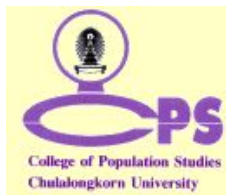


Migration and Health in China: Problems, Obstacles and Solutions

Xiang Biao



ASIAN METACENTRE
FOR POPULATION AND SUSTAINABLE DEVELOPMENT
ANALYSIS



HEADQUARTERS AT ASIA RESEARCH INSTITUTE
NATIONAL UNIVERSITY *of* SINGAPORE

Xiang Biao (BA and MA in Sociology, Beijing University; PhD in Anthropology, Oxford) has worked on migration and social change in China, India and Australia over the last decade. His main work includes a long-term ethnographic study on a migrant community in Beijing (*A Village beyond Borders*. Chinese by Sanlian Press, 2000; English by Brill Academic Publishers, forthcoming), a sociological research on migrant workers in the Pearl River delta in southern China ("*Peasant Workers*" and *Urban Development*. Beijing University, 1995; partly reprinted in *Chinese Youth Studies*, 1998, issue I-VI) and an interdisciplinary study on migrant Indian computer professionals in Australia (*Global "Body Shopping"*. 2002, PhD thesis and Princeton University Press, forthcoming).

Xiang published a series of articles in journals including *International Migration*, *Asian and Pacific Migration Journal*, *China Quarterly* and *Chinese Social Sciences Quarterly*, and a few of them were reprinted. He also contributed papers to the *World Migration Report 2003* (International Organization for Migration) and other edited books.

Xiang was a Research Officer of the International Organization for Migration (2002) and a Visiting Fellow of University of Wollongong, Australia (2000-01). He is a member of the Scientific Advisory Board for the World Congress on Human Movements and Immigration in Barcelona (2004) and members of various professional bodies. He was extensively involved in policy consultations for government and non-government organisations in China from 1993 to 1998 and was interviewed by media agencies including BBC, ABC (Australia), Chinese Central TV and Chinese Central Radio.

Abstract

There are currently at least 85 million rural-urban migrants in the mainland China. These migrants face great health risks, yet are not recognised or covered by any medical care scheme. This paper demonstrates that the key issue for migrants' health is not their social characteristics such as low income or the lack of health awareness, as most literature has emphasised, but lies in the institutional arrangements regarding health security and service provision. Unlike in other countries, rural-urban dualism and a unique household registration system in China render migrants unable to access public services in either cities or villages.

I will first review the basic health problems facing migrants, and then explore the question of why migrants are not included in the new medical care system that supposedly aims to cover as many people as possible. I suggest that the reasons lie in various structural and institutional factors far more fundamental than medical care itself. They include the rural-urban divide in welfare provision; the potential conflicts between the government's immediate goal in medical care reform (to relieve State-owned enterprises from welfare burdens) and the costs of including migrants in the system; the tension between the informal employment relationship prevalent among migrants and the current medical care schemes' reliance on formal employment relationship in implementation; and finally the friction between migrants' mobility and the scheme's localised operation pattern. Alternatively, I suggest that grassroots activities can become an important means of providing basic health services for migrants. Activities proven to be effective in practice include providing health education, extending urban community health services to migrants, allowing for or even encouraging the setting up of clinics by migrants themselves, and empowering migrants by providing legal assistance and developing migrants' self-help organisations. Though these activities cannot change formal policies immediately, they may have far-reaching institutional implications in the long run.

Acknowledgement

This paper is a preliminary report of my project of the same title funded by the Asian MetaCentre for Population and Sustainable Development Analysis and the Asia Research Institute, National University of Singapore. Many people have offered me generous help. Among others, Drs Shi Xiuying, Zhe Xiaoye, Tang Jun, Yang Tuan, Huang Ping from the Chinese Academy of Social Sciences (CASS) shared with me material and views. Ms Tan Shen from CASS provided me with her very valuable information and insights based on her long-term involvement in research on migrant welfare. Dr Sara Cook from the Ford Foundation in Beijing pointed me to various valuable contacts and literature. I particularly benefited from her insight about the tension between the informal employment relationship prevalent among migrant workers and the formal medical care scheme. I also benefited from interaction with Dr Xiong Pingyao from Beijing University, Dr Gong Sen from the State Council Development Research Centre, Dr Yuan Yue from Horizon Survey Company and Dr Li Weiping from the Ministry of Health. Dr Yang Xiushi at Old Dominion University shared with me his work on HIV and temporary migration in China. Professor Brenda Yeoh and Ms Verene Koh at Asian MetaCentre offered generous help throughout the project. Finally, I would like to thank Dr Gu Xin at the Institute of East Asian Studies of the National University of Singapore, Ms Doreen Montag at the University of Heidelberg, Germany, and Ms Theresa Wong and Mr Leong Wai Kit at Asian MetaCentre, for their careful reading of the earlier versions of this paper and constructive suggestions for revision.

List of Plates

- | | |
|---------|--|
| Plate 1 | Migrants in Beijing |
| Plate 2 | Rubbish Collecting is an Important Occupation for Immigrants |
| Plate 3 | The Living Condition of Migrants in Beijing |
| Plate 4 | An Open Medical Consultation Organised by a Residential Committee in Beijing |
| Plate 5 | A Clinic Set Up by a Migrant in Zhejiang Village, a Migrant Community in Beijing |

Introduction

The recently-released China's Fifth Population Census reported 121.07 million internal migrants as of the year 2000 (Population and Social Sciences Department, National Statistic Bureau of China, 2001). This is about double the UK's national population, three times that of Spain's, six times that of Australia's and 30 times that of Singapore's. Among them, more than 70 per cent were rural-urban migrants, equivalent to 85 million, though a more commonly cited figure in official speeches and public media is 100 million. These migrants are at their most economically-active ages - almost 70 per cent between the ages of 15-49 and 20 per cent between 25-29 (National Statistic Bureau of China, 2001). Undoubtedly, they play a crucial role in China's current growth regime, namely an economic development model based on labour-intensive manufacturing industries.

The macro-economic impacts of rural-urban migration in China, such as its contribution to industrial development, to the inflow of Foreign Direct Investment, and to the agricultural efficiency as a means of relieving surplus rural labour, have been well documented and researched. While this paper shares with this literature the overarching concern on the relationship between migration and development, it is part of a research agenda that tackles the issue from a different perspective, namely by linking migration and development through human resource formation and enhancement. Migration can be a process that enhances human capital. For example, through migration migrants learn new skills, accumulate both material and social capital (networks), obtain greater access to services, particularly health and education services, for both themselves and their families.¹ But migration can also be detrimental to human resource development. Given the fact that migrant workers often suffer from ultra-exploitation at work, yet are hardly covered by any labour protection and social security measures, migration may turn a healthy labourer to an ill person.

Some recent news reports in China may give us an idea how damaging migration can be as far as its health consequences are concerned. For example, as many as 70,000 female workers, mostly migrants, at shoemaking factories in Putian County, Fujian Province had suffered from benzene poisoning by 1996. Benzene damages the blood and nervous system and can be fatal; it is also very difficult to cure (see Chen 1996). In a few villages in Shangcheng County, Henan Province, about 200 returned migrant workers acquired severe pneumoconiosis as a result of working in quartz factories in Jiangsu Province without any protective measures. At least five of them had died and two were fighting for their lives by late October 2001 (Gao, 2001). In another case, more than 50 young male peasants in a village in Taishun County, Zhejiang Province, suffered from the same disease as a result of working in a construction project in Liaoning Province (for more details see below). All of them had subsequently lost their ability to work, and need life-long treatment. By the end of 2000, China had a total of 425,000 patients suffering from this disease (Gao, 2001). It

¹ During my fieldwork with migrant workers in the Pearl River Delta in southern China in 1994, I sensed a strong tendency of "petty bourgeoisification" of migrants. "Petty bourgeoisification" refers to the process by which migrants better their status from being employees to becoming small business owners. For them, the most attractive places to settle down are usually small towns or newly-developed cities close to their native villages, rather than the metropolises. In these places, the barrier to market entry is lower and their savings can be better utilised.

may not be exaggerating to suggest that China will have a huge population of unproductive, and even ill people comprised of former migrants, in one or two decades.

Given the massive scale of internal migration in China, the health of migrants matters not only for themselves, but also have important implications for the larger society. During the recent SARS crisis in mainland China, migrants were the most worrying group for the government and society.² They were worrying not only because of the perception that they are mobile and may therefore spread the virus to a greater extent, but also because they seldom seek timely medical treatment when sick, due to low incomes and to being excluded from medical care system (see below). This made them a particularly dangerous potential source of SARS infection. Partly because of this, the central authorities ordered all hospitals in China to offer free treatments for SARS patients who have financial difficulties.

Existing literature on migration and health in China, in both English and Chinese, focuses mainly on STD, HIV and reproductive health (e.g. Hansen and Li, 2002; Yang, 2002, 2004). Most papers are descriptive and take a biomedical approach. Yang Xuishi's papers are among the few that pay attention to the social dimension by calling attention to migrants' presumably special behaviour patterns in examining the links between migration and HIV, but they still fall short in providing an institutional analysis. At the same time, there have been many academic analyses and policy discussions on social security system reform in China from the perspective of institutional analysis, but this literature has been predominated by a rural-urban dualist framework and treats the rural and urban societies completely differently and cannot accommodate rural-urban migrants. This is fundamentally a reflection of the policy framework in reality. In China, the urban medical care system is under the charge of the Ministry of Labour and Social Security (this also directly reflects the employment-based nature of the medical system, which I will tackle later), but it is still not clearly designated which department should be the focal point for rural medical care. This paper attempts to fill these gaps by offering an institutional analysis on the relationship between migrants and the current health service provision system in China.

To this end, this paper proceeds in the following way. The first section describes the basic health problems that migrants are facing. The second section offers a political economy analysis on China's medical care system and discusses migrants' relation to this system. I suggest that it is due to a series of institutional barriers that are far more powerful than medical care itself that migrants are excluded from the system, and for the same reason migrants are unlikely to be included in the near future. Moving away from the discussion on formal policies, the third part of the

² During the week of 18-24 May, 15 migrant workers were confirmed to be SARS patients and 33 were hospitalised as suspected cases in Beijing, forming the single largest group by occupation (Ministry of Labour and Social Security, 2003). Nationwide, rural-urban migrants and farmers made up 7.42 per cent of all the confirmed SARS cases in the period of 26th – 30th April and their share jumped to 14.81 per cent during 21st – 25th May, becoming the second largest group by occupation, only marginally less than persons without formal employment (15.74 per cent) (Ministry of Health, 2003). Migration has also been blamed as a cause for the spreading of the virus from cities to the countryside. As of 15 May 2003, most outbreaks documented in 85 rural counties can be traced to mass migration (Garret, 2003). Hebei province has nearly 3 million labourers working outside of the province, many in Beijing, and 1.28 million returned home by mid-June. By 16 June, the province reported 215 SARS cases and 12 deaths, and the provincial authorities estimated that as many as 90 per cent of them returned from Beijing (Furutani *et al.*, 2003). In Hubei province, which is a major place of origin of migrant workers in Guangdong, 17 suspected cases were reported as of 19 May and 10 of them were returned migrant workers (Zou, 2003).

paper reports various grassroots activities that can constitute an effective means of providing health services to migrants. Though these activities cannot change formal policies immediately, they have important institutional consequences, particularly by creating a new arena for delivering health services, and also, by increasing migrants' bargaining power in the workplace. This paper is based on my documentary research conducted during the period from December 2002 to May 2003 and fieldwork investigation in Beijing and Zhejiang, China, in April and May 2003. During the fieldwork, I interviewed about 20 researchers and policy makers in the Ministry of Health, State Council Development Research Centre, Ministry of Labour and Social Security, Beijing University, Qinghua University and other institutes. I visited Dashila Street of Xuanwu District, Beijing, and its Community Health Centres, and interviewed officials, health workers and residents there. Apart from this fieldwork, I also draw on information from my earlier long-term research with migrants in China starting in 1992, particularly my work on migrants in the Pearl River delta and on a migrant community in southern Beijing.



