside. It is only when it reaches the bottom that the policies are not enforced well.

SY expressed the same idea: "The central government has earmarked the money and given it to the local governments and hospitals. However, the local level medical professionals and governments have put it in their own pockets." SY's idea was seconded by DX, who said, "Yeah. It greases their own bellies." SY added, "The exam is pointless. But the blame should be put on the local government officials and medical professionals." The participants connected the health care services with the ill-executed health care policies that have been sidetracked by corrupt government agencies and medical care professionals at the local level.

For LS, the town hospital doctor, the corruption in the delivery of health care at the hospital had a lot to do with the economic structure under which the township hospitals are running. LS shared that there are about 20 doctors registered as official doctors in the town hospital. However, according to him, many of the doctors do not come to work even though they are still officially registered as doctors at the town hospital⁴:

The reason for not coming to work is that they are not satisfied with the low salary there. This is the first reason. The second reason is that the head of the hospital is not very capable. He is not capable, so he is afraid that if he uses these people, these people will not listen to him. Besides, if he asks only the doctors with temporary employment status to serve there, then, he would have more power over them. It is easier to give orders to these temporary doctors than the officially registered ones. For

⁴ According to the villagers, that township hospital had only two practicing doctors.

temporary doctors, even if they are offered less pay, they do not have the power to complain.

LS further noted the imbalance of power:

The [central] government gives a large amount of subsidy to the hospital. Only the countryside medical subsidy alone for our township hospital is above 1 million yuan. But the head did not actually use the money on the countryside medical service. For instance, last year, our county had the local hospitals to establish health care archives of birth-age women and infants. . . . The hospital needs to ask doctors to go to villages and do this work thoroughly. All the women and infants need to have their health forms archived. He did not do that. That money never gets down to the local community and never gets put to its right use. So this is the real case of health care. In another case, there was this national survey of health information of the chronic diseases. This is another very important and serious engagement of the government. You must allocate the medical professionals to do the B ultrasound and heart CT, etc. When the hospital goes down to villages to serve the people, everything needs to be planned and the equipment should be ready. Doctors also need to have the right qualification for the tasks they are asked to perform. Now, the real situation was that many doctors asked to go were not actually qualified for the work. They were only asked to hold the place to perform perfunctorily the tasks. For B ultrasound, if the image is not clear, so be it. If the heart CT looks dubious, so be it. So, it is just cheating. He is actually doing that. One level will cheat another level. When the officials from the county level come, he will say, "Everything is good and in order." In fact, that is not the case at all. He is just fishing for himself in this troubled water.

The embezzlement of the public funds is connected to the structure in which the hospital leader is positioned:

He can just embezzle the subsidy. He can put it away for some other things. So he is very rich now. He can get 800,000 to 1 million yuan for a year and it is no problem for him to get that much. . . . Every year there has been the financial audit. However, after he treated those people with drinks, good food, and gifts, then those people will leave satisfied. So as the saying goes: Villages cheat towns and towns cheat counties, going all the way up to the state department. What can you do about that? [Laughing]

Corruption thus serves to reproduce the inequities in the distribution of health resources. The structure of health care was experienced at the local level in the everyday practices of corruption, disconnected from the national rhetoric of subsidies precisely because of the practices of corruption and the lack of accountability.

Engaging Structures Through Agency

In small-group discussions, villagers expressed their agency by sharing their hopes for change in how health services are currently being delivered, suggesting steps and strategies for changing the unequal distribution of resources and the uneven sites of power within the structures of health delivery in rural communities in China. MJ noted,

There should also be financial audits to supervise the financial procedures of the hospital. When only the head of the hospital can make decisions, then it will be really bad because virtually he is in charge of more than several 10,000 people's lives and health. The head just cannot run a good hospital. What makes things worse is that the hospital is the place all the people rely on for their health. At the very least, the government still has good policies. For instance, the forms that are issued by the government for the physical exams are a demonstration that the government has good policies. However poorly the local hospitals and clinics have done their work—one thing we have to admit, the government policy is still very good. The local hospitals gathered the labor resources by hiring the local clinic doctors to do the physical exams for villagers. However, these doctors are doing their tasks with an absent mind, they actually want to go back home to be able to earn money by treating patients that come to their own clinics. The problem then is in the local implementation. How could they do a good job if they have their own agenda? And what is the purpose of gathering them together for the task?

