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Welfare Regimes in the Global South

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**SASCHA KLOTZBÜCHER, PETER LÄSSIG, QIN JIANGMEI,
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**Farewell to Diversity? New State Zones of Health Care
Service in China's Far West**

1. Research question and data

James Scott has argued in his recent book *The art of not being governed*, how specific production and settlement patterns enable or hinder the state in its endeavour to extend its administration to the state boundaries (Scott 2009: 35). Focussing on the geographical terrain of Zomia, he explains how the minorities living in the mountainous region of the Southeast Asian Massif utilise a repertoire of subsistence strategies, which enable them to resist state control. While the state is located in the valleys, the minorities evade the state by fleeing into the mountains, a region of relative statelessness, in order to avoid taxation and recruitment for the army. Since the 19th century, however, the nation state has aimed at making its sovereignty reach its physical borders and has therefore aimed at making the mobile peoples at its peripheries settle down and become incorporated into the state (Scott 2009).

In this paper, we will use James Scott's (2009) theoretical framework to explore the situation of Kazak herders living as nomadic pastoralists in the far West of the People's Republic of China. We will analyse the way in which the Han Chinese state seeks to incorporate them into insurance schemes and patterns of curative care in order to expand its reach to the very periphery of the country. While acknowledging that health care service is of major importance for the lives of people, we focus on welfare as instrumental in spreading the idea of the modern nation state into areas where people hide away from state dominance by moving back and forth between different states, and between the state dominated valleys and the

mountainous areas, to which the state has only limited or no access. Thus, we regard welfare in terms of its capability to provide security to people as a modern form of “enclosure” (ibid.: 11), for which policies are designed by the central government and implemented according to a national plan, in order to overcome the distance between state and peripheral society.

The situation in the People’s Republic of China is well suited as a case study, one built on the theories developed by James Scott in his latest book. The rise of the Communist movement as a precondition of the Chinese Communist Party (CCP) takeover in 1949 is to a large extent the consequence of the Guomindang state’s inability to expand the reach of the state to the rural areas. Mao Zedong developed his revolutionary strategy by exploiting the relative statelessness of the so-called border regions in provinces far away from any urban area whatsoever. Since 1949, the CCP has tried time and again to reach out to the rural areas. However, peasants used to living in local autonomy distant from state domination have been able to limit the reach of the state (Shue 1988; Weigelin-Schwiedrzik 2008; Weigelin-Schwiedrzik 2011). Since 1978, the Chinese state has even gone so far as to retreat from the rural areas by permitting the re-introduction of a family based agriculture and by substituting the market for the state as the organiser of supply and demand. At the same time, rudimentary forms of welfare, which had been developed in Maoist China, vanished and made health care the most important driver of poverty in the countryside (Liu Yuanli et al. 2002: 18; Klotzbücher 2006: 169-185). Looked at from the perspective of health care, the Chinese countryside between 1978 and 2002 can be considered as a “nonstate space” (Scott 2009: 13): Although aware of the health care problems in the countryside, the Central Government in Beijing refused to fund any insurance schemes. It refrained from investing in training and in equipping grassroots service institutions for primary health care. Instead, it demanded that local governments find solutions for the deficient health care situation. Minimal guidelines, non-binding decisions, conflicts between ministries at the central level and lack of subsidies from the central coffer resulted in low levels of motivation, inadequate funding and a lack of responsiveness by local governments, both to the needs of the local population and to the demands of the central government. As a consequence, a highly marketised health service structure developed, with private doctors or institutions earning high profits. With the

breakdown of the previously introduced schemes of risk protection in the early 1980s and unsustainable experiments in poor regions in the 1990s, individuals and families had to shoulder the financial risks of illnesses and costs for health care services.

However, beginning in 2002, the Chinese Government began to implement new welfare policies for the countryside: rural health care for the poor, even in the remotest areas, has been transformed from a task assigned to the local governments into an issue at the top of the priority list of the Central Government in Beijing. With local uprisings occurring in China's villages on a daily basis, the distance between the state and rural society is now regarded as disadvantageous and detrimental to the stability of CCP rule in China. After years of disengagement, the policies to provide better and affordable health care service to the rural areas have been recognised as instrumental in overcoming this distance (Weigelin-Schwiedrzik 2008).