Plate 1: Migrants in Beijing

Health Problems Faced by Migrants

Work-related injuries and illness

It is widely known that migrants typically fill job positions that are unwanted by urban workers and have high health risks, which are sometimes referred to as “3-D” (Dirty, Dangerous, and Dead-end/Difficult/Demanding) jobs. According to a survey conducted by Tan and her associates in 1994, about one third migrant workers in six cities in the Pearl River delta believed that their health had been affected by their working conditions, particularly by noise, dust and poison (Tan, 2002 [2001]: 145). An incomplete estimate reported 12,000 work-related accidents and more than 80 deaths a year in Shenzhen City, Guangdong Province, most of the victims being migrants (cited in Tan, 2002 [2001]: 145). In 2000, some migrants died when a factory in Huizhou City, Guangdong Province forced workers to work more than 500 hours a month (Sun, 2002: 154). Indeed, a report on work-related accidents and illness submitted to the State Council by the then-State Economy and Trade Commission in July 2000 identified migrant workers as the main victims of all work-related health problems (cited in Tan, 2002 [2001]: 145).

Work-related health problems include work-related injury and work-related illness. Based on her investigation in migrant-sending places, Tan estimates that about 1-2 per cent of all male migrant workers had work-related injuries (Tan, 2002 [2000]: 255). In 1998, Shenzhen reported 189 cases of migrant workers becoming physically disabled at work, mostly losing fingers or arms (Yu, 2001). More strikingly, it was said that there were about 300 clinics in Kai County, Sichuan Province, offering surgery to reattach severed fingers and arms. There were 200 similar clinics in Jinjiang County of Fujian Province. While the clinics in Sichuan mainly target returned migrants, the Fujian ones serve immigrants who are injured there (Huang and Zhan, 2003). A news story reports that a visit to the surgery department of a hospital in Hangzhou, the capital city of Zhejiang Province, would find that most patients are migrant workers with injuries from work (He, 2002).



Plate 2: Rubbish Collecting is an Important Occupation for Immigrants

Far more serious than injuries are chronic diseases acquired from work. Besides the high treatment costs, victims of chronic diseases often develop symptoms only after leaving the workplace; sometimes it is even difficult to determine which factory should be responsible for the disease. Pneumoconiosis, which has been found among many construction workers, is such a disease.³ In one case, about 200 migrant workers in Liaoning Province worked for eight hours everyday in air with 97.6 per cent of silicon dioxide without any protective measure. Silicon dioxide cannot be dissolved in the body and in the long term would clog the alveoli. By October 2001, out of these 200 migrants, 10 had died and 192 of them were confirmed to have severe pneumoconiosis. Most of them had lost their basic capabilities to work. These workers had no any medical insurance and a few had to stop medical treatment half way due to financial difficulties (see Pan *et al.*, 2001, Dai *et al.*, 2001).

Benzene poisoning is probably the most common serious chronic disease found among female migrant workers. Large numbers of benzene poisoning cases have been reported in Beijing, Hebei, Zhejiang, Fujian and Guangdong, particularly in garment, shoes or suitcase factories, which often use cheap glue with high compositions of benzene. Female workers are also particularly vulnerable to fire accidents, mainly because they are often put in congested dormitories without basic safety equipment. In 1991, 72 female migrant workers lost their lives in a fire in Dongguan City, Guangdong Province. A fire in Shenzhen in 1993 killed 87 migrants, 85 of whom were women (Tan, 2002 [1997]: 312). Based on a collection of news reports, Tan (2002 [1994]: 79) estimated that by 1994, at least 300 female migrant workers in the Pearl River delta alone had been killed by fires.

HIV and other STDs

Rates of sexually transmitted diseases (STD) in China doubled between 1996 and 2000 (Kaufman and Jing, 2002). More dramatically, the United Nations estimates that there are over one million people infected by HIV, and both the UN and the Chinese government predict that number could reach as high as 15 million by 2010 (UN Theme Team, 2001). Experiences in other countries suggest that migration may form a vicious cycle in the spread of STD viruses: migrants are more likely to be infected, and in turn their mobility contributes to further spreading of the virus, particularly by bringing the virus to the countryside where medical facilities are poorly equipped.

According to a survey of more than 600 STD patients conducted by the STD Branch of the Guangdong Province Police Hospital in 2000, about 70 per cent of the patients were migrants (China News Agency, 27 October 2000). Based on a review of 11 studies on STDs conducted in different provinces in China, Yang (2004) suggests that migrants' share in reported STD cases varies considerably from a low of 7.5 percent in Jiangsu's Xinghua to a high of 69.0 percent in Shenzhen in Guangdong Province (see Appendix 1). Of the 236,188 cases of STDs reported in all the studies, an average of 36.8 percent involved migrants. As for the considerable variation across the studies, Yang argues that it can hardly be taken as evidence that the role of floating migration in the spread of STDs also varies from place to place and is therefore inconclusive; rather, it may reflect differences in the extent of the presence of floating migrants' in the general population across places. Lou *et al* (2001) reported

³ Construction is a major occupation where migrant workers are concentrated in. For example, nearly one third of all economic migrants (including self-employed) in Beijing in 1999 were construction workers (Liu and Wu 1999).

that similar numbers of migrant and permanent resident women in Shanghai visit specialist clinics for STDs, but migrants' diseases tend to be the more severe with complicated syndromes.

The correlation between migration and HIV incidence seems even stronger. Yang's (2004) survey in a northern province shows that among HIV-positive persons, migrants accounted for between 17.7 and 31.5 percent in 1996-2000, while migrants' share in the general population covered by the survey was only 1.8 percent. Furthermore, with the exception of the year 2000, migrants' share in the HIV positive population has generally been on the rise. Yang also reviewed 15 studies on HIV in different parts of China and found that on average 42.4 per cent of HIV positive cases were migrants (see Appendix 2). According to another survey of a small sample, unemployed migrants, migrant business persons, migrant workers and sex workers represented over 95 per cent of the HIV cases investigated in Shenzhen city of Guangdong province, and the figure was 66 per cent for Shanghai and 78 per cent for Zhejiang Province (Shao, 2002).

However, despite the strong statistical association between migration and HIV and other STDs, the underlying mechanism between the two is far from clear. The causal relationship is very difficult to establish. For example, the sex industry is often thought to be a link between migration and STDs. China's commercial sex industry has exploded in the last 20 years to include more than 3 million sex workers at present. HIV positive rates among sex workers tested in Guangxi and Yunnan in 2000 were 10.7 per cent and 4.6 per cent respectively (cited in Kaufman and Jing, 2002). It is true that a large part, if not the majority, of sex workers are migrants. Pan Suimin (2002) estimated that a sex worker typically stays in one place only for a few months. However, in many cases, migration may be a result, rather than a cause, of being involved in the sex industry. Sex workers have to move frequently in order to maintain anonymity and escape governments' regular campaigns to crack down on the industry. In other words, sex workers are better seen just as sex workers rather than "migrants", a category that also includes so many different groups. Some scholars (e.g. Hansen and Li, 2002; Yang, 2002) speculate that migrants contribute to the spreading of virus as active patrons of commercial sex due to their separation from families and the local society. But a national survey conducted by the Renmin University Sexology Institute suggested that migrant workers make up only a minor part of commercial sex clients. On average migrants buy sex more often than rural residents but less than urban dwellers. Enterprise managers and government officials are 10 times more likely than male manual urban workers to patronise sex workers (Pan Suimin, 2001; 2002), though migrant workers may be more vulnerable to STDs in individual cases, possibly due to their low usage of condoms (Hansen and Li, 2002).

The statistical association between migration and STDs may also be a result of factors commonly affecting the two variables. Yang (2004) cites the association between the numbers of temporary migrants per thousand permanent residents of a place and that place's incidence of HIV and other STDs as evidence for the positive correlation between the two. However, it may well be the case that a place with more migrants is economically more prosperous and socially more open and all the residents, both permanent and temporary, may be more prone to STDs.

Therefore, reducing mobility will not help contain STDs in China. We should be particularly careful not to lend new excuses to xenophobia against migrants by overstating the link between migration and diseases. There is also a critical policy choice to make with respect to this issue: should we identify migrants as a special

group when devising programmes for HIV protection or do other characteristics (such as age and occupation) serve as better criteria for identifying target groups? Should we regard HIV and other STDs as a special issue for migrants or should we focus more on general health services provision to migrants? As mentioned earlier, diseases such as SARS may impose a much higher risk to both migrants and the general population than HIV. Furthermore, migrants' vulnerability to HIV infection may well be caused by the lack of effective health service delivery mechanisms in general rather than because their behaviours are especially prone to HIV.

Child vaccination and health check

Vaccination rates among migrant children have been reported to be significantly lower than the average. It was estimated that in Guangdong Province only 50.8-70.8 per cent of migrant children obtained rubeola vaccination, 57.4-79.9 per cent BCG vaccination, and 50.5-74.2 per cent, poliomyelitis vaccination. These figures are much lower than the average for local children. The occurrence rate of these diseases among migrants, unsurprisingly, is disproportionately high. For example, in Guangdong Province where migrants were less than 20 per cent of the total population, migrants made up respectively 34.3, 31.0, 46.6, 51.9 and 53.0 per cent of the rubeola cases occurred in the years from 1997 to 2001. Migrant children made up 12.0, 14.6 and 12.9 per cent of all the poliomyelitis cases reported in the year 1999, 2000 and 2001 (Li, W.S., 2002).

Surveys conducted during the period from 1996 to 1998 on migrant children in Wuhan, Hubei Province, reported that only 30.2 per cent had been properly vaccinated as required by the government, and 4.0 - 7.5 per cent of migrant children had never undergone any vaccination. Only 25.6 per cent of the children participated in the regular health examination (known as "4.2.1" check) (Xiao, 1999: 761). According to a survey by a research team from China's Renmin University, 36 and 40 per cent respectively of migrant parents of children of 0-3 years and 4-6 years old never took the children to health checks (Ketizu, 2000: 48).