The above articulation points to the problems with the incentive structure. The privatization of health care and the decline of the CMS have resulted in profit-driven organizing logics of health care, reconstituting the role of doctors as seeking profits through treatment. The incentive to make money in their private clinics overshadows the commitment to carrying out proper government-supported physical exams. The temporary hiring practices that bring in local doctors to carry out the exams, mixed with the privatized incentive structure, lead to the failure of the physical exams.

In challenging this gap between policy frameworks at the national level and local level implementations, RZ envisioned a management system built from the grassroots:

For our whole town, we have more than 10 big villages. People selected from these villages can be representatives of villagers to supervise and to inquire about the health services. Plus they do not even ask the government anything for salary, right?

In RZ's vision, a local medical supervisory system composed of volunteers or people elected from villages to supervise the medical performances of the local clinics and hospitals is seen as providing a layer of accountability. The framework of accountability thus is located in networks of relationships and relationship expectations within the village structure, ensuring participatory spaces for voicing of the lived experiences of villagers in evaluating and monitoring the health services under the NCMS. The national-

level framework of policy is connected to the village, grounded in the lived experiences of villagers as anchors for evaluation.

In WX's opinion, the changes to the structure of health services delivery can benefit from raising local awareness of health and by connecting the local delivery of health to health information seeking and decision making at the local level. He pointed to the role of "showing videos on disease prevention or by inviting health ambassadors to come directly to the countryside to share with people such information." Information thus is seen as an important ingredient in the transformation of the delivery of health services. The village community, being informed and engaged in the process of monitoring the activities of the hospital, is a site of change in the delivery of health care as it emerges as a point of accountability through participation of villagers. Agency, expressed in the participation of villagers, serves as an anchor for monitoring the structure and for holding it accountable.

Discussion

In this article, we have coconstructed through conversations held in the village of Fukong the structural aspects of the NCMS as experienced by community members in a Chinese rural community. First, local community voices suggest that the NCMS is adapted and implemented within a broader structure that is unequal and uneven, manifested in differential patterns in the delivery of health care from the national to the village level. The voicing of the experiences with the NCMS is situated in the context of discussions of the CMS, noting the ways in which the CMS structure of health care delivery ensured that everyone had access to basic health care in the village, organized under the economic principles of collectively grounded cooperatives. The economic system of the CMS connected the local doctors to the local community and also ensured that the doctors were accountable through the process of payment via coupons per visit. In sharing their experiences with the cooperative system, participants suggested that even though the extent of services they received was limited in scope, they were ensured access to the basic services of health care at the village and township levels. The organizing structure of the CMS, in which payment by coupons served as tokens that the doctor could use to secure basic resources such as ration supplies, is contrasted with the cash-driven payment structure under the transformed economy in China. In the voices of the participants constructing their experiences of health seeking, the economic structure of the CMS ensured that doctors were accountable to the villagers, with the coupons the doctors received being physically tied to each patient they saw.