The previously neglected and de-facto private practitioners in the villages were replaced by state-financed village clinics managed by township hospitals. Most of these health care service providers have been integrated as assigned health care units into the county-based rural insurance scheme called "New Rural Cooperative Medical System (NRCMS)" (Klotzbücher/Lässig 2009; Klotzbücher et al. 2010a). This system is co-financed by the Central, Provincial and County governments as well as by the peasant families. For the first time since the founding of the PRC in 1949, the Central Government is paying for every member of NRCMS in every village of China, with the result that the villages, as former non-state spaces (Scott 2009), were integrated into the state and people began to consider themselves as consumers of state provision.

However, with China being a multi-ethnic state, the Beijing government not only has to deal with its distance to the Han dominated rural areas; it also has to find solutions to the task of incorporating minorities of different ethnic backgrounds into the state. This is especially true for minorities living in border areas and in transnational settings, such as the Kazaks living in the Yili Kazak Autonomous Prefecture of the Xinjiang Uyghur Autonomous Region near the border of Kazakhstan. Between 2005 and 2009 we were able to observe the implementation process of the above mentioned welfare policies in Xinyuan County, with its unique geographical settings and challenges defined by the special needs of a population

of Kazak semi-nomadic herders. The findings are based on a quantitative household survey of 457 households with 2286 family members and 25 in-depth interviews with herders and administrators at different levels of government. The survey, as well as the interviews, were conducted by researchers from the Department of East Asian Studies of the University of Vienna and from the Department of Public Health of Shihezi University (see design and discussion of the health related results of the project in Klotzbücher et al. 2010b).

Xinyuan (in Kazak language Künes) County is peripheral in several respects. It is part of the Yili (Ili) Kazak Autonomous Prefecture on the Chinese border with Kazakhstan, and has the highest percentage of Kazak population in any Chinese county. The county has a total population of 303,300, of whom 133,900 are ethnic Kazaks (44.1 percent), 118,000 Han (39.2 percent), 28,300 Uyghurs (9.3 percent), 18,900 Hui (6.2 percent) and others (1.2 percent) (Yili hasake zizhizhou tongjiju 2006: 63). The majority of the Xinyuan Kazaks live as semi-nomadic pastoralists in the mountains during the period of the summer pasture. Parts of the family and their cattle migrate to high plains (about 2000m altitude) in May. They live there in yurts and return to their winter housings at a lower altitude or in the valley of the Yili River in September.

The situation of the Kazaks in Xinyuan County is typical of the state having difficulties in bringing, by means of production and taxation (Scott 2009: 35), the target population of nomadic herders from the shadow zones of the mountains into assigned agricultural settlements under state administration (see discussions on settlement in Cui 2002, 2005; Mejias 2009). In the past, the state has attempted to implement a coercive form of sedentarisation policy to reach its aims. However, these measures have repeatedly shown themselves to be ineffective. Trying to settle the herders on a permanent basis in the valleys while leaving the mountains ungoverned has not been a convincing strategy. However, establishing schools and health posts with state subsidised services as a form of “expansionary state” (Scott 2009: 3) might convince the herders to change their lifestyle and assist the state in its attempt to fully incorporate “peripheral peoples” (ibid.: 4), even those from a “geographically difficult terrain” (ibid.: 6). By introducing the idea of welfare as a modern equivalent of the “distance-demolishing technology” (ibid.: 11) of state-making, we would like to add a new aspect to the

traditionally Marxist focus of James Scott (2009: 11), who limits his explorations of the interaction between state and nonstate groups to the defined interface of production and taxation, as well as the instrument of coercion as the means “to project [...] its power to the very edge of its territory”. Our paper applies Scott’s theoretical concepts, originally used for analysing the Southeast Asian past of Zomia, to China’s current health governance and its spread to the Far West of the PRC. While Scott is mostly interested in investigating mobility as a form of avoiding state appropriation, we analyse the state’s response to a nomadic lifestyle and look at welfare as an important policy arena of post-modern Chinese state-making. Health care policies are of growing relevance as a non-coercive form of state-making. Thus, we will identify governance in a centre-periphery constellation, which is state driven and to some degree advantageous to the local population, although detrimental to preserving cultural diversity.

2. The state health care providers: Inadequacies and distance from the needs of the users

There is a pressing need for outpatient treatment and illness prevention, particularly for chronic diseases in Xinyuan County and especially for the herders, who, as we argue in accordance with our Chinese research partners elsewhere (Huang et al. 2010; Rui et al. 2011; Klotzbücher et al. 2010b), are not adequately taken care of by the present health care service providers. The three tiers of rural health care service organised by state agencies (county [xian], township [zhen] and village [cun]) follow a stationary pattern: one clinic/hospital for every settlement (township or village) in the valley far from where the herders spend the summer months. Following central guidelines, the insurance schemes of NRCMS focus on in-patient treatment (Klotzbücher et al. 2010a).