Reproductive health

As mentioned earlier, the majority of rural-urban migrants are of reproductive and sexually active ages. Over two thirds of female migrants are at the age of 15-45 (Ford Foundation, 2001: 83). Of them, more than 75 per cent are aged between 20 and 34 (The State Family Planning Committee, cited in Li, 2003). Unsurprisingly, a study reported that migrants themselves identified reproductive health as the health issue that they need the most help with (Guan and Jiang, 2002: 258).

Migrants' reproductive health status is worse than that of the general population's. According to several research projects funded by the Ford Foundation, about one in every seven respondents have at least one of the symptoms of reproductive tract infection (RTI), which figure is still likely to be an underestimate (Ford Foundation, 2001: 83). Compared to permanent residents, migrant women in Shanghai started their pregnancy checks later, check less frequently, and are more prone to early delivery, stillbirth, and giving birth to babies who are underweight or have an extremely low weight (Lou *et al.*, 2001: 61). According to data from the Shanghai Woman and Child's Health Institute, the delivery-related death rate among

migrant women is 5.5 per thousand, far higher than that of local residents, which stands at 2.1 per thousand (Zhan *et al.*, 2001: 199).

Apart from pregnancy and birth delivery, migrants' active premarital sexual behaviour and lack of adequate knowledge on reproductive health form another issue of concern. A survey reveals that 10-80 per cent of young female migrants in Shanghai, depending on their occupation and type of residence, have had premarital sex (Lou *et al.*, 2001: 62). Surprisingly, female migrant workers in Shanghai are even more liberal in their lifestyle than the local women, who have been reported to be the most "cosmopolitan" in China (Wang, 1999: 52-53). In southern Jiangsu Province, 24.5 per cent of the migrant women surveyed started living with partners within half a month of the first meeting, while almost 30 per cent did so within 0.5-2 months and 21.4 per cent after 6 months (Yang *et al.*, 1999: 78).

Despite being sexually active, migrants' knowledge of contraception is far from adequate. More than 76 per cent of unmarried pregnant migrant women in a district in Shanghai never took contraceptive measures and only 3.2 per cent did so always (Wang, 1999: 53). Zhang Zhen's survey reported that only 13.4 per cent of the female migrants had had some sex education (Zhang, 1999: 56). When becoming pregnant unintentionally, migrants often turn to underground clinics for artificial abortion and do not dare to ask for medical leave from work due to the social stigma over premarital pregnancy, and this may lead to serious health consequences (Wang, 1999: 55).

Apart from physical diseases, psychological and mental disorders are also on the rise among migrant workers. According to a news report from Wenzhou City, Zhejiang Province, a psychological counselling clinic has received quite a few migrant workers in early 2003. Almost all of them are younger than 30 and the most common problem is depression due to long time loneliness (Jin, 2003).

Lack of access to existing health services

Much of migrants' health problems is caused by their lack of ability to utilise existing health services. According to a survey of migrant women in Jiading District of Shanghai, although nearly 80 per cent of the migrant women hoped to have reproductive health checks regularly, only 17.3 per cent did so and 55.5 per cent did not know where they could obtain help regarding family planning (Zhang, 1999: 56).

The key reason for the lack of this capacity is migrants' financial difficulty. Very few migrants have access to financial assistance for medical treatment. In a survey conducted in Chengdu City (Sichuan Province) and Shenyang City (Liaoning Province), no one single migrant had medical insurance (Guan and Jiang, 2002: 258). Guan and Jiang (2002) reported that migrants could only afford about 100 RMB for medical treatment a month. According to surveys carried out in 2000 and 2002, 46 per cent of respondents had been ill during their stay in Beijing, 17 per cent more than three times. Despite of this, a full 93 per cent had not received any payment for their medical expenses from their employers (Wen *et al.*, 2003, cited in Huang and Pieke, 2003).

Due to the financial constraints, access to big hospitals is now a problem for most migrant workers. One consultation for a minor problem such as the cold in a big hospital may cost 500 RMB, almost one month's salary for some migrants. One migrant drew on his experience of spending 3,000 RMB for treating his grandson's fever and said that he would rather die than going to big hospitals (Guan and Jiang,

2002). Giving a birth in a big hospital in Beijing costs several thousands of RMB, far beyond many migrants' earning capacities. According to a survey of migrant families in Haidian District, Beijing, 20 per cent gave birth at home rather than in hospitals, and surprisingly, 22 per cent of those who delivered babies at home did so in Beijing (the rest delivered in their home places) (Ketizu, 2000). The financial difficulty also forces some migrant workers to stop their treatment even after they are sent to hospitals in emergency. Fourteen migrant workers in a suitcase factory in Beijing were sent to a hospital by the local government when they were found to have severe benzene poisoning in 2002. But more than 10 checked out soon afterwards due to the lack of money (Xiao, 2002). The department of external injuries in Guangdong Province People's Hospital receives about 200 migrant workers a year and more than one third of them cannot pay the bill after the treatment. Some hospitals now simply refuse to receive migrant patients (Cheng and Wen, 2002).

The lack of access to financial help and proper treatment forces migrants to adopt some very unhealthy behaviours when falling ill. Upon falling ill, they would typically wait and see in the beginning, hoping the illness would go away. If the situation got worse, they would go to small pharmacies to buy medicines according to their own medical knowledge. Only when the illness becomes unendurable would they visit hospitals, by which time, the disease may have already become very serious. For example, gastric ulcer is a common disease among migrants. But migrants often buy painkillers when having stomach-aches, with the gastric ulcer subsequently developing due to the delay in treatment. What is worse is that since migrants are young, in many cases they are able to endure the illness for the time being, but these may develop into serious illness when they get older.

The lack of ability to utilise existing health services also severely impedes migrants from protecting themselves in some circumstances. For example, migrant workers are normally very reluctant to bring their employers to court for work-related illnesses, no matter how severe it is. Besides migrants' lack of legal knowledge and of the financial capacity to hire lawyers, a very important reason for this is that some employers pay for the medical treatment that is immediately needed to save the migrants' lives on the condition that they promised not to sue the employers. Migrants themselves simply cannot afford to shoulder the costs while waiting for the legal case to go through (for typical case see Xiao, 2002).

What compounds the situation is the rapid commodification of medical services in China. Over the last decades, medical care costs in China have risen dramatically but the quality and efficiency of services are getting worse (see Hu, 2001). Large hospitals often have their own pharmacies or are tied with pharmaceutical companies, and sales of medicines to patients is an important source of profit for hospitals. In many cases doctors are given kickbacks by pharmaceutical companies for prescribing more medicines to patients. As a result, overprescription becomes endemic. Hospitals and doctors also often conduct unnecessary but expensive tests for patients. It has been recognised that the most urgent task in urban public health system right now is to fix the hospital management in order to provide affordable medical services to the majority of the population, including migrants, which may be more important than building a comprehensive new medical security system.



Plate 3: The Living Condition of Migrants in Beijing

The Political Economy of Medical Care

In discussing migrants' health security, a commonly held view among researchers and activists is that migrant workers should be included in a universal medical care system. Although this should certainly be a long-term goal for China, my investigation suggests this to be unrealistic in the near future. This is due to a series of profound institutional arrangements that cannot be changed in the short term. In what follows, I will first discuss why migrants are excluded in the new medical care system at the national level. Basically, including migrants in the medical care system does not fit into the government's immediate goals in reforming the system. Second, based on a review of local experiments, I suggest that including migrants in the formal medical care system may not be operationally feasible either. Third, I attempt to reveal the obstacles to the implementation of labour protection measures in the work place. The obstacles largely lie in local governments' lack of incentive to protect migrant workers and migrants' lack of legal rights to establish their own organisations.

Rural-urban dualism and the political economy of medical care system reform

In order to understand China's new medical care system and migrants' relation to it, we first need to look at the traditional set-up for medical care and the rural-urban relation which forms a basic institutional background for any social policy including medical care (for a comprehensive review of the rural-urban divide in China, see Knight and Song, 1999).

In the 1950s, in order to prevent the rural population from moving to cities spontaneously and to keep the grain price as low as possible to support a high speed of industrialisation (particularly in heavy industries) in cities, the Chinese government established a special household registered system (known as "*hukou*" system in Chinese). Under this system, people born in the rural area cannot move to the city and obtain urban *hukou* status unless mandated by the State (for literature on *hukou* system, see Christiansen, 1990; Cheng and Selden, 1994; Mallee, 1995; Chan and Zhang, 1998). The rural and urban societies are also structured in completely different ways. In cities, the "work unit" plays a central role not only in economic activities but also in social life, including the area of welfare provision (for an excellent study on the work unit system in China, see Walder, 1986, also see Lu, 1989; Whyte and Paris, 1984; Shaw, 1996; Lu and Perry, 1997). The rural society is organised along the hierarchy of county-township-village and the village community is the basic unit through which the State redistributes resources and executes control. Though Chinese society has changed fundamentally in many aspects since the Reform started at the end of the 1970s, the rural-urban dualism in social management largely remains the same. This makes internal migration in China an institutionally unique phenomenon in that migrants are not only undergoing change of residence and occupation, but are also released from the state control and support system. Spontaneous migrants are in general not allowed to become urban residents, yet few are willing to return to the rural area. Therefore they become a special social category, the "floating population" (see Solinger, 1993; Xiang, 1999).

The medical care systems, both in the pre-reform era and the one of the current period, are directly shaped by the rural-urban dualist structure. In the countryside, China used to have a well-established rural Cooperative Medical System that was set up in the end of the 1960s. Peasants of a Production Brigade⁴ contributed a certain amount of money every year to form a fund to cover medical costs. Under the commune system, the contribution did not take place in the form of individual donation, instead, the Production Brigade diverted part of its collective resource to the fund directly. At the same time, each Brigade had its own “bare-foot doctor” to conduct daily health inspections, emergency treatment, and treatments for common illness. But this system collapsed in the 1980s when communes were dismantled and the new individual family-based Household Responsibility System was adopted. There is now hardly any collective resource left to support the medical fund and the management of the fund also became a problem (Li, W.P., 2002). According to the 1998 National Health Services Survey, the Cooperative Medical System covered only 1.83 per cent of all the farmers (Li, W.P., 2002: 27). Furthermore, the inputs from the government in rural health care have also been declining. During the period of 1991-2000, government input dropped from 12.5 per cent to 6.6 per cent of all the investments in rural health care, input from society (such as donations) went down from 6.7 to 3.3 per cent, while the share shouldered by peasants themselves increased from 80.7 per cent to 90.2 per cent (Li *et al.*, 2003: 2-3). In theory, migrants are supposed to claim for medical care benefits in their home places since they are still registered there. But it is self-evident that given the very poor medical care system in rural China, migrants cannot expect anything from it. Apart from this, even in places with rural medical care, it is unrealistic to require migrants to go back to their home places for treatment or to expect the rural authorities to reimburse the medical cost occurred in the city where the price is much higher.