Participants' discussions of the NCMS thus were situated in relationship to understandings of the broader transformations that are taking place in the Chinese economy. The transitions in the economy and in the structural features of health care to a cash-based system introduced "profit" as an organizing feature into the delivery of health care. Participants noted the ways in which the notion of profit then adversely affects the quality of health care they receive, with doctors in the new structure wanting to make money and finding ways of making money through treatments of patients, introducing costly and technology-based treatments. The delivery of health care is corrupted by the lure of money and by the desire to make profits from treating patients. Culturally constituted understandings of health care as a fundamental capacity rooted in the community and organized in the form of a cooperative are juxtaposed against the values of health care as a profitable structure, tied to money to be made by providers as

profit. The narratives of the participants voiced in this article point to the role that lived experiences play in making sense of structures. The application of the CCA in a policy context depicts the ways in which stories of participants at the margins can offer insights into the workings, failures, and gaps in implementation of policies. This opens up new ground for culturally centered scholarship in evaluating policy frameworks. Moreover, the accounts of the everyday lived experiences of rural community members in Fukong juxtapose privatized and collectivist community-based organizing logics of health care, depicting entry points for alternative organization of health care against the backdrop of global market fundamentals.

In the voices of the participants, the gap between policy articulation and local implementation is tied to the framing of health as a commodity in the new economic structure, the privatization of health, and the hegemony of a profit-driven incentive structure. Corruption in the implementation of the NCMS is seen by the participants as being related to the entry of cash into the health delivery system such that town- and county-level administrators within hospital structures keep aside allocated funding, leading to leakage within the delivery system. At the grassroots-level delivery of health care services, many doctors of local clinics were from the CMS, and have now been incorporated into the market economy, making profits through private practice. At the local community level, we witnessed the relationship between local clinic doctors and township hospitals through the accounts of village health care recipients as well as through the voices of health care providers. The accounts shared by village health care recipients depicted the ways in which structures are situated amid local meaning-making processes, intertwined with the everyday experiences of health seeking amid these structures. In describing their experiences with township hospitals and local clinic doctors, participants foregrounded the roles of structures in constructions of health. A national-level structure formulated in a policy formation is rendered meaningful through the experiences of that structure in the everyday health-seeking journeys of participants in local structures, thus highlighting the salient role of local meanings of health seeking in understanding a health care policy and the manifestations of that policy locally. As depicted by this study, one of the theoretical and practical implications of this project is in suggesting the ways in which everyday narratives of health seeking that emerge through dialogues in the CCA can offer entry points for understanding lived experiences with local structures of health constituted amid local–regional–national policies. Moreover, the articulations of agency of participants in addressing the structural inequities they experience suggest pathways for potential solutions to the organizing of health care that is just, accessible, and equitable.

For instance, in their accounts of the asking game of the physical examination mandated by the national-level policy, the participants depicted the ways in which the act of asking questions by providers substituted the medical exam that needed to be conducted. They noted examples of blood tests not being conducted, results being made up on the basis of questions asked, and faulty procedures being followed as examples of gaps in the delivery of health care. In spite of nationally mandated tests to be registered in the forms, the local lived experiences with the tests depict structural inaccess to services. Other forms of structural health inaccess include experiences of not being given the prescribed medication in spite of being assured medical supplies worth 500 yuan by the state, not being able to see a doctor at the time of a health need, and pregnant women not receiving the nationally mandated health check-ups.

In this backdrop of constructions of health as a structurally embedded resource, the articulations of policy transformations were rooted in the everyday experiences of community members within the immediate contexts of health services offered in the village, local clinics, and township hospitals. The narratives shared by the participants highlight the importance of structure, particularly by depicting how meanings coconstructed at the local level are connected to the broader structure and how such connections mapped out through conversation offer entry points for reimagining the opportunities for social change. In the voices of the villagers, one way to create change in the delivery of health care is to create points of accountability to the local community, putting decision making in the hands of the local community. In the local imaginations of transformations in the delivery of health care, villagers elected from their local communities at the township and county levels are seen as offering layers of accountability by monitoring the performance of the hospital and by closely watching over the movement of funds in the delivery of health services. The participation of local community members in the supervision and monitoring processes distributes the power from the hands of the administrator into the hands of local community members, also building local capacities in health information, local awareness about health, and local inputs into the decision-making processes of how health resources are to be distributed. Information capacity thus emerges as a point of enactment of local agency in holding health structures accountable, in monitoring distribution of resources, and in voicing the health concerns expressed by community members.