In addition to the People’s Hospital, the TCM (Traditional Chinese Medicine) Hospital and three hospitals at the county level, there are small out-patient facilities – one each in the 12 townships, and 29 clinics at the village (cun) level, employing 556 medical personnel, seven technical staff and 116 non-medical personnel (2005 figures). In addition, there are 29 free practitioners (Shihezi University and University of Vienna 2007: 77), and

an undefined number of illegal doctors, drug sellers and traditional healers, whose services are not covered by the newly introduced health insurance scheme, NRCMS.

The brain drain of the most capable doctors to the medical and administrative institutions at the county level or to health care facilities in the cities make any effort to improve the quality of health care in these grass-roots institutions very difficult. Work in the pasture area is neither lucrative nor seen as an important step on the career ladder. Shabby premises, old and inadequate equipment, narrow specialization of doctors, lack of general practitioners, and the low pay of the health professionals in the countryside make the situation for local patients and doctors even worse. Besides the problems in human resources, the investment in health care at the village level is generally insufficient.

3. New ‘distance-demolishing’ measures of the Central State after 2002

3.1 Enhanced role of the County Health Bureau

Before 2002, the role of the County Health Bureau in providing ‘technical guidance supervision’ (yewu zhidao) as the extended arm of the Ministry of Health (MoH) under the ‘dual leadership’ (shuangchong lingdao) concept with the lower governments was marginal. In general, local governments were hesitant to subsidise health institutions directly.

Only substantial and growing subsidies of the central state have enhanced the position of the County Health Bureau as the local agent for health care. We discussed the logic of demand-driven subsidies elsewhere (Klotzbücher/Lässig 2009; Klotzbücher et al. 2010a) and focus here only on the impact of provider-oriented subsidies.

Vertical provider-oriented subsidies are now developing into a tool to extend the reach of the state administration. It is important to understand that health care facilities in townships and villages are nowadays run by the state but are at the same time profit-oriented units, which make the patients pay for the services in order to cover the running costs of the facilities, while the state provides for the salaries of doctors and nurses. Doctors and nurses at village clinics and township hospitals who had previously provided serv-

ices on a private basis, have since 2007 been integrated into NRCMS and receive a monthly subsidy of 80 ¥ RMB (100 ¥ [Yuan] RMB [Renminbi] was equivalent to 11 € in September 2011) from the county in recognition of the administrative workload generated by the new system. Since 2009, the provincial authorities have demanded an amelioration of the payment for doctors and nurses. Since then, the county has paid an additional monthly subsidy to village doctors of 200 or 500 ¥ RMB, depending on qualification. However, 125 of the total of 130 village doctors do not have the certificate which qualifies them as village doctors and only receive the minimum of 200 ¥ RMB. In addition, bonuses are given to the doctors at the end of the year. The total average monthly income of a village doctor in 2009 was 700-800 ¥ RMB, including the mentioned subsidies, but some of the most qualified village doctors could generate an income of up to 3,000 ¥ RMB per month. In 2007, 18 doctors on the state payroll in township hospitals were reported to earn 1,000 to 1,200 ¥ RMB per month. The payment of a nurse of 1,345 ¥ RMB per month is slightly higher, because nurses are not eligible to bonus payments.

3.2 Inclusion and exclusion of local providers

The subsidies from county and higher level government bodies benefit only those health care providers participating in the NRCMS, which is defined as a new county-run insurance system introduced in 2006 (Klotzbücher et al. 2010a). The County Health Bureau places village doctors on its payroll and expects compliance with its orders. Thus, the County Health Bureau is able to improve the operation and control of the insurance system and to improve health care services, which is of major importance in order to give peasants confidence in the system. However, by integrating the medical personnel into NRCMS, they lose their autonomy and have to learn to comply with state rules and procedures. They are compelled to embark on a process of reorienting themselves from their individual profit-seeking attitude to being ‘representatives’ of the new insurance schemes designed by the state. That this new position is not always a comfortable one is shown by the fact that doctors sometimes have an unpleasant buffer function between the insurance administrators and patients in cases of dissatisfaction with the medical scheme (limited reimbursement, lengthy administrative processes, etc). This is especially true in the mountainous

areas where doctors are the only available contact point for the patients. The new medical standards, paperwork for NRCMS, deduction of fees, and obtaining refunds from NRCMS, combined with the decrease in income resulting from standardised fee structures, have given rise to considerable frustration on the part of the doctors (Interview I-06/06). Instead of working at their own risk as in the 1990s, they must transfer all fees received from their patients to NRCMS on a monthly basis and are then reimbursed in accordance with established tables (Interview I-02/09). All this implies that doctors have to follow standardised practice, comply with rules and make their income transparent to the state. They are part and parcel of a nationwide system and have to give up their autonomy for the sole advantage of being a state employee.