The urban medical care system, completely different from the rural system, is now facing a different crisis. Soon after the People’s Republic of China was founded in 1949, China established a Public Fund Medical Care (*gongfei yiliao*, also translated as Government Employee Insurance Scheme) for government staff and those working for government-related units and a Labour Security Medical Care (*laobao yiliao*, also translated as Labour Insurance Scheme) for State-owned or collective enterprise employees. Both of them offered completely free medical care, but the former was financed by the government while the latter by enterprises.⁵ The two schemes share a unique feature in that both of them were dependent on the work unit, rather than directly upon the State or other apparatus (see Gu, 2001). Under these systems, the work unit settled with the hospital engaged the costs occurred by its employees. There was no individual account, nor was there a cross-work-unit coordination in managing the medical care fund (risk pool). Therefore when a work unit other than that of a government department was not profitable, its employee’s medical care would immediately become a problem. In the event that a large number of State-owned enterprises (SOEs) and collective enterprises go bankrupt, the entire medical care system will be in crisis. There have been numerous complaints and even protests

⁴ Production Brigade is the equivalent to Administrative Village after the Reform. Typically one Production Brigade has 1,000-5,000 population.

⁵See then Political Department (now State Council) *Regulations of the People’s Republic of China on Labour Security* (1951, Zhonghua renmin gongheguo laodong baoxian tiaoli); then Political Department, *Directives on Implementing Public Fund for Medical Treatment and Prevention for State Staff of All Levels of Government, Parties, Organisations and the Work Units Belonging to Them* (1952, Guanyu quan’guo geji renmin zhengfu, dangpai, tuanti ji suoshu shiye danwei de guojia gongzuo ren yuan shixing gongfei yiliao yufang de zhishi).

staged by laid-off or retired workers from SOEs for not being given medical care or pensions. Even for the enterprises who are performing well economically, their obligation to cover the medical care of all their employees, both current and retired, become an almost unendurable burden (see Gu, 2001).

China started reforming its urban medical care systems in 1994 and a new system was put in place nationwide in 1999 to replace the Public Fund Medical Care and the Labour Security Medical Care systems. Under the new system, every employee would have an individual medical account at a medical fund, managed by the Health Security Management Bureau (*Yiliao Baozhang Guanli Ju*) of the district or county where the employer is located. Both the employee and employer contribute to the account monthly. When medical treatment occurs, the hospital would contact the fund directly for a person's medical treatment without involving the employer. Compared to the old system, the new scheme has three distinctive features, namely "unification", "socialisation" and "individualisation". "Unification" means that the scheme requires all types of employees of all urban enterprises to join the system. "Socialisation" means that medical care fund would be managed socially and not confined to particular enterprises. Finally, "individualisation" refers to the establishment of individual accounts, which enables a person to accumulate money at his/her account and to change jobs without changing his/her account. But as we will see below, all these features have limitations. The implementation of the new medical care system is not satisfactory either. By the end of 2001, only 54.71 million people participated in the medical care system, compared to 108.02 million for pension and 103.55 million for insurance for industrial injuries (Wang, 2002).

The new medical care scheme does not cover migrant workers. Documents issued by the Ministry of Labour and Social Security and the State Council refer to the new scheme as a scheme for "urban employees" (*chengzhen zhigong*).⁶ Though the term "urban employees" is not clearly defined, it is universally interpreted as those working in urban enterprises *and* with urban *hukou* status. When provinces such as Guangdong experimented to extend medical care to migrant workers, local governments had to issue separate documents for that. This may seem at odd with the reform goal of "unification" and the central government's push for a unified labour market. The reasons for this go beyond medical care itself and are related to more fundamental issues, as I will now elaborate.

First of all, the immediate motivation for the central government to reform the medical care system is to relieve SOEs from the burden of shouldering almost unlimited medical care costs for their employees, which is believed to be a precondition for SOEs to become profitable. Including migrant workers in the medical care system does not help achieve this goal and may even conflict with this objective. It has become a common practice for SOEs to replace old employees who enjoy generous welfare coverage with migrants lacking any fringe benefits. Enterprises planning to list themselves in the stock market may shift their old employees to separate subsidiaries as a means to remove the high overheads from their profit report, and then staff the sector planned to be listed in the stock market with migrants (see Baozhang Ketizu, 2002: 3). Therefore, migrants' cheap labour is critical for the SOEs' transformation to profit-making enterprises and providing migrants with welfare and security would slow down the transformation. Apart from relieving SOEs

⁶ See for example, State Council *Suggestions on Experiment Spots on the Reform of Employees' Medical Care System* (1995, Guangyu zhigong yiliao zhidu gaige de shidian yijian). State Institution Reform Committee et al: *Suggestions on Expanding of the Experiment Spots on the Reform of Employees' Medical Care System* (1996, Guangyu zhigong yiliao zhidu gaige kuoda shidian de yijian).

from the burden, another key goal in reforming the medical care system as well as other social security measures is to better maintain social and political stability. It is feared that certain groups may turn into “elements of instability” if they are deprived of basic social security. However, compared to groups such as laid-off SOE workers and retired military personnel, who were among the most privileged in the pre-Reform era but lost most of their benefits in the process of marketisation, migrants are not seen as a high-risk group in this sense. Related to the objective of ensuring social and political stability, government is more willing to allocate resources for catastrophe reliefs rather than to offer basic medical care to all the citizens universally, since the former is more effective for achieving that goal.

Second, the vested interest associated with the old welfare system forms another obstacle to including migrants in the formal medical care system. As mentioned previously, the old medical care system is directly linked to work units and different types of work units offer very different medical care. Government departments and large SOEs often designate well-equipped hospitals for treating their staff and cover all the costs, while staff of collective enterprises can only go to small hospitals with limited subsidiaries. Though the new scheme claims to break down the boundaries between different types of work units, the vested interest is so deeply ingrained that in practice the boundaries have been hardly challenged. Work units of the provincial, municipal and district levels and those without ranks such as ordinary enterprises still have different policies regarding employees’ medical care benefits though they may register with the same medical fund because they happen to be located in the same district. As a result, the health security management bureau may have to manage the medical fund along with different modes simultaneously (Gong, 2003). Persuading groups with vested interests to make sacrifices and join a unified medical care system is difficult enough for the government and no party is willing to represent migrant workers’ interest in the bargaining.

Third, there are concerns that migrants would bring extra difficulties to the management of the medical care system. For example, it is feared that the rural population may rush to the city when sick to claim to be migrant workers in order to benefit from the medical care, or migrants may use their insurance to cover their family members’ treatment costs.

Conflicts between formality and informality, between mobility and locality

The section above has clarified how including migrant workers in the formal medical system may go against government's immediate aim in reforming the system. What follows will demonstrate the operational obstacles to including migrants in the system even when the authorities are willing to do so. Since the late 1990s, places such as Shenzhen, Zhuhai and Dongguan, all cities in Guangdong Province, have mandated that all enterprises should offer medical insurance to migrant workers. But the result is far from satisfactory. For example, there were 3.3 million registered migrant workers in Shenzhen and the actual figure was estimated to be 5 million, but by the end of 2001, only about 1.04 million persons, including both permanent residents and migrants, had medical care insurance (Cheng and Wen, 2002). Given that most permanent residents join the medical care system, the share of migrant workers should be very small out of the 1.04 million.

The operational difficulty in including migrants in medical care stems firstly from the fact that many migrants enter the job market informally while the medical care system needs a formal employment relationship as a basis for operation. Unlike commercial insurance that any individual can purchase on his own accord, the medical care system is employment based. It is the employer who sends the money, partly deducted from employee's salary and partly from the employer himself, to the medical fund. The Labour Bureau would conduct inspections over enterprises from time to time to ensure that all the workers have been insured. But given the over-supply of labour and particularly the very disadvantaged position of migrants in the job market, it is common for a migrant to work for an employer without any formal contract. If the worker insists on having a contract, the enterprise may cut down the wage as a precondition on the grounds that a formal contract would cost the enterprise more by obliging it to comply with government regulations and to pay various levies. An inspection conducted by the Labour Bureau of Chang'an Town, Dongguan City of Guangdong Province in 2002 found that a large proportion of private enterprises grossly underreported the numbers of their employees. A toy factory hired about 1,000 workers, but paid medical insurance for only 150. Work-related injuries and labour disputes increased by 40 per cent compared the previous year in the town and a large part of these cases involved migrant workers without insurance (Cheng and Wen, 2002). According to a survey conducted by Tan and her associates in the Pearl River delta in 1994, only 10 per cent of the workers had a formal contract with the employer and about 60 per cent had never signed any employment contract (Tan, 2002 [1997]: 312). In many cases when migrants sue employers for mistreatment, the biggest problem turns out to be that the migrants cannot even prove that he/she was employed by that enterprise. Apart from that, a large proportion of migrants in big cities are self-employed. For example, the 1999 census of migrants in Beijing showed that more than 40 per cent of all the migrants are self-employed (Liu and Wu, 1999). These migrants do not have any "work unit" to belong to and therefore cannot join the medical care scheme.

It must be recognised that informal employments, namely employment relationships without legally effective contracts, will exist for a long time in China. Informal employment is projected by some scholars to contribute half of the total urban employment opportunities in the coming 10 to 15 years (Hu An'gang, 2001, cited in Baozhang Ketizu, 2002: 2). It may come as a surprise to outside observers to find that many migrants themselves prefer informal employment relationship and do

not want to sign contracts. This is because the option of quitting a job immediately is often migrants' only and last resort when the situation in a factory becomes unbearable, and a formal bond would deprive them of even this opportunity (Xiang, 1995; Tan, 2002 [2000]: 67). It is not advisable either for the government to force all the enterprises to adopt formal employment relationships with various social welfare benefits. The World Bank has pointed out in its *1990 World Development Report* that undue regulations on the labour market, such as minimum wage and compulsory social security, would increase the labour costs therefore reducing the demand for labour. As a result, stricter labour market regulations would favour those in the advanced sector but worsen the unemployment problem for the poor. Undoubtedly, in China today, employment should take the precedence over social security (see Baozhang Ketizu, 2002: 3).

Another reason making the inclusion of migrants in the formal medical care system difficult is the conflict between migrants' extraordinarily frequent mobility and the localised operation pattern of medical care funds. The scope of risk pooling ("social coordination" as it is normally referred to in China) of the medical fund is now at county level (or small city or district in large cities, which are equivalent to county in administrative rank) and a nation-wide unified system is far from being established. A Health Security Management Bureau is only responsible for the enterprises and their workers within the county where that bureau is located. A worker's medical care account will have to be cancelled from one bureau and reinstalled in another if he/she changes jobs across counties. It would be even more troublesome if the worker moves from one province to another since there is almost no connection or coordination across provinces in medical care. If a migrant worker goes back from the city to the countryside, as they often do, then the medical insurance has to be cancelled altogether. The lack of any effective medical care system in the rural area makes it literally impossible to transfer individual accounts from urban to rural. Because of the tension between migrants' high mobility and the individual accounts' low portability, even in the case where employers have registered their migrant workers for medical care, the workers often withdraw later, particularly around Chinese New Year when many of them change jobs or locations. For example, 17,817 persons withdrew their medical care accounts in Chang'an Town, Dongguan City alone in the first three quarters of 2001, presumably most being migrants. In 2001, a total of 120,000 migrant workers withdrew their pension insurance in the same town (Cheng and Wen, 2002).