This project, as reflected in the article, suffers from some important limitations. In working on this project, we limited our ethnographic fieldwork to one village, thus limiting the extent and scope to which we could generalize regarding the experiences of rural community members with the NCMS. Future research should look at cross-village comparisons in experiences with the health care system, simultaneously retaining the richness of the accounts. Also, this study is limited by a two-year timeframe, with limited opportunity for testing the solutions proposed by rural community members. Future research on culture-centered participatory processes in social change in the context of rural health in China should explore pathways for transformation and the communicative strategies that are likely to work in these pathways. In sum, we offer an exploratory entry point for registering the voices of villagers in a community in China in accounting for their lived experiences with health, suggesting opportunities for additional research that further explores the communicative processes in negotiating and transforming these structures of health care.

References

- Babiarz, K. S., Miller, G., Yi, H.-M., Zhang, L.-X., & Rozelle, S. (2010). New evidence on the impact of China's new rural cooperative medical scheme and its implications for rural primary healthcare: Multivariate difference-in-difference analysis. *British Medical Journal*, *341*, 1–9.
doi:10.1136/bmj.c5617
- Basnyat, I. (2014). Lived experiences of street-based female sex workers in Kathmandu: Implications for health intervention strategies. *Culture, Health & Sexuality*, *16*(9), 1040–1051.
doi:10.1080/13691058.2014.922620

- Dutta, M. J. (2004). Poverty, structural barriers, and health: A Santali narrative of health communication. *Qualitative Health Research, 14*(8), 1107–1122. doi:10.1177/1049732304267763
- Dutta, M. J. (2007). Communicating about culture and health: Theorizing culture-centered and cultural sensitivity approaches. *Communication Theory, 17*(3), 304–328. doi:10.1111/j.1468-2885.2007.00297.x
- Dutta, M. J., & Basu, A. (2008). Meanings of health: Interrogating structure and culture. *Health Communication, 23*(6), 560–572. doi:10.1080/10410230802465266
- Giddens, A. (2007). *The constitution of society: Outline of the theory of structuration*. Berkeley, CA: University of California Press.
- Lei, X., & Lin, W. (2009). The new cooperative medical scheme in rural China: Does more coverage mean more service and better health? *Health Economics, 18*(Suppl. 2), S25–S46. doi:10.1002/hec.1501
- Liu, X., Zhao, S., Zhang, M., Hu, D., & Meng, Q. (2015). The development of rural primary health care in China's health system reform. *Journal of Asian Public Policy, 8*(1), 88–101.
- Liu, Y.-L., Hu, S.-L., Fu, W., & Hsiao, W. C. (1996). Is community financing necessary and feasible for rural China? *Health Policy, 38*(3), 155–171. doi:10.1016/0168-8510(96)00856-1
- Murphy, E. A., & Dingwall, R. (2003). *Qualitative methods and health policy research*. Piscataway, NJ: Transaction.
- Vindrola-Padros, C., & Johnson, G. A. (2014). The narrated, nonnarrated, and the disnarrated conceptual tools for analyzing narratives in health services research. *Qualitative Health Research, 24*(11), 1603–1611. doi:1049732314549019.
- Wagstaff, A. (2007). *Extending health insurance to the rural population: An impact evaluation of China's new cooperative medical scheme* (Vol. 12). Washington, DC: World Bank Publications.
- Wagstaff, A., Lindelow, M., Gao, J., Xu, L., & Qian, J.-C. (2009). Extending health insurance to the rural population: An impact evaluation of China's new cooperative medical scheme. *Journal of Health Economics, 28*(1), 1–19. doi:10.1016/j.jhealeco.2008.10.007
- You, X.-D., & Kobayashi, Y. (2009). The new cooperative medical scheme in China. *Health Policy, 91*(1), 1–9. doi:10.1016/j.healthpol.2008.11.012