The right of staff allocation is taken over by the County Health Bureau, which thus exerts control over local medical agents. Medical qualification and performance standards are established as the main criteria for recruitment of medical personnel and provide legitimation for intervention at the grass roots level. This is clearly shown by data collected at the township level: in 2006, 30 positions were advertised for medical-technical assistants, nurses, medical assistants and doctors. A competitive examination procedure was designed for the whole district. The procedure, which also included an oral examination, was supervised by the Bureau of Personnel at the prefecture level. All participants had at least one year of professional experience after graduation from a medical high school, which provided basic medical training at the secondary level. No nationality quota was applied (Interview I-04/07). However, the testing was exclusively focused on knowledge of Western Medicine. The questions for the written examination were provided by the provincial government. Of 216 applicants from Xinyuan, 90 were retained for final consideration and 30 were finally selected for appointment.

Similar recruitment standards are formulated for employment in villages: here a period of at least three years of practice is expected before appointment after a semi-open selection process under the guidance of the Villagers' Health Committee (Interview I-02/09).

The implementation of NRCMS and the inclusion of village doctors into this system are used to strengthen quality control: doctors practising in villages and in pastoral areas will have their services recognized by NRCMS only if they meet the required qualification standards. The

economic survival of doctors who are unwilling or unable to adjust to the new requirements is threatened. Doctors not meeting the basic formal qualification requirements have the possibility of being converted to officially recognized village doctors upon passing a provincial examination.

The effect of these measures, as seen in Xinyuan and other counties of the Kazak Yili Autonomous Prefecture, is that traditional healers or doctors of Traditional Kazak Medicine (TKM) do not meet these standards and have difficulties in coping with the institutionalisation of their profession. As their knowledge is not part of what is required to pass the exams and as they are unable to perform in terms of Western Medicine, they are excluded from the system (Main 2011). Medical treatment at the Department for Traditional Kazak Medicine at the Xinyuan County hospital is included in NRCMS and thus reimbursable, but according to NRCMS rules patients have to pay out-of-pocket for the treatment of traditional healers by non-state health providers below this level.

In addition, the inclusion into NRCMS does not privilege the village doctor as the exclusive agent for his/her village, but in fact reduces the power of the village doctors: the scheme allows participants to choose freely between doctors within the county with more or less the same price standards for outpatient treatment at the respective administrative levels.

3.3 Geographic inclusion of the valleys and exclusion of the summer pasture in the mountains

The payment of subsidies does not only have an impact on inclusion or exclusion of providers, but also on that of geographical areas. Deciding on where and how many medical staff are available in the villages implies the possibility of prioritisation. In the case of Xinyuan County, the decision was taken to provide services in the valleys and *leave the mountains unserved*. The decision to disconnect the mountainous pasture lands from easily accessible service and to concentrate on developing the accessibility to state provision in the valley is a decision taken in order to influence where and how people settle down. It is a decision taken within the framework of post-modern state governance aimed at using non-coercive methods to reach the policy aim of sedentarisation. In contrast to the sedentarisation policy implemented by state coercion in the past, subsidised state health care can be used as a *non-coercive pull-factor* attracting nomadic or semi-

nomadic people to the new settlements designed and assigned by local governments. In addition to providing subsidies for housing and schooling facilities, including school housing and teaching staff, state-subsidised health care makes life in these areas so much easier that more and more people will – so the government logic goes – give up their nomadic lifestyle.

The non-availability of state provision of health care service in pastoral areas is a well-designed measure. There are no laws at the central government or party level for health care services in pasture areas, except for a circular with non-binding recommendations jointly issued by the Ministries of Health (MoH) and Finance in 2008, which reads as follows:

“Fourth, in old revolutionary regions, regions with national minorities, near the frontier or in poor regions, pilots of mobile health service and telemedicine should be conducted for improving health service quality and medical standards” (Weinong weifa 2008-17).

However, the Central Government did not provide additional subsidies. The Central Government called for pilots providing mobile services for nomads, but the local government in Xinyuan decided not to respond to this call, although the Vienna and Shihezi teams were sent to Xinyuan to explore the possibility of mobile hospitals for Kazak herders. It clearly discerned the *optional* character of these calls for pilots. Consequently, no pilots for herders’ clinics or telemedical facilities to obtain instant diagnostic feedback and results from laboratory tests were financed by the county health administration between 2005 and 2009.