The unbalanced relationship between the government, employer and migrant worker

As demonstrated earlier, work-related illness constitutes the immediate health threat for migrant workers. On the surface this problem does not seem particularly difficult to tackle since it is relatively easy for the authorities to inspect working conditions and to enforce its improvement. There are also a series of relevant regulations in place. For example, in October 2001, the National People's Congress passed the *Law of the People's Republic of China on the Prevention and Treatment of Occupational Diseases*, effective on 1 May 2002. The law clearly stipulates that workers must be fully informed of the dangers related to work, employers must take adequate preventive measures and employers should provide treatment in case illness occurs. The law also designates that employer's obligations should be clearly indicated in the labour contract. Some provinces and cities, such as Beijing, also require enterprises with high risks of work-related accidents to pay special insurance for employees' work-related illness. Some regulations specifically aim to protect female workers' health, such as the *Regulations on Labour Protection of Female Workers* (1988), the *Regulations on Activities not Suitable for Female Workers* (1990), and the *Regulation on Female Workers' Health Protection* (1993). In 1997, the Eighth National Political Consultation Conference proposed a bill on *Protecting Female Workers' Rights in Foreign-Invested Enterprises, Township and Village Enterprises and Collective Enterprises*.

But these laws and regulations seem to fail to protect migrant workers, particularly those in Township and Village Enterprises (TVEs) and small-sized private enterprises, who form exactly the major part of migrant workers. A news story in the *China Woman's News* reported that private and foreign-invested shoe factories in Putian, Fujian Province, earned billions of RMB since 1984 by using female migrant workers, but were not willing to divert even 1 per cent of their profit to improve the working conditions that had destroyed thousands of workers' health (*China Woman's News*, 6 January 1996, cited in Tan, 2002 [1998]: 241).

The failure of these formal regulations is to a large extent due to the unbalanced power relationship between the government, employer and migrant workers. It must be borne in mind that in China, government intervention is still the most powerful measure, far more so than legal means, in regulating social and economic life. Local governments are generally reluctant to intervene to protect migrant workers' rights against enterprises' interest. While the traditional SOEs were built as the "working class' paradise" rather than as profit-making firms, TVEs and private enterprises run to the other extreme and profit-making takes precedence over almost everything else. For local governments, TVEs and other private enterprises form not only important fiscal sources, the enterprises revenue income is also taken by the higher level of authorities as a key criterion of evaluating the local government's performance. During my fieldwork in the Pearl River delta in 1994, local officials explicitly told me that it was not in their interest to devote much effort towards protecting migrant workers' rights. The reason is simple: if they did so, it would increase the labour cost for the enterprises and foreign investors may just move to somewhere labour regulations are more lax. In 1993, the government of Kuiyong Town under the Shenzhen Municipal wrote to the Shenzhen Fire Prevention Enforcement Team to urge them to issue a fire safety certificate to a Hong Kong businessperson invested factory in Kuiyong Town, the Zhili Toy Factory. The letter threatened that "if (the certificate) is not given, the economic development of Kuiyong Town will be

affected, Hong Kong investors will organise a collective complaint to the municipal government directly” (*Workers’ Daily*, 26 December 1993, cited in Tan, 2002 [2000]: 69). Soon after the letter was sent and the certificate was issued, a fire broke out in the factory and killed 87 migrant workers.

What is more fundamental for protecting migrant workers’ rights is the relationship between the employers and the workers themselves. Migrant workers have literally no bargaining power in relation to the employer. Internationally, the most common way to protect workers’ rights, including work safety and occupational health, is to organise trade unions. So far, very few non-State-owned enterprises have any union and more than 95 per cent of workers in these enterprises are not unionised (Weldon, 2001/2002b: 28). Even for those enterprises who have unions, the union is something very different from what is supposed to be internationally. According to orthodox Marx-Leninist theory, workers in a socialist state are the owner of the State and are fully represented by the Party, and there is no labour-capital struggle anymore. Therefore trade unions in China are mainly concerned with issues such as entertainment, education and other welfare (such as purchasing food collectively at a lower price for the workers). Furthermore, all trade unions in China must be branches of the All-China Federation of Trade Unions (ACFTU) and the ACFTU so far works strictly under the Party’s leadership.

The highly skewed relation between migrant workers and employers in private enterprises is not merely a reflection of the general antagonism between labour and capital. Enterprises normally treat local (non-migrant) workers much better than migrants. Once again local government plays an important role here. Under the current *hukou* system, government departments have no responsibility for those who are not formally registered with them. For example, in many towns along China’s eastern coast and particularly in the Pearl River delta, migrants have outnumbered the local population by large margins, but these migrants are very rarely mentioned in the local government’s development plans and reports. All the social and economic development indicators, such as per capita income and numbers of hospitals for every thousand persons, are calculated on the basis of the size of the permanent population. Therefore, in a sense the existence of cheap, unprotected migrant labour is in the local government’s interest since this labour would attract foreign investment, boost land rent rates, and dramatically increase the income level of the local people (for a brief discussion on the development model based on the alliance between foreign investors and local government on one hand, and migrant workers’ cheap labour on the other, see Xiang, 1995).

Grassroots Activities: Windows for Improvement

The above analysis has shown that due to various structural and institutional reasons that are far more fundamental than medical care itself, it may not be realistic to expect migrants to be included in the formal medical care system in the near future. But this does not mean nothing can be done. On the contrary, realising the difficulties in changing formal institutions urges us to refocus our work on something more attainable in the short term. Recently, there have been various experiments at the grassroots level which may offer alternative means of delivering health services to migrants. Though these activities cannot change formal policies immediately, they have important institutional implications, particularly by empowering migrants themselves and developing new channels (mainly through the urban residential community and NGOs) of health service provision. In what follows, I will describe some of these activities individually and try to identify the practices that can be learned on a larger scale and the areas where more work can be done.

Community-based health care

Developing community-based health care is an important current agenda of the Chinese government. Previously, urban residents visited large hospitals that their work units engaged even for trivial problems. This partly contributed to the hikes in medical treatment costs, the worsening of care quality and the lengthening of waiting time. The basic idea of community-based health care is to develop small hospitals and clinics in residential communities to provide residents with comprehensive preventive services and treatment for common diseases within the neighbourhood. The equipment in community hospitals and clinics and the staff's salary are covered by the government budget, but doctors can earn more if they treat more patients. Community health institutes are not tied with pharmacies and the doctors are subject to the close scrutiny of the patients, who are often next-door neighbours of the doctors for many years, therefore the problem of over-prescription is minimal.

The community-based health care system can open new channels for the delivery of health services to migrants in two ways. First, community-based health care is not tied with any work unit and anyone residing in the community can visit community hospitals and clinics. Second, more resources can be mobilised for migrants' health care through the community. Big cities with large numbers of migrants often have more medical resources than one would expect. These medical resources are not directly at the government's disposal and are often highly dispersed, therefore activities at the grassroots level provide a particularly effective means of mobilising them. The neighbourhood that I visited during my fieldwork in Beijing provides a typical example of this.

Dashila Street⁷ in the Xuanwu District of Beijing is a typical community in a large city, with 56,000 permanent residents and just over 20,000 temporary migrants. The community has one fully-fledged Street hospital, three Community Health

⁷ A "Street" (*jiedao*) is the lowest level of the urban government set-up, under District and Municipal. Below Street are Residents' Committees which are supposed to be residents' self-governance bodies rather than government institutes. The rural equivalent of a "Street" is "Township" (*xiang* or *zhen*).

Centres and one branch clinic. The community health centres and clinic have a total of 20 doctors and nurses. Though the District Government and the Street Office have not initiated any programme with respect to migrants' health, these community health institutes have made some experiments of their own. For example, the Liulichang Health Centre, one of the community centres, offers free treatment to migrants, and another health centre, Shitou Centre, charges migrants only half price for consultation. In order to promote themselves among migrants, doctors from the Shitou Centre held seminars on reproductive health for more than 30 migrants working in a nearby restaurant in 2002. Community doctors have the incentive to do so firstly because one third to half of their working hours are free. Secondly, treating more patients brings a higher income. The head of the Shitou Centre, a young doctor, told me that a higher income was an important incentive for her to extend services to migrants. The Liulichang Centre offers free treatment to migrants because the centre head is a retiring doctor and who, as she put it herself, simply takes it as a "joy" to treat more patients.

Community-based family planning work also offers a new arena to improve migrants' health status, particularly reproductive health. The Chinese government has attached so much importance to family planning that many resources have been allocated to this at the grassroots level. For example, Dashila Street has four full-time officers in charge of family planning. But the demand for family planning services from permanent urban residents has been decreasing due to their increasingly high awareness of reproductive health and decreasing willingness to have more than child. The family planning officers therefore have enough spare time and energy to reach out to migrants. The Family Planning Office of the Dashila Street now organises annual reproductive health checks for female migrants in the community. The checks cost migrant women 30 RMB each, compared to 100-120 RMB that hospitals normally charge. One hundred and seventy migrant women participated in the 2002 check. On the Children's Day of every year (1st June), the Office organises health examinations for migrants' children. About 20 children are checked every year. The Street and its Residents' Committees also help to organise migrants' children to participate in vaccinations. In 2002, the Street committee undertook a special survey to uncover those left out of the vaccination exercises and identified 27 migrant children unvaccinated that year, out of the 336 migrant children in the Street (Wenjiaoweiti Ke, 2002). Many Streets in Pudong District of Shanghai City have set up Reproductive Health Consulting Office. According to a survey, 56.2 per cent of the 316 migrant women investigated in Pudong District visited these Offices as of 1999, representing a 45.5 per cent increase compared to two years earlier (Peng *et al.*, 2003).

Community family planning work can be effectively utilised for improving migrants' reproductive health also because of its well-established institutional framework. Apart from the Family Planning Office, each Street normally has a Family Planning Association. The Association has a leading team, comprising the Party Secretary, the Administrative Head and other important officials of the Street. Members of the Associations comprise the Heads of Residents' Committees who are directly connected with ordinary residents, and other relevant personnel such as doctors. The Association is meant to coordinate various parties in the family planning work and ensure ordinary citizens' participation. It has now become a common practice to have a special Migrants' Association for Family Planning (*wailai renkou jihua shengyu xiehui*) as a branch of the standard Family Planning Association. The Migrants' Association for Family Planning is often led by migrant women with

relatively high levels of education and who are influential among fellow migrants. The Migrants' Association reports to the Street authorities on migrant women's family planning situation and help relevant institutes organise migrant women to participate in activities such as health lectures and examinations. Two companies located in Dashila Street, Tan's Fish Head and Yuanfu Hot Pot with more than 100 migrant workers each, have registered all their workers to be members of the Association. The problems with reproductive health and child vaccination among migrants as mentioned earlier to a large extent can be attributed to the underdevelopment of residential community as a channel for social service delivery, particularly in newly-industrialised areas.



Plate 4: An Open Medical Consultation Organised by a Residential Committee in Beijing

Education and training

It is almost a consensus among the medical personnel, social workers and researchers whom I interviewed that health education among migrants should be given more priority since it can have immediate effects on migrants' health status. Some even suggested offering special medical training to migrants to enable them to provide emergency aid and daily health advice to their fellow migrants. Migrants themselves also voiced similar views. A survey in Shanghai (Zhan *et al.*, 2001: 197-8) found that few migrants desired to join the formal medical care system, but most wished to have more opportunities to improve their knowledge about health care.

Research has found strong association between migrants' health knowledge and their behaviour. For example, a survey found that about 70 per cent of unmarried pregnant migrant women did not use contraception measures because they either had no knowledge about it or feared that contraception may have negative consequences (Wang, 1999: 54, table 7, translated as Appendix 3). According to a statistical

analysis based on a survey conducted in Shanghai, Zhan Shaokang *et al* concluded that knowledge about reproductive health is one of most important factors influencing migrant women's reproductive health behaviour, more important than income level (Zhan *et al.*, 2001, see Appendix 4).

In practice, a variety of ways have been explored to provide health education to migrants. First, there are government-organised or government-facilitated activities. For example, on 1st December 2002, the Beijing Municipal Health Bureau in cooperation with more than 20 NGOs organised a one-day public counselling on AIDS specifically for migrants at the West Beijing Railway Station (Deng and Xie, 2002). Transport Bureaux and Rail Bureaux in some places, particularly in Yunnan and Guangxi Provinces, have launched information campaigns for AIDS prevention targeting truck drivers as well as passengers. Many migrant sending places now hold pre-departure training for migrants and some training courses include health protection as an important subject.

Second, the residential community forms an important arena for transmitting information and improving awareness. For example, Dashila Street holds at least four lectures or seminars a month on subjects related to health. They also hand out booklets and set up special notice boards on street corners to promote health knowledge. These activities target both permanent residents and migrants.

Third, NGOs are becoming more and more important in delivering services, including training, to migrants. The Shenzhen Women Worker's Centre runs a "Women's Health Express", a minibus that visits factory sites throughout the Pearl River delta. It is equipped with a small library, facilities for playing videos, and exhibition boards with information on health and rights (Weldon, 2001/2002a:25). The Migrants' Education and Training Centre in Beijing offers courses on basic literacy, computer literacy and reproductive health. The last decade has seen a significant growth of "migrant literature" (*dagong wenxue*), which refers to articles, newsletters and even magazines specially devoted to migrants. The well-known Beijing-based magazine *Nongjianv Baishingtong* (*Rural Women Knowing All*), which targets female migrant workers, has published booklets such as *Learn to Take Care of Your Health – Knowing All about Reproduction and Health Care*. Telephone hotlines provide another effective means of education. Currently there are at least two lines devoted to migrants in Beijing and health is an important topic of counselling.

Alternative clinics

For places with large numbers of migrants yet are short of community health facilities, clinics set up by migrants themselves may be a solution to the shortage of medical equipment. "Zhejiang Village" is a migrant community located in southern Beijing with about 100,000 migrant residents. Most migrants in the community obtain their daily health services from clinics set up by their fellow migrants from Zhejiang. Since so many people emigrated from rural areas in southern Zhejiang, local doctors there lost their clients and some moved to Beijing to set up clinics. Migrants prefer these clinics to formal Beijing hospitals because they are convenient to visit, cheaper, and most importantly, the doctors are more familiar with the patients' lifestyle and understand their problems better. Interestingly, a clinic in "Zhejiang Village" specialising in artificial abortion turned out to be particularly popular. The doctor is a well-known gynaecologist in eastern Yueqing County, where many migrants came from, and he told me that many migrants in fact did not want extra children and

sometimes they gave birth partly because of the lack of convenient access to hospitals for abortion (see Xiang, 2000).

Such clinics are also found in other migrant communities. Some researchers plan to set up specialist hospitals in areas where migrants face particular health risks. A research team from Qinghua University has planned to help set up a specialist blood hospital in Baigou Town, where surrounding villages host numerous suitcase workshops whose migrant workers are particularly prone to benzene poisoning. At the same time they plan to train village primary school teachers to carry out inspections of working conditions and conduct regular health checks for migrant workers. Village primary school teachers are chosen as potential part-time health workers because, apart from their relatively high education level, they tend to be neutral to both the local employers and migrant workers and are also less mobile and therefore can fulfil these duties on a regular basis (Shen, 2003).

One of the biggest problems facing these alternative clinics is their lack of formal licenses from the government of the destination place. Health authorities in large cities often turn down applications for licenses from these clinics on the grounds that they fail to meet the basic standards in facilities. When the Beijing Municipal government tried to justify their repeated efforts to crack down “Zhejiang Village”, one reason given was to eliminate “illegal medical practice” there. But in fact providing health services to migrants can be an effective measure of facilitating migration management. For example, local governments can use the services to foster closer relations with migrants and to collect basic information about mobility. Given the ever-increasing medical treatment costs and the widening gap between the rich and poor in urban China, the government should seriously consider encouraging clinics catering for migrants and other urban poor.



Plate 5: A Clinic Set Up by a Migrant in Zhejiang Village, a Migrant Community in Beijing

Empowering migrants

Since the late 1990s, when the memory of the 1989 Tian'anmen event started fading away and the composition of Chinese society became more diverse, there has been increasing discussion and experimentation on non-governmental organisations. Some semi-governmental organisations, most notably the All-China Federation of Trade Unions (ACFTU) and China Women's Federation, started working more independently on issues that they deem to be important. A new *Trade Union Law* was passed in 2001, which clearly defines that the trade union's main function is to protect workers' rights. In the new law, Articles 23 to 26 significantly increase the Union's powers with respect to occupational safety and health, specially giving the Union a mandatory role in investigating accidents and infringements on workers' other rights (Weldon, 2001/2002b:28). In March 2002, a Migrant Workers' Association, possibly the very first migrant workers' union in PRC's history, was set up in Chenzhaiwang Village, Tangxia Town, Yongjiao County of Wenzhou Prefecture in southern Zhejiang Province. The Association attracted 1,500 members soon after its establishment. One thing that motivated the founder, Mr Ning Jiabin, a migrant worker himself, to organise the union was an accident where his nephew was electrocuted in a factory as a migrant worker (see Pan P., 2002). There are signals that the ACFTU may be considering supporting trade unions organised by workers themselves in the future (see Chan, 2001; Weldon, 2001).

The emerging civil society in China is another important means of empowering migrants. For example, the Guangzhou Migrant Workers' Document Handling Service Centre, an NGO, provides help much needed by migrants: to produce proper legal documents when suing employers or other parties. The Legal Assistance Centre at Beijing University and the Labour Rights Clinic at Qinghua University offer similar assistance. The Shenzhen-based Institute for Contemporary Observation collaborates with the authorities and large companies to impose surveillance over plants to ensure work safety.

Conclusion

This paper has offered an overview of the health risks that rural-urban migrants in China are facing, the basic policy gaps in providing basic health services to them, and possible solutions to it. Existing literature on migration and health, be it from a medical or sociological perspective, tends to attribute migrants' health problems to their social characteristics, such as spatial mobility (therefore more likely to become conduit as well as victims of infectious diseases), low income, lack of awareness, and the lack of social contacts with the local society (e.g. Yang, 2002). All these arguments are valid in the Chinese case. But more importantly, as this paper has demonstrated, migrants' health problems in China are a result of existing formal institutional arrangements. For example, problems with reproductive health and children's vaccination are mainly a problem of the service provision system. The fact that migrants face high health risks at work is seemingly a result of market segmentation, but fundamentally it is attributable to the unbalanced relationship between migrants, enterprises and local government, which is in turn related to the *hukou* system and the current growth regime in China.

This paper went further to demonstrate that existing institutional arrangements not only render migrants highly vulnerable, but also impede them from being included in formal medical care system. The reasons include: the vested interests and the government's immediate goal in reforming the social security system lend the State no motivation to do so; the gap between the urban and the rural in medical care system makes it impractical to provide migrants with formal medical care; the localised therefore geographically fragmented operation pattern also discourages migrants to join the system; and finally, the informal employment relationship prevalent among migrant workers conflicts with the fact that the medical care system relies on formal employment contracts for its implementation.

Based on this assessment, we may need move our focus away from formal policies to grassroots activities in improving migrants' health status. Activities proven to be effective include providing health education, extending urban community health services, allowing or even encouraging the setting up of migrants' own clinics, and empowering migrants. Compared to change in formal policies, these grassroots activities have three important advantages. First, they can be initiated and carried out immediately while any formal policy change may take a long time. Second, grassroots activities can mobilise social resources effectively. This is particularly important given that the governmental channels for resource allocation have become increasingly ineffective in the Reform era. For example, one of the biggest obstacles to establishing a universal medical care system in China is the financial constraint that the government faces. But in fact there are plenty of resources outside of the State system, such as the extra medical personnel in big cities and the emerging civil society that grassroots programmes can tap on. Thirdly and most importantly, grassroots activities will lead to institutional changes at the operational level and in a bottom-up manner, which is essential for the implementation of any formal scheme in the future. For example, migrants' awareness of self-protection and legal rights is indispensable for improving their welfare status no matter how perfect a formal policy design can be. An active civil society is also crucial for ensuring that government and enterprises would comply with laws and regulations. But having highlighted the importance of grassroots activities, it must be stressed that this is only an immediate

action agenda and this does not mean that formal institutions are not important. A unified and universal medical care system must be taken as a long-term goal for China.