This move is quite astonishing given the fact that our survey clearly shows a need for better service in the pastoral areas. While the local government showed a high degree of responsiveness to the needs of the population in the process of implementing NRCMS in the region (Klotzbücher et al. 2010a), the county government refrained from responding to the needs of a large semi-nomadic population. Mobile clinics, where they exist, are the result of initiatives of township hospitals and/or of village heads and were created without government interference. One village head ‘persuaded’ the village doctors to accompany the herders’ families into the mountains (Interview I-10/07). Whenever we found doctors – most of them of Kazak background – providing services in yurts near the herders, they explained to us that they had economic or personal reasons to spend their summer in the mountains. These ad hoc solutions at the township level are operational

solutions which do not follow the state logic and are consequently regarded as irrelevant when it comes to the County Health Bureau formulating its policy on how to tackle the challenge of medical services for herders in pastoral areas. The state governance logic consists in disregarding the health needs of the herders and opting for solutions which have the potential for discouraging their nomadic lifestyle.

In contrast to the state's non-action as regards nomadic and semi-nomadic herders in the mountains, the "expansionary" state increases the accessibility to medical service in the valleys: according to recent plans designed at the central and provincial levels and implemented by the County Health Bureau, each village health station should be equipped with at least one doctor and one nurse. As part of this programme, Xinyuan County established seven "pastoral hospitals (muye yiyuan)" in 1995, some of which are under township and some under village administration. None of these pastoral hospitals are mobile. The Chinese technical term is in fact misleading, because all these facilities are stationary and located close to winter settlements (in most cases in villages of Kazak pastoralists). During the summer, the doctors can only treat herders after many hours on horse or motorcycle after being contacted by phone. No subsidised doctors were allocated to mobile communities or villages with a high percentage of pastoralists. Instead, pastoral hospitals which had existed since the 1990s (according to plans earmarking medical personnel and services for the seven summer pastures in the highlands of Xinyuan County) were turned into village health posts (*cun weisheng shi*) under the administration of a township hospital. As the clinics were to be staffed by only one doctor and one nurse, each surplus doctor or nurse was either transferred to other health institutions, or had their contracts terminated. At present, six of these health posts are staffed by 12 medical personnel (three licensed doctors, six village doctors and three nurses) in Xinyuan County. One pastoral hospital (Shaha Pastoral Village) was closed because an earthquake had destroyed the school building. The village health post building was therefore turned into a school, and the retired doctor had to use his own house as village health post. No replacement for his position had been allocated at the time of our survey. (Interview I-II/07). However, due to the absence of some 80% of the herding population during the summer months, the pastoral hospitals in the valley are overstaffed for almost half of the year.

4. Local implementation options for pastoral health care

Besides these national trends, central agencies, local administrations and scientists have formulated different strategies for improving health care for pastoralists in Xinjiang. This chapter discusses policy options and policy-making during in the period from 2005 to 2009. We argue that bottom-up solutions like mobile health stations are ‘breakthroughs’ which reflect and build upon the strengths of the local diversity in the area. They should be regarded as belonging to the portfolio of subsistence strategies (as described by James Scott) people have developed in the area. As such, they are not compatible with options of the central state aiming at the extension of existing administrative patterns or procedures to peripheral areas. Compliance with a top-down implementation is not compatible with bottom-up breakthroughs.

4.1 Mobile clinics vs. a national unified service organisation

The idea of mobile clinics has its own tragedy. Mobile clinics are needed for better health care and prevention, but they contradict the idea behind the ongoing restructuring of the rural health care system. They cater to the needs of the Kazak people and their culture of mobility (Cui 2002, 2005; Mejias 2009), but they do not comply with state scenarios for the future of nomads in China.

In the summer of 2005, the project team of Chinese and Austrian researchers started conducting interviews with administrators from the provincial and county levels about health care provisions for the summer pastures in Xinjiang. The situation of health care for pastoralists was considered unsatisfactory; consequently, since 2005, the Provincial Health Bureau has been considering ways of improvement and prepared in 2005 an internal document for circulation at the central level, wherein the lack of service is addressed and the advantages of the pastoral clinics discussed. The document opted for more financial and human resources as a basis for a better service in the pasture areas (Xinjiang Weishengting 2005).