References

- Baozhang Ketizu (China Social Security System Reform Research Team, Yiwu Investigation Group), '*Chengshi pingkun de shenceng yuanyin: jiuye yu baozhang de erlv beifan*' (The root cause of urban poverty: The paradox between employment and social security), *Shenhui Zhengce PingLun* (Social Policy Review), April 2002, 1-3.
- Chan, A. (2001) 'China and the international labour movement', *China Review*, Issue 19, Summer.
- Chan, K.W. and Zhang, L. (1998) 'The Hukou system and rural-urban migration in China: Processes and changes', *The Center for Studies in Demography and Ecology Working Paper*, University of Washington.
- Chen, Y.H. (1996) '*Mazu you lie*' (Tears of Mazu), '*Chengmo de gaoyang*' (The silent lamb), '*Shiheng de tianping*' (Unbalanced scale), *China Woman's News*, 15-17 January.
- Cheng, Y.F. and Wen, Y.Z. (2002) '*Shui lai wei tamen tigong baozhang? Nongmingong shebao wenti yinren guangzhu*' (Who will provide security for them? Migrant workers' social security deserves attention). Xinhua News Agency, 21 June.
- Cheng, T.J. and Selden, M. (1994) 'The origins and social consequences of China's hukou system', *China Quarterly* (CQ), 139, 644-668.
- China News Agency, 27 October 2000, 'Majority of STD patients in Guangdong are migrants', Available at www.news.fm365.com/sheshui/20001027/169111.htm
- Christiansen, F. (1990) 'Social division and peasant mobility in mainland China: The implications of hu-k'ou system', *Issues and Studies*, 26 (4), 78-91.
- Dai, S.L., Meng, P.T. and Zhong, X. (2001) '*Taishun xi feng an yishen puanjue*' (First trial concluded on quartz lung case in Taishun), *Wenzhou Shangbao* (Wenzhou Commercial News), 25 October.
- Deng, T. and Xie, Y.J. (2002) '*Liudong renkou: Aizibing de gaowei renqun*' (Floating population, the high risk group for AIDS), *Shenghuo Shibao* (Life News), 1 December.
- Ford Foundation (2001) *Labor Mobility in China: A Review of Ford Foundation Grantmaking 1997-2001*.
- Furutani, K. et al (2003) 'People continue to flow', *Asahhi Newspaper*, 17 June.
- Gao, Y. (2001) '*Fei qian gei hui le*' (Lungs completely destroyed), *Beijing Qingnian Bao* (Beijing Youth News), 7 November.
- Garret, L. (2003), 'SARS spreaders could be executed', *The Seattle Times*, 16 May.
- Gong, S. (2003) Interview by author.
- Gu, E. (2001) 'Market transition and the transformation of the health care system in urban China', *Policy Studies*, 22(3/4), 197-215.
- Guan, X.P. and Jiang, M.Y. (2002) '*Chengshi wailai renkou de jiben shenghuo yu jiankang fuwu*' (Basic life and health services for migrants in cities), in Li Peilin (ed.), *Nongmingong, Zhongguo Jincheng Nongmingong de Jingji Shehui Fenxi* (Peasant Workers: Economic and Social Analysis of Peasant Workers in the City), *Shehui Kexue Wenxian Chubanshe* (Social Sciences Documentation Publishing House).
- Hansen, P. and Li, M. (2002) 'Sexually transmitted infection risk in migrant construction worker populations in Beijing, China', Paper presented at Annual Meeting of the association of American Geographers, March 22.
- He, S. (2002) '*Guanzhu minggong*' (Pay attention to migrant workers), *Takungpao.comm*, 20 August.
- Hu, S.Y. (2001) '*Zhongguo chengzhen yiliao baozhang zhidu gaige zhong de wenti yu jiejie lujing*' (Problems and solutions of China's urban medical care system reform), *Zhongguo Renkou Kexue* (China's Population Science), 4, 37-43.
- Huang, P. and Pieke, F. (2003) China Migration Country Study, 1 May, A report for the UK Department for International Development.
- Huang, P. and Zhan S.H. (2003) Interview by the author, 8 April, CASS.

- Jin, G. (2003) 'Dagongzhe gudu cheng 'bing'' (Migrants are so lonely to be sick), *Wenzhou Wanbao (Wenzhou Evening)*, 24 March, 21.
- Kaufman, J. and Jing, J. (2002) 'China and AIDS--the time to act is now', *Science*, 296, 2339-2340.
- Ketizu ('Wailai xuelinqian ertong baojian yu jiaoyu diaocha' ketizu [Research team of the health and education situations of migrant pre-school children]) (2000) 'Dui dachengshi wailai xuelinqian ertong baojian yu jiaoyu zhuangkuang de diaocha sikao' (Investigation and analysis on the health and education situation of pre-school migrant children in large cities), *Zhongguo Renkou Kexue (Chinese Population Science)*, 2, 46-54.
- Knight, J. and Song, L.N. (1999) *The Rural-Urban Divide: Economic Disparities and Interactions in China*, Oxford University Press.
- Li, K. (2003) 'Chengzhen liudong renkou jihua shengyu guanli wenti yu duice' (Problems and coping strategies regarding family planning of migrants in cities), *Renkou yu Jihua Shengyu (Population and Family Planning)*, 2, 29-31.
- Li, W.P., Shi, G. and Zhan, K. (2003) 'Woguo nongcun weisheng baojian de lishi, xianzhuang yu wenti' (The history, current situation and problems in China's rural health care), Unpublished paper.
- Li, W.P. (2002) *Zhongguo Nongcun Jiankang Baozhang de Xuanze (Options for Rural Health Security in China's New Policy Environment Synthesis Report)*, *Zhonggou Caizheng Jingji Chubanshe (Chinese Fiscal Economy Press)*.
- Li, W.S. (2002) 'Jiaqiang liudongrenkou guanli, jianshao mianyi kongbai renqun' (Strengthening the management of floating population, downsizing the vacant groups for vaccination), *Weisheng yu Jiankang (Hygiene and Health)*, <http://www.cdc.org.cn/newgc/jiaqiang.htm> .
- Liu, S. and Wu, X.P. (1999) 'Dui dachengshi wailai laodongli liuru de sikao' (Thoughts on migrant labour in large cities), *Zhongguo Renkou Kexue (Chinese Population Science)*, 3, 46-52.
- Lou, C.H., et al. (2001) 'Chengshi wailai qingnian vugong de shengzhi jiankang zhuangkuang yu xuqiu' (The situation of the reproductive health situation of migrant young female workers in cities and their needs), *Renkou Yanjiu (Population Research)*, 25(3), 61-63.
- Lu, F. (1989) 'Danwei: yizhong teshu de shehui zuzhi xingshi' ('Work-unit: A special pattern of social organization), *Zhongguo Shehui Kexue (Chinese Social Sciences)*, 1, 71-88.
- Lu, X.B. and Perry, E.J. (eds) (1997) *Danwei: The Changing Chinese Workplace in Historical and Comparative Perspective*, Armonk, NY, M. E. Sharpe.
- Mallee, H. (1995) 'China's household registration system under reform', *Development and Change*, 26, 1-29.
- Ministry of Health (China) (2003) 'Quezhen binli an zhiye fenbu' (Distribution of confirmed SARS cases by occupation), In *Chuanranxing Feidianxing Feiyan Yiqing Dili Xinxi Xitong, Geographic Information System on Infectious Atypical Pneumonia*, <http://168.160.224.167/sarsmap/>.
- Ministry of Labour and Social Security (2003) *Feidian yu Jiuye (Atypical Pneumonia and Employment)*, Research Report III, 'Laodong he shehui baozhang zhuangjia zhichu: fangzhi feidian yaoqiu nongcun laodongli liudong quebao anquan, anxu liudong' (Labour and social security experts: migrant rural labourers' safety and demand-driven mobility needed for controlling SARS), www.molss.gov.cn.
- National Statistic Bureau of China (2001) '2000 nian zhongguo nongcun liudong renkou xin tezhen' (New characteristics of rural floating population in China in 2000), *Zhongguo Guoxing Guoli (Chinese National Situation and National Power)*, 9.
- Pan, G.L., Tan, K.L. and Li, J.P. (2001) 'Quanguo shouli jiti 'xi fei an' gongshang suopei an jishi' (A report on the first legal case for seeking compensation for occupational 'quartz lung disease' work in China), *Fazhi Ribao (Law Daily)*, 8 June.

- Pan, S.M. (2001) 'Aizibing zai Zhongguo: Xing chuanbo de kenengxing jiuqing you dou da?' (AIDS in China: How likely it is transmitted through sexual channel?), *Sohu Net*, <http://health.sohu.com/87/44/harticle15534487.shtml>, Accessed on 2 November 2001.
- Pan, S.M. (2002) 'Rough trade, rough justice', interviewed by China Development Brief, *Vol. V*, 1, 36-38.
- Pan, P. (2002) 'In China, Labor Unions Offer Little Protection', In *Washington Post*, 16 October.
- Peng, X.Z., et al. (2003) 'Tuijin liudong renkou shengzhi jiankang youzhi fufwu de shijian he sikao' (Practices and thoughts on providing high-quality reproductive health services to migrants), *Renkou yu Jingji* (Population and Economy), 1, 21-7.
- Population and Social Sciences Department, National Statistic Bureau of China 2001, 'Quanguo kuasheng liudong renkou chaoguo 4000 wan' (Trans-provincial floating population exceeds 40 million), at www.stats.gov.cn.
- Shao, Q. (2002) 'Nvxing xidu zhe yu Aizibing' (Female drug takers and AIDS), *Falu yu Shenghuo* (Law and Society), 12.
- Shaw, V.N. (1996) *Social Control in China: A Study of Chinese Work Units*, Westport and London, Greenwood Publishing Group.
- Shen, Y. (2003) Interview by author.
- Solinger, D.J. (1993) 'China's transients and the state: A form of civil society?', *Politics & Society*, 21(1), 91-122.
- Sun, L.P. (2002) 'Chengxiang zhijian de 'xin eryuan jiegou' yu nongmingong liudong' (The new rural-urban dual structure and the rural-urban labour mobility), in Li Peilin (ed.), *Nongmingong, Zhongguo Jincheng Nongmingong de Jingji Shehui Fenxi* (Peasant Workers: Economic and Social Analysis of Peasant Workers in the City), *Shehui Kexue Wenxian Chubanshe* (Social Sciences Documentation Publishing House), 149-160.
- Tan, S. (2002) [1997] '1990-1995 zhongguo fuvu fazhan baogao' (Report on Chinese women's development, 1990-1995), *Funv yu Laogong* (Women and Labour), Unpublished collection, 298-323.
- Tan, S. (2002) [1998] 'Zhujiang sanjiaozhuo wailai dagongmei de xianzhuang yu fazhan' (The current situation and development of the situation of the female migrant workers in the Pearl River delta), *Funv yu Laogong* (Women and Labour), Unpublished collection, 235-51.
- Tan, S. (2002) [2001] 'Waichu he huixiang: Gei nongcun liudong nvxing dailai le sheme?' (Going out and returning: What do they bring to rural women?), *unv yu Laogong* (Women and Labour), Unpublished collection, 139-148.
- Tan, S. (2002) [1994] 'Zhujiang sanjiaozhou wailaigong diaocha fenxi' (An investigation and analysis of migrant workers in the Pearl River delta), *Funv yu Laogong* (Women and Labour), Unpublished collection, 74-84.
- Tan, S. (2002) [2000] 'Jujiao zhujiang sanjiaozhou: wailai nvgong yu waizi qiye, dangdi shehui zhi guanxi' (Focusing on the Pearl River delta: The relationship between female migrant workers, foreign-invested enterprises and the local government), *Funv yu Laogong* (Women and Labour), Unpublished collection, 61-73.
- UN Theme Group on HIV/AIDS for the UN Country Team in China, *HIV/AIDS: China's Titanic Peril* (2001 Update of the AIDS situation and Needs Assessment Report, UNAIDS, Beijing, 2001).
- Walder, A. (1986) *Communist Neo-Traditionalism: Work and Authority in Chinese Industry*, Berkeley, University of California Press.
- Wang, J.F. (1999) 'Shanghaishi liudong renkou weihun xianyun funv de xingxingwei, biyun fangfa shiyong yiji huaiyun jiegou' (Sexual behaviour, contraception measures and choices regarding pregnancy of migrant unmarried pregnant women in Shanghai), *Renkou Yanjiu* (Population Research), 23(1), 50-55.
- Wang, Y.Z. (2002) 'Zhongguo baixing lanpishu, shehui baozhang de shida jiaodian' (Blue cover book for ordinary Chinese: Ten focuses on social security), *Beijing Youth Daily*, 30 July.