On this basis, the team developed a plan for mobile health clinics. The model was based on results of the above mentioned field study and designed after extensive talks with stakeholders. It ties in with experiences gained at an already operating pastoral health station at Biesituobie Town-

ship in Xinyuan County. However, instead of demanding more personnel and buildings for the pasture area, the researchers opted for mobile health units under the leadership of the township hospital. They were to be staffed by experienced surplus doctors and nurses from the township hospitals, and not by the generally less qualified health workers from the village health stations. This advice was given as we could show that herders would only make use of the mobile clinic if they had confidence in the quality of its services. Also, we could show that doctors would only be willing to go to the pasture areas if they stayed on the state payroll.

Solutions do not need to be costly. The running costs for this model were estimated by us at less than € 7,000 p.a., including write-offs for 'hardware'. The estimated cost of the initial investment in hardware for one pilot station was calculated at approx. € 6,500.

However, while this policy advice catered to the need of the herders and cost considerations were favourable to the local government, it did not comply with the overall health policy of the central government, as described above. The priority for the Central Government in Beijing lies with general problems applying to all of China. It intends to build up a three-tiered rural health care system with a stationary concept of primary health care. Health posts are to be established in villages and no further funding or subsidies for mobile clinics from central level are envisaged. The homogenised local health care administration and service institutions lack the flexibility required by the mobile community of herders and their families. They do not provide for special solutions or additional subsidies regarding health care for semi-nomadic herders. As the special life style and health requirements of nomads are generally not considered, it is difficult to attract additional funding for adequately qualified doctors in the pastoral areas. (Interview I-14/07). Claims for more funds are also difficult to sustain in the light of studies which show that the average ratio of medical personnel/population is already higher than in other areas of Xinjiang (Huang et al. 2010).

The proposed mobile health clinics were supposed to be an administrative part of the township hospitals and would have fitted quite well into the three tier health system. However, the Director of the Finance Section in the Provincial Health Department cautioned that the administrative upgrading of village health stations and pastoral clinics to the level of town-

ship hospitals, an upgrading which, according to his logic, would have been necessary to establish mobile health clinics, would be too costly and that there was no budget available at the provincial level. To apply for central funds would be difficult as there was no provision made by the central legislation for special health care in pastoral areas. Without this provision, the Section for Financial Planning of the Xinjiang Health Department can neither pay for special health care for the pastoral areas from its own funds nor apply for additional funding at the central level. Due to the absence of special budgets from the provincial and central governments, additional funding provided at the local level or by international donors would be a prerequisite for the success of the model (Interview I-14/07).

The Provincial Department of Rural Health Care had argued for more and better equipped mobile doctors in the pastoral areas and urged for more consideration of local diversity by the central state authorities in 2005. However, the Central Government regarded the regional and cultural factors of health care as obstacles to establishing a unified primary health care service structure. Confronted with the problems of government control of rural areas, the Central Government's policies were focussed on overcoming the distance between the state and rural society. Central policies were aimed at extending state structures and services to settled agricultural communities. Mobile health care stations run counter to this logic. In this context, to implement the idea of mobile health care would have been politically risky. Of course, the local agents at the county level are more interested in projects without political risk. In addition, compliance with state policies pays; breakthroughs at the local level have to be paid. Therefore, the proposals of the project team, although well received in principle, did not meet with sufficient support from either the local or the provincial leaderships.

4.2 Charity funds from Hong Kong for mobile health care

Another option was discussed intensively within the provincial administration in 2007. A rich patron from Hong Kong had pledged funds for pastoral health care to the MoH. The International Office (*guoji hezuochu*) of the Center for Communicable Diseases in the MoH suggested Xinjiang as a possible location and pastoral hospitals as a possible project (Interview I-02/07, I-15/07). The donor would provide funds and let the provin-

cial health administration decide on the implementation. The donor had indicated that funds should be used for new buildings and equipment of pastoral hospitals, particularly in southern Xinjiang and in the Altai region, where the donor's 'Hong Kong group' already co-operates with village health posts, attracting the interest of the public with the distribution of gifts. In official language, the outcome of this initiative is 'unclear' (Interview I-02/09).

This model thus does not contribute to the implementation of the national inclusion strategies. It does not open up new models for funding on a broad provincial or even national level and does not solve the problem of human resources, which had turned out to be a major obstacle in running mobile clinics, according to our research.

4.3 Renovation of existing (stationary) 'pastoral hospitals'

In the autumn of 2006 at the same time as the discussion on the mobile clinic was taking place, the Xinyuan County Health Bureau applied for Central Government funding to upgrade seven existing stationary pastoral clinics to become independent from the township hospitals, obtain the same status and be equipped like hospitals at the township level. As part of their plan, doctors would receive 100% of their pay from the State. This would generate additional costs, to be provided by the Province (Interview I-04/07). The County proposal also included the construction of six new village clinics of 300 m² each (Interview I-02/07). The Xinyuan County application was successful: the necessary funds were transferred through the Province to the County Finance Office for disbursement in 2009.