- Weldon, J. (2001) 'Government pledges to get serious about labour rights', *China Development Brief*, Vol. IV, 1, 20-2.
- Weldon, J. (2001/2002a) 'New moves for Pearl Delta migrants', in *China Development Brief*, Vol. IV, 3, 25-27.
- Weldon, J. (2001/2002b) 'Revisions to law address the state of the union', in *China Development Brief*, Vol. IV, 3, 28,
- Wen, T.J., *et al.* (2003) '*Guoren Xiangcun Jianshe Shiyanyuan Jianyishu*' (Proposal for the reconstruction of rural schools), Unpublished paper.
- Wenjiaoweiti Ke, Dashila Street Office (2002) '*2002 nian jiaoyu jiankang gongzuo zongjie*' (Summary on the health and education work for 2002).
- Whyte, M.K. and Parish, W.L. (1984) *Urban Life in Contemporary China*, Chicago, University of Chicago Press.
- Workers' Daily* (1997) '*Xiangqi, Nvgong baohu sijiao youcun*' (TVEs, still uncover corner for female workers protection), 30 June.
- Xiang, B. (1995) *Minggong Wenti yu Chengshi Shehui Chengzhang* (Peasant Workers and Urban Development: A Case Study of DongGuan City, Pearl River Delta), The Department of Sociology, Peking University.
- Xiang, B. (1999) 'Zhejiang Village in Beijing: Creating a visible non-state space through migration and marketized traditional networks', F. Pieke and H. Mallee, (eds.), *Internal and International Migration: Chinese Perspectives*, Richmond, Surrey: Curzon Press, 1999, 215-250.
- Xiang, B. (2000) *Kuayue Bianjie de Shequ—Beijing 'Zhejiang Cun' de Shenghuo Shi* (A Village beyond Borders: The Life History of 'Zhejiang Village' in Beijing), Beijing, Sanlian Shudian (Three-joints Books).
- Xiao, X.W. (1999) '*Wailai liudong renkou ertong baojian xianzhuang diaochao*' (An investigation of the current situation of migrant children's health protection), *Zhongguo Fuyou Baojian* (Women and Children's Health Protection), 761-2.
- Xiao, Y. (2002) '*Yi nian sunshi 4.5 yi, 'zhiyebing' rang Beijing tong xia shashou*' (450 million lost a year, occupational diseases force Beijing to act), www.21dnn.com.cn, 11 April.
- Yang, L.S., *et al.* (1999) '*Jiangsu nongcun wailainv de hunyu guanli yu jiaoyu yanjiu*' (A research on the marriage and reproductive health of migrant women in Jiangsu), *Rekou Yanjiu* (Population Research), 23(4), 78-80.
- Yang, X.S. (2002) 'Migration, socioeconomic milieu, and HIV/AIDS: A theoretical framework', Unpublished paper.
- Yang, X.S. (2004) 'Temporary migration and the spread of STDs/HIV in China: Is there a link?', *International Migration Review*, 38(2).
- Yu, X.M. (2001) '*Kuayue jieji de bianjie*' (Transcending the class boundaries), Paper presented at the International Conference on the Mobility of Rural Labour Force, 3-5 July, Beijing.
- Zhan, S.K., *et al* (2001) '*Chengshi zhong nongcun liudong renkou de funv baojian*' (Health care of female migrants from rural area in cities), missing.
- Zhang, Z. (1999) '*Liudong renkou zhong yulin funv shengzhi jiankang de xianzhuang yu sikao*' (The current reproductive health situation of female migrants of reproductive age and some thoughts), *Renkou Xuekan* (Population Journal), 4, 55-59.
- Zou, Y.W. (2003) '*17 li yisi fanxiang mingong zhan 10 li, minggong dasheng fangzhi ren bu fangsong*' (Ten out of 17 suspected cases are returned migrants, major emigrant province vigilant), *Chutian Dushi Bao* (*Chutian Urban News*), 19 May.

Appendix

Province /City	Reported STD Cases	Reported Year(s)	Temporary Migrants (%)	Permanent Residents (%)
Guangdong/Shenzhen	1,570 ^a	1997-1998	1,084 (69.0)	486 (31.0)
Liaoning/Lianyungang	13,464 ^b	1989-1998	2,343 (17.4)	11,121 (82.6)
Jiangsu/Xinghua	6,119 ^b	1991-2000	457 (7.5)	5,662 (92.5)
Hainan	97 ^a	2001	32 (33.0)	65 (67.0)
Shanghai/Nanhui	672	2000-2001	143 (21.3)	529 (78.7)
Guangdong/Shenzhen	102,538 ^b	1983-2000	59,400 (57.9)	43,138 (42.1)
Liaoning	26,038	1998	3,787 (14.5)	22,251 (85.5)
Beijing/Shijingshan	3,492 ^b	1990-1999	1,189 (34.0)	2,303 (66.0)
Guangxi	2,040 ^c	1996-1997	394 (19.3)	1,646 (80.7)
Yunnan/Qujing	178 ^d	2001	62 (34.8)	116 (65.2)
Shanghai	79,980 ^{a b}	1994-1997	17,962 (22.5)	62,018 (77.5)

Notes: ^a Based on sentinel surveillance data.

^b Cumulative cases.

^c Syphilis only.

^d Based on samples.

Reproduced from Yang, 2004.

Appendix 1: Reported STDs by Migration Status in Selected Provinces, China

Province /City	Total HIV /AIDS Cases	Reported Year(s)	Temporary Migrants (%)	Permanent Residents (%)
Shanxi	174	1995-1999	116 (66.7)	58 (33.3)
Zhejiang	9 ^a	1999	9 (100.0)	0 (0)
Hunan/Zhuzhou	9 ^b	1998-2000	8 (88.9)	1 (11.1)
Shaanxi	58 ^b	1986-2000	24 (41.4)	34 (58.6)
Guangxi/Wuzhou	148 ^a	1998-2000	14 (9.5)	134 (90.5)
Guangdong	91 ^b	1997	53 (58.2)	38 (41.8)
Yunnan/Chuxiong	226 ^b	1991-2000	27 (11.9)	199 (88.1)
Liaoning/Shengyang	45	1991-9/2001	35 (77.8)	10 (22.2)
Yunan/Kunming	71 ^b	2000	14 (19.7)	57 (80.3)
Jiangsu	133 ^b	1986-6/2001	85 (63.9)	48 (36.1)
Liaoning	137 ^b	1991-7/2001	43 (31.4)	94 (68.6)
Hainan	12 ^b	1996-1998	6 (50.0)	6 (50.0)
Guangzhou	267 ^b	1985-1999	150 (56.2)	117 (43.8)
Henan/Jiaozuo	51 ^a	1994-2000	24 (47.1)	27 (52.9)
Fujian	188	1987-2000	80 (42.6)	108 (57.4)

Notes: ^a Based on samples.

^b Based on sentinel surveillance data.

Reproduced from Yang, 2004.

Appendix 2: HIV/AIDS Cases by Migration Status in Selected Provinces, China

Reasons	Percentage
No contraception knowledge	49.3
Worried about by-effects of contraception	20.4
Too shy to buy or take equipment	22.7
Do not know where to get the equipment	7.6
Lack of money	0
Total	100
Sample	211

Source: Wang, 1999: 54, Table 7

Appendix 3: Reasons Why Migrant Women Never Used Contraception Measures

Scores of knowledge	Percentage of respondents who have taken checks of different frequencies			
	0 time	1-3 times	4-8 times	9 plus times
0 ~	12.9	32.3	32.3	22.6
10 ~	0	25.4	46.0	28.6
15 ~	0	7.9	27.7	64.4
20 ~	0	0	5.9	94.1

Statistical test $H = 61.1$

$V = 3$ $P < 0.01$

Source: Zhan *et al.*, 2001: 193, Table 13

Appendix 4: Association between Migrants' Knowledge about Reproductive Health and Their Frequency of Taking Prenatal Exam (Survey Conducted in Minghang and Meilong Districts in Shanghai)

OTHER TITLES IN THIS SERIES:

Asian MetaCentre Research Paper Series No. 1

Age-Sex Pattern of Migrants and Movers: A Multilevel Analysis on an Indonesian Data Set

Aris Ananta, Evi Nurvidya Anwar and Riyana Miranti

Asian MetaCentre Research Paper Series No. 2

The Future Population of China: Prospects to 2045 by Place of Residence and by Level of Education

Cao Gui-Ying

Asian MetaCentre Research Paper Series No. 3

Singapore's Changing Age Structure and the Policy Implications for Financial Security, Employment, Living Arrangements and Health Care

Angelique Chan

Asian MetaCentre Research Paper Series No. 4

The Effect of Social Interaction on Desired Family Size and Contraceptive Use Among Women in Bangladesh

Lisa Marten

Asian MetaCentre Research Paper Series No. 5

Modeling Contraceptive Prevalence in Bangladesh: A Hierarchical Approach

E.M. Nazmul Kalam and H.T. Abdullah Khan

Asian MetaCentre Research Paper Series No. 6

Health Consequences of Population Changes in Asia: What Are the Issues?

(A summary paper from an Asian MetaCentre workshop held in Bangkok, Thailand, 13-14 June 2002)

Asian MetaCentre Research Paper Series No. 7

Age Structural Transition and Economic Growth: Evidences from South and Southeast Asia

Kannan Navaneetham

Asian MetaCentre Research Paper Series No. 8

Asians on the Move: Spouses, Dependents and Households

(Special collection of papers by Chotib, Siew-Ean Khoo, Salut Muhidin, Zhou Hao and S.K. Singh)

Asian MetaCentre Research Paper Series No. 9

The Relationship Between Formal and Familial Support of the Elderly in Singapore and Taiwan

Angelique Chan, Ann E. Biddlecom, Mary Beth Ofstedal and Albert I. Hermalin

Asian MetaCentre Research Paper Series No. 10

Organisations that Care: The Necessity for an Eldercare Leave Scheme for Caregivers of the Elderly in Singapore

Theresa W. Devasahayam

Asian MetaCentre Research Paper Series No. 11

The "Flight from Marriage" in South-East and East Asia

Gavin W. Jones

Asian MetaCentre Ressearch Paper Series No. 12

Fertility and the Family: An Overview of Pro-natalist Population Policies in Singapore

Theresa Wong and Brenda S.A. Yeoh

Asian MetaCentre Ressearch Paper Series No. 13

Strategies and Achievements in Expanding Lower Secondary Enrollments: Thailand and Indonesia

Gavin W. Jones

Asian MetaCentre Ressearch Paper Series No. 14

Infant Mortality in a Backward Region of North India: Does Ethnicity Matter?

Santosh Jatrana

Asian MetaCentre Ressearch Paper Series No. 15

**Factors Associated with Contraceptive Discontinuation in Bali, Indonesia:
A Multilevel Discrete-time Competing Risks Hazard Model**

Evi Nurvidya Arifin

Asian MetaCentre Ressearch Paper Series No. 16

Explaining Gender Disparity in Child Health in Haryana State of India

Santosh Jatrana