Similar to 1994, the County applied successfully for subsidies for the renovation of pastoral hospitals. 300,000 Y RMB (€ 36, 300) for six clinics of 300 m² each was received in January 2009 from the state budget. The six new pastoral clinics were constructed at settlements with a relatively high density of herders. They are administratively supervised by the County Health Bureau. The township hospitals concerned are responsible for technical management and control and also provide equipment and staff.

This decision is not uncontroversial: the Director of the Center of Disease Control (CDC) at county level heard of this County initiative and felt that this would only be a second best alternative to mobile health stations (Interview I-08/07, I-04/09). Other agencies, e.g. the director of the

local NRCMS bureau, said that mobile health stations would have been a much more effective measure to improve accessibility to the health service (Interview I-02/09).

However, low cost and bottom-up solutions were disregarded when external funding became available and higher compliance with central governmental policy became possible. The project team made clear in its proposal that no additional posts, but rather flexibility and mobility of health personnel would be required for staffing the mobile health stations during the summer months. However, as early as 2007, county and province health administrators had pointed to the incompatibility of mobile pastoral stations with the government logic.

Another factor was gaining importance during the talks of 2007 and especially in 2009. The sedentarisation of herdsmen with their families in the valleys is one of the untouchable key policies in Xinjiang and marked as an important factor of policy-making. Government and Party at the provincial and county level regard semi-nomadic pastoralism as economically inefficient and ecologically problematic. Nevertheless, provincial health administrators made it clear that the high political ambitions of building new settlements for the herders had turned out to be impracticable since 2005 (Interview I-15/07). Semi-nomadism as a production pattern is not disappearing, and herders stated that the number of people and animals on the summer pasture is increasing. These trends should nourish arguments in favour of strengthening the health service in pastoral areas. However, national policies do not allow for this kind of responsiveness. It is a political dogma that sedentarisation will, in the long run, solve all problems of semi-nomadic economy and lifestyle (including health care service), as these are the results of an anachronistic and non-ecological form of pastoral economy.

This all-in-one-solution is highly ideological and lacking any supporting evidence. No efforts are being made to quantify, in a long term study, the effects of sedentarisation in terms of income growth or the better health status of new settlers in comparison to pastoralists. Instead, state administrators continue to draw the herdsmen away from the humid meadows in the high plains to the new settlements in the dry valleys. They intend to discourage nomadism in summer pastures and try to transform herdsmen into farmers (Interview I-15/07). Excluding the summer pastures as spaces of nomad mobility from state-funded health care service and extending

administration and service in the valleys, is looked at as a feasible and non-risky way to achieve this aim. Simultaneously, health administrators secure their positions by showing how health care policies can be the *pull-factors* for encouraging the herders to settle in newly built valley villages. Last but not least, to integrate the sedentarisation policies with the homogenisation of health care structures can demonstrate compliance with upper levels.

According to James Scott, the policy of the central and provincial governments in the PRC conforms with the aim of projecting state power into the most peripheral areas of the country and to the most marginalised people who so far have survived, despite state negligence. Although the sedentarisation of the Kazak herders might not have a positive economic effect on the development of Xinjiang, it surely is designed to have a positive effect on the stability of an otherwise highly contested border region. The moving of the Kazak herders between China and Kazakhstan does not comply with the idea of the nation state. The fact that they prefer life in the mountains despite hardship induced by cold weather, lack of sanitary equipment and dietary deficiencies is regarded by the Han dominated state as a form of self-barbarisation, which cannot be allowed to continue.

5. Conclusion

The different approaches to pastoral health care in Xinjiang since 2006 provide insights into the decision-making process and the implementation of policies in the field of health care in regions of ethnic and cultural diversity. The County and Provincial Health Department have realised the need for action in pastoral health care. The existing pastoral hospitals do not satisfy the health needs of herders. Health service in the hills or on high plains is inadequate or absent. However, the county did not opt for a low-cost solution to establish mobile clinics in the mountains, but relied on funds for the renovation or upgrading of facilities in the valleys. This focus on the winter settlement areas ignores the needs of the semi-nomadic population during the summer pasture. The prioritisation of health care in the valleys complies with central state policies of unification and homogenisation, but also serves the aim of inducing the Kazak herders to give up their semi-nomadic lifestyle.

In our analysis, we argued that welfare or health care policies should be seen as a strategic tool of post-modern governance in China. The modern state, analysed here with James Scott's theoretical approach, tries to project its administrative capacity to the very last edge of its territory. As Scott put it, a characteristic of the classic states of Southeast Asia was to colonise the hills and relocate the so-called barbarians in order to exploit production in the valleys, even with coercive means like slavery etc. The 'modern barbarians' – like the Kazak nomads – are characterised as sticking to economically backward or ecologically unsustainable production and migration patterns. Through its logic of modernisation, the state claims to know that the lifestyle of these peoples is inadequate, both for themselves and for the requirements of state modernisation, and therefore feels legitimised to force them into compliance with central policies.

Regarding the post-modern state, we argue that it has the capacity to integrate the peripheral peoples into a state-paid system of welfare or medical service. They have to settle in the valleys, become members of NRCMS and give up nomadism. Only once settled in the valleys and as members of NRCMS, they are able to profit from state-subsidised medical care. The state builds up a service system of health care that disconnects 'escape medicine' (a term inspired from Scott's [2009: 23] notion of "escape production") and their representatives, such as traditional practitioners of TKM, from the system. Financial support from the central level, the integration of the rural areas into NRCMS and the township hospital system have facilitated the management of the local health care system by the County's health administration.

Bottom-up initiatives such as the introduction of mobile pastoral clinics do not comply with the aim of homogenising the rural health care system because they tend to preserve the mobility of the Kazak herders and their culture. They are therefore politically risky for local governments, particularly if they are supported by foreign donors and researchers. The idea of a people-based, culturally sensitive approach legitimising diversity is not compatible with the modernisation effort of the Chinese state, which draws its strongest arguments from the deteriorating ecological situation on the grasslands caused by over-grazing.

So far, the sedentarisation policy has had only very limited effects. The future will show whether inflow of central money and the re-orienta-

tion of the rural health care system to upper levels of decision-making and unquestioned compliance with central party policies will not only ensure cost-control and financial sustainability, but also preserve local diversity.

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I-04/07: Party Secretary for Health and Chief of Health Office of Xinyuan County, X County, 17.7.2007.
I-08/07: Director of Center for Disease Control in Xinyuan County, X County, 18.7.2007.
I-10/07: Village head and herdsmen of Sh Pastoral Village in T Township, Sh Pastoral Village in T Township, 18.7.2007.
I-11/07: Director of H Township Health Center, and Village Doctor of Sh Village in H Township, Sh Village in H Township, 19.7.2007.
I-14/07: Deputy Chief for Financial Health Planning, Health Department of Xinjiang Uyghur Autonomous Region, U City, 26.7.2007.
I-15/07: Chief and Deputy Chief for Rural Health, Health Department of Xinjiang Uyghur Autonomous Region, U City, 26.7.2007.
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Abstracts

Using James Scott's (2009) theoretical framework of the interaction between the state and peripheral people, we argue that the welfare state should be regarded as a *pull-factor* in the context of the state's endeavours to project its power to distant peoples in assigned state zones. Our discussion is based on interviews in Xinyuan County in the Western part of the Xinjiang Uyghur Autonomous Region, China. Presenting current policies and alternative policy options discussed at the local level for providing primary health care in rural China, we argue that decisions made in the implementation process did not respond to the special health needs of mobile pastoralists in the high plains, but were part of the central state logic of homogenising settlement efforts and health care.

Der theoretische Ansatz von James Scott zur Expansion von staatlicher Ordnung auf periphere Gebiete wird auf den Aufbau von Wohlfahrts- und Gesundheitspolitik des modernen Staates angewendet und weiterent-

wickelt. Anhand mehrjähriger Feldstudien zwischen 2005 und 2009 zur Gesundheitsversorgungsstruktur im Kreis Xinyuan der Autonomen Uighurischen Region Xinjiang in der Volksrepublik China werden zuerst die nationalen Restrukturierungsmaßnahmen vorgestellt und Lösungen für eine bessere Versorgung der halbnomadisierenden kasachischen Hirtenfamilien diskutiert. Lokal entwickelte und an die nomadischen Lebensformen angepasste mobile Lösungen zur Gesundheitsfürsorge konnten nicht implementiert werden. Die Anstrengungen der staatlichen Akteure sind als Versuch zu sehen, bisher marginalisierte Gruppen aus den peripheren Gebirgsregionen über die Integration in eine staatliche Gesundheitsversorgung in den Tälern anzusiedeln.

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